



## CHAPTER ONE

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# WOMEN'S ADDICTION AND TREATMENT THROUGH A HISTORICAL LENS

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Women's addictions span a wide scope—from alcohol and other drug dependence to smoking, gambling, sex, eating disorders, and shopping. Nonetheless, it is the use of alcohol and other drugs that has been, and remains, the most pervasive and most stigmatizing of all addictions for women. According to the National Center on Addiction and Substance Abuse, 4.5 million women in the United States are alcohol abusers or alcoholics, 3.5 million misuse prescription drugs, and 3.1 million regularly use illicit drugs.

It is instructive to look at the history of women's use of alcohol and other drugs in the United States, because such a historical perspective helps us understand women's substance abuse problems in the context of their role in society. It also helps us understand society's responses to women's problems with these substances, and consequently the treatment offered them.

This chapter examines the history of women's use and abuse of alcohol and other drugs and points out how women's substance abuse and treatment in the United States has been affected by gender and racial bias, economic factors, and ignorance by treatment providers. The emphasis is on the history of alcohol and other drug problems among White, heterosexual women. Although there are some current data regarding substance abuse and treatment of African American and other women of color and of lesbians, their historical relationship to these issues has yet to be fully explored.

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## A Historical View of Women and Alcohol Use

Women have used alcohol from ancient times and frequently have been condemned for its use. The Old Testament talks about Hannah, the mother of the prophet Samuel, as being falsely accused of being “drunken” (1 Sam. 1:13–15), and during the early Roman era a woman who was caught drinking, or even suspected of it, was treated the same way as one who was adulterous—with a prompt execution by her husband or another man in the family (Sandmaier, 1980). The availability of cheap gin in eighteenth-century England led to its widespread use by poverty-stricken women in London and to widespread disgust toward those who became addicted to it. This so-called gin epidemic also led to a growing concern about the impact of women’s drinking on their offspring (Fielding, 1751, cited in Hornik, 1977), a dynamic first noted by ancient Greeks.

The history of women’s use and abuse of alcohol in the United States is intertwined with the political movements of temperance, prohibition, and suffrage and with the ever-changing role of women in political and family life.

Alcohol has been part of White America since the arrival of the Pilgrims and was a constant presence in colonial life. As indicated by White (1998), “what is striking about early colonial history is the utter pervasiveness of alcohol. It was consumed throughout the day by men, women and children and integrated into nearly every ritual of social and political discourse” (p. 1). Despite its widespread acceptance, as early as 1780 Dr. Benjamin Rush, a signer of the Declaration of Independence and the “father” of American psychiatry, voiced concern about abusive drinking habits of both men and women. He was the first person in the new republic to view chronic drunkenness as a “disease of the will” (O’Dwyer, 1993). Moreover, according to White (1998), Rush anticipated the self-medication theory of women’s substance abuse when he pointed out that women “were sometimes drawn into drunkenness in the use of ardent spirits to seek relief from what was then called ‘breeding sickness’ (menstrual distress)” (p. 3).

In the 1830s, Harriet Martineau, the author of *Society in America* (1837), toured the United States and wrote critically of women’s excessive drinking habits. She determined that there were four reasons why privileged women in a country of peace and prosperity would turn to inebriety: cultural oppression, “vacuity of mind,” desire to stop using prescription medication, and physicians’ prescription of cordials (pp. 159–160). Physicians prescribed alcohol for a variety of medical ills specific to women: “to alleviate discomfort during pregnancy and delivery, as well as a relaxant in premenstrual tension, and for preventing infection after childbirth. Beer was thought to fortify a woman for breast feeding” (Hornik, 1977, p. 20). Women, of course, followed the advice of their male doctors. By the end of the

1800s, there was another reason for women's increasing reliance on alcohol: the liquor industry's advertising campaigns. "As narcotics became increasingly stigmatized, liquor sellers stepped into the breach, socializing women to the benefits of drinking" (Murdock, 1998, p. 49).

The Victorian values of the nineteenth century led to the formulation of the "ideal" American family, and public inebriety, violence, and family disruption related to excessive drinking were increasingly frowned on. Thus, unlike the generally tolerant attitude at that time toward women's use of opium, which, as we will discuss shortly, was viewed as more "genteel" and "feminine" (Murdock, 1998, p. 49), alcohol use was associated with male inebriety, especially with the drinking of poor Irish and German immigrants. Consequently, women's drinking was strongly condemned. As pointed out by Sandmaier (1980, p. 41),

drunkenness among both sexes was often punished by imprisonment; however, Victorian morality may have imposed an even harsher fate on some chronically drunk or alcoholic women. In an address before the Medico-Legal Society in 1897, a Brooklyn physician recommended that the alcoholic woman "be desexualized . . . whether maid or matron" if she failed to respond to routine treatment. As "desexualization"—removal of a woman's uterus and ovaries—was a fairly common procedure performed on sexually active or otherwise unruly women in the late 1800s, it is likely that this operation was carried out on at least some alcoholic women during this period.

Such severe treatment of alcoholic women was also reflected in the growing eugenics movement during the early part of the twentieth century, with its emphasis on the sterilization of "the unfit." Sterilization of alcoholic women continued as late as the 1950s. White (1998) describes interviewing a number of alcoholic women who had been committed to state psychiatric facilities in the 1940s and 1950s and whose medical records confirmed that they were able to obtain discharge only after "voluntarily" agreeing to be sterilized.

An interesting profile of nineteenth-century alcoholic women is provided by Dr. Lucy Hall (1888), who served as the physician in charge of the Reformatory Prison in Sherborn, Massachusetts. In a study of 204 inebriate women under her care, Hall found that the majority of them started drinking excessively before they were twenty-one years old. Their first drink was usually alcohol-laced tonics, and gradually they switched to beer and then distilled spirits. Half of these women had a history of multiple imprisonments for drunkenness-related offenses, and they tended to drink with other women, not alone. Of interest is her observation that more than one-third of the married women had been so beaten by their drunken husbands that they had scars on their heads.

