A Phenomenological Investigation of Women's Experience of Recovering from Childhood Trauma and Subsequent Substance Abuse

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Abstract

Proceeding from a phenomenological perspective, the present study investigated the experiences of seven homeless women who had lived through childhood trauma and subsequent substance abuse, with specific focus on the recovery process experienced by each. Applying the analytical protocol of Giorgi (1985) to the written accounts obtained from the participants, 15 constituent themes of the recovery process were identified. In order to illuminate the participants' experiences with minimal influence of any possible researcher bias, the researcher refrained from labelling, judging or diagnosing the women's life circumstances. Consequently, no treatment paradigm was applied to help explain, predict or judge the behaviour of the participants during the course of this research.

The field literature is replete with examples of clinical cases in which psychological disorders have gone hand-in-hand with concurrent and/or subsequent drug use, abuse, and dependence (Zvolensky, Buckner, Norton, & Smits, 2011). Over the past two decades, there has also been a preponderance of evidence that supports the view that childhood victimization can have a significant impact in adulthood in a variety of ways and in many areas of life (Edleson, 1999; Felitti et al., 1998; Goldberg, 1994; Herman, 1997). Nevertheless, there would appear to be little understanding of the impact of these coexistent issues on individual experience, and, despite the volume of literature that supports the existence of such complex problems, there are not many studies that focus on giving voice to the very people experiencing them. Consequently, healthcare professionals who work with this population tend to base their own understanding on presumptive theories deriving from well-known natural scientific models that may or may not adequately address the needs of persons with co-occurring disorders (COD). Indeed, in many cases, what is manifested by those affected is misdiagnosed and incorrectly labelled. While it is thus interesting to note that certain individuals with COD are somehow able to overcome their challenges successfully, little is known regarding the nature of this process.

A phenomenological approach allows for this process to be investigated by hearing directly from the people who have not only lived with such complexities, but who have come to integrate and move beyond them. As Huxley (1932) emphasized, experience is not what happens to a person, but what that person does with what happens. Herein lies the question that underlies this research: When the experiences of childhood trauma and substance abuse interfere in the lives of individuals, specifically homeless women, how are the resultant difficulties and complexities best to be addressed? The aim of this research was to listen to and explicate the experiences of seven women who have lived through and are recovering from homelessness, childhood trauma, substance abuse, and, in some cases, the additional impact of racial discrimination, in order to identify the key constituent elements of their recovery process.

Women, Substance Abuse, and Co-Occurring Disorders

Considerable attention has been given to documenting the treatment of adult female clients with histories of childhood victimization and co-occurring substance abuse, trauma, and major mood and/or stress-related disorders. Various studies have shown that the complex behaviours of these women are often considered to be quite challenging, with difficulties arising that disrupt the forming of a therapeutic alliance due to histories of interpersonal instability, emotional immaturity, and behavioural acting out (e.g., self-mutilation, substance abuse, and illegal activities). Although co-occurring issues of substance abuse and mental illness as well as childhood trauma occur in the male population and significantly impact men in harmful ways, the focus of this research is on women. One of several reasons for this is that women have characteristically tended to respond to the problems presented above in unique and skilful ways. In fact, they have often been left to face their challenges on their own. Research findings have demonstrated that women who have experienced childhood trauma and co-occurring substance abuse and mental health disorders have traditionally lacked appropriate access to treatment and other services that address their special needs (Morrissey et al., 2005; McHugo et al., 2005; Penn, Brooks, & DeWitt-Worsham, 2002). I was curious, therefore, as to how these women navigate their issues, especially when their personal circumstances might be compounded by additional challenges such as those addressed below.

Research has indicated that women are more likely than men to be single and to be raising children on their own (Federal Interagency Forum on Child and Family Statistics, 1999). This creates hardship for the single-parenting mother as well as for the children she is raising. For example, it has been found that children living with a single parent may be at higher risk of experiencing physical abuse, sexual abuse, and neglect than are children living with two biological parents (Boney-McCoy & Finkelhor, 1995). It has also been found that this type of victimization is often perpetuated, recurring in future generations. Egeland, Jacobvitz, and Papatola (1987) found that women who reported experiencing both childhood trauma and COD with substance abuse and mental illness were at higher risk of creating an intergenerational cycle of abuse, there being a greater likelihood of their abusing their own children. In sum, there is no doubt that trauma affects the mind, body, and spirit of a person, with its impact reverberating from childhood into adulthood. The residual effects of multiple traumatic experiences are discussed in this study, along with the common problems that are exhibited in women with histories of childhood trauma and subsequent substance abuse.

As gender-related research has increased, findings have demonstrated important differences between men and women with trauma-related and comorbid substance use disorders (SUDs) (Back et al., 2000). Researchers have found that, among those who abuse substances, women are more likely than men to be diagnosed with posttraumatic stress disorder (PTSD) (American Psychiatric Association, 2013). Research findings also suggest not only that approximately 18% of all women have experienced some form of sexual abuse in their lifetime (Tjaden & Thoennes, 2006), but that this experience tends often to have various adverse health-related consequences socially, mentally and physically (Hunter, Robinson, & Jason, 2012).

Along these lines, researchers have determined that there is an urgent need to address standards of care and best practices related to women-specific treatment for substance abuse, trauma-related disorders, and co-occurring problems (Harrison, Jessup, Covington, & Najavits, 2004). While there have been many studies of and investigations into the nature of existential issues in mental health, very little has been written about how these issues pertain to homeless women and their lived experiences of childhood trauma and subsequent substance abuse. Given the complex constellation of psychosocial needs and challenges facing homeless women with histories of childhood trauma, substance abuse and co-occurring mental illness, it is imperative to hear from these women themselves in order to address their service needs adequately. By helping to reveal, illuminate, or give birth to the meaning of such women's lived experiences, this study can serve to assist community-based agencies and healthcare professionals more effectively to help women such as these navigate through available resources and reduce preconceived notions or beliefs that might otherwise impede their seeking support.

