



# **POSITION PAPER: GENDER-SPECIFIC TREATMENT & RECOVERY**

## **ABSTRACT**

An exhaustive document elaborating on women and addiction, the stigma they face, the risks, the concept of recovery, crosscutting issues, and ways forward to allow women with substance use disorders to receive the necessary services while reducing barriers to their treatment and recovery.

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# 1.

## WOMEN & ADDICTION

Substance use has been subjected to gender-differences historically. Generally, men have higher rates of use or dependence on illicit substances than women. However, the so-called 'gender-gap' is narrowing amongst adolescents. While women typically begin using substances later and at lower levels than men, their use escalates [to addiction] quicker. Additionally, women may be more susceptible to cravings that lead to relapse, which is the key phase of the addiction cycle.

Women generally have different substance use patterns than men and face unique obstacles to access [effective] treatment. The unique issues of substance use are partly influenced by sex (differences based on biology) and gender (differences based on culturally defined roles for men and women). Substance use among women can be triggered by physical or mental health issues, economic deprivation, and trauma connected to physical or psychological abuse in childhood or by abusive partners. Women facing addiction are

### Understanding the Cycle of Addiction:

Understanding the cycle of addiction (Figure 1) is necessary to be able to receive and provide support. As a person continues using an addictive substance, their body grows more used to the effects. Consequently, they need more of the drug to feel the same effects. This sets up a dangerous pattern that can lead to addiction.

Once an addiction forms, a person often remains trapped in a vicious cycle. If they try to stop using the substance, they, for example, may face bothersome physical withdrawal symptoms. Additionally, the desire to experience the pleasurable sensations that substance abuse creates is strong and can lead to severe cravings. These factors combined create an addiction cycle that is difficult to break without professional help.

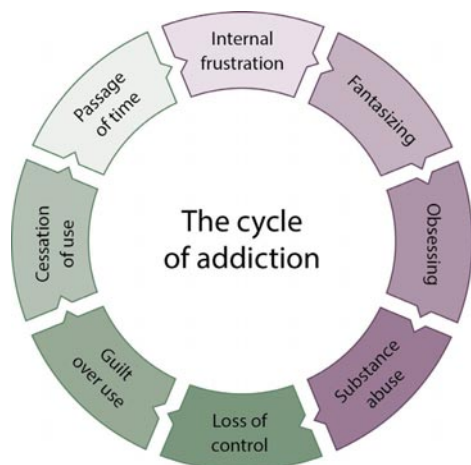


Figure 1

Additionally, several sub-groups of women with substance use problems have special needs. These subgroups often intersect or overlap and include pregnant and parenting women; women involved in sex work, who may often experience violence and stigma; women from ethnic minorities; immigrant women; women who have been trafficked; women in prison; elder women; women with disabilities; and those within the LGBTQ+ community. Special attention should be provided to women who live with a partner addicted to substances. Many women do not only have a substance dependency. They also often experience co-dependency related to their partner's substance use disorder, including frequent psychological and physical abuse.

4

Drug dependence is ranked in the five most stigmatised health conditions in the world, with stigma being a major problem for people affected by substance addiction and their families. The UK Drug Policy Commission defines stigma as "an indelible mark or a stain, and the term is generally applied to an attribute that makes a person unacceptable in other people's eyes". The effects of stigma on women are far-reaching and pose barriers that hinder women's access to treatment and recovery and it can accentuate negative feelings of shame and isolation (see figure 2).



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social and family responsibilities while using drugs. Overall, women are more likely to progress rapidly to serious and complex consequences upon substance initiation than men. For this reason, women who eventually enter treatment usually have heightened and severe profiles of social, medical, and behavioural problems. Therefore, it is particularly important to include sensitivity to stigma in all aspects of prevention, treatment, recovery, and reintegration programmes for women and girls. Simultaneously, it should be aimed to decrease stigma on all levels (including professionals, service commissioners, governments, civil society, etc.), to address barriers and encourage women to embark on the recovery journey earlier on.

## 1.2 Gender-Based Violence

Gender-based violence (GBV) is strongly correlated with substance use. GBV is an act done to someone against their will based on gender norms and unequal power relationships and often involves crimes of power intending to degrade, humiliate, and subjugate victims. There are different forms of GBV, including physical, sexual, psychological, material, and socio-economic violence. Gender-based violence is not always between partners but can also be between family members or happens in the community and has no age limit. Gender-Based violence is reportedly higher among women who use drugs, where the violence is not only perpetrated by family members but by service providers, acquaintances, and other role-players within societies. Some studies even show that women who use drugs have a 2-5 times higher prevalence of GBV than women who do not use drugs.

