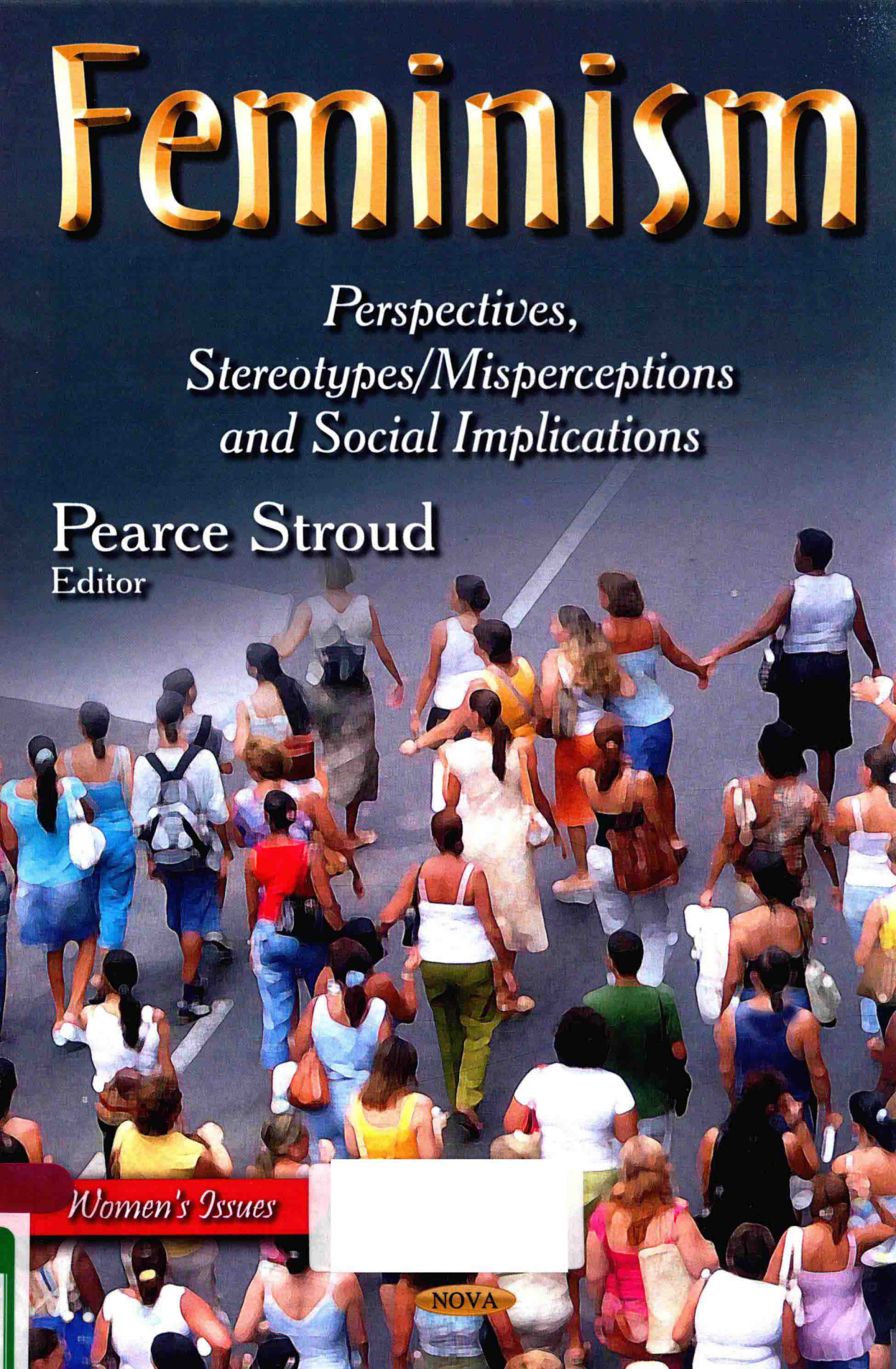
Feminism

Perspectives, Stereotypes/Misperceptions and Social Implications

Pearce Stroud
Editor



Women's Issues

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WOMEN'S ISSUES

FEMINISM

PERSPECTIVES, STEREOTYPES/MISPERCEPTIONS AND SOCIAL IMPLICATIONS

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WOMEN'S ISSUES

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PREFACE

In this book the authors present current research in the study of feminism. Topics discussed in this compilation include the feminist focus on women and substance abuse treatment; the question of whether or not purely female societies can truly exist; women in elite positions within medicine; black women and their situation of discrimination and vulnerability in Brazil; the impact of migration on the reconfiguration of family dynamics; feminism and difference; theorizing African feminism; gender stereotypes and the effect on women's persistence in STEM fields; and an antidote for global feminist gaps as encoded in Sindiwe Magona's black south African autobiographies.