Trauma

Herman (1997) maintains that traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning. For, as she elucidates the distinctive nature of traumatic events, "Unlike commonplace misfortunes, traumatic events generally involve threats to life or bodily integrity, or a close personal encounter with violence and death. They confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe" (p. 33). Traumatization occurs when both internal and external resources are inadequate to cope with the external threat (van der Kolk, 1989, p. 389).

The foregoing provides a basic understanding of what is meant by trauma. It is only in recent years, however, that we have come to truly understand trauma beyond the narrow definition of symptoms as described in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* [*DSM-5*] (American Psychiatric

Association, 2013). Broader conceptualizations have led to the coining of the terms "complex PTSD" or "complex trauma" (e.g., Courtois & Ford, 2009; Lawson & Quinn, 2013), which recognize that trauma is not necessarily the result of a single event. The notion of complex trauma takes into account the incidence and impact of chronic trauma and repeated traumatization, thus in essence recognizing that trauma can be a multi-layered and complicated phenomenon. Specifically, it is important to point out that complex PTSD/trauma and PTSD are not one and the same, and even though an individual might be traumatized, the criteria for a formal diagnosis of PTSD may not be met.

Although complex PTSD/trauma has not received as much attention as PTSD, and has not been accorded formal diagnostic status in the *DSM-5*, it does denote an accepted way of classifying an array of symptoms associated with cases of ongoing, repetitive exposure to early trauma (Herman, 1997; Litt, 2013; van der Kolk, Roth, Pelcovitz, & Mandel, 1993). In concept, complex trauma encapsulates a broader spectrum of issues than those included under a diagnosis of PTSD – and, as D'Andrea, Ford, Stolbach, Spinazzola, and van der Kolk (2012) have shown, the symptoms of complex trauma in fact even include PTSD symptoms, especially in the early stages of the development of complex symptoms.

When traumatic events occur in a human being's life, each individual will react differently. A broad range of trauma-induced impairments may be experienced, thus indicating the presence of complex trauma. These impairments have, however, been largely unaddressed and untreated because of their classification as lesser problems that only affect a more normal non-clinical population who live with a lesser degree of distress. Lawson and Quinn (2013) point out that evidence-based treatments that include complex trauma as a target for interventions are still only beginning to emerge, these interventions originally having been based on trauma from a single incident rather than more specifically from situations involving complex trauma. Pursuant to the particular population being investigated in the present study, it is to be anticipated that both PTSD and complex PTSD/trauma may have been experienced, and it is thus important to understand the traumatic stress reactions of these women within each of these classifications.

Impact of Trauma and Violence on Children

Childhood victimization including abuse and neglect is, world-wide, probably the single most important public health challenge – a challenge that has the potential to be significantly resolved by appropriate prevention and intervention (van der Kolk, 2005). Studies on the sequelae of childhood trauma in the context of care-giver abuse or neglect indicate chronic and severe co-

existing problems with emotional regulation, impulse control, attention and cognition, interpersonal relation-ships, dissociation, and schemas (D'Andrea, Spinazzola, & van der Kolk, 2009). Research has shown that trauma significantly reduces children's Intelligence Quotient (IQ) (Moroz, 2005). There is also a strong correlation between trauma and low academic achievement (Perry, 2003). Numerous studies have pointed to a relationship between exposure to interpersonal trauma during child-hood and an increased incidence of affect and impulse dysregulation (e.g., an inability to temper emotional responses, or emotional reactivity), disturbances of attention and consciousness, alterations in attribution and schema, and interpersonal difficulties (D'Andrea, Spinazzola, & van der Kolk, 2009).

Perry (as cited by Tennant, 2005) reports that in trauma-tized children there is a greater concentration of mid-brain (limbic) cell growth that takes place at the cost of prefrontal cortex cell growth. A compromised prefrontal cortex can result in an underdeveloped capacity for empathy, which is regulated by the higher level thinking processes of the prefrontal cortex. As a consequence, Perry found that traumatized children tend to be "overly sensitive to cues of perceived threat, creating a 'quick trigger' for survival behaviours", and hence to have "a predisposition to impulsive, aggressive behaviours or withdrawal and depression" (Tennant, 2005).

Pollak, Cicchetti, Hornung, and Reed (2000) found that maltreated children have difficulty in understanding and expressing emotions in experimental settings. Pine et al. (2005) reported that maltreated children are either hypersensitive to, or avoidant in response to, negative emotional stimuli, or are likely to interpret positive emotions as ambiguous. D'Andrea, Ford, Stolbach, Spinazzola, and van der Kolk (2012) point out that "disturbances of attention and consciousness follow-ing exposure to interpersonal trauma may manifest as dissociation, depersonalization, memory disturbance, inability to concentrate (regardless of whether or not the task involved evokes trauma reminders), and disrupted executive functioning (e.g., ability to plan or problem solve)" (p. 189). Burack et al. (2006) found that maltreated children had a lower sense of self-worth than their peers. Similarly, Valentino, Cicchetti, Rogosch, and Toth (2008) found that abused children were more likely to recall false negative information about themselves.

Trauma Re-enactment

Exposure to childhood trauma is common and has the potential to lead to serious long-term consequences. People with histories of trauma, and in particular inter-personal trauma (i.e., trauma occurring as a result of the interaction of individuals), also have a higher risk of revictimization in the event of experiencing another interpersonal trauma (Nelson et al., 2002). According

to Arata (2002), while about one-third of women who were child sexual abuse victims reported experiencing repeated victimization, all child sexual abuse victims are at two to three times greater risk of revictimization in adulthood than are women without a history of childhood sexual abuse, with those at greatest risk being women who have experienced revictimization in adolescence.

