Providing Gender Specific Treatment: Strategies for Implementing Effective Approaches

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What is Sexuality? Sex?

**Sex** – In this context describes anatomy, for our purposes specifically – genital and reproductive anatomy. If you have a penis, a scrotum, testicles and a prostate, your sex is generally referred to as male. If you have a vagina, labia, clitoris, a uterus and ovaries, your sex is generally referred to as female.
What is Gender?

Gender is defined as the behavioral, cultural and psychological traits typically associated with one’s sex. It is a term that really describes a set of social expectations about how one behaves in relation to what sex one is perceived to be.
For every girl who is tired of acting weak when she is strong, there is a boy tired of appearing strong when he feels vulnerable. For every boy who is burdened with the constant expectation of knowing everything, there is a girl tired of people not trusting her intelligence. For every girl who is tired of being called over-sensitive, there is a boy who fears to be gentle, to weep. For every boy for whom competition is the only way to prove his masculinity, there is a girl who is called unfeminine when she competes. For every girl who throws out her E-Z-Bake oven, there is a boy who wishes to find one. For every boy struggling not to let advertising dictate his desires, there is a girl facing the ad industry's attacks on her self-esteem. For every girl who takes a step toward her liberation, there is a boy who finds the way to freedom a little easier.
What is Gender Role?

Gender role or sex role is highly culturally and socially derived; it comes from the group, culture or society one lives in. What is defined as being associated with a gender is determined by your group on a given period of time. For example, in white middle class America in 1940, for a woman to wear trousers was considered out of her gender role. Today it is normative. So, gender role can change depending on the times, the culture and who is in power.
Sexual Beingness

- Sensuality
- Intimacy
- Sexual Identity
- Gender Identity
- Gender Role
- Sexual Orientation
Activity: Gender Messages

- Talk about the street you grew up on.
- What did you learn about gender roles growing up from your parents? Peers?
- Describe what you learned about boys roles?
- Describe what you learned about girls roles?
- What happened to boys who did not fit the stereotypical/masculine role?
- What happened to girls who were not perceived as feminine?
Treatment Retention

- The quantity or amount of treatment received by a client

- The many factors that influence clients to enter treatment are often the same ones that keep them in treatment

- Today, retention is more likely defined using the term “length of stay,” and is measured by months or a timeframe rather than by the number of sessions (Comfort and Kaltenbach 2000; Greenfield et al. 2007)
Factors That Influence Retention Among Women: Sociodemographics

- Relationships – influence tx completion
- Age – over 21, older at first incarceration
- Education – HS completion
- Women of color – economic resources
Women’s treatment issues and needs

- Relationships and the need for connection
- Influence of family
- Partner relationships
- Sexuality
- Pregnancy
- Parenting
- History of trauma
- Abuse
Criminal justice and child protective services referral and involvement

- It appears that either referral or involvement with the criminal justice system or child protective services is associated with longer lengths of treatment (Brady and Ashley, 2005; Chen et al. 2002).

- Women who were mandated by the criminal justice system to enter treatment and who also had custody of their children were more likely to stay in treatment longer.

- In general, retention was higher among women who had been mandated to treatment (Amaro et al. 2007).
Pregnancy

- Pregnancy status can significantly influence treatment engagement and retention.

- Pregnant women were more likely to spend less time in treatment and pregnancy interrupted treatment. Yet, the length of stay may be more related to the stage of pregnancy (Grella, 1999).

- In another retention study among women, women who entered treatment late in their pregnancies had good retention whereas women who entered treatment in their first trimester tended to leave treatment early (Chen et al. 2004).
Treatment environment and theoretical approach

- **Supportive therapy**: Review of the literature indicates that positive treatment outcomes for women are associated with variables related to the characteristics of the therapist (e.g., warmth, empathy, the ability to stay connected during treatment crises, and the ability to manage countertransference during therapy; Beutler et al. 1994; Cramer 2002; Crits-Christoph et al. 1991).

- Women need a treatment environment that is supportive, safe, and nurturing (Cohen 2000; Grosenick and Hatmaker 2000; Finkelstein et al. 1997);

- The therapeutic relationship should be one of mutual respect, empathy, and compassion (Covington 2002b).
Treatment environment and theoretical approach

- **Collaborative approach**: effective therapeutic styles are best characterized as active, constructive, collaboratively and productively challenging, supportive, and optimistic (Covington and Surrey 1997; Finkelstein 1993, 1996; Miller and Rollnick 1991).

- Effective therapeutic styles focus on treatment goals that are important to the client. This may mean addressing issues of food, housing, or transportation first. Having her primary needs met builds a woman's trust and allows her to address her substance use.

