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**The Treatment of Addicted Women:
Modern Perspectives from the Betty Ford Center, Caron Treatment
Centers and Hazelden**

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The history of specialized addiction treatment for women in the United States has a long history dating to such nineteenth century institutions as the Martha Washington Home in Chicago (1869), the Temple Home in Binghamton, N.Y (1876), and the New England Home for Intemperate Women in Boston (1879) (White, 1996). Previous articles in this column have chronicled the history of addiction among American women (White & Kilbourne, 2006), summarized the early history of gender-specific treatment (White, 2002), and honored some of the pioneers in gender-specific treatment (White, 2004). This article profiles the treatment of addicted women at three prominent private institutions: Betty Ford Center, Caron Treatment Centers, and Hazelden. The article closes with a discussion of what these institutions have learned about the treatment of addicted women.

Hazelden

A synergy between three alcoholism treatment programs—Pioneer House, Hazelden and Willmar State Hospital—created a new approach to treatment in the mid-twentieth century that became known as the “Minnesota Model.” Hazelden opened its doors for the treatment of “curable alcoholics of the professional class” in 1948. When the need for special services for women became apparent in 1956, the Hazelden board, under the leadership of Patrick Butler, responded to this need by opening Dia Linn, a special facility for women located near White Bear Lake, Minnesota. This action occurred at a time few if any treatment programs for addicted women existed in America. Hazelden’s Dia Linn expanded its capacity at the

White Bear Lake facility in 1962 and then moved to the main Hazelden Campus in Center City, Minnesota in 1966.

Dia Linn offered a significant resource for alcoholic women in the 1950s and 1960s as addiction among women was highly stigmatized in these years, and there were few treatment options other than the wards of state psychiatric hospitals. Several people contributed to the design of Hazelden's early services for women, including Dorothy Borden, Phoebe Brown, Hazel Taylor, and Jane Mill. The program itself was a simple one, with daily life filled with housekeeping chores, lectures, conversations, and AA meetings (McElrath, 1987). Such simplicity obscured the fact that women were on a separate campus because of fears of what effects their presence would have on the men treated at the main campus. During that time, being a woman and alcoholic was associated with being a "loose woman". There was considerable fear of bringing the women to what was originally an all male campus. Fortunately, these fears were totally unfounded in practice.

During the 1960s, Dia Linn revamped its program under the guidance of clinical psychologist John Harkness. Each woman was assigned a primary counselor, group therapy, a more formal lecture schedule was added to the daily schedule, 24 hour nursing coverage was added, and clergy and social workers. This evolved into the multidisciplinary team that became a core part of the "Minnesota Model" and then spread to many treatment centers. Friday aftercare sessions were also added for alumni, and a formal family program was developed (McElrath, 1987). In the 1970s, Hazelden launched Women for Women, a volunteer program that identified and referred women to treatment, developed specialized aftercare groups for women, and designated 16 halfway house beds at Fellowship Club for women. This was followed in the 1980s with the development of a specialized 14-week women's outpatient program in Minneapolis as well as specialty programs offered for women at Hazelden's Renewal Center, a retreat environment for people in recovery.

During the 80s, Hazelden started offering specific mental health services for women in chemical dependency treatment, including services related to trauma and eating disorders. While the primary focus was on chemical dependency, Hazelden became aware that these and other issues could be major blocks in recovery and needed to be addressed. Throughout the 80s and 90s, integration of the multidisciplinary team around women's mental health needs assisted more women into recovery.

Hazelden's specialized services to women continued to grow with the opening of the Women and Children Recovery Community in New Brighton, Minnesota in 1997. This marked Hazelden's movement into the

development of sober housing for newly recovering women and their children (McElrath, 1999). Hazelden's commitment to women's services culminated in 2006 with the opening of the Women's Recovery Center. The center is located on the main Hazelden campus and consists of two 22-bed primary treatment units. Since the first woman was admitted to Dia Linn in July 1956, Hazelden has helped more than 40,000 women through their various programs and service sites.

Today, women treated at Hazelden are afforded many gender-specific services, including a daily women-only topical lecture series, special education on trauma and eating disorders and parenting in recovery, creative services time for mother and children to do a project together during visiting hours, and specialized women's health services—all grounded within Hazelden's historical emphasis on the Twelve Step philosophy. Also available to these women are the more than 50 products developed exclusively for women in recovery by Hazelden Publishing and Education.

The Caron Treatment Centers

In 1957, Richard and Catherine Caron created a vision of helping alcoholics find sobriety by creating an alcoholism treatment center in Pennsylvania. The vision came to reality in the founding of Chit Chat Farms, which evolved into the Caron Foundation and today Caron Treatment Centers, one of the most prominent addiction treatment organizations in the country. This year, Caron celebrates 50 years of providing comprehensive addiction treatments.