## Women and the Temperance Movement

The early nineteenth-century temperance movement, which, as reflected by its name, was initially conceived as a movement that sought to temper excessive drinking with moderate, socially approved levels of drinking, soon attracted the attention of women who suffered significantly from men's drinking: "Barred by law or custom from divorcing inebriate husbands, unable to earn a living wage themselves, isolated in a society with few mechanisms to reform drinkers or their families, drunkards' wives faced brutality, poverty and abandonment" (Murdock, 1998, p. 16). These women, as exemplified by the well-known saloon-wrecker Carrie Nation, whose first husband was an extremely abusive alcoholic man, knew that religious-led efforts to "convert whisky-drinking drunkards into temperate beer-drinkers" (White, 1998, p. 5) were futile. Consequently, they became staunch advocates of shifting the philosophy from temperance as moderation to temperance as abstinence. As early as 1805, women had formed their own temperance societies, and by 1848, the Daughters of Temperance had thirty thousand members (Murdock, 1998).

The temperance movement gained momentum toward the end of the nineteenth century. The so-called Women's Crusade of 1873–1874 was a culmination of many years of women's taking action against saloons and the widespread availability of liquor. Because at this time they had no direct political power, women used petitions, prayer vigils, and demonstrations to persuade saloonkeepers to close their doors. By 1874, local antisaloon crusades were widespread, and they united to form the Women's Christian Temperance Movement (Murdock, 1998; Sandmaier, 1980; White, 1998).

One of the most politically influential movements of the late 1800s, the Women's Christian Temperance Movement (WCTU) initially focused on endorsing prohibition, temperance education, and dry government facilities. However, under the leadership of Frances Willard, president from 1879 to 1898, the WCTU expanded its agenda significantly and "soon considered woman's suffrage the catalyst for prohibition's victory" (Murdock, 1998, p. 25). Willard, a brilliant strategist, recognized that even though women were not allowed into the political sphere, they were allowed to perform "good works." Consequently, she was able to build on the virtuous work of women on behalf of the prohibition movement as an entrée to gain voting rights for women. It is thus not surprising that the eighteenth amendment, which established Prohibition, and the nineteenth amendment, which gave women voting rights, were ratified within one year of each other.

Yet the relationship between the suffrage and prohibition movements in the late nineteenth and early twentieth centuries was complicated. Although at times the groups seemed to work toward common goals, each also viewed the other as compromising the goals and values of its cause (Murdock, 1998). While the suf-

fragettes worked toward the establishment of the moral and legal right of women not only to vote but also to be viewed as independent women with their own rights apart from their fathers and husbands, the underlying assumption of the temperance movement was that a woman's role was to *moderate* the potential excesses and immorality of her husband's drinking. This role called for a "virtuous" abstinent woman. The idea that women also could drink alcohol would have threatened the status quo; thus women drinkers were stigmatized and typically depicted as prostitutes (Murdock, 1998).

### Women's Alcohol Use During the Nineteenth Century

In her book *Domesticating Drink*, Catherine Gilbert Murdock (1998) offers exhaustive research regarding women's use of alcohol during the nineteenth and early twentieth centuries. Murdock documents the growing concern about women's drinking and what was viewed as "'masculinization' and the perceived unwomanly, nonmaternal qualities of women drinkers" (p. 51). She goes on to state that "women alcoholics, barred from treatment or sympathy by their own denial and others' prejudices, are one of the greatest tragedies of the period" (p. 51).

Thus, at the turn of the century, many women are involved in a vigorous campaign against all drinking, while other women are clearly drinking quite liberally. Sandmaier (1980, p. 40) makes reference to an 1899 article in *Catholic World* that estimated that eight thousand women were arrested in New York City for drunkenness the previous year. Murdock (1998) delineates regional differences in women's drinking: in the rural Midwest—home of the WCTU—women did not drink or even serve wine, but they did do so in many urban communities.

Ironically, the majority of *all* women used over-the-counter patent medications that promised relief from whatever ailed them. Some of these patent medicines contained 50 percent alcohol or opium. According to Sandmaier (1980, p. 45), "Edward Bok, editor of the *Ladies Home Journal* in the late 1800s and a leading opponent of the patent medicine business, surveyed fifty members of the WCTU and found that three out of four used patent medicines with an alcohol content of one-eighth to one-half spirits." By the end of the nineteenth century, Americans were spending \$100 million on patent medicines per year, and, as will be discussed later, the majority of the users were women (Wood, 1906).

### Women's Alcohol Use During the Twentieth Century

During the early part of the twentieth century, as women's use of opiates and patent medicines began to decline, it was not uncommon for women in the larger cities to be seen in cabarets and public dining areas drinking with men. And even

when the Volstead Act of 1919 prohibited the sale or use of alcohol, “millions of women began drinking openly, sometimes defiantly, at cocktail parties, in speakeasies, at women’s luncheons and bridge parties, at country club dinners, in cars with their dates” (Sandmaier, 1980, p. 48). This change in drinking patterns reflected the changing role of women in society.

As a result of World War I, women entered the workforce in unprecedented numbers. At the same time, Sigmund Freud’s message about the appropriateness of sexual expression had reached the United States—and alcohol helped with this expression. The 1920s and 1930s also saw a political split: some women remained true to the prohibition movement, while others joined the Women’s Organization for National Prohibition Reform. The debate between the “wets” and the “drys” was vociferous, with the “drys” continuing to portray the “wets” as sexually promiscuous drunkards (Sandmaier, 1980).

