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Treating Women with Substance Use Disorders: The Women's Recovery Group Manual, by Shelly F. Greenfield.
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CHAPTER 1

Treating Women with Substance Use Disorders

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Substance use disorders (SUDs) are a growing health problem among women (Brady, Back, & Greenfield, 2009). However, compared with men, women are less likely to receive treatment for substance use disorders in the course of their lifetimes (Dawson, 1996; Mojtabai, 2005; Wu & Ringwalt, 2004). Specific barriers and obstacles to receiving care for women include stigma, lack of child care for those who are parenting, lack of support from partners and family, and insufficient financial resources, among others (Greenfield, Trucco, McHugh, Lincoln, & Gallop, 2007b; Greenfield, Brooks, Gordon, Green, Kropp, et al., 2007a). In addition, women often report a preference for women-only treatment, perceiving that such care provides a greater sense of comfort and safety for its members; however, lack of access to such treatment poses a barrier for many of them.

Women with SUDs differ from men in a number of characteristics, including the prevalence of co-occurring psychiatric disorders, medical problems, barriers to care, and reasons for relapse (Greenfield et al., 2007a). There is evidence that some of these issues may not be adequately addressed in mixed-gender substance abuse treatment groups (Kauffman, Dore, & Nelson-Zlupko, 1995; Nelson-Zlupko, Dore, Kauffman, & Kaltenbach, 1996). Since the mid-1990s, several group therapies for a number of subgroups of women with SUDs have been developed and empirically tested. For example, some group therapies have focused on treating women who are pregnant and parenting (Luthar & Suchman, 2000; Mackie-Ramos & Rice, 1988), or who have a specific co-occurring disorder (such as posttraumatic stress disorder) (Hien, Cohen, Miele, Litt, & Capstick, 2004; Najavits, Weiss, Shaw, & Muenz, 1998). However, in many clinical settings and practices, treatment-seeking women with SUDs are quite heterogeneous with respect to the type of substance they use, their age, their background (e.g., with or without a trauma history, children, partner), whether they have co-occurring psychiatric disorders (e.g., mood, anxiety, posttraumatic stress, eating disorders), and, if so, which disorders they may have.

In light of this, we recognized that there was no evidence-based recovery group therapy for treatment-seeking women who are heterogeneous with respect to their abuse or dependence on a range of substances (e.g., opioids, alcohol, cocaine), a variety of other psychiatric disorders (e.g., depression, anxiety, eating disorders), as well as different ages and stages of life (e.g., pregnant, parenting, widowed). We, therefore designed the Women's Recovery Group (WRG) to fill this gap.

How This Book Is Organized

The balance of this chapter provides background on SUDs in women, followed by an overview of the WRG and the current evidence for the WRG treatment. The chapter also includes quick reference tables, therapist examples, and discussion points in text boxes that provide concise summaries of the material presented as well as clinical illustrations relevant to running the WRG. Chapter 2 provides specific information on how to conduct the WRG treatment and includes therapist examples. Part II of this book provides a detailed therapist guide to conducting each of the 14 topic-oriented sessions as well as an individual pre-group meeting. Appendix A and Appendix B contain all the supporting materials for conducting the treatment, including a therapist self-assessment tool and materials to copy and post on a bulletin board during sessions, check-in and check-out sheets that are passed among participants, and session-specific participant educational sheets and skill practices for distribution. A section with references to research on the WRG as well as additional reading for each session topic is also provided in Appendix B.

Prevalence and Course of SUDs in Women

Gender differences in the rates of SUDs have been observed in both the general population and in treatment seekers, with a greater prevalence of SUDs in men than women (Lopez-Quintero et al., 2011). However, in the last two decades it has become clear that the gender gap in the prevalence of alcohol and drug use is narrowing (Centers for Disease Control and Prevention, 2013; Substance Abuse and Mental Health Services Administration, 2012). For alcohol use disorders, good evidence indicates that this is accounted for by the rising prevalence of these disorders among girls and women in recent birth cohorts, with rates in boys and men remaining fairly steady (Grucza, Bucholz, Rice, & Bierut, 2008). Until the 1980s, alcohol use disorders were thought to be five times as common among men as among women (Robins & Regier, 1991); however, by the 1990s, it had become clear that these rates had changed, with men being only 2 to 2.5 times as likely to have an alcohol problem as women in the course of their lifetime. Drug use disorders are approximately twice as likely in men as women, and in some instances, depending on the substance, these rates are even closer (Greenfield et al., 2007a).

In recent decades, girls have been initiating their use of alcohol, tobacco, and other drugs at approximately the same age as their male counterparts (Centers for Disease Control and Prevention, 2013; Greenfield et al., 2007a; McHugh, Wigderson, & Greenfield, 2014; Substance Abuse and Mental Health Services Administration, 2012). This is of clinical and public health concern because compared with men, women have increased vulnerability to the physical and

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medical adverse consequences of alcohol and other drugs. In particular, women can experience a so-called telescoping course of their addiction, which means shorter average intervals than men between first use and first problem use, between first problem use and dependence, and between dependence and treatment (Piazza, Vrbka, & Yeager, 1989; Randall et al., 1999). The telescoping course means that, even with fewer years at lower doses than men, women experience on average more medical, psychiatric, and social consequences of their addiction. A number of clinical studies demonstrate that with fewer years of use, women experience more psychological distress, mood and anxiety disorders, exposure to childhood and adult trauma and associated symptoms, greater mental health problems, and more family and employment problems (Grella, 2008; McKay, Lynch, Pettinati, & Shepard, 2003; Stewart, Gossop, Marsden, Kidd, & Treacy, 2003; Wechsberg, Craddock, & Hubbard, 1998). There is also evidence that women who use substances such as alcohol, nicotine, or stimulants may experience more rapid dependence on these substances (Hernandez-Avila, Rounsaville, & Kranzler, 2004; Sugarman, Brezing, & Greenfield, 2013).