Chapter 1 – This chapter reviews the feminist focus on substance abuse treatment for women, past and present. A brief history is provided to acquaint the reader to the second and third waves of the modern American feminist movement and the emerging women's healthcare agenda subsumed under the wider feminist agenda. Continuities and tensions between the two waves of the feminist movement are reflected in the approach toward women and substance use disorder (SUD). The primary assertion of this essay is that substance abuse treatment has been heavily tied to women's reproductive roles and this is not always as progressive development. Three areas of concern are highlighted as those that the feminist agenda needs to focus. These include the ongoing role of stigma, the nexus between social policy and substance abuse treatment for women, and the service delivery of gender specific treatment. This essay concludes with a forecast of how substance abuse treatment will fare under the Affordable Health Care Act (ACA) and what feminists should be looking toward in order to further advance treatment options for women with SUD.

Chapter 2 – Over the last decades, the possibility, or even the need, for permanent, purely female, societies, has been at the forefront of the various forms of radical or separatist feminist thought. This has overshadowed the fact that purely female societies have been a constant feature in the mythological collective imagination of humankind. And over nearly two centuries, a large number of books have tried to envision, or describe, such societies, as thought experiments rather than as highly controversial statements. Conversely, so insurmountable do the biological hurdles appear that no purely male society has ever been dreamt of, or even described. It is striking that during the actual period when radical feminism was at its peak, scientific progress demonstrated that male and female autosomal (not involved in sex differentiation) genes were not interchangeable and that parental imprinting directed that some genes in the offspring had to originate from either a father or a mother. More recent advances in the knowledge of the epigenetic (not linked to the DNA sequence)

mechanisms have made it possible to disentangle the molecular basis for such parental imprinting.

At the same time, all mainstream scientists have recognized that from a biological point of view, females have certain physiological and psychological advantages over males. And some indications that males could be an endangered species (the fragility of the Y chromosome, the decrease in the sperm count) have begun to emerge. The fact that men might become redundant has become an obvious concern for many scientists independently of sex or gender. Finally, more recently, experiments with female mice have shown that it is possible, through relatively simple modifications of the epigenome, to produce a viable female offspring from two female mice. Such techniques, unlike parthenogenesis, allow gene shuffling and therefore do not freeze the evolutionary processes. It is in the realm of the possible that such techniques might be applied to women, from simple cases (such as permitting a female couple to have children on their own) to more complex or futuristic aspects, such as the establishment of purely female societies.

Chapter 3 – Women are now in the majority of qualifying doctors and within the UK there has been an increase in the numbers of women gaining consultant posts and becoming general practitioners. The authors are interested in the competing views surrounding women in medicine. There are essentialist arguments around feminisation of the profession and the impact of women 'working less' and other ideas that an increase in the numbers of women doctors will change healthcare practices for the worse. The authors contest many of these perspectives and considered how this would be understood by 'women at the top'.

The authors examined the views and experiences of women in 'elite' positions within medicine to develop conceptual understandings about their career trajectories and the implications for women's careers in the future. The participants were 13 women who held the highest offices with medicine, for example, Head of a Royal College. Interviews were undertaken with each woman; 11 face to face and 2 interviews were undertaken on the telephone.

Detailed analysis of the transcripts led to the emergence of three overarching themes: Careers…room at the top? (where the participants described how their gender had influenced their working life); Identity: woman or doctor (where the participants elaborated on how gender defined their role within the profession); Conformity or rebellion: battles and thick skins (where participants discussed and described how they managed the response to their gender within the profession). Within each of these themes the authors related the participants' views and experiences with the current literature and developed a conceptual understanding of the careers of women presently holding 'elite' positions within medicine. Though there have been many changes to women's progression within the profession the authors identified areas where barriers to progression remain. The authors have suggested areas of further work to support changes within the profession to empower women's career progression. Women who currently hold 'elite' positions within medicine are, as expected, in the minority. Alterations to working hours and the introduction of structured training have been helpful to women doctors' careers but cultural change is required if we are not to lose talented women as they climb the career ladder. Similarly women need more support within the profession so they can be empowered to fulfil these 'elite' roles.