During the Great Depression of the 1930s, however, many of the “modern” liberated “wet” women retreated home, and although Prohibition was repealed in 1933, women’s drinking once again became unacceptable. A *Ladies Home Journal* survey in 1938 found that the majority of women disapproved of women’s drinking: “More than fifty percent of all the respondents thought it was wrong for women to drink at all, while fully two-thirds believed that women should not be seen imbibing in public” (Sandmaier, 1980, p. 55). The unknown number of women who not only drank but also were unfortunate enough to become addicted to alcohol remained well hidden.

World War II shook up things again and provided new opportunities for women. Women’s independence and greater economic freedom also increased their rates of alcohol use. According to the Gallup Poll, from 1939 to 1978 the percentage of women in the United States who drank jumped from 45 to 66 percent (Sandmaier, 1980, p. 56). The multibillion-dollar alcohol industry was quick to recognize a new clientele. “Until 1958, the liquor industry code forbade portrayal of women in its advertising. And even through the 1960s, the only alcohol advertising likely found in most women’s magazines was an occasional ad for sherry, possibly accompanied by a recipe for chicken a la king” (Sandmaier, 1980, p. 66). But by 1978, *Cosmopolitan* and *Better Homes and Gardens* became the top magazine targets for the liquor and wine industries, and ads depicting attractive women with a drink in their hands filled the pages of these and other women-oriented magazines.

These changing social mores were paralleled by the growing public and professional recognition of alcohol problems among women. A literature review by Marc Schuckit (1972) found that between 1929 and 1970, only twenty-nine studies on women alcoholics were published in the English language. Such literature grew rapidly during the 1970s and 1980s (for example, Beckman, 1984; Blume, 1978; Corrigan, 1980; Gomberg, 1986; Greenblatt & Schuckit, 1976; Hornik,

1977; Sandmaier, 1980; Straussner, 1985). A new journal, *Focus on Women: Journal of Addictions and Health*, began (and folded) in 1980.

Unfortunately, whereas there has been a virtual explosion of research on women and illicit drugs, such as crack cocaine, during the 1990s, research on women and alcohol seems to have disappeared once again, reflecting federal funding priorities.

According to Edith Gomberg's review (1986) of survey data and treatment reports published during the 1970s, alcohol problems among females remained steady, with a male-to-female ratio of 3:1 to 4:1, depending on the criteria used to define problem drinking, but were higher than the 5:1 male-to-female ratio indicated by government data put out by the National Institute on Alcohol Abuse and Alcoholism during the 1960s. Moreover, a study by Straussner, Kitman, Straussner, and Demos (1980) of alcoholic housewives who were in an alcoholism treatment facility during the early 1970s found a 3:1 ratio of alcoholic fathers to mothers among these middle-age housewives. Based on their findings, the authors point out that the ratio of alcoholic women to men in the previous generation may have been higher than officially acknowledged; the 3:1 alcoholic male-to-female ratio may not have changed much from the 1940s to the 1970s, and even today.

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## Women's Drug Use During the Nineteenth and Twentieth Centuries

The documented history of women's addiction to drugs in the United States begins during the 1800s, when physicians (almost exclusively male) exhorted women to take medications for every ache and pain. Laudanum, "a liquid form of opium dissolved in alcohol" (Jonnes, 1999, p. 15), was prescribed for all kinds of physical complaints presented by women; opium itself was prescribed for what was diagnosed as "neurasthenia" or "nervous weakness," a set of vague symptoms that were seen as being directly connected to the female gender (Kandall, 1996).

The use of opium became widespread during the Civil War as treatment for soldiers dealing with pain from their wounds and for those suffering from dysentery (Friedman, 1993). In 1856, the hypodermic needle, invented in Europe in 1843, was brought to the United States. The availability of the syringe made it even easier to alleviate pain, and America's huge appetite for opium imports grew from twelve grains per capita in the 1840s to fifty-two grains by the 1890s (Jonnes, 1999, p. 17). Although both men and women used opium to deal with pain, women were especially vulnerable to addiction because they were often advised to take opium for longer periods of time (Kandall, 1996). Unlike men, women

were more likely to eat or smoke opium than to inject it. (Women's greater dislike of injection may account, in part, for the rapid spread of smokable crack cocaine among women 130 years later.)

Women's addiction to drugs was largely iatrogenic, as existing medical customs contributed to the use of drugs (Aldrich, 1994). For example, in 1879, Dr. T. Gailard Thomas (1879, p. 316), president of the American Gynecological Society, advised his fellow doctors that "for the relief of pain, the treatment is all summed up in one word, and that is opium. This divine drug overshadows all other anodynes. . . . You can easily educate her to become an opium eater, and nothing short of this should be aimed at by the medical attendant."

Due to the limited state of formal training, the medical community largely ignored concerns about the addictive qualities of opium despite some warnings, such as the widely read book *Confessions of an English Opium Eater*, written by Thomas DeQuincy in 1821. DeQuincy, an Oxford-educated writer, began his use of laudanum for medical purposes and subsequently chronicled his devastating "habitation" to this drug (Jonnes, 1999). Many doctors in the United States and Europe, including Freud, experimented on themselves with new drugs, and it was not unusual for doctors themselves to become addicted.

By the end of the nineteenth century, the majority of morphine and opium addicts in the United States were women (Kandall, 1996). J. M. Hull of the Iowa Board of Health observed in 1885 that most of the addicted women were well educated, and they had both access to physicians who prescribed their drugs and the means to afford long-term opiate use (Jonnes, 1999). A description of the genteel, abrasive Mrs. Dubose in Harper Lee's *To Kill a Mockingbird* (1960) stands out as the prototypical upper-class Southern lady of the 1800s. She is described as a bigoted woman whose tortured personality was complicated by opium addiction. Her greatest accomplishment was her ability to wean herself from the drug during an excruciating process. Another literary example can be seen in Eugene O'Neill's autobiographical play *Long Day's Journey into Night*, which takes place from 1912 to 1940 and describes Mary Tyrone's decompensation as a result of her long-term opium addiction, and her hatred of the medical profession: "He deliberately humiliates you! He makes you beg and plead! He treats you like a criminal and understands nothing! And yet it was exactly the same type of cheap quack who first gave you the medication—and you never knew what it was until too late!" (1956/1989, p. 74).