Gender-based violence towards a partner is also known as Intimate Partner Violence (IPV). One explanation of IPV can be toxic masculinity, which refers to a narrow and oppressive definition of manhood where ag-

gression is valued and emotions are seen as a “feminine” weakness. Elements of toxic masculinity include:

- Solving problems with aggression or physical violence
- Viewing women as inherently weak and inferior
- Being reluctant to accept help from others
- Ignoring potential health problems for fear of being seen as less than manly
- Avoiding talking about unpleasant emotions, including sadness, fear, anxiety, and frustration
- Forming shallow and superficial connections to others instead of discussing genuine thoughts and feelings
- Taking unnecessary risks with your safety to prove that you are “brave”
- Using drugs and alcohol as a form of stress relief

Not only can substance use lead to violence by the perpetrator due to it being used as an excuse or trigger to adopt a controlling and violent behaviour, but it can also become a coping mechanism of traumas and emotional and physical pain for the victim. In a situational relationship, involving GBV and substances, the woman who experiences abuse may use substances together with her abuser in an attempt to manage his violence and increase her safety or she may be forced to use substances with her abuser. Additionally, women using substances, such as alcohol and [illicit] drugs, are more likely than non-substance using women to live with men who use substances, leading to a higher risk to face physical violence. Finally,

women who use drugs may be less likely to have the social and financial means to escape from their abuser. They might not report the violent attack due to the fear that their partner will physically, emotionally, or financial retaliate. At the same time, stigma in the communities also stops women from speaking up and reporting violent cases. Not only will the women remain subject to violence and possibly use substances, but the violent and substance use pattern can also become generational. Hence, the need to include gender-based violence specific treatment in interventions while creating a safe environment for the abused women and encouraging them to leave the violent situation, speak up, and enter substance use treatment.

### *1.3 Sexual abuse*

Globally, it is estimated that up to 1 billion children aged 2–17 years have experienced physical, sexual, or emotional violence or neglect in the past year. 1 in 3 women globally

has experienced physical or sexual violence. These types of traumas often make up the root causes of developing an addiction for girls. Therefore, the trauma has to be addressed parallel with drug-related issues to make the process effective.

Women who use drugs are more vulnerable to substance-related pathologies and often more exposed to physical and sexual abuse and violence. Substances can be used to incapacitate their partner to perform sexual acts that they would otherwise not agree to. The partner can also force sexual favours. Sexual abuse attracts more stigma and together with the stigma around substance use, they can complicate the treatment of both the addiction and trauma related to sexual abuse. A misconception that sexual and other violence is a result of consumption of substances by the victim is present globally. Instead, it should be recognised that trauma often leads to substance use and that trauma-informed treatment programmes are very much needed.

# 2.

## [LACK OF AVAILABLE & ACCESSIBLE] TREATMENT

Treatment of substance use disorders can take many different forms and may vary in intensity and length. Treatment can support the person to stop using substances whilst also supporting initiation of the recovery journey and active participation in family, work, and society. There is a growing body of research done on effective evidence-based treatment programmes, including the need for behavioural counselling, evaluation of co-occurring health issues, follow-up, after care, etc.,

According to UNODC data, only 1 out of 8 people who use drugs receive treatment worldwide. In the case of women, this percentage is even lower. Not only stigma and certain barriers withhold women to enter treatment, for many women treatment is inaccessible. It has been shown that women have specific needs and require gender-sensitive treatment. Currently, most treatment services are catered to meet the needs of men and are, therefore, less likely to be effective due to the lack of gender-sensitive and gender-disaggregated evaluation. To increase effectiveness, treatment services need to acknowledge the barriers, stigma, normative expectations, etc. that women face, including the high prevalence of violence and other types of abuse, and ensure trauma-informed and gender-sensitive interventions.

Below, the definition of and principles for gender-responsive services and the Women's Integrated Treatment (WIT) model are presented as a guideline. This model is based on three foundational theories: relational-cultural theory, addiction theory, and trauma theory. It also recommends gender-responsive, trauma-informed curricula specifically for treatment services geared towards women and girls. The six principles of the Trauma-Informed Approach, to which the application thereof is highly recommended by the international scientific community, are particularly relevant to women.