Chapter 4 – This article discusses the ways that Black women's bodies and images have become sites of discrimination in Brazil, placing them in enormous vulnerability. First, it conceptualizes vulnerability on the terms of Black women situations in Brazil. Second, it

looks at the link between the Black female bodies, representations, and racial discrimination. This part also reveals the existence of three major gendered-racialized categories of representations of this group of women in the country: sexually promiscuous, domestic workers, and bad or unfit mothers. In order to explore these three stereotypes I employ the concepts of controlling images developed by Patricia Collins (2000) that categorized African-American women representations as: the "mammy", the "matriarch", the "welfare queen", and the "jezebel". I conclude pointing out the major issues discussed in the text.

Chapter 5 – Drawing on participant observation and interviews collected during a critical ethnographic study, this chapter explores the everyday experiences of paid work and caring activities from the perspectives of first generation Haitian immigrant women in the Canadian province of Quebec. Focusing on Haitian cultural traditions and the need to adapt to Canadian social, cultural, and economic contexts, this chapter aims to understand how migration influences Haitian women`s roles and describes the patterns of negotiation used by women to achieve the reconfiguration of gendered roles in the host country. Guided by a postcolonial feminist lens, this study was directed at understanding the gendering and racialization of migration through the prism of caring for aging parents at home. Sixteen participants participated in the study. Participants were recruited through purposeful and snowball sampling strategies. Results show that late immigration of aging parents has an impact on gender roles and family dynamics. Migration makes it necessary for women to involve husbands or spouses in the sharing of domestic tasks and caring activities. This reconfiguration of gendered roles in Haitian immigrant families in Canada illustrates women's patterns of bargaining against patriarchy and decision-processes necessary to conquer and maintain independence and reconcile the demands of caring for aging relatives at home and paid work.

Chapter 6 – While gender categories and post-modern thinking deconstruct "women" as indeterminate names and undecidable individuals, feminism of difference seeks to assert their name, identity and subjectivity. It stresses sexual difference and highlights symbolic motherhood as the key to women's reconstruction. Far from returning to a fixed, substantialist female identity, it transcends it in favour of a creative and reduplicative view of the subject, whose dynamism embraces and sustains the other. Female identity is the source, container and mediator of the human world, a paradigm of the whole. The present chapter explores the way in which feminism approaches sexual difference, reconstructing women's name, identity and subjectivity both politically and ontologically.

Chapter 7 – This chapter explores the questions of whether feminism as such exists in Africa and if so in what form. The chapter attempts to answer the questions of whether there is any discernible feminist school of thought that is actively African, traces the history of African feminism, argues that feminism is not "un-African" and that the concept has always existed in Africa. It further discusses perspectives in African feminist thought, the difference between Western feminism and African feminism and men's presence in feminism while at the same time providing an analysis of key determinants of the solidification of modern African feminism.

While this chapter is anchored in the phenomenon of African feminism as an important contemporary issue, it is not an exhaustive analysis of the prevalent discourses of African feminism as such because of Africa's diversity. However, it is important to note that despite great cultural diversity between and within the geographies of Africa, there are, too, great commonalities in African women's lived experience. It is these shared experiences that have

helped, shaped and developed this distinct brand of feminism, which is universally concerned with the ways women manage and challenge multiple oppressions. Although the polarities of thought on African feminism by scholars suggest some differences, closer examination reveals the intersections that transverse the different perspectives. While all African women experience the world they inhabit differently, they face common struggles.

Chapter 8 – Being a minority in any field or experience creates tension in regard to an individual's identity and sense of belonging. This is true for women in science, technology, engineering, and mathematics (STEM) fields. STEM fields have been historically male dominated. And today, stereotypes still affect the unconscious bias that leads to women's continued underrepresentation and marginalization in STEM fields, particularly physics, engineering, and computer science. Typically the concern is that the men who are the majority in these fields, particularly in leadership roles, are the ones who perpetuate this marginalization, but this study raises the question of what role women, who persist in the fields, play. This chapter is based on a study that focuses on 26 undergraduate women who originally declared a STEM major at a university in the southeastern United States. The participants' narrative life histories focused on their interest in, experience with STEM and the role that their gender played in these experiences. An interesting finding was the stereotypes these women held in regard to women and how these stereotypes could prevent more women from persisting in STEM. The comments raise concerns that women who identify with more feminine traits will still not identify with STEM.