Women with SUDs are more likely than men to have co-occurring psychiatric disorders, such as depression, anxiety disorders, and eating disorders (Cohen et al., 2010; Greenfield et al., 2007a). These mental health problems can complicate treatment of SUDs (Brown, 2000; Compton, Cottler, Jacobs, Ben-Abdallah, & Spitznagel, 2003; Greenfield et al., 1998; Kranzler & Tinsley, 2004; Sinha & Rounsaville, 2002). In addition, women with SUDs are more likely to have a history of childhood and adult trauma than men with SUDs (Hien, Cohen, & Campbell, 2005). Some studies have found that histories of trauma can be associated with poorer SUD treatment outcomes (Brown, 2000; Comfort, Sockloff, Loverro, & Kaltenbach, 2003; Green, Polen, Lynch, Dickinson, & Bennett, 2004; Greenfield et al., 2002; Sugarman, Kaufman, Trucco, Brown, & Greenfield, 2014). In spite of the increasing prevalence of alcohol and drug use disorders, the earlier ages of initiation of use, and the telescoping course of SUDs in women, women are less likely than men to seek or receive treatment for their addiction (Dawson, 1996; Greenfield et al., 2007a; Wu & Ringwalt, 2004). While women may seek treatment for other co-occurring psychiatric disorders, such as anxiety and depression in mental health settings, they may not discuss their co-occurring problems with alcohol or drugs and their alcohol and drug use may therefore remain undetected and untreated (Weisner, 1993; Weisner & Schmidt, 1992).

Outcomes of Treatment of SUDs in Women

Once in treatment, a convergence of evidence demonstrates that there are few gender differences in success rates of treatment for women and men (Greenfield et al., 2007a), but recovery trajectories may differ longitudinally. One study of long-term outcomes for older women and men with alcohol dependence demonstrated that women were twice as likely as men to be abstinent at the 7-year follow-up, and the strongest predictor of outcomes for both men and women was the length of the initial treatment episode (Satre, Blow, Chi, & Weisner, 2007). Another study demonstrated more self-help use among women with alcohol dependence at the 16-year follow-up and that self-help engagement had greater association with drinking reductions for women than for men (Timko, DeBenedetti, Moos, & Moos, 2006). A longitudinal study

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of outcome showed that at 36 months there were no gender differences in drug and alcohol use but that women reported more psychological distress while men had more criminal justice involvement (Grella, Scott, & Foss, 2005).

While a convergence of evidence shows that gender itself does not predict treatment outcomes, studies have demonstrated a number of gender-specific prognostic factors that affect treatment outcomes (Greenfield et al., 2007a). For example, a co-occurring diagnosis of depression, anxiety, or PTSD may adversely affect SUD treatment outcomes for men and for women (Brown, 2000; Cohen et al., 2010; Compton et al., 2003; Greenfield et al., 2007a; Greenfield et al., 1998; Kranzler & Tinsley, 2004; Sinha & Rounsaville, 2002). Because these disorders are more prevalent among women than men, they may disproportionately affect women's recovery. The same is true for histories of trauma and other characteristics. There is evidence that treatment that addresses these and other gender-specific factors in recovery can enhance SUD treatment outcomes for women (Greenfield et al., 2007a). For example, programs for pregnant and parenting women with substance use disorders that provide child care and prenatal care can have improved treatment outcomes for women (Ashley, Marsden, & Brady, 2003; Orwin, Francisco, & Bernichon, 2001). In addition, several longitudinal studies have demonstrated different pathways to recovery for women and men (Grella, 2008).

A Rationale for Women-Only Treatment Groups

Few randomized trials have compared all-women's treatment to mixed-gender treatment for SUDs. Several studies that have compared women's residential treatment programs with mixed-gender treatment programs have not found superior outcomes for women-only residential compared with mixed-gender treatment (Bride, 2001; Kaskutas, Zhang, French, & Witbrodt, 2005). However, a number of studies have found that programs that provide enhanced services for women that focus on women's specific needs have higher rates of treatment completion and improved outcomes (Claus et al., 2007; Orwin et al., 2001; Smith & Marsh, 2002), and a systematic review of multiple studies provides convergent evidence on enhanced treatment outcomes for women in women's programming tailored to women's specific treatment needs (Grella, 2008). Such gender-responsive treatment for women is strengths-based, stresses the importance of relationships, and is trauma-informed (Covington, 2003; Grella, 2008).

There are therefore several rationales for single-gender SUD treatment groups for women. These include patient preference; the opportunity to enhance comfort, support, and cohesion within treatment groups; and the opportunity to present women-focused content (Greenfield, Cummings, Kuper, Wigderson, & Koro-Ljungberg, 2013a). In several qualitative studies, women report decreased sex-role stereotyping and feeling safer in a single-gender substance abuse treatment group (Kauffman et al., 1995; Nelson-Zlupko et al., 1996). A preference for single-gender groups may exist for a wide range of reasons such as dissatisfaction with treatment or self-help groups that are mixed-gender or predominantly male; a positive experience with an all-women's recovery or self-help group in the past; and a history of trauma or abuse such that an all-women's treatment format feels safer and more comfortable. Patient preference in a variety of medical and psychiatric treatments is often a factor in satisfaction and provides one rationale for a single-gender format for treatment of SUDs. For example, in one study comparing single- versus mixed-gender programs, lesbian women, women with dependent children, and women

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with trauma histories were less likely to drop out of a single-gender than mixed-gender SUD treatment program (Copeland & Hall, 1992).

