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Sociedad Interamericana de Psicología
Austin, Organismo Internacional

Available in: http://www.redalyc.org/articulo.oa?id=28434102
Substance Abusing Women with Children in Treatment: A Virgin Islands Residential Model

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Abstract

A residential program for drug addicted women and their children is described. This program is based in a community organization and financed by the Center for Substance Abuse Treatment, Women and Children’s Branch of the U.S. Virgin Islands. The Recovery Project for Women and Children offered long term integrated services expecting to reduce the use of alcohol and other controlled substances, reduce dependency on the social welfare system and increase the use of specific vocational and life skills. Program results, as well as recommendations for the future, are presented.

Compendio

En este trabajo se describe un programa residencial para mujeres adictas con niños y niñas en una organización comunitaria que es financiado por el Centro para Tratamiento de Mujeres y Niños/as Adictos de las Islas Vírgenes estadounidenses. El Proyecto de Recuperación de Mujeres y Niñas/as ofrecía un plan integrado de servicios a largo plazo con la expectativa de reducir el consumo de alcohol y sustancias controladas, reducir la dependencia del sistema de beneficencia social y aumentar el uso de destrezas específicas de vida y vocacionales. Se presentan los resultados del programa y se discuten recomendaciones que deben considerarse prospectivamente.

Key words: Substance abuse; Women in residential treatment
Palabras clave: Abuso de drogas; Mujeres en programa residencial

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The Caribbean is currently experiencing a major social and cultural upheaval. Changes are apparent in the United States Virgin Islands where the impact of North American colonialism has resulted in a community which struggles to maintain its identity in the face of forces which it can barely understand, much less control. The United States Virgin Islands (USVI) is a set of three islands: St. Thomas, St. Croix and St. John. Their keys are located 40 miles east of Puerto Rico. The population of approximately 110 thousand is 77% African Caribbean, 9% Hispanic or other minority (such as East Indian, and Middle Eastern) and 14% Caucasian. There have been nine cultures, seven of whose flags have flown over these islands. The longest ownership prior to the United States was by Denmark which sold the islands to the United States in 1917.

Although accustomed to changes in political and cultural leadership, the current forces nevertheless represent values, economic and social systems which are in conflict with traditional West Indian structures. Thus, communality is replaced by individualism, "family first" is threatened by the desire for self-centered success, and efforts for planned and measured development give way to unbridled expansion with the necessity to survive in an ever more economically and socially competitive world. Women's roles in these changes is crucial. It has been said that "women are the carriers of the culture", thus the burden of maintaining a standard and a way of life that is uniquely Caribbean appears to fall more heavily on women in our community.

In addition to these inevitable social forces which have brought some positive changes, the Virgin Islands, like other islands in the West Indies, have become a major point of transshipment of drugs from South America to the United States. The influx of drugs into our communities has resulted in increases in crime, violence and substance abuse addictions. In 1990, the Virgin Islands' government contracted with the Village - Virgin Islands' Partners in Recovery, a not for profit, community based, comprehensive substance abuse service agency to develop residential drug addiction treatment in the territory. In 1993, this agency successfully applied for and was awarded a five year competitive demonstration grant by the Center for Substance Abuse Treatment
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Women and Children's Branch Programs, to develop a residential treatment program for women and children in the Virgin Islands. This paper will describe the program as it operated in 1994-95 including interviews of staff and residents.

SCOPE OF THE PROBLEM

Substance abuse in the USVI has seen dramatic increases over the past decade. The Division of Mental Health and Substance Abuse of the V.I. Department of Health reported a 600% increase in the incidence of crack cocaine in 1986. There has been a steady increase since then, especially among the female addict population. A recent presentation to the Women, Infants and Children (WIC) program spoke about the third generation of crack babies. Grandmothers who are often caring for these children were alcoholics themselves. However, they were able to keep their families together. The mental and emotional devastation of crack places any family or self preservation value below the need for the drug (Dudley, 1992).

Dizon, Hatcher and Dudley (1992), reporting on patterns of black and white women's consumption in the Virgin Islands, found a lower incidence of drinking among black women than whites. There was a significantly higher level of drinking among white women, and black women were more likely to be abstainers. The authors concluded in part that, similar to the United States, multiple roles and more active lives played a major role in reducing alcoholism in the lives of Virgin Islands’ women.

While women are increasingly at risk for alcohol and drug use, it has been widely acknowledged that they have not been appropriately nor adequately served by the traditional substance abuse treatment system (Breyer & Hill, 1993). Traditional programs have not developed means of addressing the biological, social and emotional needs of women. They do not consider differences in potential sources of referral, nor in needs that promote longer term stays in treatment. Even programs that are beginning to be designed specifically to meet women's needs, or are specifically all female, often demonstrate some if not all of these deficiencies.