*The six principles of the  
Trauma-Informed Approach  
(See figure 3)*

- Safety and Gender-Based Violence (GBV): women may find it exceedingly difficult to access services when they are at continued high risk of GBV or Intimate Partner Violence (IPV), which they already experience in their everyday life.
- Trustworthiness & transparency: trust is critical for women in treatment. Therefore, the treatment service providers need to systematically work on [improving] the process of developing trust.

- **Peer support:** support from other women in treatment is perceived as a fundamental part of the recovery process.
- **Collaboration & mutuality:** without feeling part and a protagonist of her recovery process, women in treatment are at a higher risk of perceiving the perpetuation of their victimisation.
- **Empowerment & choice:** globally, women are often marginalised and often deprived of formal education and professional training opportunities. Providing a development path to these opportunities within the treatment process will contribute significantly to enhancing their self-esteem and self-confidence. It provides them with the opportunity to make their own choices and decisions relating to their future.
- **Cultural, historical & gender issues:** these issues are imperative when implementing services that are welcoming and accessible to women

Treatment services that do not meet the above requirements can add significant risk to women seeking and gaining access to suitable treatment. The existence of services that can meet women's needs are a strong indicator of the community capacity to eliminate stigma. Overall, treatment services for women should include a holistic and women-centred approach where a safe a trustworthy environment is created through, for example, staff selection, programme development, programme content. This environment should understand and respond to the challenges and strengths of the women.



Figure 3

# 3.

## REHABILITATION

**R**ehab or rehabilitation is part of the treatment process for people with substance use disorders. Rehabilitation refers to a wide range of approaches that are used to treat emotional and psychological problems and is considered an important step in the recovery process. Aftercare is an important part of rehabilitation, which aims to provide long-term support, help individuals avoid relapse, and achieve full recovery. Rehabilitation, together with the whole treatment process, aims to let people return to productive

functioning in the family, workplace, and community and become full members of society. Figure 4 showcases the essential elements of recovery-oriented rehabilitation and social reintegration (WHO and UNODC 2020).

Rehabilitation programmes are implemented in residential centres or outpatient programmes, where people with addictions can participate in the various phases of the programme. Gender sensitivity should also be included in rehabilitation services/interventions.



Figure 4

# 4.

## THE CONCEPT OF RECOVERY

**R**ecovery is a process through which an individual is enabled to move from problematic substance use to a life without substances as an active and contributing member of society, as illustrated in Figure 5. This change is necessary for individuals to stop committing crimes, harming themselves and their community, and contribute successfully to society.

Services such as substance use disorder treatment, psychosocial treatment, trauma counselling, rehabilitation centres, harm reduction programmes, various social integration services, and others, have their place in the recovery process, which is one of the strengths of this approach. All services that promote

CHIME (Connectedness, Hope, Identity, Meaning, Empowerment) can be considered successful and desirable. Recovery is often initiated with the support of a professional but upheld through peer support and supportive communities. Services offered within the recovery journey should include gender-sensitive interventions, recognise the various needs and co-occurring health issues, and be defined by the individual. Simultaneously, the stigmatisation of the women who use drugs and those in recovery must be reduced urgently. For a successful recovery from substance dependence and trauma, the availability of and accessibility to peer and community support services are necessary for women to sustain recovery.

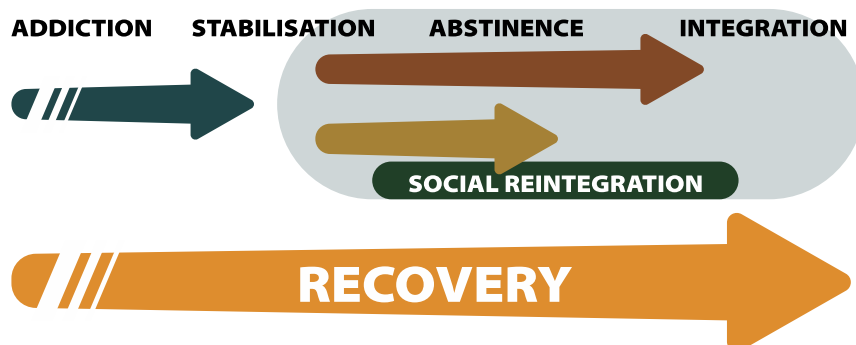


Figure 5

# 5.

## SOCIAL REINTEGRATION

Ideally, social reintegration should be seen as an integral part of the treatment process. The EMCDDA uses the following definition of social reintegration: *“Social reintegration is defined as ‘any social intervention with the aim of integrating former or current problem drug users into the community’”*.