- A collaborative, supportive approach builds on the client’s strengths, encourages her to use her strengths, and increases her confidence in her ability to identify and resolve problems.
Type of treatment services

- **Same sex versus mixed gender groups:** women perceive same-sex or female-only groups as more beneficial than mix-gender groups because they provide the women more freedom to talk about difficult topics such as abuse and relationship issues.

- **Service delivery:** Women who have access to various services in one location appear to have higher retention rates.

- **Onsite child care and child services:** women whose children stayed with them had a longer length of stay (retention).
To date, there is a lack of investigation on how sexuality issues impact the recovery process for women in SA tx

- Addicted women with sexual abuse history and sexual abuse as predictor variables are correlated

- Prevalence – 35–90% (Grice et al. 1995; James, 2007; NIDA, 1994; Rohsenow et al. 1988; Triffleman et al. 1995)

- 10 yr. project (National Study of Health and Life Experiences of Women), identified sexuality variables among strongest drinking predictors (Wilsnack et al. 1997)
Problem Statement:

- Substance abusing women have low sexual self-esteem and increased risk for health disparities.

- Links to sexuality issues and subsequent substance abuse in women include:
  - Trauma (including sexual and physical abuse)
  - Sexual dysfunction
  - Reproductive issues
  - HIV/STIs
  - Sexual orientation
  - Body image
  - Intimacy and relationships

- If individuals have acquired negative sexual self-esteem, this may contribute to their substance abuse, addiction and relapse if not addressed in treatment (James, 2011).
Sexual Beingness

- Sensuality
  - Body Image
  - Human Sexual Response Cycle
  - Skin Hunger
  - Fantasy

- Intimacy
  - Caring
  - Sharing
  - Loving/Liking
  - Risk Taking
  - Vulnerability

- Sexual Identity
  - Gender Identity
  - Gender Role
  - Sexual Orientation

- Sexualization
  - Rape
  - Incest
  - Sexual Harassment
  - Withholding Sex
  - Seduction

- Sexual Health & Reproduction
  - Factual Information
  - Feelings & Attitudes
  - Intercourse
  - Anatomy
  - Reproductive Bias

(Advocatesforyouth.org)
I would say more for me, it wasn’t so much like, I mean it was intimacy, it was more my self-esteem. I didn’t have any self-esteem whatsoever till about six months ago maybe, maybe even a little bit less than that. So my way of getting people to like me was to buy their affection, or buy their love, buy their friendship. And I would push myself on people to try to get them to like me, because I never felt apart, I never felt like I fit in. So that’s probably where my biggest circle would be is that I had absolutely no self-esteem. I was capable of loving other people, but I wasn’t capable of loving myself. So I needed that outer attention in order to feel somewhat full, and I wasn’t still getting it, so I turned to drugs.
I think a big part of why I used was due to body image, um. I’ve never been comfortable with my own image of what I’ve had of myself and that’s a lot of what played a part of my family and the guys that I dated. Constantly, the men in my life told me that you need to lose weight, you need to dress like this, you need to act like that, so that really lowered my self-esteem and I already had a low self-esteem as it was. So I used the drugs as a way to cope with those emotional pains that I had, but also to reach my goal of the body weight, that was a big reason for a lot of my relapses because I’ve gained the weight back and that I was told those things again. So I would use because it would instantly make me lose [the weight]

And with regard to vulnerability, I had that and skin hunger, you know, just wanting to be touched and I had problems with that and that’s what I wanted, I wanted someone to like me, I wanted someone to like me, love me and I would pick people that were wrong for me. Big time and I think that it was because of low self-esteem, let me take this person because no one else is going to want me so let me take the first thing that comes along
Sexualization

• I was raped when I was 16 and that caused a lot of depression in me so I drank to escape the pain and loneliness, I thought that when I drank and became more socially active, I wasn’t as shy, became involved in different things. My drinking caused me to engage in some risky behaviors, which I’m not proud of having unprotected sex and waking up next to strangers, which really scared me.

• I was molested by my uncle raped twice and I’ve been in and out of jail. Um, this is my third time in rehab within the last year. I guess from me being molested is why I started drinking to try and escape from the pain that I was feeling...
Sexual Identity

- I had an uncle, who is gay and my parents were...like “that’s disgusting and immoral and it’s a choice and I don’t know why anyone would choose that” so growing up, what I started realizing was that I was attracted to girls and I was kind of uncomfortable with that and it’s still hard for me cuz in the last 6 months, my own spirituality has really been growing and I identify myself as a Christian now, but I still have a hard time, I don’t believe that that, that its ok that I’m bisexual.