The use of opium was not limited to women in higher socioeconomic classes, however. In his book *Substance and Shadow*, Stephan Kandall (1996) describes how rural women resorted to opium to relieve boredom and social isolation. Other women, forced through economic necessity to work in the mills and sewing fac-



tories, also were frequent users of opium to relieve pain and physical exhaustion. And, of course, opium was frequently used by prostitutes and sold in many brothels (Jonnes, 1999).

Nineteenth-century women were also heavy users of cocaine. By the end of the 1800s, the American Pharmaceutical Association estimated that 1 in every 375 Americans was a cocaine addict and 1 in every 300 was an opiate addict; the majority were women: "Assuming there was some overlap in these two groups of addicts, one might guess that at the turn of the [twentieth] century, *one American in two hundred was a drug addict. And the bulk of these were genteel, middle-class women*" (Jonnes, 1999, p. 25, italics added).

The extensive long-term use of opiates and cocaine by women was "to some degree responsible for the growth of an entire branch of the American pharmaceutical industry at the turn of the century" (Kandall, 1996, p. 3). For example, the pharmaceutical company Parke-Davis was promoting coca to physicians, and hundreds of coca tonics were marketed by the patent medicine industry as "enterprising Americans formulated the logical alternative for a temperance-minded society: coca-based soft drinks that promised to pep you up" (Jonnes, 1999, pp. 20–21). At the same time in Germany, the pharmaceutical company Bayer launched a cough sedative derived from morphine that they called Heroin, "a play on the German word *heroisch*, meaning powerful" (Jonnes, 1999, p. 36). This was marketed in America as a safe, powerful, and nonaddictive substitute for the addictive opium derivatives morphine and codeine (Abadinsky, 1997). Not until the 1920s would the use of heroin be recognized as a serious problem itself.

### Women's Use of Opiates During the Twentieth Century

By the end of the 1800s, the widespread use of patent medicines and the harmful effects of drugs were beginning to be widely recognized. Special attention centered on the search for a cure and on the impact of women's drug use on their infants and children. Although women were initially advised to use opium derivatives to soothe their infants—a practice known as infant doping (Aldrich, 1994)—by the turn of the century, this practice became abhorred, and mothers were held to blame for their and their babies' addictions. For example, Kandall cites an article titled "The Opium Habit in Children," published in a medical journal in 1894, in which the author, Louis Fischer, warns about "ignorant mothers, stupid nurses and careless women, who in order to get sleep at night feed their nurslings with soothing syrups, teething cordials, and other soothing liquids, not to mention the most common and also the most easily obtainable paregoric" (quoted in Kandall, 1996, p. 56). It is obvious that Dr. Fischer, as was true of many other men at that time, did not

have to worry about lack of sleep due to crying, teething infants; tending to the child was a responsibility that fell solely to “ignorant” mothers and other women. As will be discussed later in this chapter, such “mother blaming” reared its ugly head again during the 1990s as the federal and state governments turned toward the criminalization of drug-using mothers and away from the provision of treatment for their addictions.

Women’s use of narcotics decreased dramatically following the passage of the Harrison Act in 1914, which outlawed the prescribing of drugs by physicians. The Harrison Act and subsequent court cases effectively criminalized the use of opiates and reduced the life options of their users. From then on, drug users were viewed as members of a deviant criminal class and treated accordingly. Now, instead of obtaining drugs over the counter or by prescriptions from their male doctors, women were introduced to drugs as a result of contact with other addicts and male drug dealers (Dai, 1937/1970). Overall, while the use of opiates among women decreased, use of alcohol increased, and other drugs took their place in the medicine cabinets of women throughout the country.

### Women’s Use of Other Drugs

Originally touted as safe and nonaddictive, barbiturates were one of the major drugs of abuse in the 1950s (Abadinsky, 1997), and, once again, women became addicted through the help of their male doctors. In addition to prescribing amphetamines for weight loss and barbiturates for sleep, many physicians in the 1960s prescribed addictive tranquilizers or sedatives to reduce anxiety. These substances were heavily promoted by advertisers as a way of helping women get through the day and achieve ideal slenderness (Abadinsky, 1997; Kandall, 1996). Statistics also revealed that the vast majority of prescriptions filled for Valium and Librium were for women, and they were prescribed to counter the effects of other, allegedly non-addictive stimulants they were taking (Kandall, 1996).

The medicinal use of marijuana dates back to ancient China, and during the nineteenth century it was recommended for use as an analgesic, a hypnotic, and a treatment for migraine headaches (Doweiko, 1999). Basing their statements on stories told by their African American grandmothers, a number of students of coauthor Straussner indicated that marijuana was widely used by rural Black women as folk medicine in many Southern communities during the first half of the twentieth century. While the medical use of marijuana within the White community disappeared with the development of more effective medications and growing legal constraints, its use as a psychoactive substance spread during the 1920s and 1930s as a substitute for alcohol. The antimarijuana hysteria during the 1950s—fed by the Federal Bureau of Narcotics, which kept referring to marijuana

as a narcotic—diminished its use by women until the rise of the hippie movement in the 1960s (Kandall, 1996).

Use of all kinds of illicit drugs by female baby boomers was widespread during the 1960s and 1970s; during the 1980s, women's use of cocaine increased, both for its stimulant and appetite-suppressant effects. Crack cocaine, which hit inner-city communities during the mid-1980s, had a particularly devastating impact on Black and Latina women and their families (Straussner, 1994) and brought a renewed focus on the impact of women's drug use on their children (Kandall, 1996). Although some of the concern was justified, much of it was fueled by public hysteria reminiscent of public reaction to the gin epidemic in eighteenth-century London. The concern was directed less toward the addicted women than toward the impact on their children.