Women report feeling an enhanced sense of comfort and support in an all-women's treatment setting. They report feeling that there is a sense of easy communication within a group of women and that because of this shared understanding and communication, they can move more rapidly to discuss difficult issues that are often obstacles to recovery (Greenfield et al., 2013a). Some of these issues focus on sexuality, male or female partners, and histories of abuse, among others. Discussion of these difficult issues and the effect they have on addiction and recovery is often critical for many women, but may not be possible in a mixed-gender context. In one qualitative study of the WRG, women reported feeling nonjudgmental support on the part of other women in the group and a sense of validation of their own experience that is helpful in recovery from alcohol and drug addiction (Greenfield et al., 2013a).

Finally, a single-gender SUD group therapy format provides the context for women-focused content. For example, in the WRG, the topics provide information and education about the antecedents and consequences of alcohol and drug problems that are especially pertinent to women. Specific topics include the effects on recovery of women and caretaking; women and their partners; the effect of substance problems on women's health; substance problems through a woman's life cycle; substance use and women's reproductive health; mood, anxiety, and eating disorders and SUDs; and violence and abuse.

Studies of the effectiveness of gender-specific treatment for women with SUDs have increased in number since 2000, but nevertheless remain relatively few (Greenfield et al., 2007a). Studies of women's treatment programs (e.g., residential or day hospital programs) that may or may not be compared with mixed-gender treatment, have produced mixed results depending on the population studied, the outcomes evaluated, and the comparison groups chosen. Nevertheless, evidence is accumulating that treatment that focuses on women's specific needs and services can provide enhanced outcomes for women (Greenfield et al., 2007a; Greenfield & Grella, 2009; Grella, 2008). Ongoing research in this area holds promise in expanding our understanding about the characteristics of women who might benefit the most from women-focused treatment and how to maximize the effectiveness of these clinical services.

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Overview of the WRG

The WRG is a relapse prevention group therapy that utilizes a cognitive-behavioral approach for women who are heterogeneous with respect to their age, stage of life, specific substance used, and the presence or absence of co-occurring psychiatric disorders.

Goals of the Group

The major goals of the group are (1) to promote abstinence from all substances including alcohol; (2) to improve understanding of specific aspects of substance use disorders, recovery, and relapse that are relevant to women; and (3) to help participants develop skills and strategies that will be useful in preventing relapse and promoting recovery.

The WRG uses a 90-minute, structured relapse prevention group therapy session with a cognitive-behavioral focus that includes session topics based on gender-specific antecedents,

consequences, and treatment outcomes for SUDs. There are 14 specific session topics (see Table 1.1) that can be flexibly chosen in any order for a 12-week sequence of groups, or all 14 topics can be used for a 14-week sequence.

Each session is structured with a brief check-in, review of the previous week's skill practice, presentation of that day's session topic, an open discussion, the reading of the take-home messages, distribution of the skill practice sheet for the upcoming week, and a check-out.

The group makes use of visual aids (in the form of bulletin board materials) and session-specific educational sheets and skill practices for participants. Bulletin board materials stating the group theme "Recovery Means Taking Care of Yourself," the central recovery rule "Recovery = Relapse Prevention + Repair Work," and the symptoms of substance problems are posted weekly (see Table 1.2). Summary points and take-home messages from the day's topic change weekly and are also posted.

The group theme—"Recovery Means Taking Care of Yourself"—emphasizes self-care and the idea that recovery is both a major part of self-care and that self-care activities will also enhance recovery. Therapists should refer back to this group theme throughout the treatment by encouraging self-care activities and routines that enhance recovery. The central recovery rule—"Recovery = Relapse Prevention + Repair Work"—emphasizes that recovery must encompass both relapse prevention and repair work (see Table 1.3). Repair work includes repairing the damage to self and relationships due to substances and learning how to enjoy your life substance-free.

The WRG sessions that focus mainly on relapse prevention include Sessions 2, 3, 6, and 8 (see Table 1.3), which encourage identifying triggers to using and building alternative skills and coping to prevent substance use. Other sessions, such as Sessions 11, 13, and 14, focus on other domains of life including disclosure, achieving a balance, and having fun without using

TABLE 1.1. WRG Session Topics

- Session 1. The Effect of Drugs and Alcohol on Women's Health
- Session 2. How to Manage Triggers and High-Risk Situations
- Session 3. Overcoming Obstacles to Recovery
- Session 4. Managing Mood, Anxiety, and Eating Problems without Using Substances
- Session 5. Women and Their Partners: The Effect on Recovery
- Session 6. Coping with Stress
- Session 7. Women as Caretakers: Can You Take Care of Yourself While You Are Taking Care of Others?
- Session 8. Using Self-Help Groups to Help Yourself
- Session 9. Women's Use of Substances through the Life Cycle
- Session 10. Violence and Abuse: Getting Help
- Session 11. The Issue of Disclosure: To Tell or Not to Tell?
- Session 12. Substance Use and Women's Reproductive Health
- Session 13. Can You Have Fun without Using Drugs or Alcohol?
- Session 14. Achieving a Balance in Your Life

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TABLE 1.2. Central Recovery Rule and Group Theme

Central Recovery Rule: Recovery = Relapse Prevention + Repair Work
Group Theme: Recovery Means Taking Care of Yourself

substances. These are part of "repair work." Certain sessions have elements of both relapse prevention and repair work including those focused on partners, the caretaking role, and violence and abuse. Both relapse prevention and repair work are central to recovery.