Women's underrepresentation in STEM is a global concern since half of the world's population (females) is severely underrepresented in careers that are important to national health, prosperity, and innovation. In the United States, women represent less than one third of the participants in STEM fields. This underrepresentation of women persists despite policies and programs that aim to provide access to and opportunities for women in these fields. To fully understand the culture of STEM that continues to prevent women from identifying with these fields, one first has to understand the history of women in STEM and the role that feminism has played.

Chapter 9 – The relatively new black woman South African writer Sindiwe Magona's autobiographies *To My Children's Children* (1990) and *Mother to Mother* (1998) urge the agency of oppressed black South African women in a nuanced manner. That she portrays female characters from a characteristically feminist perspective framed normatively within a milieu in which women are confronted by and confront challenges in a racialized and gendered context should not misidentify her as a discursively indistinct feminist writer. This chapter argues that Magona's category of writings epitomized mostly in her two major works hinges on female protagonists reinventing themselves in an exploitative and discriminatory atmosphere not in a way compatible with what are conventionally acknowledged as the types and evolutionary features of dominant feminist theory. The author analyzes Magona's works with the objective of illustrating how they are anchored in fresh explanations of aspects of black south African cultures as mindful of and sympathetic to the social position of women. By a close look at Magona's work and some aspects of black South African cultures constituting the fabric of her art, the author engages earlier feminist interpretations reached by Magona analysts through what she demonstrates to be distorting lenses that deny self-description through (mis)representation. The author makes a distinction between Magona's individual character depiction dwelling on disposition coalescing into what may be understood as individual trait unfolding within a specific cultural matrix, as opposed to a kind

of characterization identifiable as metonymically symbolic of communal ethos. The study seeks to highlight how discourse in Magona's novels contributes to a theory of feminism accommodative of social vantage points hitherto repressed in dominant feminist discourse tilted towards the more powerful centre.

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Chapter 1

LINKING PAST TO PRESENT: FORECASTING THE FEMINIST FOCUS ON WOMEN AND SUBSTANCE ABUSE TREATMENT

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ABSTRACT

This chapter reviews the feminist focus on substance abuse treatment for women, past and present. A brief history is provided to acquaint the reader to the second and third waves of the modern American feminist movement and the emerging women's healthcare agenda subsumed under the wider feminist agenda. Continuities and tensions between the two waves of the feminist movement are reflected in the approach toward women and substance use disorder (SUD). The primary assertion of this essay is that substance abuse treatment has been heavily tied to women's reproductive roles and this is not always as progressive development. Three areas of concern are highlighted as those that the feminist agenda needs to focus. These include the ongoing role of stigma, the nexus between social policy and substance abuse treatment for women, and the service delivery of gender specific treatment. This essay concludes with a forecast of how substance abuse treatment will fare under the Affordable Health Care Act (ACA) and what feminists should be looking toward in order to further advance treatment options for women with SUD.

Keywords: Feminism, healthcare, substance-abuse treatment

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LINKING PAST TO PRESENT: FORECASTING THE FEMINIST FOCUS ON WOMEN AND SUBSTANCE ABUSE TREATMENT

This chapter offers cautions and recommendations in an attempt to frame future, feminist concerns in regard to women and substance abuse treatment in the U.S. In the post-feminist era, it is easy to assume certain problems have been dealt with and therefore no longer need an intense feminist focus. Indeed, the advancement of women's healthcare, in general, has enjoyed much success since the second-wave of the feminist movement.[1] However, in specific reference to substance abuse and addiction, women still experience significant barriers to treatment. These barriers are both structural and cultural, and persist in spite of action taken over the past three decades.

Minority women, in particular, and those of lower socio-economic class encounter more hurdles in attempts to access treatment than other groups. In response to this, third-wave feminists[2] have continued the fight to make addiction treatment more readily available and relevant to those who have least access but often the most need for treatment. This approach has opened the doors for women to get treatment who in the past had been denied due to lack of resources or outright discrimination. Some of the structural barriers have been confronted. However, cultural barriers continue to deter women from seeking treatment. Namely, the pervasive double standard that is applied to women and not to men, the stigma women feel as addicts, and public health policy that seeks to control and punish women rather than treat and rehabilitate. These cultural barriers that are highly gendered are harder, in some ways, to eradicate than some of the more tangible structural barriers. Therefore, this chapter focuses on the chronic, cultural challenges facing women who need help with substance abuse and notes progress made and forecasts concerns that lie ahead. A review of the modern feminist era, both second and third waves, is provided in order to provide a context in which to frame what feminists have been and should be worried about moving forward. Following a discussion about the intersection between feminism and healthcare, areas of concerns specific to substance abuse are presented. These include the ongoing role of stigma, the nexus between social policy and substance abuse treatment for women, and the service delivery of gender-specific treatment.