There are many factors that influence revictimization. As early as 1889, Janet theorized that memories of traumatic events may persist in the victim's mind as unassimilated fixed ideas that act as foci for the development of altered states of consciousness including dissociative phenomena such as fugue states, amnesias, and chronic states of helplessness and depression. Freud (1920/1954) postulated that a victim who fails to integrate the trauma is doomed to repeat the repressed material as a current experience instead of remembering it as something belonging to the past. While Freud viewed this repetitious pattern as a means of gaining mastery over the traumatic past, clinical research reflects that this is not necessarily the case. In fact, repetition can often cause further suffering for its victims (van der Kolk, 1989). A study conducted by Hetzel and McCanne (2005) found that dissociative tendencies (i.e., disrupted integration of a person's experience into conscious awareness) may increase the likelihood of a person's exposure to yet further trauma. Women with histories of substance abuse are also at risk for trauma exposure, possibly through exposure to environments where the risk for violence is high (Afful, Strickland, Cottler, & Bierut, 2010; Cottler, Compton, Mager, Spitznagel, & Janca, 1992).

Other studies suggest that children are more vulnerable than adults to compulsive behavioural repetition and loss of conscious memory of the trauma (Horowitz & Becker, 1971; Terr, 1988). Green (1980) found that 41% of his sample of abused children engaged in burning, cutting, head banging, biting and other trauma re-enactment behaviours. The frequency with which abused children repeat aggressive interactions suggested to Green (1980) that there may very well be a link between the compulsion to repeat these interactions and identification with the aggressor, with fear and helplessness thereby replaced with a sense of omnipotence (van der Kolk, 1989). Finkelhor and Brown (1985) reported that victims of child abuse are at high risk of becoming prostitutes. Carmen, Rieker, and Mills (1984) have indicated that abused boys and men tend to identify with the aggressor and later victimize others, whereas abused women are prone to become attached to abusive men, thus opening themselves and their offspring to being victimized further.

Early repetitive childhood abuse can be so extremely devastating that it can interfere with the development of the child's sense of self and adversely affect the very foundation of the personality (Beckham & Beckham, 2004). Traumatic experiences can also impact adversely on cognition, leading to difficulty in concentrating and remembering, confusion, difficulty in planning for the future, negative thoughts about the future, and intrusive memories, rendering a victim vulnerable to believing and feeling that s/he is different from others (Beckham & Beckham, 2004).

Existential Trauma: From Childhood to Womanhood

The effects of trauma on adult women are substantial, impacting on a woman's physical, emotional, spiritual, mental, social, and economic well-being. This is particularly true for women victimized in early childhood, especially when the abuse was perpetrated by family members or other intimates (Moses, Reed, Mazelis, & D'Ambrosio, 2003). As Beckham and Beckham (2004) point out, PTSD is more severe and longer lasting when it is the result of human choice and action rather than when it results from a natural disaster, accident, or disease. So what might the impact of trauma look like in the life of a survivor?

Survivors of trauma can seem remarkably resilient, demonstrating unique ways of coping in the face of traumatic events. In essence, they survive the trauma by developing and utilizing crisis coping strategies. Nonetheless, it is important to note that utilizing such strategies can cause long-term psychological damage. This is aptly illustrated by, for example, Carmen and Rieker's (1989) model of the cumulative psychosocial consequences of the survival strategies a child may adopt to deal with being a victim of chronic traumatic abuse. The child attempts to understand the basis for the victimization through accommodation of the abusive experience by (a) denying that the abuse exists, (b) minimizing its importance, (c) blocking memories of the events, and (d) believing the abuse is appropriate and reasonable as a consequence of some behaviour on his or her part (which belief is often encouraged by the perpetrator).

Initially, these strategies can help the victimized child to endure the traumatic experiences while they are occurring; however, such tactics of survival can have a negative impact on ways of functioning over the years and into adulthood (Moses et al., 2003). These strategies can also present barriers to treatment and recovery (i.e., using denial as a defence mechanism) and are also often mistaken as indicative of other pathological conditions and mental health diagnoses (e.g., major depressive disorder) during assessments that are not trauma-informed (Moses et al., 2003). Victims who do not fully understand that they have been traumatized are ill-equipped to manage the overwhelming feelings and/or numbing that often occur as a result of the abuse. Indeed, such lack of awareness can increase the possibility of a victim's creating pain-

ful situations in order to counteract feeling numb. For instance, Harris and Gallot (2001) found that people who have experienced trauma have common reactions such as sudden outbursts of anger or self-inflicted violence, extreme risk-taking behaviour, being suicidal, re-enacting unhealthy relationships, and having great difficulty trusting others.

There are also situations where the trauma victim may not give any indication of having experienced anything traumatic. Litt (2013) speculates that clients in therapeutic settings may be unprepared to discuss a traumatic past, or they may be unsure of their ability to tolerate the feelings that go along with revealing their traumatic history. She adds that, in some cases, the victim may not consider what she has experienced to be traumatic, particularly if it was just a way of life in her home or environment. She may look at something that happened in childhood as having occurred many decades ago, like ancient history, which in her estimation has no relevance to today's tough times. These serve as examples of how a trauma victim might unconsciously deny herself much needed treatment and/ or evade receiving appropriate treatment where help is sought. Regarding the latter point, for instance, if a woman doesn't view the abuse she endured (past or present) as her primary problem while being seen by a clinician, she could label or view herself as experiencing another problem (e.g., depression or substance abuse). Some traumatized women view themselves as complete failures, having limited understanding of the severe psychological impact that past abuse has had on them.

Various studies suggest a link between exposure to extended interpersonal, interfamilial victimization and symptoms associated with borderline personality traits (Sansone, Songer, & Miller, 2005), eating disorders (Matero, 1999), dissociation (Banyard, Williams, & Siegel, 2001), substance abuse (Najavits, Weiss, & Shaw, 1999), self-injurious behaviours (Briere & Gil, 1998), excessive/dysfunctional sexual activities (Briere & Rickards, 2007), and identity disturbance, problematic interpersonal relationships, and affect dysregulation (Briere & Rickards, 2007). Several symptoms appear to be more specifically linked to experiencing repeated and sustained child abuse and neglect (van der Kolk et al., 1993), along with interpersonal traumas that occur later in life (Najavits, Sonn, Walsh, & Weiss, 2004).