The WRG also emphasizes the message that while differences might exist between individuals in the group, all participants are united in seeking treatment for their problems with substances.

Therapists can refer to the common symptoms of substance problems that are posted on the bulletin board weekly (see Table 1.4) in order to highlight a key point for participants: that while they may differ in the specific substance they use, symptoms of co-occurring disorders, and family and social circumstances, they share with one another at least some of the symptoms of substance problems posted on the board. They also share a desire to recover.

TABLE 1.3. The WRG Central Recovery Rule: Recovery = Relapse Prevention + Repair Work

Relapse prevention

- Identify triggers and high-risk situations.
- Plan to avoid high-risk situations and develop coping skills to deal with unavoidable situations.
- Create a "trigger-free" environment.
- Get treatment.

Repair work

- Repair damaged relationships and damage to self.
- Learn to enjoy life substance-free.

WRG sessions include both relapse prevention and repair work.

Sessions focusing on relapse prevention and/or repair work

Relapse prevention	*Repair work*
1. Effects of drugs on health	11. Issue of disclosure
2. Managing high-risk situations	13. Can you have fun?
3. Obstacles to seeking treatment	14. Achieving a balance
4. Managing mood, anxiety, eating disorders	
6. Using self-help to help yourself	
8. Coping with stress	

Elements of both

5. Women and their partners
7. Women as caretakers
9. Women's use of substances through the life cycle
10. Violence and abuse
12. Reproductive health

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Therapist Examples: Discussing the Central Recovery Rule

Example 1

THERAPIST: I think to just keep in mind that there is a timeline to recovery. The first part is relapse prevention and not using drugs and alcohol, and the second is the repair work you can do to work on the circumstances in your life and come to a better place with those things. And it takes time and it's so hard to work on the relapse prevention part, especially when life is feeling that bad to you.

Example 2

THERAPIST: This sort of brings home to me—we were talking about the repair work that happens after we sort of, you know, there is the relapse prevention and there is the repair work piece of it—that some of the repair work piece of it has to do with learning how to interact with families in a way that's helpful.

PARTICIPANT: Right.

THERAPIST: And it's also relapse prevention work, and it's kind of both together. So in some ways, working on relationships so they're not triggering, working on relationships so that they're helpful, and working on relationships so that they're good all around—I can see that all as being part of the relapse prevention, repair work continuum.

Table 1.4 lists symptoms that are common to individuals experiencing substance-related problems. Individuals with these symptoms may or may not qualify for a diagnosis of a substance related disorder. For example, the American Psychiatric Association's (2013, p. 483) *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5), specifies 11 symptoms that are common to SUDs. DSM-5 notes that SUDs can be further specified as mild, moderate, or severe based on the number of these symptoms that the patient experiences. Generally patients having two or fewer symptoms have a mild disorder, those with three to five symptoms qualify for moderate severity, and those with six or more are considered to have a severe disorder. For information related to assessment of SUDs and psychiatric disorders as well as standard criteria

TABLE 1.4. Common Symptoms of Substance Problems

- Increasing the amount of the substance(s) used over time.
- Trying unsuccessfully to cut down or stop using substances.
- Spending an increasing amount of time using substances, often leading to decreasing time spent in other activities related to work, school, relationships, or recreation.
- Having craving for the substance(s) when you are not using.
- Continuing to use substances even knowing they cause or worsen problems with work, family, school, relationships, or other activities.
- Using substances even when knowing they cause physical or mental health problems or when they may be physically dangerous to use.
- Developing tolerance to the substance over time (i.e., developing a need for more of the substance in order to achieve the desired or usual effect).
- Experiencing withdrawal symptoms when substance use stops or is reduced.

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TABLE 1.5. Four Levels of Participation

- Attendance every week
- Active listening
- Sharing and responding
- Doing the skill practices between sessions

for the diagnosis of substance-related disorders according to the World Health Organization's *International Classification of Diseases*, version 10 (ICD-10), or the American Psychiatric Association's DSM-5, the reader is referred to standard texts (Stevens & Dennis, pp. 107–116, and Woody & Cacciola, pp. 117–122, in Ruiz & Strain, 2011; World Health Organization, 1992; Greenfield & Hennessy, 2015; American Psychiatric Association, 2013).

The WRG encourages an environment of mutual support and social connectedness. Throughout the group women are encouraged to participate in four different ways (stressing that women assess their own comfort with each level of participation): attending the group, active listening, sharing and responding, and doing the skill practices between sessions. The WRG recognizes that not everyone will be able to participate at all four levels; however, everyone is encouraged to participate as much as she is able at all four levels as best outcomes may be achieved through full participation (see Table 1.5).

The WRG was designed to include two main components of group therapy that are posited to be key effective components of the treatment: (1) the all-women group composition and (2) women-focused topics to provide education about the antecedents and consequences of addiction in women, as well as women-focused recovery topics (see Table 1.6). The WRG was designed to include both components in order that the all-women group composition would enhance comfort and support for participants, facilitate group cohesion, and promote communication. The women-focused topics would provide education specific to the women participants.