A major current issue for women, especially women of color, is the spread of HIV-AIDS. Between 1991 and 1997, the rates of HIV-AIDS in women increased by 364 percent (American Psychiatric Association, 2000). Since the epidemic began, 58 percent of all AIDS cases among women have been attributed to sex with infected partners who inject drugs and, to a lesser extent, to their own injection drug use, often in the company of men (Centers for Disease Control and Prevention, 1998). Thus women's dependence on drug-abusing men can be deadly. Moreover, whereas males financed their drug use through criminal activities, such as theft and drug dealing, women turned to prostitution. As Straussner (1997) indicates, "men sell drugs, while women sell themselves" (p. 21), further increasing their sense of shame and guilt.

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## Treatment of Women with Drug and Alcohol Problems

As seen previously, women's addiction to alcohol and other drugs was often the unintended outcome of the latest well-meaning treatment approaches. For example, morphine was recommended as a cure for alcoholism, and coca syrup was touted as a cure for morphine addiction (Murdock, 1998; White, 1998). Across the Atlantic, Sigmund Freud recommended the use of cocaine as

a panacea for pain, exhaustion, low spirits and morphine addictions. . . . He recommended it recklessly, even sending moderate quantities to Martha Bernays [his fiancée] when he thought her indispositions warranted it. In June 1885—this was not the only time—he mailed to Wandsbek [Martha's home] a vial of cocaine holding about half a gram and suggested that she "make for yourself 8 small (or 5 large) doses from it." She acknowledged the shipment promptly, thanked him warmly, and told him that, even though she did not

need any, she would divide up the shipment and take some of the drug [Gay, 1988, p. 44].

Heroin, as indicated earlier, was widely marketed as a cure for addictions to morphine and codeine, which themselves were recommended originally as cures for opium addiction. And during the mid-1960s, methadone maintenance clinics were established as another “magic bullet” cure for heroin addicts, despite methadone’s greater addictability than the substance it replaced. It is worth noting that Bill Wilson (known as Bill W.), one of the cofounders of AA, took LSD during the 1950s and 1960s under medical supervision as a possible cure for his depression and in line with then widely proclaimed benefits of LSD in the treatment of alcoholism (Abramson, 1967). Moreover, Bill W. even persuaded his spiritual mentor Father Dowling and the two important women in his life, his wife, Lois, and his secretary, Nell Wing, to try LSD (White, 1998).

### Growth of Asylums

In *Slaying the Dragon*, his fascinating history of addictions treatment in the United States, William White (1998) notes that although the idea of provision of care for people who were “mad from wine or beer” has been identified in Egyptian records dating back approximately five thousand years ago, “in America, the idea of creating special institutions and special professional roles for the care of inebriates began in the late eighteenth century and blossomed in the mid-nineteenth century” (p. 22). According to Murdock (1998), “institutions to cure, or at least dry out, problem drinkers were a common feature of the late Victorian landscape. Between the Civil War and the turn of the century, more than a hundred inebriates’ hospitals opened in the United States” (p. 46). Awareness of the special needs of women was evident.

The first institutional programs for inebriate women were started in 1841, when “industrial homes” for women were established by temperance programs (White, 1998). In Chicago, the home of the wealthy Charles Hull served as a residence for the care of alcoholic women. In June 1869, the women moved to the Martha Washington Home, a new institution that was built for them. Hull’s house then became the first settlement house in the United States under the leadership of Jane Addams, one of the “mothers” of social work, who, by the way, also experimented with opium “as a seventeen-year-old seminary student” (Kandall, 1996, p. 18), although she later became an important advocate for prohibition of alcohol and against the sale of pure cocaine (as opposed to the then commonly used cocaine catarrh powders) (Jonnes, 1999; Murdock, 1998).

The fees for treatment at the Washington Home ranged from \$5 to \$15 a week for those who could afford them; treatment was free for the indigent. It is interesting to note that the length of treatment for women ranged from two to four months, in contrast to only two to four weeks for men who were treated in a sister institution. Thus it is evident that from early on, women were seen as needing longer treatment than men.

At a time when many alcoholic women were imprisoned or locked in insane asylums, an increasing number sought voluntary admission to the rapidly growing asylums for inebriates that were being established in the mid- and late 1800s. Although some of the new asylums, such as Kings Country Home in Brooklyn, admitted both men and women, others opened special women's units within their existing programs, and still others were built specifically for women only. The male-to-female ratio of admissions to treatment institutions in the years 1884 to 1912 ranged from 3:1 to 9:1, reflecting a surprisingly large number of women in many of these programs (Lender, 1981). Despite women's great use of treatment services, "stigma and shame . . . shaped the nature of treatment for women. Inebriate asylums that catered to women made special note of the separate quarters and entrances for women whereby the secrecy of their presence could be guaranteed" (White, 1998, p. 44).

### The Cure Industry

Inebriate asylums, whose general success rate was low, gradually disappeared and were replaced by psychiatric asylums and by a tremendous rise in quack "miracle cures." The "cure industry" of the late 1800s and early 1900s included sanitariums, exercise, steam and heat treatments, and special diets. The most famous were the Keeley Institutes, whose use of recovering doctors to provide treatment and other innovative approaches presaged many aspects of modern treatment for addictions. (For a detailed description of the treatment, see White, 1998.) Advertisements for miracle cures were plastered in newspapers and magazines. Although numerous "testimonials" as to the efficacy of these cures and treatment regimens were offered, few data were available regarding outcome or efficacy, and most of them went out of business following the passage of the 1906 Pure Food and Drug Act, although some continued as late as the 1940s (White, 1998); their modern manifestations can be seen in today's herbal medicines that claim to relieve many of life's problems.