Muller (2010) describes how many trauma survivors pretend, both to others and to themselves, to be doing much better than they actually are, sustaining this tendency for years on end. Muller (2010) describes this behaviour as *avoidant attachment*, which is generally characterterized by the minimization of the impact of hurtful attachment experiences. Muller elaborates on the way in which this tends to manifest in the clinical context, and the implications thereof, as follows:

> When the avoidant client speaks of a given traumatic interfamilial event, his [or her] tendency is to minimize the event's meaning or its perceived negative impact. Painful stories are discussed in an emotionally detached, intellectualized manner, often rationalized in one way or another or avoided altogether by focusing on other less threatening material. Having developed a worldview that others cannot be depended on, the individual tends toward a pattern of self-reliance and a view of self as independent, strong, and normal. Along with this pattern, there is a tendency to dismiss and devalue experiences of closeness, intimacy and vulnerability. (p. 2)

Muller states that, in the typical course of life, the avoidant spends much time routinely excluding information from conscious processing so that his or her capacities are not overloaded and s/he is not overly distracted. He calls this process "defensive exclusion" (p. 12). Since critical information is considered to cause considerable suffering, it tends to be defensively excluded in a frantic attempt to manage personal safety.

Freyd (1996) used the term "betrayal trauma" (p. 5) in describing the effects that occur when individuals or institutions on which a person depends for survival significantly violate that person's trust or well-being. Betrayal trauma theory (Freyd, 2011) predicts the degree to which a negative event represents a betrayal by a trusted or needed other and will influence the way in which events are processed and remembered. Positing that psychogenic amnesia and dissociative awareness are often necessary for survival in cases in which abuse occurs at the hands of a parent or caregiver (DePrince & Freyd, 2002), this theory rests on the presupposition of evolutionary psychology that human beings are adept at detecting betrayal in others as a means for survival. As an example, Freyd (1996) points out that, when a child is dependent on an abusive caregiver, and cannot avoid or discontinue the harmful and threatening relationship, the child's survival instinct is to remain unaware of the betrayal, thereby increasing the child's chance of surviving. In addition, betrayal trauma theory identifies attachment as an important key to understanding the child's motivation to remain unaware of the abuse (DePrince & Freyd, 2002), and furthers our understanding of the reason revictimization occurs.

Co-Occurring Disorders (COD)

In general, COD refers to the manifestation of two or more diagnosed co-occurring disorders (*DSM-5*) where at least one of the disorders can be diagnostically established independently of the other(s). According to the Centre for Substance Abuse Treatment (CSAT) (2005), COD has replaced the term "dual diagnosis"

in the field of substance abuse, and typically refers to any simultaneous diagnoses of a substance abuse or dependence disorder and mental illness. Efforts to provide treatment that meets the unique needs of people with co-occurring substance use/mental disorder (COD-SM) have gained momentum over the past twenty years in both substance abuse treatment and mental health service settings. It is estimated that one out of every four Americans will experience drug or alcohol abuse/dependence at some time in his or her life, and that half of these will also have a co-occurring mental disorder (CSAT, 2005).

The United States Department of Health and Human Services (2002) clarifies the need for both the COD-SM components to be treated::

> If one of the co-occurring disorders [COD-SM] goes untreated, both usually get worse and additional complications often arise. The combination of the disorders can result in poor response to traditional treatments and increases the risk for other serious medical problems (e.g., HIV, Hepatitis B and C, cardiac and pulmonary diseases), suicide, criminalization, unemployment, homelessness, and separation from families and communities. As a result, individuals with [COD-SM] often require high-cost services, such as inpatient and emergency room care. (p. i)

To further complicate the problem, individuals with COD-SM are not easily integrated in either substance abuse treatment or mental health services. Grella (2003) reported that many mental health practitioners have strict policies that will not allow them to see clients who are actively abusing substances. For example, if a patient who comes to see her psychiatrist at the community mental health centre for her depression is under the influence of alcohol at that time, she runs the risk of being told to return home and remain there until sober. This client will not be given a prescription for a refill on her psychiatric medications until she tests clean. If she was relying on these medications in order to cope with her depression, the chances are that she will then turn to alcohol in order to cope and possibly become more depressed, thereby complicating her situation.

Persons with COD-SM have been known to be less compliant with regard to taking their medications and treatment in general, to be impaired by social and economic stressors (e.g., homelessness), to experience more negative outcomes (e.g., HIV, incarceration), and not to respond well to accepted treatment modalities for a single diagnosis (e.g., cognitive behaviour therapy for treating the substance abuse disorder) (Brooks, Malfait, Brooke, Gallagher, & Penn, 2007; Drake et

al., 2001). In addition, some clients enter the mental health system seeking treatment only for their mental illness and thus denying having any substance abuse issues. Consequently, clients who are actively using drugs and alcohol are not always formally identified and often deny that they are using (Sciacca, 1997).

Historically, substance abuse and major mental illness have been treated separately, since the treatments for each often derive from different philosophical bases and have accordingly differed significantly in focus and approach (Bride, MacMaster, & Webb-Robins, 2006). Traditional treatment models for addiction have been known to be more confrontational in approach, being characteristically intense and designed to break down a client's denial, defences and/or resistance to his or her addictive behaviour (Sciacca, 1997). In contrast, mental health practitioners are typically more empathetic, supportive, non-confrontational, and non-threatening. Clinicians are trained to be especially sensitive in order to deal with a client's fragile sense of self.