The effect of patient–therapist gender matching in individual therapy has been the subject of studies and has produced mixed results (Fiorentine & Hillhouse, 1999; Sterling, Gottheil, Weinstein, & Serota, 1998, 2001). Because patient–therapist gender matching may affect treatment outcomes, in the studies comparing the WRG to mixed-gender group therapy, all therapists conducting either the WRG or mixed-gender group therapy were women. It is therefore not known what effect a male therapist would have on the outcomes of the WRG and we currently recommend that the group be led by a woman therapist.

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TABLE 1.6. Key Components of the WRG

All-women group composition
- Enhances group cohesiveness; sense of safety, comfort, and support.

Women-focused topics
- Provides education on gender-specific antecedents and consequences of SUDs for women.

The Distinction between the WRG and Other Group Approaches

The WRG is a cognitive-behaviorally oriented relapse prevention treatment that focuses on understanding internal and external triggers to substance use and works on developing strategies to manage these triggers, rather than using substances. The WRG focuses on thoughts, feelings, and environmental cues that may make the person more vulnerable to drug craving. It stresses identification of the individual's own triggers, learning skills that foster one's own recovery, discussion of ambivalence about the recovery process, and thinking through practical problems that might be obstacles to staying abstinent and in recovery. The WRG utilizes cognitive-behavioral methods such as a focus on an individual's cognitions and feelings that might trigger craving to use and helps develop alternative ways to manage these thoughts and feelings. The WRG also provides "skills practices" to be completed between sessions. However, the WRG differs from standard cognitive-behavioral therapy (CBT) groups in that it does not exclusively focus on identifying and changing cognitions and feelings that might be triggers to substance use, nor does it set the expectation that doing the "skills practice" between sessions is a required part of the group. Rather, the WRG uses this approach (e.g., identifying thoughts and feelings that may provide triggers to substance use), and provides skills practices as an element of the treatment, but other key elements of treatment are utilized as well. These other key elements of treatment include the mutual support of the other women participants and group cohesiveness that are achieved through both the single-gender group composition, the dedicated session time for open discussion of recovery-oriented concerns as a standard part of each group session, the supportive atmosphere established by the therapist (e.g., nonconfrontational and emphasizing commonalities rather than differences among participants), and education about antecedents and consequences of SUDs in women. These WRG-specific elements are not standard components of CBT groups.

The WRG is not a psychodynamically oriented group. While the WRG does have time in the session dedicated to open discussion of recovery concerns, it focuses on the present and the future but does not explore the past and the effect of early relationships on current problems. The WRG might explore an individual's past relapses insofar as this helps illuminate the patient's triggers and alternate ways that she might cope with those triggers.

The WRG is more directive than motivational interviewing or motivational enhancement insofar as the therapist and patient are clear that the goal of the WRG is abstinence from all drugs and alcohol. On the other hand, women in the WRG are heterogeneous with respect to substance used and treatment history. Like motivational interviewing or motivational enhancement, the WRG adopts a nonjudgmental, nonconfrontational stance and encourages participants to explore ambivalence as part of their risk for relapse. In addition, women report any use, slips, or lapses they might have had during the weekly check-in. Often these circumstances are explored during the open discussion. Women in the group may be abstinent from one substance (e.g., alcohol) but struggling with ambivalence regarding cessation of another drug (e.g., marijuana). They may also be engaged in a first treatment or may have recently relapsed after a period of sobriety.

The WRG encourages individuals to make use of self-help groups, but the WRG is not a 12-step group, nor is it a 12-step facilitation group. The WRG does not include the directive

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that all participants must use self-help or attend a self-help group in the course of the WRG treatment. Instead, Session 8, "Using Self-Help Groups to Help Yourself," discusses the pros and cons of many self-help groups and encourages participants to discuss their own experiences. It also explores issues pertaining to women utilizing self-help and examines women-only versus mixed-gender self-help groups.

Because the WRG is not a 12-step group, the therapist should not ask participants to identify themselves as "an alcoholic and/or an addict," to review specific steps from the 12-step model, or to say the Serenity Prayer. Similarly, because the WRG is not a psychodynamic group, the therapist will not focus on transference or interpersonal issues within the group and how they might relate to their own families of origin, or ask participants to explore early relationships and how they have bearing on the participant's current situation. Rather, in the WRG participants are asked to identify high-risk situations and internal and external triggers, and to assess what they have been able to do to facilitate their own abstinence or what actions have made them feel more vulnerable. They are asked to identify alternative strategies to managing triggers rather than using substances. In the course of the therapy, the WRG provides a variety of approaches and resources for women who are trying to prevent relapse and recover from their SUD. These approaches include learning to identify individual triggers and alternative strategies to cope and manage them; education about alcohol and drug's adverse consequences on women's health, as well as antecedents and consequences of alcohol and drug use disorders that are specific to women; skill practices designed to reinforce the session topics; education about self-help; open discussion of recovery related issues; and mutual support from other women participants in a nonconfrontational group that emphasizes self-care, preventing relapse, and focusing on repairing domains of life (e.g., family relationships, feelings of shame) that have been harmed through the process of addiction.

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What Is Different about the WRG?