The three ‘pillars’ of social reintegration are (see figure 6):

- (1) housing,
- (2) education, and
- (3) employment (including vocational training).

Other measures, such as counselling and leisure activities, may also be used. Besides the three pillars, reunification with the family/children is important for mothers to remain motivated to sustain recovery. Often mothers in early recovery can face numerous challenges and stressors associated with reunification. For example, time-pressured recovery deadlines to avoid termination of parental rights, sustaining recovery activities while assuming the parenting role, managing the effects of the previous substance use on their children’s mental and physical health, etc. Preparatory skills, such as

parenting, stress, and anger management, will help to support positive social reintegration.

Additionally, reintegration requires long-term aftercare services that support the recovery process after finalising the treatment programme as women will remain to face social stigmatisation and punitive barriers. Aftercare services include, for example, support groups and self-help groups, and help to sustain the recovery process. Simultaneously, a continuum of care should be made available, including psychotherapies, vocational training, employment programmes, etc.



Figure 6

# 6.

## CROSSCUTTING ISSUES

### *6.1 Pregnant women*

Substance use during pregnancy is not only harmful to the mother but also to the foetus. The severity depends on the type of substance. Hence, substance use treatment is necessary for the mother and the newborn, since the newborn can show withdrawal symptoms and other health risks after its birth.

The current approaches for pregnant women who use drugs are most often limited. There are, unfortunately, no universally established treatment standards for pregnant women with SUDs or newborns. Concurrently, pregnant women often face further barriers to entering treatment. Not only do they face guilt towards the foetus and fear regarding motherhood, but they also face stigmatisation by the community as well as medical caregivers. Besides this, pregnant women might struggle with physiological problems linked to pregnancy and SUD, face economic hardship, and often are in a relationship with substance-using men. Within the limited availability, research has established the value of evidence-based treatments for pregnant women (and their

babies), including medication. Even though medication in the substance use treatment of pregnant women is often not approved by the authorities, the inclusion of methadone or buprenorphine has been considered to be helpful in opioid dependency. It is important to note that the risks should be weighed against the benefits, taking into account the possible short- and long-term consequences for the child.

Treatment services need to offer pregnant women a non-judgmental environment with respectful healthcare providers with whom they can build up a trustworthy relationship. Healthcare professionals should be trained to meet the special [and often multiple] needs of pregnant women while recognising that pregnancy can be a strong motivator for the woman to stay in treatment. Additionally, a multidisciplinary treatment approach should be adopted, coordinating between the different needed services. The main goal of the treatment should be to stabilise the mother in her substance use and prepare her for motherhood to be able to care for her newborn child. Finally, more research on the SUD treatment of this particular group needs to be established.

## 6.2 Women with children

A relatively high percentage of women who use drugs have children. Considering the usual difficulty for women to access treatment, it may be nearly impossible for mothers in particular contexts. Residential centres deny access to the residents their children and the parental responsibilities make it difficult for women to regularly participate in outpatients' programmes. Additionally, women experience the risk, or fear thereof, of losing the custody of their children which is decided by the courts. This often prevents women from asking for help or seeking treatment.

Preferential access to treatment/recovery should be guaranteed to give women with children the dignity of a treatment path tailored to their needs. Of utmost importance to include in these tailored programmes is a strengthening families and parental skills programme, which must include the life partner if s/he is present in the lives of the woman and child(ren). Of equal importance is to provide them with the tools for the economic sustainability of the family: vocational training, job opportunities, and support in-home seeking. The process must be based on a principle of a continuum of care that extends its action to include an accurate and accompanied social reintegration.

## 6.3 Women with Disabilities

Overall, people with disabilities, including physical, learning, and other disabilities, have a higher rate of substance use dependency. They oftentimes face various triggers that may encourage substance use and encounter problems such as personal adjustment, normalisation, socialisation, and health-related difficulties. Research on substance use among people with disabilities is growing, yet the gender-disaggregated data is lacking.