Despite the passage of the Harrison Act in 1914, drug maintenance clinics flourished in the 1920s and early 1930s in New York, Memphis, New Orleans, New Haven, Cleveland, and Los Angeles, and statistics show that about 30 percent of

those seeking treatment were women. These women came from diverse backgrounds and included nurses, doctors' wives, and prostitutes (Abadinsky, 1997). As the country moved away from treatment and toward criminalization, these clinics were closed. Women of means could generally still obtain small amounts of drugs from sympathetic doctors, but others were forced to commit illegal acts to support their addiction. As law enforcement sought to cut off the supply, the shame of being addicted increased and drove many women further underground.

In 1940, the singer Billie Holiday was quoted as saying, "There was no cure. They don't cut you down slow, weaning you off the stuff gradually. They just throw you in the hospital by yourself, take you off cold turkey and watch you suffer" (quoted in Kandall, 1996, p. 103). As criminalization took hold, the only treatment that was available was in federal treatment centers that were part of the criminal justice system. Facilities like the Clinical Research Center, a component of the U.S. Public Health Service Hospital in Lexington, opened in 1935 with voluntary and involuntary male clients and began admitting women in 1941 (Dai, 1937/1970). By 1955, over 40 percent of the Demerol addicts at the Lexington treatment facility were women, the majority of whom were registered nurses (Kandall, 1996).

### Modern Treatment for Alcoholic Women

Alcohol and drug treatment programs began to operate widely once again during the 1950s and 1960s. One of the earliest of modern programs established exclusively for the treatment of alcoholic women was Dia Linn, which opened its doors in 1956. It started as a fifteen-bed women's offshoot of Hazelden on a three-hundred-acre estate near White Bear Lake, Minnesota, and was based on a twelve-step abstinence philosophy pioneered at Willmar State Hospital in Minnesota and expanded later at Hazelden. According to Damian McElrath (1981), who chronicled the establishment of Dia Linn (Gaelic for "God be with us—a term expressing polite concern for the status of another person's health," p. 7) on its twenty-fifth anniversary, there were few alternatives for women alcoholics at that time. "Throughout the United States, the female alcoholic had a problem finding suitable and dignified help in the 1950s. It was very much a male-dominated field and the idea of female counselors was hardly conceivable. . . women, for the most part, were still viewed as moral degenerates. Women had few choices: a state institution like Willmar State Hospital in Minnesota, where alcoholic treatment was changing, but the institutional environment was not; or a psychiatric ward where alcoholism was treated as a secondary problem" (p. 3). The author goes on to state, "Local rumors of immorality at Dia Linn, although not rampant, were not uncommon. During the initial years, people would drive by on Sundays actually look-

ing for the wild women drinkers” (p. 11). The women suffered additional discrimination: local hospitals would not accept them when they required emergency treatment during withdrawal from alcohol, and they had to be transported for many miles to a medical clinic in St. Croix Falls, Wisconsin.

From the beginning, female alcoholics at Dia Linn were acknowledged as needing a longer period of treatment than the three weeks provided to men at Hazelden; in recognition of their connection to their loved ones, a family component was established in 1962. By 1963, the program grew to twenty-three patients who were treated by a multidisciplinary staff consisting of a psychologist, nurse, counselor, clergy member, and social worker. In 1966, the women's program was moved to Hazelden in Center City; the merged program served as a model for the many alcoholism inpatient treatment facilities, or rehab units, that opened throughout the United States and abroad during the 1970s and 1980s—what has been termed “the golden age of alcoholism treatment” (O'Dwyer, 1993, p. 121).

### Modern Treatment Approaches for Drug-Abusing Women

Treatment options for drug-abusing women, particularly those using opiates and cocaine, have increased since the 1950s. The two most influential approaches have been the use of methadone maintenance and the development of drug-free therapeutic communities.

Although women were excluded from the original methadone trials (Dole & Nyswander, 1965), the growing numbers of heroin-addicted women in the 1960s and 1970s readily flocked to the new methadone maintenance treatment programs. Reminiscent of the narcotic clinics of the early 1920s, women once again sought “to free themselves from their quest for illegal drugs and their dependence on men as pimps, protectors or sexual partners” (Kandall, 1996, p. 221). From 1969 to 1973, almost one-fourth of the forty thousand patients treated in federally funded drug treatment programs were women, and their proportion quickly increased. In 1973, over a third of all New York City patients on methadone were women (Kandall, 1996). Yet “their specific needs usually remained unaddressed. Early programs were male-oriented and male-dominated. . . . Women in these programs felt pressured to conform to sexual stereotypes, and endured exploitation, voyeurism and psychological abuse” (Kandall, 1996, p. 224). Although some women found methadone treatment to be “life saving,” many others continued to abuse other drugs. Moreover, unlike heroin, “methadone restored women's normal menstrual function, sexual function, and fertility” (Kandall, 1996). Consequently, women on methadone were more likely to become pregnant than those on heroin, resulting in the birth of numerous babies addicted to methadone.

Although most experts felt that it is better to maintain a pregnant woman on methadone and then to detoxify the baby after birth rather than to have the pregnant woman use adulterated street drugs or even to detoxify from heroin while pregnant, the long-term developmental consequences of being born addicted to methadone are unknown (Kandall, 1996).

The term *therapeutic community* (TC) typically refers to a residential, self-help, drug-free treatment program (Abadinsky, 1997). Originated in 1958 by a recovered alcoholic, Charles Dederich, TCs grew in importance during the 1960s and 1970s. Although women were part of TCs from the beginning, the TC's historically highly structured, confrontational, group-centered approach has been seen as "inappropriate for female addicts, who were often guilt-ridden, ashamed of their addiction, involved in debasing and abusive relationships, and in great need of supportive interventions" (Kandall, 1996, p. 204). Coauthor Straussner remembers hearing from one of the earliest women committed to treatment at a TC in lieu of legal action for drug theft at a medical setting in which she worked. As official "punishment" for her perceived "bad attitude" and misbehavior while in treatment, she was gang-raped during her long-term stay in a TC during the 1960s. Although she went on to recover from her drug addiction, the trauma of her rape has stayed with her for years.