There have been other substance use disorder recovery groups for women, and some have been manual-based. However, to our knowledge, the WRG is the first recovery group for women who are heterogeneous with respect to the type of substance used, age and stage of life, and presence or absence of co-occurring psychiatric disorders. The manual-based WRG has been tested empirically in Stage I and Stage II behavioral treatment development trials and tested in comparison with an effective, manual-based, mixed-gender group treatment for SUDs. While there have been other group treatments for women, these have generally focused on a specific group of women, such as women offenders, women with co-occurring trauma and SUDs, pregnant and parenting women, among other specific groups. Some of these group therapies have been studied for their efficacy and effectiveness in randomized trials and others have not; some are now supported by evidence but others are not. In many clinical practices and programs, clinicians need to treat a heterogeneous group of treatment-seeking women with SUDs, but prior to the WRG there were no manual-based, empirically supported, women-focused recovery groups that would fit this clinical need. The WRG is empirically supported and utilizes a cognitive-behavioral, relapse prevention approach with a structured group format, an all-women group composition, and women-focused group content. The investigators hypothesized that the all-women group composition and the women-focused group content synergize to produce improved outcomes for women participants.

Outcomes Research on the WRG

The WRG was initially developed and tested in a small randomized controlled Stage I behavioral development trial funded through the National Institute on Drug Abuse (NIDA). The goal of the WRG Stage I pilot study was to develop a manual-based, 12-session WRG and to pilot-test this new treatment in a randomized controlled trial against mixed-gender group drug counseling (GDC). GDC is an effective manual-based treatment for SUDs delivered in a mixed-gender format. GDC was chosen because it approximates standard group treatment delivered in community-based SUD treatment programs. The format of GDC is similar to the WRG in that it can be delivered as 12 weekly 90-minute sessions, each focusing on a specific topic. The goals of GDC are to facilitate abstinence, encourage mutual support, and teach new ways to cope with substance-related problems. GDC is delivered in a mixed-gender group composition and does not address gender-specific themes for men or for women (Greenfield et al., 2007b).

After the initial development of the WRG manual, two 12-session WRG groups were conducted in sequence with a total of 13 women participants in order to determine the group's feasibility, as well as patient and therapist satisfaction with the group treatment. Minor modifications to the manual were made in response to feedback from patients, therapists, and experts who reviewed the manual. Then, in the pilot stage, women were randomly assigned either to the WRG or mixed-gender GDC, with a total of 16 women assigned to the WRG and seven women and 10 men assigned to the control group, GDC. The groups were run in a semi-open format. Groups started with four participants, and participants were added until there were a total of eight in each group. Each participant continued in the group for the entire 12-week sequence until completion. Because randomization in this Stage I trial took place with a single GDC group in which half the participants were men, there were about half as many women assigned to GDC as to the WRG.

In this Stage I trial, participants were predominantly white and well educated, with more than 90% having some college or a graduate education. Forty-one percent of the women participants were married. Overall, there were no demographic differences between women assigned to the WRG and those assigned to GDC, except that the women assigned to the WRG were younger on average (mean age 45 years) than those assigned to GDC (mean age 58 years). Because of this statistically significant difference, all outcome analyses for the pilot study controlled for age differences between groups.

The study was open to women with any current substance dependence (in addition to any nicotine dependence). Eighty-six percent of the women enrolled in the study had current alcohol dependence as their primary substance dependence. In addition, approximately 7% had current cannabis dependence, 3% had current cocaine dependence, and 3% had other current stimulant dependence. Although alcohol dependence was the current substance dependence for the majority of the women, almost 70% of these women also had lifetime histories of other SUDs, including cannabis, cocaine, other stimulants, opioids, sedatives, and hallucinogens (Greenfield et al., 2007b).

In many respects, participants had rates of co-occurring psychiatric disorders that were similar to what would be expected in an outpatient population of women seeking treatment for SUDs. For example, more than one-third had a current mood disorder and 75% had a history of mood disorder in their lifetime. Thirty-one percent had a current anxiety disorder and 44%

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had a history of anxiety disorder in their lifetime. Approximately one-third of enrolled women met criteria for a personality disorder. It is important to note that women who met criteria for current, active PTSD, bipolar disorder, and psychotic disorders were excluded from the Stage I study. There were no significant differences in the prevalence of psychiatric disorders between women enrolled in the WRG and GDC groups.

Feasibility and assessment of patient satisfaction with the WRG were major goals of the Stage I trial. In the prepilot phase, 100% of participants enrolled completed the treatment and the follow-up assessments. In the pilot phase, 81% of women randomized completed treatment. Satisfaction with groups was assessed using the Client Satisfaction Questionnaire (Nguyen, Attkisson, & Stegner, 1983). While satisfaction with both the WRG and the GDC groups was high, women were significantly more satisfied with WRG than GDC. Subsequent research not included in the original paper demonstrated that greater satisfaction with the WRG group was attributable to a number of perceptions and experiences of the women participants. These included women's perception that there was enhanced comfort, support, and feelings of safety in the WRG group, as well as greater ease of communication among the women. Women appreciated the focus on educational topics related to women's recovery as well as the open discussion that allowed for immediate connection and support. Women participants stated that they shared the intimate details of their addiction and recovery in the all-women's format, which would not have been possible for them in a mixed-gender setting, and that this had been a key ingredient in their satisfaction with the group and their recovery (Greenfield et al., 2013a).