Because of the differences in treatment approaches, there has been a push towards integrating them when working with persons with COD-SM. While a growing number of empirical studies have found that integrated, comprehensive dual diagnosis treatments are effective (Brooks et al, 2007; Drake et al., 2001), other studies have found no differences in the effectiveness of integrated as opposed to traditional programmes (Jeffrey, Ley, McLaren, & Siegfried, 2007). In any event, the integration of mental illness and substance abuse treatment systems continues to be pursued. As CSAT (2005) has stated:

> The integration of substance abuse treatment and mental health services for persons with COD has become a major treatment initiative. Integrated treatment coordinates substance abuse and mental health interventions to treat the whole person more effectively; the term refers broadly to any mechanism by which treatment interventions for COD are combined within a primary treatment relationship or service setting. As such, integrated treatment reflects the long-standing concern within substance abuse treatment programmes for treating the whole person, and recognizes the importance of ensuring that entry into any one system can provide access to all needed systems. (p. xix)

A history of trauma has increasingly been viewed as a factor in co-occurring substance abuse disorders (SUDs) and mental illness among women (Chilcoat & Menard, 2003). With this in mind, the present study will further explore the relationship between experienced trauma and substance use.

Experiencing Trauma with Substance Abuse

A high proportion of clients (25-66%) seeking SUD treatment have been found to report a history of inter-personal trauma (Najavits et al., 1999). In addition, Ouimette, Moos, and Finney (2003) established that one-third of patients diagnosed with a SUD are also diagnosed with PTSD. Najavits (2005) reported from community samples that 52% of men with PTSD have an alcohol use disorder, and 35% have other drug use disorders. In the case of women, the rates are 28% and 27% respectively (Kessler et al., 1995). In their detailed review of PTSD among women with SUD, Najavits et al. (1999) reported that 55-99% of these women had a history of trauma.

In the case of both men and women with SUDs, and also women residing in an inner-city neighbourhood, Amaro et al. (2007) documented an average of five traumas experienced by each of these individuals in the course of their lives. Alcohol and drug use have also been shown to increase women's vulnerability to violence due to their increased risk of exposure to un-safe situations (Miller, Wilsnack, & Cunradi, 2000). Forms of mental illness associated with COD-SM include depressive symptoms and diagnoses, anxiety symptoms and diagnoses, phobias, and interpersonal problems often associated with personality disorders (Brady, Killen, Saladin, Dansky, & Becker, 1994). Retaining individuals who have COD-SM along with histories of trauma in treatment has also proven to be difficult. Brown, Huba, & Melchior (1995) report that dropping out of treatment is a major problem among women with multiple needs, especially in the case of those who have children.

Moshier et al. (2012) found that one of the factors that keep drug users out of treatment is having a sense of belongingness to their drug subculture. They define belongingness as reflecting an extreme degree of self-identification with particular persons or groups. Other researchers (Battistich & Hom, 1997; Duncan, Boisjoly, Kremer, Levy, & Eccles, 2005; Nasim, Belgrave, Jagers, Wilson, & Owens, 2007) identified belongingness to the subculture of drug use as being influential in the initiation of drug use, and found that identification with peer groups, cultures, or communities served as either a risk or a protective factor in respect of deviant behaviours. What is collectively inferred is that having the propensity to belong to something bigger than oneself could, in the case of identification with the members or the ethos of the drug subculture, cause a person to start using drugs in order to belong more fully to the subculture, membership of which could either prove to be a risk factor or serve as a protective force in respect of progressively engaging in more deviant behaviours (e.g., drug sales and distribution, or prostitution). Chronic drug use may create a context in which belonging to a subculture of drug use may supersede the motivation or the perceived ability to belong to more mainstream, drug-free communities (Moshier et al., 2012).

For COD-SM individuals living in urban populations, integrated substance abuse treatment approaches that incorporate trauma treatment are especially relevant. Misidentified or misdiagnosed trauma-related symptoms interfere with help-seeking, lead to early dropout, and increase the risk of relapse (Brown, 2000; Brown, Huba & Melchior, 1995). When examining the clinical characteristics of women with a diagnosis of PTSD-SUD, Najavits et al. (1999) found that they display a more severe clinical profile than their non-SUD peers. The COD-SM sample scored significantly higher in respect of poor life conditions (e.g., health concerns), number of suicide attempts, incidence of criminal behaviours, having a number of siblings with SUD, and fewer outpatient treatments.

Litt's (2013) research suggests that, in treating indi-viduals with complex PTSD and SUD, it is useful to address targeted interventions for issues of lability, affect dysregulation, dissociation, and substance misuse. She further points to the inability to manage strong emotions both within therapy and outside as one of the greatest challenges presented by complex PTSD clients. This challenge prevents the client with complex PTSD from functioning successfully on a daily basis, maintaining treatment, and having the ability to address more delicate emotions and experiences.

Clinicians, counsellors, and other professionals in the addiction and mental health fields have increasingly been challenged by the dilemma as to whether to treat a client who is still actively using substances. While some clinicians are especially concerned that address-ing trauma concerns while simultaneously addressing substance use or mental illness issues may cause clients to become more symptomatic (Litt, 2013), there are integrated models for addressing PTSD and SUDs that allow the helping professional to work under such conditions. Covington (2002), for example, reports that integrating trauma treatment with addiction treatment lowers the risk of trauma-based relapse.

Treatment decisions regarding substance use also need to take into account the client's motivation to change his or her drug or alcohol consumption (Litt, 2013). Miller and Rollnick (2002), who were at the forefront of the development of motivational interviewing as a technique, have pointed to the need for addiction and mental health professionals to appreciate the crucial importance of understanding a client's readiness for change. They maintain that accurately ascertaining where a client's motivation lies can assist in guiding the therapist to meet the client where he or she is in this regard. Interventions can then be customised to suit the client's needs.

Prochaska and DiClemente (1982) devised the stages of change model (also known as the transtheoretical model of change) that identifies six distinct stages of the process of intentional behavioural change: pre-contemplation, contemplation, preparation, action, maintenance (which includes "recycling" or "learning from relapse"), and termination.

Since this model of intentional behavioural change explains how people progress through a series of stages in the process of eliminating unwanted habitual behaviours, it can assist in the development of effective interventions to promote success in treating psycho-logical and health problems (Prochaska, Norcross, & DiClemente, 1994). This is realized by focusing on the decision-making process of an individual, which explains the difference in a person's chance of success during treatment in terms of how well he or she gains awareness of his or her readiness to change.