TCs became more "women friendly" over the years, and today there are numerous women-only and women-child TCs providing supportive and truly therapeutic communities to thousands of substance-abusing women with no place else to go and without the ability to care for themselves. However, the destructive potential of such programs for vulnerable women needs to be kept in mind.

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## Women and Mutual Aid

Mutual-aid, or self-help, programs for alcoholic women can be traced to the Martha Washington Society, organized in 1841 in New York as a companion to the male-based Washingtonian Total Abstinence Society, which was first established in Baltimore in 1840. In line with their social role at the time, members of the Martha Washington Society encouraged women to abstain from drinking and to banish alcohol from their house. Women members provided food, clothing, and shelter to male "reforming inebriates" (White, 1998, p. 10). However, they also provided "special support to female inebriates and to the wives and children of inebriates. . . . The Martha Washington Societies were the first organizations in the temperance movement in which women assumed leadership roles. They were also the first organized effort to focus on the needs of inebriate women, who were recruited, restored to health, and embraced as full members of the Martha Wash-



ington Societies" (White, 1998, p. 10). For a variety of reasons, the Washingtonian Societies were short lived and few of them remained after 1845.

At the beginning of the 1890s, another mutual-aid group, the Women's Keeley League, was established (White, 1998). Like the Washingtonian Societies, this league was started as a companion to a men's organization, the Keeley League, which grew rapidly during the 1890s to form 370 chapters in over ten eastern and midwestern states. The mission of the league, which originated as a club for Keeley Institute patients, included treatment, prevention, and public education. According to White (1998), the league's constitution listed the following purposes: (1) "curing the drunkard of the disease of intemperance," (2) "preventing the youth of the country, by education and example, from contracting it," (3) binding "together in one fraternal bond all who have taken the Keeley treatment," and (4) "extending public knowledge of the Keeley cure" (quoted in White, 1998, p. 57). The Women's Keeley League included not only the wives, mothers, and other female relatives of Keeley graduates but also those women who "have themselves been delivered from slavery of drunkenness, or opium" as well (quoted in White, 1998, p. 57). With the demise of the Keeley Institutes, the league declined; the last Keeley League National Convention was held in 1897 in Minneapolis, Minnesota.

It was not until the formation of Alcoholics Anonymous (AA) in 1935 that women once again become part of a mutual-aid movement for alcoholics. AA was started by two men, Bill Wilson and Dr. Bob Smith, and initially was seen as aiming at alcoholic men only: "The founding fathers of AA . . . adhered to rather traditional family values and to conservative gender roles. Dr. Bob, for example, was not happy about letting women into AA" (Makela et al., 1996, p. 170). The first women in AA did not do well: "Florence R., whose story appeared in the first edition of the Big Book, and who objected to one of the book's proposed titles, 'One Hundred Men' . . . later returned to drinking and died of alcoholism. Lil, the very first woman to seek help from A.A., got loaded with Victor, another prospect, pioneering what would come to be christened 'thirteenth stepping' (sexual or romantic involvement with someone whose sobriety is relatively new and therefore potentially unstable)" (White, 1998, p. 158). Sponsorship of women was a problem. Initially, nonalcoholic wives of recovering men attended meetings with their husbands, and alcoholic women were turned over to them for help (Coker, 1997). During the early years, AA wives attempted to start a women-only group, which would include both alcoholic women and wives of alcoholic men: "This can be interpreted as support for alcoholic women, but also as a means of protecting wives' relationships with their husbands" (Makela et al., 1996, p. 170). From the beginning, the relationships between the wives and the women attempting to recover in AA were strained, and eventually the wives left to form their own group, which became known as Al-Anon. It is worth noting that initially the goal of Al-Anon was

very much in line with the traditional role of wives: to help women adjust to their husbands' alcoholism and recoveries. Only later did the emphasis shift to focusing on the wives' own needs, a move that allowed the inclusion of a growing number of husbands of alcoholic wives (Makela et al., 1996).

Marty Mann, who joined AA in 1937, became the first documented alcoholic woman to remain sober through AA (Robertson, 1988). She went on to make a major contribution to the field of alcoholism as the founder of what was initially called the National Committee for Education on Alcoholism and more recently renamed the National Council on Alcoholism and Drug Dependence.

The membership of women in AA has increased over the years. AA surveys indicate that the proportion of women rose from 22 percent in 1968 to 32 percent in 1977 (Coker, 1997; Makela et al., 1996) to 34 percent in 1998 (Alcoholics Anonymous, 1999). Although women-only AA groups increased rapidly during the 1970s and 1980s, they seem much less popular today.

In 1975, Jean Kirkpatrick, believing that AA's focus on powerlessness was not appropriate to meet the needs of the already powerless alcoholic woman, founded Women for Sobriety (WFS). The goal of WFS was to increase women's self-esteem, empowerment, and self-reliance and to reduce their sense of guilt and shame. WFS meetings, similar to the women-only AA meetings, grew rapidly during the late 1970s and 1980s. However, by the end of the 1990s, few WFS groups remained in existence.

Thus, despite the increasing recognition of the need for women to connect to other women (Byington, 1997; Miller, 1976), the history of self-help groups for women reveals that most tend to be offshoots of men's self-help movements and that women-only groups, as well as women-only treatment facilities, appear to have a limited life span. Clearly, these dynamics need to be understood better.