- I circled rape, skin hunger, risk taking, vulnerability and sexual orientation. The ones that impacted my use the most, I would say the rape, since I was raped so young. And sexual orientation, I am bi-sexual and when I was younger, I felt real uncomfortable with it and felt like I had to hide that. So, to be more comfortable with myself, drugs made me more comfortable with myself.

- When I was younger, like I started watching pornos before I started having sex, so I noticed that I would watch the pornos to watch the girls and not the guys, and I always felt ashamed of that, wanting to have sex with girls. Until one day I was just drunk and just had sex with a girl and a guy and I liked it. So if I knew I was gonna have a threesome with a girl and a guy, I’d just get drunk and high and go have fun and fill out my fantasies. That made me really comfortable.
Sexual Health and Reproduction

- I put feelings and attitudes and the physiology and anatomy of reproductive organs because I had a miscarriage with like one of my boyfriends and I wasn’t using at the time. And so after that, we tried to get pregnant for a whole year after that and I was like ok, maybe I can’t have kids. And then things didn’t work out with him, I got another boyfriend, and we was together for two years and we tried getting pregnant and I had another miscarriage, and so after that I just grew really depressed, I was like ok I’m never gonna have kids, I really went into a depression after my miscarriages, and started using a lot more, it really affected me as a woman because I felt like I couldn’t have kids.
Therapeutic alliance & Counselor characteristics

- Staff gender
- Implications for male counselors
- Client’s confidence in the process
- Theoretical approaches for women
Girls Matter!
A webinar series addressing adolescent girls’ behavioral health
Digital Girls: Confession, Connection, and Disconnection

Remember when teen girls put private thoughts in their diaries or on notes, showing them to only their closest friends? Today, girls communicate dreams, thoughts, and impulses with texting, posting videos, blogging, chatting, and sharing, photos, photos, and more photos. Social media is part of the worldview and way of life of adolescent girls. It offers information, opportunity for connection, and support in both unhealthy and healthy behaviors. After completing this webinar, participants will have an understanding of how the digital world influences girls’ identities, relationships, mental health, and wellness; what providers and supporters should know about the digital world of girls; and how professionals can use technology to reach, engage with, and support girls in achieving recovery and resiliency.

Participants will be able to summarize:

- What it means to be a “digital native” and how this affects girls’ worldviews
- How social media is changing the ways girls connect and relate
- Risky and unhealthy technological behaviors
- Technological advances in behavioral health and recovery supports

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Masculine Ideologies

- The stereotypical roles that define men within a culture are referred to as masculinity ideologies (Good et al. 1994).
- Ideologies are systems of values, beliefs, or ideas shared by a social group and often presumed to be natural or innately true.
- Masculinity ideologies, then, are a body of socially constructed ideas and beliefs about what it means to be a man and against which men are measured by their societies (Addis and Mahalik 2003; Good and Sherrod 2001).
Impact of male role socialization

- Masculinity ideologies also affect how men think and feel about themselves, and they influence male roles in a society (Pleck 1981, 1995).
- Men internalize these concepts from an early age.
- Through a process of “masculine role socialization,” boys learn how they are expected to act, feel, and think, and they often face negative consequences if they fail to meet those expectations (Addis and Mahalik 2003; Eisler 1995; Good and Sherrod 2001).
Characteristics of male socialization

- Emotional restraint
- Competition and success
- Aggressiveness, fearlessness and invulnerability
- Sexual accomplishment
- Independence and self-sufficiency
Male substance use

- Men may use or start to abuse substances for different reasons than women, and male institutions (e.g., fraternities, amateur sports teams) often encourage alcohol use (Brooks 2001).

- Men who cannot talk about their feelings or manage them constructively sometimes use substances to deal with difficult emotions.

- Shame, especially, can limit help-seeking behaviors for substance use and mental disorders (Brooks 2001; Pollack 1998b).
Helping Men Get Comfortable With Seeking Professional Assistance

- Establish rapport and trust with the client from the start.

- Male clients may feel threatened by or uncomfortable with the help-seeking process, so consider spending some time initially talking with the client about neutral topics (e.g., his work or hobbies) before beginning screening and assessment.

- Understand, as much as possible, what set of circumstances prompted the help-seeking behavior. “Why are you here now?” and “For help with what problem?” are useful questions to ask when beginning the screening and assessment process.