A key example follows. There has been a prevailing attitude
within traditional residential substance abuse programs for women, that having children present would be a deterrent to recovery. It was felt that the addicted women needed time away from maternal and familial responsibilities to focus on their own mental and emotional issues. Indeed, it was thought that children would serve as an escape or a barrier to the addict admitting and confronting her addiction. However, the problems women faced obtaining child care often meant women could not enter treatment nor complete the prescribed time once they were in the center. Thus, this orientation against children in the setting became a barrier to accessing treatment for most women, and women's programs had traditionally done very poorly. The Center for Substance Abuse Treatment, a section of the Substance Abuse and Mental Health Services Administration, put special emphasis and 20% of the block grant on women's and children's programs. Further yet, in 1992 they disseminated a Request for Proposals to fund demonstration programs which could address the special needs of women with children.

TARGET POPULATION

In 1992, the Division of Mental Health and Substance Abuse served approximately 800 clients in the territory, 225 of whom received substance abuse services. Of those receiving addiction treatment, only 13% (30) were women, (Mental Health and Drug Dependency, Block Grant, 1993), yet national estimates suggest that anywhere from 30% to 50% of addicts in need of treatment are female (Hull, 1994). While the number may be somewhat smaller in the Caribbean in general, and the V.I. in particular, it remains clear that many women in need of addiction services are not willing or able to access the services traditionally provided to date.

This article presents the Women and Children's Recovery Project (WCRP) which seeks to provide residential services to 60 women over the life of the five year grant. The women must be addicted to alcohol or another drug and have at least one child 13 or under who will live with her on site.
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WOMEN AND CHILDREN’S RECOVERY PROJECT

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Goals and Objectives

The primary goal of the WCRP is:
To demonstrate that a comprehensive continuum of intervention and treatment services for women along with prevention services for their children and families, delivered in a safe resource focused community based setting, coupled with primary health, mental health and social services will result in: (1) reduced alcohol and other drug use, (2) reduced reliance on social health welfare systems, and (3) increased functioning in specific life skill and vocational areas (Williams, 1993).

Program Description

The residential program is located on the western end of St. Croix in a renovated motel. Each of the 10 efficiency units houses a woman and up to three children ranging in age from new-borns to 13 years old. Program components include: outreach/engagement activities, primary residential treatment for women, infant/child/adolescent oriented prevention and intervention and coordinated case management of ancillary services. Referrals come primarily from the Department of Health, Maternal, Child Health, Mental Health and Substance Abuse and Medical Assistance programs, the Department of Human Services, and targeted outreach to communities such as the Latino community, as well as through the court system.

The women are provided with:

1) Comprehensive, long term, gender/cultural/ethnic specific treatment to women who have from one to three children;
2) Specialized educational and vocational services to assist women to have specialized job skills;
3) Specialized educational, mentoring, tutoring and other services to adolescent children of substance abusers;
4) Intense case management;
5) Educational strategies to reduce HIV/AIDS risk behavior; and
6) Specialized family services integrated into the daily regimen of women and children in treatment.
Other services and resources are accessed as deemed necessary and appropriate by Case Manager and other staff.

**Treatment Philosophy**

The V.I. Village believes that chemical dependency is a chronic, complex, bio-psycho-social disease phenomenon, and that treatment is most successful when providers offer a sustained continuum of comprehensive therapeutic interventions including health, substance abuse, education and social services. The programs are abstinence based and utilize the 12 step programs of Alcoholics Anonymous, Narcotics Anonymous, and other self-help groups, in conjunction with reality based therapeutic interventions and peer support. The environment created by each program is deliberately set up to encourage self responsibility and self-reliance, while, at the same time, recognizing the need of women and children to feel cared for and nurtured. Within this framework, trained staff will focus not only on substance abuse, but on socialization efforts including interpersonal relatedness, competence, and autonomy (or self-determination) (Williams, 1993, p. 21).

Tobacco is also restricted to residents and staff on the premises, and residents are not allowed to smoke in front of their children.

There are five phases of treatment. In:

(a) Phase I, Orientation/retention- the resident is given extensive medical and psycho-social evaluations, basic communication skills and is introduced to the treatment environment.