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## Societal Responses to Users of Alcohol and Other Drugs

The historical legislative response to the widespread use of alcohol and drugs in the United States has always been strongly influenced by the social forces of racism and economic profiteering, and laws were frequently passed in the guise of saving American women. For example, antiopium legislation was fostered by stories of women being seduced by Chinese white slavers and sex-crazed dope fiends and by the fear that women would become targets of sexually predatory racial groups (Abadinsky, 1997; Kandall, 1996). During the 1930s, anti-Mexican feelings in the Southwest became centered on Mexicans' use of marijuana, resulting in hysterical concerns about how "marijuana has led to some of the most revolting cases of

sadistic rape and murder of modern time” (Earle & Rowell, 1939, quoted in Abadinsky, 1997, pp. 51–52).

Similarly, discussion of alcohol usage during the end of the nineteenth century remained inseparable from “discussion of women’s sexuality, oppression, and physical danger” (Murdock, 1998, p. 78). Fears were rampant about “men who reputedly lured girls into movie houses or saloons, administered a drugged drink or injection, and then entrapped their victims in a life of prostitution” (Murdock, 1998, p. 78). These fears were fueled in great part by anti-immigrant sentiment of the 1840s and 1850s and by “rural, white Protestants antagonistic to urban Roman Catholics, particularly the Irish, who used the social world of the saloon to gain political power in large cities” (Abadinsky, 1997, pp. 24–25).

Recent federal laws reflect our current racial fears and our changing views of women: sentencing for the possession of cocaine show a dramatic disparity between the possession of powdered cocaine, which is more likely to be used by White men and women, and crack cocaine, which is commonly used in Black communities: “In 1988, Congress, responding to the fast-spreading crack epidemic, decided to make the possession of five grams of crack in federal cases punishable by a mandatory sentence of five years in prison. To get a comparable sentence for powdered cocaine, you would have to be caught with five hundred grams, *or one hundred times as much*” (Jonnes, 1999, p. 433, emphasis added).

Consequently, a disproportionate number of young Black men and women are imprisoned “because 88.3 percent of those arrested in federal crack cases are black” (Jonnes, 1999, p. 433). Although the great majority of those arrested are men, it is important to note that since the start of the crack epidemic, the rate of increase in the female prison population has exceeded the male rate (Bureau of Justice Statistics, 1999). Thus women—particularly poor, Black women—are no longer seen as needing protection; rather, as we will discuss shortly, they are seen as part of the problem of the War on Drugs.

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## History Revisited

Women in the United States have come a long way: they not only can vote but also have access to unprecedented political power and economic independence. They also can, and do, use drugs to a degree unseen since the nineteenth century, and drink more than ever before and at a younger age. According to government reports (Substance Abuse and Mental Health Services Administration, 1998), whereas in the 1960s only 7 percent of new alcohol users were girls between the ages of ten and fourteen, by the early 1990s the figure had risen to 31 percent.

Moreover, during the early 1960s, girls were likely to begin drinking later than boys, but by the 1990s such gender difference became negligible. Nonetheless, although alcohol- and drug-abusing women are no longer “invisible,” they continue to be stigmatized, and insurance coverage and treatment resources for addicted women remain woefully inadequate. The early life traumas of today’s substance-abusing women, as well as their inadequate housing and child care, lack of transportation, health and medical problems, low self-esteem, and experiences of discrimination, are just some of the issues that are not being addressed even by those lucky enough to get into treatment (Straussner & Zelin, 1997; Woolis, 1998).

As was true for many of the women in the temperance movement, and for countless others before and since, women today continue to suffer from domestic violence and physical and sexual assaults. The treatment needs of these women are unlikely to be supported by their abusive husbands and boyfriends (Straussner, 1997). Despite these realities, at the beginning of the twenty-first century, women with drug and alcohol problems are once again facing increasing criminalization of their addictions, as states intervene in the lives of pregnant substance abusers in an effort to protect the fetus (Gustavsson & MacEachron, 1997). Health care professionals in many states are now required to report cases of pregnant drug- and alcohol-abusing women. Among the consequences are imprisonment, mandatory treatment, and foster care placement of the child after birth. There is abundant evidence that the laws requiring mandatory reporting are applied unfairly toward poor women and women of color. For example, a Florida study demonstrated that despite equal percentages of Black and White mothers testing positive for cocaine in obstetrical offices, Black women were ten times more likely to be reported to state officials than were White women (Gustavsson & MacEachron, 1997). Moreover, as states struggle to keep up with the federal mandates of the Temporary Assistance for Needy Families Act, women with a history of substance abuse are pushed into the workplace, and the magnitude and severity of their needs are becoming more evident (Bush & Kraft, 2001).

Unfortunately, only a very small percentage of all women—regardless of race, ethnic background, and socioeconomic class—are offered appropriate treatment. Managed care, an industry whose top leadership is overwhelmingly male, has put severe restrictions on treatment access for working- and middle-class substance-abusing women (and men, for that matter, although they are much more likely to have greater resources for treatment and fewer family obstacles). Many communities have long waiting lists for publicly funded treatment for low-income women. Moreover, few facilities, and even fewer appropriately trained clinicians, are available to address the high rates of co-occurring mental disorders common to women of all classes. Thus, at the start of the twenty-first century, and despite the fact that women have “come a long way” and achieved much, many

women continue to struggle alone in their search for an effective solution to their painful addictions to alcohol and other drugs.

## Conclusion

The history of women and addiction presents an opportunity to glimpse the world of American women for the last two hundred years. Women's use of and addiction to alcohol and other drugs is closely related to their dependence on men—including their doctors.

The close connection between the temperance movement, prohibition, and the suffrage movement highlights the linkage between substance use and women's role in society. It is obvious that the treatment of substance-abusing women cannot be viewed without taking into account the social context in which they live. Entire communities, such as inner-city Black neighborhoods, fell apart once women started using crack cocaine—which was supplied by men. Today women pay a high price for the War on Drugs—conducted by men. Yet women are not necessarily helpless victims; they also wield power, which they can use either to save or to destroy themselves. It is our job as clinicians to help addicted women get in touch with this power and use it on their own behalf.

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