Impact of Homelessness on Trauma Victims

Substance abuse (Folsom et al., 2005) and mental illness (Jainchill, Hawke, & Yagelka, 2000) are both common contributing factors to becoming homeless. Homeless individuals with COD-SM are among the most vulnerable client populations (Sun, 2012), with an estimated 10-20% of homeless people manifesting these co-occurring disorders (Drake, Osher, & Wallach, 1991). The homeless population appears to have high rates of social isolation with virtually no support in the form of social resources, which contributes to their physical ill health (Fischer, Shapiro, Breakey, Anthony, & Kramer, 1986; LaGory, Ritchey, & Fitzpatrick, 1991; Solarz & Bogat, 1990). Some researchers have also proceeded to support the notion that homeless people have minimal support available before they become homeless (Morrell-Bellai, Goering, & Boydell, 2000).

Tessler, Rosenheck and Gamache (2001) analysed the self-reports of a sample of homeless people asked to cite the main reasons they thought they had ended up being homeless. The respondents generally attributed their homelessness to factors such as mental illness, interpersonal conflict, drug or alcohol addiction, some-one giving up on them and no longer providing support, and/or the loss of a job. Morrell-Bellai et al. (2000) found that the homeless people they surveyed thought that their homelessness was sustained by a substance abuse problem. Compared with homeless individuals without COD, SUD, or a serious mental illness (SMI), who often are merely transitionally homeless, indivi-duals with CODs are more likely to experience chronic homelessness and less likely to engage in treatment and recovery from their disorders (Sun, 2012).

Homeless adults have also been shown to be at risk of premature aging (Brown & Steinman, 2013). Some studies have reported that middle-aged homeless adults can face much the same geriatric problems as elderly housed adults (Cohen, 1999; Gelberg, Linn, & Mayer-Oakes, 1990). Researchers have found similar pre-mature aging patterns in other vulnerable populations including prisoners (Williams et al., 2009) and persons with developmental or intellectual disabilities (Perkins & Moran, 2010).

Research has also indicated some notable gender differences with regard to rates of victimization. Lam and Rosenheck (1998), for example, discovered that women were more likely than men to report a higher number of victimizations including sexual assault and victimizations that had occurred in the preceding two months. Homeless women are particularly vulnerable to multiple experiences of abuse throughout their lives (Goodman, Dutton, & Harris, 1995), tending to report recent physical and sexual assault (Kushel, Evans, Perry, Robertson, & Moss, 2003) as well as childhood abuse (Zugazaga, 2004). When compared with women who are housed, homeless women report much higher rates of childhood physical and sexual abuse, adult physical assault, previous sexual assault in adulthood, and histories of mental health problems (Stermac & Paradis, 2001).

Based on their review of empirical studies, Milburn and D'Ercole (1991) reported that victimization might have a negative effect on women's lives to the point that it could decrease their ability to remove them-selves from their homelessness. This could reflect the tendency for trauma victims to re-enact their trauma. More exposure to violence and traumatic events can increase the likelihood of further traumatic experiences. Being in a state of fear, which is typical for someone who has PTSD, while living on the streets, threatens a woman's sense of personal safety, causing her to constantly remain vigilant and on guard (Anderson & Chiocchio, 1997). D'Ercole and Struening (1990) found that constantly remaining on guard can predispose a homeless person to develop depressive and psychotic symptoms, and to being hospitalized for alcohol abuse.

The Meaning and Process of Recovery

The term recovery has different meanings in different contexts. In the field of substance abuse treatment, counsellors view recovery as the state of persons who have changed their substance abuse behaviour for the rest of their lives (CSAT, 2005). In the mental health field, clinicians may think of recovery as a process in which the client moves toward specific behavioural goals and assess whether recovery has occurred by whether or not these goals are achieved (CSAT, 2005). With specific regard to recovering from trauma, Rothschild (2010) proposes that recovery involves a number of key issues: (a) recognition or awareness that the trauma survivor actually did survive the trauma, (b) understanding that a flashback is a memory, (c)

self-forgiveness for not having been able either to prevent or to stop what occurred, (d) alleviation of shame, (e) reducing recovery steps to a manageable size, (f) mobilizing the body out of a frozen or defeated state, and (g) extracting meaning or purpose from the trauma to better the person's world. In sum, the term recovery encompasses a broad array of conceptual meanings and treatment modalities. A more comprehensive overview of these treatment models is beyond the scope of this paper, but can be found in Hunter (2015). A brief commentary on the concept of recovery and the treatment of women with COD follows.

Recovery from SMI emerged as a new concept in the 1990s and has led to the emergence of a number of new treatment programmes. Deegan (1996) states that personal accounts of recovery from people with SMI have indicated that, in spite of their illnesses, they have developed new meanings and purposes in their lives and have accomplished lifelong goals. Recovery is a complex process and is driven by the individual's goals and needs (Mueser et al., 2002). Despite the impairment of mental functioning associated with people who have SMI, Wright (1983) believes that they are able to learn to control symptoms of their illness in order to accomplish professional and personal goals and experience a better quality of life. Anthony (1993) stated that people in the process of recovery from SMI tend to go through a uniquely personal process that involves the development of a new meaning and purpose in life that goes beyond the effects of the illness. He also felt that recovery is a multi-dimensional concept that involves self-esteem, hope, adaptation to disability, self-determination, and personal empowerment, and that professionals should focus primarily on facilitating the process of recovery in the client, rather than directing it, so that clients can take charge of their illness and their lives.

Moore (2004) addressed recovery from a perspective that honours the "dark nights" of those with SMI. Dark nights is a metaphor for difficult and painful periods of time – such as periods of grief, emotional distress, or frustration – that occur in a person's life. Moore suggests that, in the midst of these dark times, a person can learn from them; that through emotional and spiritual struggles, a person can grow, creating a new understanding of life's meaning and purpose. He theorized that these disturbing episodes are valuable and lead to opportunities for transformation, revealing one's deepest needs and providing healing.