BRAIDING THE TWO WAVES: FEMINIST MOVEMENT BACKGROUND

Together, the second and third waves of the modern feminist movement have advanced a women's health agenda with some attention given to substance use disorder (SUD). The second wave of the feminist movement, associated with 1960s and 1970s liberal and radical activism, spearheaded the women's health movement that has in large part been incorporated into the delivery of healthcare for women today. The feminist focus on healthcare remains a significant part of the feminist agenda and both liberal and more radical movement influences

[1] The second-wave of the Feminist Movement occurring in the late 1960s through the 1970s was spearheaded by white, middle and upper class women who advanced mainly a liberal, political platform in order to gain gender equity. The second wave is what most people think of when referring to the "Feminist Movement."

[2] Third-wave feminists represent those women :left out" of the second-wave liberal agenda to include minority women, those from the lower-socioeconomic class, and has been extended to include women of the developing world.

can be seen. For example, liberal feminists fought for the protection of privacy in regard to reproductive rights, while the more radical feminists, sometimes referred to as cultural feminists, established women's health collectives. In spite of its ultimate success, the women's health movement as part of the larger feminist movement mirrored some of the same tensions that existed between liberal and more radical feminists in how best to promote, advocate, and practice its agenda including healthcare for women.

The second wave having been much more focused on political advances and protection of civil liberties has given way to the third wave which concerns itself with a broader cultural envelop from which to define feminism. Both the second and third waves encompass aspects of feminist culture but the interpretation of what that culture is changes between the two waves. Amy Richards helps to discern the differences when she refers to the feminist culture of the second wave as a result of politics intertwined with the social activism of the era such as the Kennedy presidency, the Vietnam war, civil rights, and women's rights" while the third wave sprang from a culture of "punk-rock, hip-hop, 'zines', products, consumerism and the Internet." (Baumgardner & Richards 2000). In other words, the culture from which women practice feminism helps to shape the expression of that feminism. Even so, each era of feminism is not completely discrete with a clear cut beginning and end. In fact, various strains of feminist thought can be seen across each wave in the advancement of women's healthcare and specifically to women and SUD treatment.

The liberal feminists of the second wave called for and advanced the women's healthcare agenda. Just some examples of progress made can be seen in the inclusion of women in health research, health occupations, and the overall increase in access to and insurance coverage for women's health. Part of this progress, however, has been shaped by the earlier, almost exclusive, focus on women's reproductive activities. Much of the women's health agenda, in both the second and third waves, equates to women's reproductive health. Linked to this, of course, is the protection of women's privacy rights. Roe vs. Wade was decided during the second wave and still, today, the legislation and policy directly related to this court decision and women's reproductive health remains highly controversial. This intersection between public policy and women's health has only been further knotted together when considering healthcare for pregnant addicts. This focus on reproduction has helped to establish programs specifically for pregnant addicts, a progressive development, but has also further reinforced the focus on reproduction. This is a particularly dubious development when considering minority or socially-disadvantage, pregnant substance abusers. The privacy rights debate has been extended to include the fetal vs. parental rights with pregnant substance abusers the object of this contested policy terrain. Because the focus is on reproductive rights, second- and third-wave feminists have been working together and continuity between the waves has been preserved. However, their mutual interest is more about rights or liberal equity feminism than it is about the unique or culturally specific needs of the minority or otherwise socially-disadvantaged pregnant substance abuser. In any case, SUD treatment for women has never been at the forefront of the feminist healthcare agenda, during either wave. Therefore, any focus, even if heavily tied to reproduction, can be counted as a progressive development.