(b) Phase II, Primary Treatment – the center provides intensive individual, group and family treatment, vocational counseling and extensive education regarding parenting skills, as well as the nature of their disease. It is in this phase that cognitive restructuring, and insight can lead to deep and long lasting behavioral change. The fact that these
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insights and new knowledge can be immediately implemented in the mothers’ interactions with their children reinforces the learning and greatly enhances the potential for healing.

(c) Phase III, Re-entry - the focus changes from intrapersonal and mother/child relationships to interpersonal and social relationships. The mothers develop skills in carrying out goals and managing relationships with family members and significant others. Male-female relationships, heretofore unaddressed by treatment programs in this stage of treatment are examined and the residents assisted in understanding healthy relationships and recognizing codependent symptoms.

(d) Phase IV, Reintegration where the focus is on bonding, relapse prevention, full employment, continued intense case management and in-home training regarding parenting, household management, among others; and

(e) Phase V, Continuing Care – where the program develops and maintains support systems for the women as well as providing for intensive long term treatment as needed.

The children also obtain specialized interventions of a comprehensive nature. Their services include a) physical development, b) social development (substance abuse resistance skills training, self-esteem development, mother/child bonding, peer oriented activities’; and c) cognitive development (educational services). The program is also available to residents who are HIV positive.

RESULTS TO DATE

Since the program’s inception in April, 1994 (Start up October, 1994 due to renovation), there have been 16 admissions. Those women have been accompanied by 31 children. Admission criteria cut off the original age for children at 7, however, the realities of women’s lives have necessitated admissions up to age 13. In 1995 there were 7 residents and 15 children in treatment who ranged in age from one to 13. The women ranged in age from 25 to 44 with most in their early to mid thirties.

An extensive interview with Magdalene Jackson Cooper (1995),
the primary therapist at the center, provided detailed information about the women's treatment issues. The primary drugs of choice were alcohol and crack/cocaine. All women admitted have been sexually, emotionally and physically abused, according to the program director, Ms. Karen Hunt (Personal communication, April 15, 1995).

Most (99.5%) of their issues are around men (Jackson Cooper, Personal communication, June 29, 1995). Codependency has for the most part led them into addiction. They struggle with themes of abandonment and emotional and physical neglect of their children. Due to the depths that their disease has taken them, they have repeatedly put their children at risk, have been unable to protect them from being physically and sexually abused by the men in their lives, and have even bartered their children to obtain drugs.

As they begin to recover, they are often overwhelmed by the devastation that has been wrought by drugs on their lives, and its impact on their children. They have to learn how to gain their children's respect, how to develop and maintain boundaries and set limits. Often there has been minimal bonding with the children at birth or thereafter because of their addiction. Thus, there is a process of rebonding which is fostered in the therapeutic setting. Parenting skills and inner child work occurs in group therapy and parenting skills classes.

The women are emotionally undeveloped, essentially "walking around like little girls" (Jackson Cooper, Personal communication, June 29, 1995). Some are so filled with rage or have been so emotionally damaged that the therapeutic process had to start at a very primitive level. The first goal of treatment is to help the woman identify her feelings, and then in a safe environment, attempt to return to the source/pain that first caused them. Reichian, and other related approaches to treatment are often utilized in a group setting where the regression occurs with the support of fellow residents and staff. Mattress work and relaxation techniques are often used to facilitate the process.

Cultural Differences

This particular program was modeled on one successfully implemented by the Village in Miami (Jackson, 1992). Similar
programs have been operating in Orlando and elsewhere around the United States for some time (Reed, 1987). However, this is the first project of its kind that has been attempted in the Caribbean. Some of the major cultural differences appear to occur as barriers to treatment. According to Ms. Jackson Cooper, (Personal communication, June 29, 1995), West Indian women stay out of treatment longer due to the intensity of the stigma and shame associated with treatment still deeply embedded in our cultural values. Motherhood is highly regarded in our culture. Any sign of the disease of addiction severely contradicts this image. Thus, the value of motherhood enhances denial rather than fostering the need for treatment.

Secondly, there are large gaps in the array of services necessary to obtain and maintain a life of sobriety. A strength of the West Indian community is the strong extended family system. Unfortunately this positive aspect of our community becomes a barrier to treatment. The woman’s length of stay is shorter. She and her children will often end up living with a grandmother or aunt where she can continue to use drugs without fear of being put out as she would be in the extended network of a service system. Thus, the extended family becomes an enabler of the disease rather than the source of support that it is intended to be. Another issue identified is that self-esteem appears to be very low. Women that do come in to treatment often feel ashamed and dehumanized. They believe they will never be able to regain the respect of their family members nor of the community.