In the early days, before treatment services were formally developed, the Carons opened their home in Wyomissing Hills, Pennsylvania, to men and women seeking recovery from alcoholism. As this dream developed, the Carons had to find additional facilities to house the men and women who continued to show up at their doorstep. A home was purchased in Reading, PA which served as a half-way house for men while, women continued to stay at the Caron home until 1961. Many of these women were from the State Correctional Institution for Women at Muncie, Pennsylvania, and were on parole doing a work-release program. In that year, Chit Chat Farms joined a small number of organizations in the country offering inpatient addiction treatment for women. On April 1, 1961, Chit Chat admitted its first female patient, and by the close of 1961, 13 of Chit Chat's 192 residents were women (Holton, 1997).

Early treatment of women at Chit Chat included individual and group counseling sessions, meetings with a physician and psychiatrist as needed,

mandatory AA meetings in Reading, Pennsylvania, on Monday and Saturday nights, and occupational therapy for each woman. The latter earned each woman \$1 per hour, which was deducted from her bill. In 1968, the first new facility built specifically for women was opened, and the number of women treated at Caron continued to expand throughout the 1970s and into today. Formal 12-step work was integrated into the treatment programs, but there were no gender specific groups and little family work during these early years.

An important person who had a profound effect on Caron's services to women was Miss Rosie Kearney, a self-described "bag lady" living on the streets of Brooklyn, who found sobriety at Chit Chat Farms and dedicated her life to helping other women achieve recovery. Rosie used to joke that she "came for 28 days and stayed for 24 years." Rosie organized alumni dinner dances and used the funds she raised to purchase a home for recovering women in Mohnton.

The Rosie Kearney House (RKH), in Mohnton, PA housing 18 women, began as a halfway house and over the years expanded into an extended care facility. It opened in 1983 and was relocated in 2004 to Caron's main campus in PA. In the beginning, RKH was designed to assist women who were misplaced/homeless after treatment. The patients received AA-based therapy, shared in housekeeping duties, and sought employment.

Treatment services at Caron from the 1960s through the mid-1990s were co-ed, with few specialized services for women. In 1996, under the direction of Caron's new CEO, Douglas Tieman, the Board of Directors at Caron approved gender-separate and gender-specific treatment as part of Caron's strategic plan. Treatment of women from that point forward has been distinguished by its emphasis on empowerment, safety, reducing feelings of stigma and shame, learning tools for effective decision-making strategies, balancing self-care and care-taking, establishing and maintaining boundaries, identifying and changing negative relationship patterns, and providing a healthy, healing relationship between the therapist and the patient.

Today, women who are admitted to Caron receive additional specialized services for such problems as eating disorders, codependency, trauma, and self-injurious behavior. They work on issues such as parenting, work problems, establishing balance between self-care and other responsibilities, and are encouraged to seek employment or do volunteer work. The Rosie Kearney House is now a Women's Extended Care Unit and provides up to an additional 90 days of treatment by focusing on identification of triggers and the development of interventions for these

triggers. Some of the focuses during extended care are to develop intimacy with other women, develop a spiritual practice, build a recovery network, find a 12-step sponsor, and attend meetings for transitioning back into society. In 2000, after conducting extensive research on its women patient population, Caron published a special research report entitled, *Women and Addiction*, focused on the critical and unique treatment needs of women. (Gordon, 2000).

The Betty Ford Center

The Betty Ford Center opened on October 4, 1982, to fulfill the vision of Mrs. Ford and Center Director John Schwarzlose to create a treatment program based on the 12 Steps of Alcoholics Anonymous that was also sensitive to the needs of women. President Ford and Leonard Firestone encouraged Mrs. Ford to allow the Center to be named in her honor because of the effect this would have on women seeking services. Dr. Dan Anderson, then President of Hazelden, encouraged Mrs. Ford to focus the new center on the treatment of addicted women.

Four residence halls were built at the Betty Ford Center between 1982 and 1986, with the fourth designated by the donors as a treatment unit for women. The question of whether to treat all clients in gender-specific units was frequently debated by Mrs. Ford and the Board of Directors. In 1988, the question of whether to offer gender specific treatment was posed to the staff of 14 counselors. The outcome was seven in favor of separate sex treatment and seven in favor of co-ed treatment. Mrs. Ford cast the deciding vote: the Center would work toward providing separate treatment units for men and women. Fully implementing this decision took considerable time.

In the early 90's, the Betty Ford Center contracted with an external organization to conduct follow-up research with patients who had completed treatment, with particular attention to abstinence rates of the women who were treated in the co-ed unit versus the women treated in the single sex unit. The data from their 1992-1993 follow-up calls revealed that the women who were treated in the single sex unit were significantly more likely to be sober at the end of a year than those who were treated in the co-ed unit. These results were amplified by the fact that women who were predicted to have a better prognosis for recovery (i.e. stable home life, older, established career) tended to be assigned to the co-ed unit while those who were thought to have a worse prognosis for recovery based on being younger, single, and having histories of multiple drug use were assigned to the single sex hall. Surprisingly, the "high risk" women treated separately

had better recovery outcomes than those women treated in the co-ed unit. This prompted the Board and administration to fully shift to single-sex treatment units in late 1993. As a part of this shift, staffing in the women's halls became exclusively female.