Although it appears that the liberal feminist influence is dominant, the radical branch of the second wave has informed SUD treatment, as well. The radical feminists of the second wave focused more on consequences of patriarchy than to equity issues and exposed the interpersonal violence against women that cuts across social class, race, and ethnicity. Radical feminists promoted awareness about domestic violence, developed programs to serve victims,

and advanced legal protections for women. Today, during the third wave, domestic violence counseling and referral is a part of SUD treatment. The most progressive treatment example that links violence against women and SUD is trauma-informed care. This model challenges traditional SUD treatment and calls for trauma-based counseling and referral to be offered in all SUD programs. Unfortunately, too few programs have yet to offer this kind of care. In general, these services are not as plentiful as the research that clearly links violence against women and SUD calls for. The public healthcare sector and local social service agencies have attempted to fill the gap but continue to fall short of the demand.

Related to radical feminism is cultural feminism which is sometimes referred to as a depoliticized form of radical feminism. Cultural feminists focus on what is unique to women and celebrate the difference between women and men rather than have women work to become more like men. In terms of healthcare, cultural feminists brought forth a holistic approach toward women's health and the best second-wave example of this is the publication of "Our Bodies, Ourselves."[3] Again, largely focused on reproduction, the second-wave feminist health movement called for the acknowledgment that women have unique healthcare needs and also challenged the traditional practice and delivery of medicine. Demystifying healthcare and particularly pregnancy and childbirth brought with it the practice of "natural childbirth," midwifery, breast feeding enthusiast (the La Leche League) and other holistic approaches toward reproductive activities. Today, birthing classes, women's clinics and birthing rooms in hospitals capture some continuity between the second and third wave. Also, specific to women and SUD, residential programs offer services for pregnant women and accommodations for young children to live with their mother while she recovers.

Today, the question is not what type of feminism or theoretical perspective should be applied when advancing women's health but rather, "What should the priorities within the women's health agenda be and to what extent should women's health occupy the larger feminist agenda?" Some feminists allege that women's health has taken on too much attention while others argue that it remains the cornerstone of the larger feminist movement. In the most striking critique, it has been leveled that the fight against breast cancer has become the new feminist movement (Ehrenreich 2009). Whatever place it occupies within the current feminist movement, women's health is the best platform from which to gauge how well (or not) women are doing in regard to substance abuse treatment.

FEMINISM AND SUBSTANCE ABUSE AND ADDICTION

Feminists, generally, continue to cite that substance abuse and addiction is a women's issue but do not actively pursue it as a research agenda. Although largely viewed as a man's problem until most recently, women have been closing the gap in use, abuse, and addiction to alcohol and other drugs (AOD) (Greenfield, 2000). Liberal feminists have offered that women are catching up to men (for better or worse) and that more substance abuse is a natural growth of full emancipation of women. It has been further argued that AOD use is, by itself, a

[3] "Our Bodies, Ourselves" was written in the early 1970s by the Boston Women's Health Book Collective and is in its 9th edition published by Touchstone, New York. Its focus remains women's sexuality and reproductive health but has expanded to include topics ranging from sexual anatomy, body image, and gender identity to pregnancy and birth, perimenopause/menopause, and navigating the healthcare system. Please visit http://www.ourbodiesourselves.org/ for more information.

feminist act. The so called "liberation hypothesis" helps to explain women's use and abuse of substances. From this perspective, substance abuse is a form of resistance that allows women the opportunity to break from traditional gender roles and therefore can be empowering. However, other feminists are not comfortable with this explanation and some assert that Women Studies Programs are not much interested in this topic of women and substance abuse because it is tied to consumption (Schmidt & Weisner 2002). It is perceived that women who abuse substances are acting without constraint which is a necessary personal characteristic for the market economy. An alternative perspective, and one most aligned with a cultural interpretation, points to the pervasive stigma attached to women as substance abusers and the "double deviance" (Copeland 1997) that is perceived of women who are substance abusers. Underlying the construct of double deviance is the double standard that stigmatizes women more than their male counterpart for engaging in the same behavior, in this case, abuse of substances. The double standard is clearly seen in the pervasive images of the fallen woman, the "crack whore," and the bad mother. These are cultural stereotypes that are far from liberating and contradict the claim that substance abuse among women is a form of empowerment, as a liberal feminist might assert. Therefore, a more radical critique is needed in order to learn more about why the feminist community does not contribute more to the study of women and SUD. A cultural analysis that includes race and class considerations in addition to gender is sorely needed. Both second- and third-wave perspectives can help to shape a cultural analysis that can bring back into focus attention on women and substance abuse.