Generally, women with disabilities who are in a position of dependency face greater risks of partners' and professionals' violence and neglect. Many women with disabilities who struggle with addiction live with abysmal finances and face oppression based on their gender, ability, and substance use. The addiction can become a tool to oppress and execute violence by the partner or professional. In treatment and recovery, it is a prerequisite that the special needs of women with disabilities are met, and their integrity and boundaries are respected. This entails that treatment professionals and other services are well acquainted with knowledge and tools to offer the best services and do not act on prejudice or preconceptions based on normative ideals of how women with a disability are or should act. The person with a disability should be supported in setting boundaries and building mutual trust.

The treatment programmes, thus, should be design-based on individual needs, including additional screening, are trauma-informed, built to protect and maintain personal integrity, and involve the person him/herself. It is important to note that the Convention on the Rights of Persons with Disabilities (CRPD) adopted by the United Nations in 2006 states that obstacles must be removed for persons with disabilities and have their full human rights respected. Finally, more research and evidence-based programmes need to be established for women with disabilities.

## 6.4 Elderly Women

Substance use among the elderly community has long been an under-researched area, even less so among elderly women. Substance use patterns tend to be different among elderly people and younger age groups. They are less exposed to new drugs and rather follow the drug patterns as used in their younger years.

Although typically, substance use declines after young adulthood, SAMHSA concluded in 2018 that in the United States, nearly 1 million adults aged 65 and older live with substance use. It has been showcased that in some countries the use of substances is growing at a faster rate among elder people than younger age groups.

More research needs to be conducted on the effects of substances on the ageing body and brain. Yet, it is recognised that the metabolism of substances of elder people is slower and their brains can more sensitive to drugs. Generally, elderly people are more likely to experience health issues, such as mood disorders, lung and heart problems, memory issues, etc. These conditions can be worsened by substance use as well as being a trigger. Additionally, the use of substances and their effects, such as impaired judgement, coordination, or reaction time, can lead to accidents causing injuries that need a possible longer recovery time than younger persons. Another risk that occurs is the need for prescribed medication for chronic health conditions, which makes the older group more exposed to potentially addictive medication. Accidental misuse of prescribed drugs is another risk that needs to be considered.

Appropriate substance treatment for elder people is challenging due to the insufficient amount of research on evidence-based interventions. Important to consider within effective treatment is that older drug users, in combination with medical and psychiatric problems, often live with the negative social consequences of long-term drug use. Older users are more likely to be socially and economically disadvantaged and marginalised, with a greater chance of having experienced homelessness or periods of incarceration, are experiencing isolation, and often lacking social support.

Therefore, more research and evidence-based

treatment need to be established to be able to offer effective interventions for the elderly population, including all social and psychological factors.

## 6.5 Women and crime

Illicit substance use, by definition, is a crime. Illicit substance use linked to law-breaking behaviours has long been dominated by men. Hence, women's patterns of illicit substance use related to criminal activities must be addressed within the broader context of gender differences in criminal and delinquent behaviour. The literature reviewed here is unequivocal on two points: research on women has been neglected in the fields of both criminology and addictions, and male and female patterns of both crime and substance use are very different.

Substance use is one of the factors associated with women's path into the criminal justice system. Female offenders have a high prevalence of substance misuse, which has strongly correlated with repeated involvement in the criminal justice system. Female offenders have reported that substance misuse was a consequence of a previous "battering incident" where substances were used as a way to "reconnect" with men. Additionally, imprisoned women also emphasized their entrance into drug trafficking and the criminal justice system co-opted by their intimate partners. A vast majority of qualitative studies used a pathway perspective to construct pathways to highlight important features or events that lead women to offend. One pathway tracked women in the street environment who likely ran away from abusive homes and became involved in the criminal justice system due to theft, substance misuse, drug dealing, or prostitution; that is, survival strategies were, in and of themselves, criminal.

Offering appropriate and gender-sensitive

substance use treatment and rehabilitation services to incarcerated women is of high importance. The [often traumatic] experiences mentioned earlier need to be included in the treatment for it to be effective as well as co-occurring conditions, such as mental health. For those with children, parental support will be useful as children are often a motivation to sustain treatment. *(Find more information on the topic under section 6.1 and 6.2)* Similarly to other cross-cutting issues, more research and evidence-based programmes need to be established for incarcerated women with substance use disorders.