Treating Women with COD

The connections between those who experience trauma and those afflicted with mental health and substance use problems are not typically addressed, and nor do they typically start with a gender-based understanding of these issues (Poole & Urquhart, 2009). There have been reports that some women are turned away from mental health and addiction counselling services for having more than one presenting problem (Poole & Pearce, 2005). When treatment is initiated, there is often a question as to whether or not the treatment is appropriate for women with COD-SM and histories of trauma (Covington, 2008). Although many treatment facilities or service organizations claim to be women-centred, they nevertheless continue to use outdated treatment approaches that are uninformed regarding how to best serve women with COD-SM and trauma (Harrison et al., 2004).

In order to address the unique therapeutic needs of women with SUDs and PTSD, Najavits developed a group cognitive-behavioural therapy called Seeking Safety (Najavits, 2002; Najavits, Weiss, & Liese, 1996). Therapeutic intervention focuses on helping women to manage negative feelings and learn relationship and problem-solving skills in conjunction with achieving abstinence from their substance use. The intervention provides an alternative set of stress-reducing coping strategies (Gatz et al., 2007), thereby influencing women with COD-SM to change or reduce negative cognitions and thus increase their capacity to make safer choices in respect of their behaviour (e.g., abstinence).

Najavits, Gotthardt, Weiss, and Epstein (2004) evaluated cognitive distortions in a sample of women with COD-SM and compared them with those of a sample of women with a single diagnosis (PTSD alone). The results indicated that the COD-SM sample reported higher levels of cognitive distortions than the single diagnosis sample. This implies that COD-SM women tend to experience more faulty thinking than women with only one diagnosis. As an example of this kind of thinking, Najavits et al. (2004) identify the cognitive distortion of "beating myself up", a phenomenon that is characterized by the tendency for the individual to continually focus on her own negative character traits, actions or mistakes rather than cognitively releasing them. COD-SM women can be guided to understand that this is extremely common for women who have experienced similar life issues and that it may reflect an internalization of the negative treatment they had experienced at the hands of caregivers during their childhood.

Putnam (2003) suggests that treatment addressing childhood abuse should entail a psycho-educational intervention that focuses on the prevention of further victimization, clarification and normalization of the voctim's feelings regarding the abuse, and general education about abuse for victims and their families, even for individuals who present no visible or verbal symptoms of abuse. Cognitive-behavioural methods have also proven significantly effective in helping children as well as adult survivors recover from abuse (Deblinger, Lippman, & Steer, 1996; Putnam, 2003).

Phenomenological Research Methodology

The present study utilized a phenomenological method to investigate the experiences of homeless women who had lived through childhood trauma and subsequent substance abuse. Implicit in this approach is eliciting descriptions of the everyday world of immediate lived experience, and then explicating these descriptions in order to reveal their prereflective dimensions; that is, that which takes place before we consciously think about the experience or put it into language (Finlay, 2005). Owen (1994) characterizes phenomenological inquiry as "carried out in a rational, investigative manner" (p. 1), and points to it as an appropriate method for studying awareness, aims, and meaning in terms of personal and social experience, giving equal attention to both the personal and social aspects of communal life. This approach allows the researcher to hear the voices of those whose experience is being investigated, its paradigm focusing on exploring how people make sense of lived experience and transform it into consciousness (Patton, 2002). Aiming to understand and appreciate experiences from the perspective of conscious and aware human beings (DeCastro, 2003), its "fundamental concern [is being] faithful to life as it is actually lived" (Halling & Dearborn Nill, 1995, p. 2). In the present study, women shared how they felt, remembered and made sense of their experiences, providing an opportunity for others to gain a deeper understanding of the life-world described.

Recruitment of Participants

The participants in this study were seven women who lived in the San Joaquin area of the Central Valley of California, all of whom had experienced childhood abuse with subsequent substance abuse. In selecting appropriate research participants, five criteria identified by Moustakas were applied (1994): (a) experience of the phenomenon being investigated, (b) interest in understanding the reasons for their having had this experience, (c) ability to speak about the experience in a meaningful and detailed way, (d) willingness to write about their own experience in response to the questions posed, and (e) agreeability to the possible publication of the findings.

Data Gathering and Analysis

The raw data comprised the written accounts of the seven participants in response to the question, "What was your experience in recovering from childhood trauma and subsequent substance abuse?" Following on from the initial reading of their written responses, a brief interview was conducted with each participant to clarify any questions arising from what had been conveyed in writing. Transcriptions of the participants' responses in the interview were added to the original, and the comprehensive transcripts of the data were then analyzed following the "four essential steps" described by Giorgi (1985) as follows:

> (1) One reads the entire description in order to get a general sense of the whole statement. (2) Once the sense of the whole has been grasped, the researcher goes back to the beginning and reads through the text once more with the specific aim of discriminating "meaning units" from within a psychological perspective and with a focus on the phenomenon being researched. (3) Once "meaning units" have been delineated, the researcher then goes through all of the meaning units and expresses the psychological insight contained in them more directly. This is especially true of the "meaning units" most revelatory of the phenomenon under consideration. (4) Finally, the researcher synthesizes all the transformed meaning units into a consistent statement regarding the subject's experience. This is usually referred to as the structure of the experience and can be expressed at a number of levels. (p. 10)

Descriptive Findings

Fifteen basic constituents or thematic elements of the experience of recovering from childhood trauma and subsequent substance abuse were revealed by the data analysis. Each constituent listed below is substantiated by a statement or statements from the transcriptions.

Recovering means:

1. **Subjecting oneself to adaptive and maladaptive compensatory behaviours of coping**

   I found comfort in meth, crack, and marijuana use that created for me a safe place.

   I began self-medicating with marijuana and alcohol.