A third-wave perspective, developments in the feminist movement during the 1980s forward, tends to specifically address the needs of women who have been at the margins of both society and the feminist movement. Women of color, poor women, and more recently lesbian women have been included in the third wave. Sometimes simply referred to as studies in race, class, and gender, Women's Studies Programs and other social science disciplines have helped to extend the feminist agenda to become more inclusive of all women and not just represent the white, middle-class women of the second wave. This umbrella of inclusion has grown to include women of the third world (or developing countries), women with disabilities, immigrant women, and others. In reference to healthcare and women with SUD, in particular, the third wave has extended the second-wave focus on the alcoholic woman and the prescription drug addict to include women who are addicted to illicit drugs. Along with the emphasis on drug abuse, has come attention to STDs, HIV/AIDs, and hepatitis. A third-wave critique further echoes the sentiment mentioned in the previous passage that attention in healthcare is given to the Pink Ribbon Campaign for Breast Cancer but not to the Red Ribbon Campaign for AIDS. This critique is an example of the continued tension between those who represent the second wave and its health concerns and those who represent the third wave and its health concerns. Given this example, the second and third wave are more about who each represents than to a particular time within the feminist movement.

Some feminists of the second wave have criticized the primary resources for addicts in recovery—the twelve-step movement. Second-wave feminists have leveled concerns that the recovery movement is apolitical, that it focuses on individual spiritual development rather than political empowerment, and that it represents a male-dominated subculture. Criticism of the twelve steps, the movement literature, and the twelve-step culture have been registered, as well (Rapping 1996). Given the anonymous nature of the twelve-step movement and it

singleness of purpose,[4] women have not advocated for themselves as recovering addicts outside the rooms of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) and other twelve-step fellowships. This silence has contributed to the critique that twelve-step fellowships are anti-feminist. The perception is that women in the twelve-step programs are self-absorbed and working on emotional problems rather than seeking to advocate for social change. This is a departure from the second-wave feminist agenda.

A third-wave approach, on the other hand, allows for many and varied ideals of empowerment including spiritual reference and does not equate feminism with political advocacy. Yet, even with a more inclusive or compatible understanding advanced by third-wave feminists, the twelve-step movement remains closed in its singleness of purpose and women still do not disclose their involvement. This continuity of anonymity between waves makes it difficult to highlight the success of treatment and recovery rather than the failures. Moreover, while twelve-step recovery is an informal, voluntary, and ongoing support system and should not be considered the same as formal, professional treatment, the two are often viewed similarly. Indeed, as much as 49 percent of those who attend AA or NA report having been referred to the twelve-step programs by a professional treatment provider (AA 2007; NA 2009), but the two venues, treatment and recovery, are distinctly different.

Just as the twelve-step movement is apolitical, the therapeutic enterprise is not political either. Feminist therapists work to empower women but the therapeutic alliance by its very nature is a private and individual act. Mental health experts, even those with a feminist leaning, are not looking for collective change but individual transformation based on psychological rather than changes in the social structure. Therefore, those therapists who may support feminism as a movement look disinterested in its political and research agenda. Today, the therapeutic may take into account women's oppression, structural constraints, and the stigma associated with women and addiction but the therapeutic exercise remains focused on the individual. This continuity, reliance on therapy and treatment, reflects a private rather than a public concern.

A reoccurring cultural challenge for women and SUD treatment is the persistent stigma attached to women with SUD. Both waves of the feminist movement have acknowledged that perceived stigma acts as a barrier to seeking treatment. However, neither wave has fully recognized the extent to which stigma has permeated the study of, the policy that governs, or the other social institutions involved with SUD treatment. It is the argument of this work that stigma persists due to the continued double standard applied to women seeking SUD treatment and that the double standard is reinforced by the almost sole focus on reproductive roles. The remaining discussion will focus on three areas related to this assertion about the role of stigma and women's SUD treatment. First, a general discussion about stigma and how it is shared across different parts of the AOD field is provided. Second, public policy concerning women's reproductive roles as related to SUD is summarized, and thirdly, an abbreviated review of the gender-specific treatment available is noted. Finally, this essay turns away from stigma and its effects to the promise of the recently legislated healthcare reform and what it will do for women and SUD treatment.

[4] The twelve-step model states in its traditions that its sole purpose is to help the addict (or alcoholic) who still suffers. The traditions that guide the twelve-step groups and organization discuss issues related to preservation of the program by not aligning itself with any outside causes, politics, creed, controversy, and in general, has no public opinions.