## 6.6 Women in Homelessness

Women living in street-based communities are more likely to use substances than women who are housed, and the number of women living on the street is continuously growing. Since women who experience homelessness are exposed to multiple traumas, experience a high mental health burden, the risk of substance use increases to either support, distract, or cope. These traumas can be caused by various events, often greatly influenced by adverse childhood experiences or dysfunctional families/relationships, including parental addiction, [domestic] violence, physical, emotional, mental, or sexual abuse, neglect, etc. Additionally, women living in street environments often face unemployment, which can stimulate substance use. Simultaneously, substance use is a significant reason for Any combination of mental illness and co-occurring people to experience homelessness. Lastly, those in living in street environments face stigmatisation by the society, which is often intensified when the individual uses substances.

Overall, homelessness is a complex social problem with a variety of underlying economic and social factors and can be temporary as well as long term. Women living in

homelessness face victimisation and co-occurring issues, such as health risk behaviours, mental health problems, and substance use disorders. Addressing risk factors and violence within this key population requires a significant focus on their social context. In treatment, the burden of past traumas, Intimate Partner Violence, mental health, and other health conditions need to be considered to fully understand their substance use disorder. Further evidence-based practices and methods, including co-occurring issues, needs to be established for this key population. Additionally, within trauma work, addressing feelings of shame, emotional distress, and depression should be addressed while preventing re-traumatisation. Simultaneously, additional support should be provided to those living in homelessness, such as housing, reintegration, and support in recovery pathways. Furthermore, awareness programmes reducing stigmatisation will allow the community to understand, help, and support those living without a home, stimulating reintegration. Besides this, the local government and criminal justice responses to women without homes should be reconsidered by policymakers while promoting human rights, health, and welfare of individuals. Finally, treatment and screening services should become more accessible towards women living in homelessness.

## 6.7 Women with co-occurring mental health conditions

Any combination of mental illness and co-occurring addiction is referred to as a dual-diagnosis or co-occurring disorder. As showcased in figure 7, comorbidity can worsen both diagnoses. According to the National Association for Alcoholism and Drug Abuse Counsellors, women are at a higher risk for developing a co-occurring disorder. Results from the 2018 National Sur-

vey on Drug Use and Health show that approximately 4.3 million women (about 3% of all women in the United States) have both a substance use disorder and a serious mental illness. Women are less likely than men to pursue substance use disorder treatment due to the fear and stigma involved in receiving treatment. Unfortunately, many of the women with a dual diagnosis who do enter rehab programmes experience poor treatment outcomes. This can be partly explained by the fact that most unisex treat-

ment centres are not equipped or properly trained to treat the issues of most concern for many women, including childhood trauma and abuse.

Therefore, it also remains important for this group to receive gender-sensitive treatment programmes, a safe environment, a holistic and multidisciplinary approach, and receive treatment for the co-occurring mental health conditions simultaneously.