The Stage I pilot study also assessed outcomes at the end of treatment and 6 months posttreatment. The main outcomes assessed were the decrease in days per month of any substance use compared with use at baseline (i.e., 60-day period before entering the study) and for those who used alcohol, the decrease compared with baseline of the average number of drinking days per month, drinks per drinking day, and changes in the alcohol severity composite scores. The Time Line Follow Back (Sobell & Sobell, 1992) and the Addiction Severity Index (McLellan et al., 1992) were used to ascertain frequency and quantity of substances used, as well as severity. At the end of the 12-week group treatment, on average women in both the WRG and GDC reduced their days of any substance use and days of alcohol use; there were no significant differences in these substance use outcomes between the WRG and GDC. However, during the 6-month posttreatment follow-up, the WRG participants demonstrated a pattern of continued reductions in substance use while women in GDC did not. In addition, women in the WRG pilot with alcohol dependence had significantly greater reductions in average drinks per drinking day and improvement on the alcohol composite scale than women in the mixed-gender GDC group at 6 months following treatment completion.

The Stage I trial concluded that the newly developed 12-session, women-focused WRG was feasible with high satisfaction among participants. It was as effective as mixed-gender GDC in reducing substance use during the 12-week in-treatment phase *and* produced significantly greater reductions in drug and alcohol use in the 6 months following treatment than did mixed-gender GDC. In spite of the small size of the sample of women enrolled in the Stage I trial, these results were promising. The investigators therefore pursued several additional analyses of the initial data from the trial in order to ascertain if there were certain characteristics of women who might have had different outcomes depending on whether they were assigned to the WRG or GDC.

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For example, analysis of the Stage I data examined baseline self-efficacy and substance use outcomes among women assigned to the WRG and GDC. Self-efficacy is generally defined as the belief that an individual has the ability to cope effectively with a particular high-risk situation, and abstinence self-efficacy is known to play a role in SUD treatment outcomes (Trucco, Connery, Griffin, & Greenfield, 2007). Generally, high self-efficacy is associated with better treatment outcomes than low self-efficacy. Nonetheless, in the Stage I trial, women with low self-efficacy who were assigned to the WRG had the greatest decrease in days per month of substance use during the 12-week treatment and in the 6 months after treatment, while the women with low self-efficacy enrolled in the GDC increased their days of use both during the treatment and in the 6-month follow-up period. There were no significant differences in reduction of days of substance use between women with high self-efficacy who were assigned to the WRG or GDC during treatment or in the 6-month follow-up period. However, women with low self-efficacy assigned to the WRG exceeded women with high self-efficacy in either group in the magnitude of reductions in days of substance use each month (Cummings, Greenfield, & Gallop, 2010).

Changes in coping were assessed using a standard measure administered at baseline and at the end of the 12-week treatment during the Stage I trial. This analysis showed that there were no significant differences in coping-change scores between groups but that the relationship of certain types of coping changes with treatment outcomes varied by treatment group. For example, increases in problem-focused coping were associated with decreased drinking days in the WRG but with increased drinking days in GDC. For both groups wishful thinking was associated with increases in substance use, and increases in social support coping were associated with decreases in use in both groups (Kuper, Gallop, & Greenfield, 2010).

More than one-third of women in both the WRG and GDC groups had co-occurring depression and anxiety disorders. The 36 women enrolled in the Stage I trial were administered self-report and clinician-rated measures of anxiety (Beck Anxiety Inventory [BAI]; Beck, Brown, Epstein, & Steer, 1988); depression (Beck Depression Inventory [BDI]; Beck & Steer, 1987), and general psychiatric symptoms (Addiction Severity Index [ASI]; McLellan et al., 1992). An analysis of changes in these symptoms throughout the trial showed that women in both groups demonstrated significant improvement in depression, anxiety, and general psychiatric symptoms that were not related to changes in their substance use (McHugh & Greenfield, 2010). Symptom reductions were especially notable among women with greater psychiatric symptom severity at baseline.

In order to understand women's experiences in the WRG compared with the mixed-gender GDC, semistructured interviews with 28 women study participants were conducted and transcripts were analyzed for themes. Compared to GDC, women in the WRG more frequently endorsed feeling safe; embracing all aspects of one's self; having their needs met; and feeling intimacy, empathy, and honesty. In addition, women endorsed the theme that group cohesion and support allowed them to focus on gender-relevant topics supporting their recovery (Greenfield et al., 2013a).

Given the preferences women often articulate for the safety and comfort of single-gender group treatment (Greenfield et al., 2013a; Nelson-Zlupko et al., 1996), the underlying theory of the WRG is that the all-women group composition would be a key effective component in the treatment and would enhance supportive and empathic affiliation among group members compared with mixed-gender group treatment. In order to examine affiliative statements made in

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the WRG and GDC groups, 28 group therapy tapes were coded and compared for five types of affiliative statements. This study found that in the WRG, there were more frequent statements that were coded as "affiliative" compared with GDC. In the mixed-gender GDC, women were more likely to give than to receive an "affiliative" statement (Greenfield, Kuper, Cummings, Robbins, & Gallop, 2013b). This study demonstrated that an element of the enhanced support and safety that women endorsed in the WRG (Greenfield et al., 2013a) may be the greater frequency of supportive and affiliative statements exchanged by the group members in the single-gender WRG compared with the mixed-gender GDC.