The structure of women's treatment at the Betty Ford Center was influenced by several key people: Mrs. Ford, Susan Ford Bales, Center staff members Ann Vance, Geneva Burns, Monessa Overby, and Dr. Nancy Waite-O'Brien. When women were moved into separate units that were staffed completely by women, the content of therapy, particularly group therapy, shifted almost immediately (as it also did in the men's units). Areas of vulnerability and hurt such as childhood sexual and physical abuse as well as violence in current relationships that had not been talked about in mixed-sex groups quickly emerged as significant topics of discussion. Women who had shaped their self-images and their addictions in the shadow of the men began to learn how to assert themselves in the units and in all-women AA groups. Over time, specialty groups were added that focused on such issues as trauma and eating disorders, special educational groups were added, and the center's bookstore stocked books and pamphlets supporting women's recovery.

In 2000, a longer term Residential Day Treatment program was started that allowed patients to live in homes purchased by the Center and to participate in formal treatment five days a week. This program allows women to be a part of the local recovery community, to live with other recovering women, and to practice their recovery skills in the community.

Between 1982 and 2006, the Betty Ford Center has treated more than 75,000 individuals and family members, with women making up 44% of primary care patients. The women's program continues to evolve as staff and former patients reflect on their collective experience.

The Betty Ford Center, Caron Treatment Centers, and Hazelden have all, collaboratively and independently, hosted major professional conferences on addiction, recovery, and women since 1996.

Shared Lessons

The distinguished institutions profiled in this article have been pioneers in the development of gender-specific treatment services. The lessons about the treatment of addicted women drawn from the cumulative experience of these three institutions are reflected in the following 14 propositions.

Patterns: Our clinical experience confirms the major finding of modern gender research: everything we have examined in the lives of the women we have treated is different than what we see in men. This includes differences in etiological pathways of problem development; patterns of use; speed of problem progression; frequency, types, and severity of co-occurring medical and psychiatric disorders; obstacles to treatment; clinical issues during treatment; scope of service needs; prognosis for recovery; and styles of long-term recovery.

Relationships with other Women: Treatment is often the first opportunity addicted women have to break out of their historical pattern of distrusting and disliking other women. Treatment and linkage to the larger recovery community opens opportunities to develop safe, healthy relationships with strong, sober women.

Trauma: Developmental trauma (physical, sexual, emotional) is a dominant theme in the lives of many addicted women. Addiction recovery must be grounded within the larger process of healing such trauma.

Intimate Relationships: Trauma in the lives of addicted women is often recapitulated in their adult intimate relationships through a process that has been christened *assortative mating* (Vanyukov, Neale, Moss, & Tarter, 1996). Recognizing, managing, and then breaking these patterns are central recovery issues for many women.

Anger: It was previously thought that anger management was predominantly for the male patient. Today more women are self-identifying the need to work on anger management.

Body Image: The self-esteem of addicted women is closely tied to culturally-transmitted beauty myths that feed self-hatred, self-injury, and vulnerability for collateral eating disorders.

Sanctuary: The successful treatment of addicted women is contingent on creating physical and psychological safety within a healing community. Gender specific treatment units and gender specific groups allow women to bond and develop that environment of safety.

Spirituality and Strength: Recovery for women often involves discovery of previously hidden strengths and sources of power within the self. Discovery of these resources is enhanced through strengths-based assessment and counseling processes. The core of addiction treatment for women is the experience of empowerment: the acquisition of power through new knowledge, skills, and relationships.

Self-Discovery and Self-Acceptance: Recovery is about self-discovery (finding the authentic I) and self-acceptance (shedding

expectations of perfection). It is also about transcending the shame-inducing social stigma that has long been attached to addicted women.

Balance: Recovery for women is often a balancing act between self-care and care giving for their intimate partners and children. Treatment must help nest recovery within the unique role demands placed on women at the same time it empowers women to challenge culturally-imposed role restrictions.

Family Healing: Addiction wounds all family subsystems; recovery involves a restructuring of intimate relationships, parent-child relationships, and sibling relationships. Family-centered treatment is a crucial catalyst of such healing and helps all family members achieve and maintain healthy relationship boundaries.

Sustained Support: Recovery outcomes are enhanced through post-treatment recovery support such as is found in women's meetings in Twelve Step groups and in Twelve Step sponsorship, as well as in other recovery support groups/relationships. The goal of recovery is not independence, but healthy interdependence in relationships marked by continuity of mutual support.

Varieties of Recovery Experience: Women exhibit multiple pathways (religious, spiritual, secular) and diverse styles of long-term recovery. These pathways and styles are also influenced by age, ethnicity/culture, sexual orientation, developmental experience and family circumstances. Such diversity is a cause for celebration.

Gender-segregated Treatment: All of the authors have had sustained experience with both co-ed treatment and gender-segregated treatment. We believe the latter to be qualitatively superior and the source of the best long-term recovery outcomes for women.

We have personally and institutionally learned a great deal through the histories profiled in this article. Our best teachers have been the women whose recovery stories have touched and inspired us. They are the unsung heroes who have used their lives to write new chapters in the history of addiction recovery in America.

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