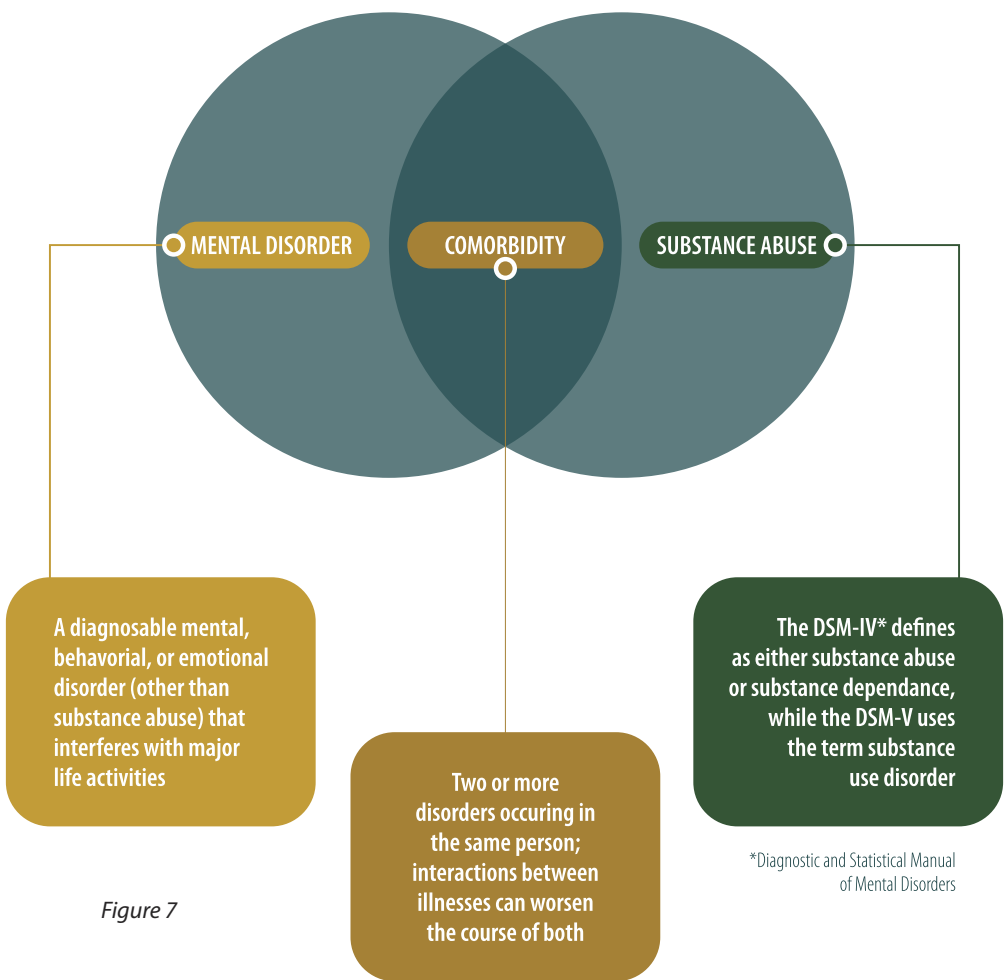


Figure 7

# 7.

## PRACTICAL WAYS FORWARD

Women facing addiction are associated with vulnerable and abusive situations. Society needs to acknowledge the important role of supportive communities in reintegration and agency of the women. Gender-based violence and Intimate Partner Violence (IPV) has emerged as the most critical and widespread issue, plagued by a lack of institutional support and reliable data. It is acknowledged that gender-based violence is rooted in women's unequal status reflecting the unequal distribution of social, political, and economic power between women and men in society along with gender-based stereotypes and biases. It can also be concluded that research is yet lacking on many cross-cutting issues and treatment should be approached holistically and adapted to the individual needs. Only by considering all needs, creating a safe environment, respecting the woman in treatment, destigmatising substance treatment within society and professionals, and supporting family-based reintegration, a sustainable recovery can be aimed.

Various action points should be considered when going forward in research on treatment as well as in the establishment of treatment for all.

- Emphasise the need for trauma-informed, evidence-based, gender- and culturally specific/transformational treatment.
- Accessing treatment barriers must be addressed by ensuring that healthcare and social services are both sufficiently available, trained, and appropriate to the needs of their client groups.
- Destigmatise women who use drugs and recognise the need for treatment not only among society but also among health care professionals
- Establish the use of gender-sensitive and trauma-informed indicators within monitoring and evaluation systems, and include gender-disaggregated data, as well as follow up of women seeking support services.
- Pledge for short- and long-term interventions and a continuum of care, including after-care and referring women to community-based evaluation, treatment, and recovery programmes. Limit the risk of relapse and offer further services for those who have relapsed.

- Consider the specific needs of children and mothers in counselling and treatment.
- Share knowledge so treatment providers and gender-based violence workers can understand the complexity of the problem. Address their misperceptions and prejudices, improve individual care, and lay the foundation for a coordinated community response.
- Provide more information on tools to strengthen access to more gender-sensitive recovery support that addresses emerging needs leading to a recovery-oriented system of care.
- Prevent gender-based violence in society and among professionals.
- Increase awareness of women's rights among duty-bearers, become a sustainable source of information, and use all possible channels to increase the number of women seeking help.
- Include comprehensive and integrated services that recognise substance use disorders as a health care issue while also drawing input from a range of other health and social support services, such as those addressing housing, employment, or educational needs.
- Strengthen a systematic and systemic approach targeting all levels of influence that aim to motivate duty bearers to take all necessary legislative, administrative, and policy measures to ensure that women's specific needs and circumstances are considered in efforts to address substance dependency and support recovery and reintegration.
- Expand the concept of gender to include all genders and women, not only within the heterosexual norm. Additionally, include women of all ages and backgrounds, abilities, etc., while integrating enlarged concepts, such as consumption patterns and barriers in access to treatment and recovery for the LGBTQ+ Community. It is necessary to train professionals in gender-informed approaches to refrain from acting upon normative ideals.

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