**Personal Histories**

Interviews with two of the residents proved to be particularly enlightening. Both reported having been emotionally, physically and sexually abused as children, one just having fully recalled this traumatic experience the day before our interview. The other female, was born in St. Thomas and was the mother of four children, a 19 and a 17 year old, both pregnant, a 15 year old who is in the eleventh grade and living with her paternal grandmother, and a seventeen month old who resides with her at the center. She had been in treatment at the Village Women and Children's program for the past fourteen months. Her mother died when she was 11,
from a tumor caused by ongoing beatings by her alcoholic father. She was then raised by her father, maternal grandmother and an aunt, but she felt that she basically raised herself from that point on. She dropped out in the eighth grade, but was able because of family connections to get a job as a nurses’ aide in the hospital. Ten years ago she was introduced to crack, and had been using alcohol and marihuana as well until entering treatment. She reported that she lost custody of her older children because of her addiction, at one point prostituting herself for $5.00 per “trick” in order to pay for her drugs. She had previously tried another women’s program run by the Village, also located in St. Croix but dropped out, still in denial about her addiction. She agreed to come into treatment because when the baby was four months old, she dropped him off with her eldest daughter and went to smoke pot. Her daughter reported her to Child Protective Services because "she didn’t want what had happened to her to happen to him". The resident admits that she now realizes that she was in a “state of insanity”. She was "doing O.K. in the present without looking at the future”. Human Services offered her an ultimatum, lose custody of the baby or come into the Women and Children’s treatment program. She felt that the program changed her outlook on life, and taught her skills such as parenting and self care which she never had before. She felt that they were helping her to break the cycle, not only with the baby but with the older children as well. Her current goals were to obtain employment, and a home in a safe environment so that her family could reunite. She states “Thank god that they have not given up on me,... they feel that they can trust me,... I feel that I can trust myself ”.

The second resident we interviewed had been there five months and was obviously going through a painful period in her treatment. She was 35 years old with four children, ages 17, 13, 7 and 3, three of whom were currently residing with her at the center. She explained that while she had always remembered her father's physical abuse, only in the past day did she remember his sexual abuse. She reports that her father was abusive but not an alcoholic. Drug abuse appeared to be more on her mother’s side. She was afraid to tell her mother how much her father was beating her. She reported that she was his eldest girl child and he appeared to be
paranoid about any relationships that she had with boys. She was even prohibited from sitting next to her male cousins. She was introduced to marihuana by her uncle and then to other drugs by her boyfriends. She maintained a tremendous amount of anger towards her father, stating "He's dead yet he's still there, in my head".

Treatment Issues

Both women typified a major treatment issue often previously overlooked by traditional programs. Their relationship issues were pervasive. The program director, Karen Hunt, stated that their sexual addictions superseded their chemical addictions and if not dealt with early on in treatment, were often the cause of premature termination and or relapse. Therefore, another major focus of treatment was on developing and maintaining healthy relationships with significant others. These women had low self esteem and were more likely to blame themselves for their troubles than men. In fact "...women drug abusers feel very badly about their lives, and may even be blaming themselves for things they are unable to change" (Reed, 1987, p. 155). They are so accustomed to being used, and using their bodies to get their intimacy and nurturance needs met, that they have limited knowledge and great fear of having to take care of themselves. This lack of information is denied and often repressed by drug use.

At the same time, drug abusers will alternately neglect and become overly dependent on their children. They treat the boys as their "little husbands" and may compete with their girls for affection and attention from others. The treatment setting attempts to address all these concerns in a long term manner that can bring about significant behavioral changes for the entire family.

FUTURE DIRECTIONS

This model treatment program, the first of its kind in the Caribbean, seeks to serve a large and highly underserved population, namely substance abusing women and their children. Several barriers to care have been removed by including children in the residential setting, providing culturally relevant treatment modalities, and assisting the women to restructure their lives in a safe, long term environment. Essential aspects of the program
include interagency collaboration from Human Services, Health and Education, as well as community based organizations and voluntary individuals' which foster a holistic approach to recovery. Ongoing program evaluation will continue to identify areas of the project which should be strengthened to ensure complete success.

One area that could be further developed is the children's program. The children come with severe histories of exposure to their mother's addictive behavior. They often have experienced the consequent inadequate nurturing resulting from the disease, and may have been victims of physical and/or sexual abuse as well. In order to address their emotional needs, individual and group therapy, as well as extensive educational/recreational programs, must be expanded if the goal of prevention for this next generation is to be achieved.

Should the positive results of the Village Women with Children's program continue, it should serve as a model for replication throughout the Caribbean. Further data will be made available as the program progresses.

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