Because of the small sample size and the relative homogeneity of the sample in the Stage I trial, the next phase of the study was to assess the effectiveness of the WRG relative to GDC in a Stage II randomized controlled trial using a larger group of women who were heterogeneous with respect to the substances they used, presence of co-occurring psychiatric disorders, trauma histories, and age and stage of life (e.g., pregnant, parenting, or neither; with or without a partner). The Stage I trial was implemented in a semi-open enrollment format. However, group therapy is most often implemented in clinical settings in an open (e.g., rolling) enrollment format in which participants can enter at any time in the group sequence and exit the group after 12 weeks are completed (Morgan-Lopez & Fals-Stewart, 2006; Washton, 2005) rather than starting and ending with a cohort of other participants. Therefore, a second aim of the Stage II trial was to demonstrate the feasibility of implementing the WRG in an open-enrollment group format at two outpatient clinical sites.

In the Stage II trial, participants were included if they were substance-dependent and had used substances within the past 60 days. Fifty-two women were randomized to the WRG and 48 to GDC. Substance use outcomes were assessed at months 1–6 and month 9. The Stage II trial was implemented at two clinical sites in an open enrollment format with groups continuously "rolling" for 24 months. Among women participants enrolled in the trial, current substance dependence diagnoses included 88% alcohol, 17% opioid, 15% cocaine, 9% cannabis, and 9% sedatives. Co-occurring psychiatric disorders among women participants included major depressive disorder (61%), anxiety disorders (22%), and posttraumatic stress disorder (20%). Seventy-five percent of the women had an Axis I disorder and 17% had an Axis II disorder (according to DSM-IV-TR criteria; American Psychiatric Association, 2000), with avoidant personality disorder accounting for the majority of the Axis II disorders (76.5%). The mean age of women participants was 47 years, with a range of 23–79 years; 95% were white; 32% were married, 35% divorced or separated, and 25% were never married (Greenfield et al., 2014b).

The Stage II trial found that women in both the WRG and GDC had reductions in mean number of substance use days during treatment (12.7- vs. 13.7-day reductions for the WRG and GDC, respectively) and 6 months posttreatment (10.3- vs. 12.7-day reductions), but there were no significant differences between groups. Overall, women in both the WRG and GDC groups had significant ($p < .0001$) reductions from baseline in mean number of alcohol use days during treatment (9.9- and 12.4-day reductions for the WRG and GDC, respectively) and at 6 months posttreatment (8.3- and 12.2-day reductions). Similarly, women in both the WRG and GDC groups had significant ($p < .05$) reductions in mean number of drug use days during treatment (3.0- and 1.5-day reductions for WRG and GDC, respectively); however, at 6 months posttreatment, the reductions were significant for the WRG (2.8-day reduction; $p < .05$) but not for GDC (1.6-day reduction; $p > 0.1$). In addition, women in both the WRG and GDC groups had significant ($p < .0001$) reductions in mean number of heavy drinking days during treatment

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(8.6- and 12.1-day reductions for the WRG and GDC, respectively) and at 6 months posttreatment (8.0- and 11.8-day reductions).

In the Stage II trial, the WRG demonstrated comparable effectiveness to standard mixed-gender treatment (i.e., GDC) and was feasibly delivered in an open-group format typical of community treatment. The investigators concluded that the study demonstrated that the WRG is an effective manual-based group therapy with women-focused content that can be implemented in an open-enrollment format in a variety of clinical settings for women who are heterogeneous with respect to their substance of abuse, co-occurring psychiatric disorders, and life stage (Greenfield et al., 2014b).

In summary, the WRG was developed and tested in a small pilot study in the context of a Stage I trial. In this study, on average, reductions in days of substance use and drinking days per month for women in the WRG were equivalent to reductions for women in a standard mixed-gender GDC group during the 12-week treatment trial. However, on average, women assigned to the WRG continued to improve and decrease their alcohol and other substance use in the 6 months following treatment, while those assigned to GDC continued at the same level or increased their substance use during that same time period. Importantly, the WRG was feasible to conduct in a semi-open format and received ratings of high satisfaction from its participants. From the additional analyses of the Stage I trial data it appears that the effect of changes of coping on treatment outcome varied with the group treatment and those with improved problem-focused coping assigned to the WRG had improved treatment outcomes. In addition, the evidence from the pilot study showed that women with low self-efficacy were best served by the women-focused WRG. Symptoms of anxiety and depression decreased in the course of treatment, especially among those with greater symptom severity at baseline. Women in the WRG had high satisfaction with the group treatment and endorsed feeling safe and having their needs met. There is evidence that the WRG group process has a greater frequency of affiliative statements between group members providing support and empathy. These findings suggest that women who have low self-efficacy and may be considered especially vulnerable because of these characteristics may do especially well in the WRG. When the WRG was administered in the semi-open enrollment groups in the Stage I trial, the 6-month posttreatment outcomes were better than GDC. The groups in the Stage I trial had a more stable group membership due to the semi-open enrollment compared with the larger Stage II trial that was implemented in two sites in an open-enrollment format characteristic of clinical settings in the community. In this Stage II trial, women participants were heterogeneous with respect to their substance disorder, trauma histories, presence of co-occurring psychiatric disorders, and life stage, and had within-treatment reductions in days of substance use that were sustained at 6-months posttreatment and were comparable to mixed-gender GDC (Greenfield et al., 2014b). Taken together, the findings of the Stage I and Stage II trials demonstrate that the WRG is an effective group treatment for women with substance use disorders who are heterogeneous with respect to the substance used as well as co-occurring psychiatric disorders that can be implemented in an open-enrollment format typical of community treatment settings. The next chapter will provide detailed information on how to conduct the WRG.

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