- Creatively engage a male client in discussions of his life and situation.
Helping Men Get Comfortable With Seeking Professional Assistance

- Consider acknowledging common fears related to relationships, health, abandonment, career, and financial issues.
- Conceptualize the engagement process as a series of steps in which the client moves from screening to assessment to treatment planning to active treatment to follow-up care.
- Men are typically socialized to be goal-directed and action-oriented: Try ending each screening or assessment session with a clear plan for what will happen next.
- Something concrete (e.g., a letter documenting attendance, a telephone call to arrange a session with a significant other) may facilitate compliance with the next step.
- It can be helpful to give men something to do to prepare for the next step, which can support their sense of confidence, control, and usefulness.
Treatment Engagement Considerations With Men

- Emphasizing options and the importance of free choice, even when choices are limited, generally supports men’s need for a sense of independence and autonomy.

- Confrontation about behavior and right/wrong issues almost always increases resistance. Avoid arguments and use a more subtle, less confrontational manner.

- Reframe coming to treatment as a success and a sign of strength and courage.
Treatment Engagement Considerations With Men

- Some men are uncomfortable expressing some or all emotions or have difficulty recognizing and labeling their emotions early in treatment. When discussing emotions, monitor intensity, and don’t push clients to experience emotions that may overwhelm them. In some settings, talking while walking can decrease the intensity of direct eye contact and allow clients to dissipate excess energy.

- Some men find it easier to explore and discuss their problems using visual references, such as timelines, node-link maps, and genograms.
Difficulty Expressing Emotion: Characteristics

- Difficulty coping with situations in which emotions that the client has disavowed are pervasive (e.g., sadness at a funeral; tenderness at seeing a grandchild for the first time).

- Being dismissive of certain emotions (“anger is worthless”) or people who express emotions (“scared people are chumps”).

- Channeling a difficult emotion into another emotion (e.g., expressing fear as anger).
Difficulty Expressing Emotion: Characteristics

- Fearing that emotional expression will result in losing control (“if I start crying, I won’t be able to stop”) or being overwhelmed (“if I feel my shame, I’ll sink into nothingness; I won’t exist anymore”).

- Projecting emotions onto others (e.g., assigning an emotion that is disavowed in oneself to others).

- Being very uncomfortable when someone expresses an emotion that is difficult to experience (e.g., being uncomfortable in the presence of someone expressing anger).
Addressing Male Clients Who Have Deficits in Emotional Expression

- Clients who emphasize rationality over emotionality often respond to psychoeducational efforts, which can reduce problems related to feeling and expressing emotions for men (Levant et al. 2009).

- Work with these men during group and in individual sessions to apply feeling words to their internal/physical experience.

- Help the client identify emotions that are more comfortable for him (e.g., being scared) and support his efforts to manage the emotions that are more readily available first.
Addressing Male Clients Who Have Deficits in Emotional Expression

- Intervene and support him if other clients in the group shame or strongly confront his inability to express certain emotions.

- Help the client set goals for his group participation, particularly in terms of learning about emotions and how to express them to others.

- Work with him to develop self-grounding techniques for use when he becomes anxious in the presence of others who are expressing powerful emotions.

- Provide homework assignments to help him express his emotions within a highly structured context (e.g., through expressive writing assignments, which have been found to decrease emotional distress for men with restrictive emotionality (Wong et al. 2006)).
Other Male-Oriented Issues

- Anger Management
- Learning to Nurture and Avoid Violence
- Learning to Cope with Rejection and Loss
- Family Issues and Parenting
Sexual Issues

- Substance use and sexuality
- Male reproductive system
- Sexual identity
- Sexual performance and sexual dysfunction
- Sex and the internet
- Sex trade
- Sexual abuse, rape and CSA
Excessive Shame

- Help the client positively bond with other group members and aid him in finding commonalities with them rather than seeing himself as different.

- Additional individual counseling is less likely to provoke shame and may be efficacious.

- In individual sessions, psychoeducation about shame and its effects can be helpful.

- Involve the client in a 12-Step program where he’ll feel safer identifying with others.

- Gently intervene when the client becomes sarcastic with other group members, taking care to confront him in a nonshaming way.
Resources

- **Substance Abuse Treatment: Addressing the Specific Needs of Women.** Treatment Improvement Protocol (TIP) Series, No. 51. Center for Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2009. [Link](http://www.ncbi.nlm.nih.gov/books/NBK83257/)

- **Addressing the Specific Behavioral Needs of Men.** Treatment Improvement Protocol (TIP) Series, No. 56. Center for Substance Abuse Treatment (US). Rockville, MD: Substance Abuse and Mental Health Services Administration (US); 2013. [Link](http://www.ncbi.nlm.nih.gov/books/NBK144290/#top)


References