2. **Feeling more mindful, having a sense of personal freedom/liberty, finding meaning, and having a sense of peace, along with positive thoughts that recovery is possible**

   I was able to be strong enough to let it go and be free.

   I have felt more at peace with myself. I then finally felt free, really free of my childhood.

3. **Recognizing the very difficult struggle involved with the recovery process**

   Recovery is a struggle for me. There is so much pain and disappointment.

This is really hard for me.

4. **Having setbacks including relapsing from time to time**

My experience recovering from abuse took many, many years in and out of substance programmes.

I can't even count how many times I've OD'd. Today as I write this I'm still recovering.

[After quitting], *I began smoking marijuana again*.

I keep relapsing.

5. **Past abuse is difficult to talk about**

I never ever told anyone about this.

This has never been brought up till this day.

6. **Realizing that recovering from childhood abuse is more difficult than from substance abuse**

Experiencing recovery from childhood abuse is more of a struggle.

7. **Encountering a force greater than oneself that is attributed to the healing recovery process**

Today I remember that my higher power, who I chose to call God, saved me and has brought me the intervention [therapy].

8. **Experiencing various kinds of emotionally painful feelings that are difficult to experience**

I have panic attacks. Today I still get paranoid.

9. **Lacking trust in self and others including blaming self and others**

It still hurts real bad to this day and I can't forgive myself.

I thought of myself as at fault for what my parents were going through.

10. **Recognizing that past experiences have helped to shape who one has become**

To this day, living with this [childhood abuse] *almost my whole life has been really hard 'cause a part of me thinks that this is why I have a drug problem*.

Because of what happened to me as a child, I think, in fact I know, that's why I don't like myself.

11. **Understanding that it is a lifelong process**

Living with this pain and bondage almost my whole life has been really hard.

12. **Having a supportive network**

[The intervention through Child Protective Services] *brought the blessing of intervention*.

Had it not been for those requirements I would never have learned how valuable I am.

13. **Becoming autonomous and realizing the importance of this**

I am a confident and assertive woman today. Everyday is something new to look forward to.

14. **Having interpersonal problems**

I've lost all of three of my children to meth use and instability mentally.

15. **Being doubtful and pessimistic that one can ever recover**

I don't believe I will ever heal.

I don't think I can ever recover from this.

Implications of the Findings

The findings are noteworthy in that they confirm conclusions documented in the literature regarding the experiences of women recovering from childhood trauma with subsequent substance abuse. In particular, the findings appear to confirm that, when trauma begins early in one's life and persists for an extended period of time, it can cause women to present with a wide range of psychological difficulties, emotional distress, behavioural dysregulation, and interpersonal challenges (Litt, 2013). The women in this study not only shared experiences that reflected a large number of such difficulties, but they also illuminated various more personal aspects of the experience.

One important dimension is that, in recovering from traumatic experiences, a person can begin to find meaning in what he or she has experienced. What exactly does meaning of this kind entail? Proulx and Inzlicht (2012) understand "meaning" and its various functions as follows:

In terms of what it [meaning] does, either by means of what or why, it allows us to feel like we understand our experiences. These under-standings in turn serve a variety of functions, mainly in terms of predicting and controlling ourselves and our environment, and giving us reasons to predict and control either or both. ... These whats and whys provide an ultimate sense that the world is understandable, and, as such, familiar. (pp. 319-320)

Much has been written about the role of the narrative reconstruction and re-narration of life events not only as a means for the individual both of making sense of what s/he has experienced and of innerly developing a coherent life story, but, more essentially, as well as therapeutically significantly, as a vehicle for identity construction and reconstruction (Mathieson & Stam, 1995). Some of the research participants reflected on experiencing an identity transformation from bad to better as part of their recovery process. Those who were more optimistic about their recovery seemed to engage in meaning-making to regain coherence and comprehensibility (schema change). They were able to re-narrate their stories, finding not only new meaning but also a new sense of themselves (Brennan, 2001). One participant said, "*The experience has changed me for good and bad, but for the most for the good.*" Another stated, "*I was not going to live with the pain and shame of what they had done to me as a child for the rest of my life.*"

Conversely, the individuals in this study who were more pessimistic about their recovery, expressed greater confusion, despair and uncertainty about their identity and their understanding of their environment. These women conveyed having more emotional pain, a sense of hopelessness, and an awareness of less support with their recovery. One said, "*I don't believe I will ever heal*", while another stated, "*I don't think I can recover from this*". None referred to having any source of spiritual support or of having encountered a greater force than themselves that was beneficial to them. They emphasized the "*very hard*" struggle that recovery can entail with a "*lack of light at the end of the tunnel*". These participants shared their attempts at using coping skills that inevitably seemed to fail.

Several of the participants who were able to "make meaning" of their painful experiences acknowledged that, prior to encountering a force greater than them-selves, they felt devoid of any experiences of spiritual regard, were lacking in meaning, and did not have any solid reasons to end their substance abuse. The chief characteristic of those who were able to make a transition from meaninglessness to meaning-making was the recognition that such a transition required admitting that they were powerless over their sub-stance abuse. Prior to recovery, life had been regarded as not only spiritually barren but hopeless. "*I didn't have anything to believe in before I changed how I looked at life. Now, I can see things clearer*", said one of the women.

Many of the participants experienced self-blame and self-loathing for having been abused as a child. They expressed feeling damaged, at fault, and that these feelings were irreparable. This perspective seemed to be the prevailing point of view of those who had not found something to give their life meaning. Important life events, for instance, gave individuals a reason to recover, whether it was having a new addition to their family or a spiritual connection with a higher power. Such events seemed to mark a turning point in their lives, constituting a pivotal turn from hopelessness to hopefulness. According to one of the women, "*I feel through God I was able to be strong enough to let it go and be free, free from nightmares, free from drugs, and free inside*", while a second noticed how valuable she feels – "*Had it not been for those requirements, I would never have learned how valuable I am.*"

These findings would appear to be consistent with the perspective offered by Viktor Frankl (1962/1985) who, in light of his own painful life experiences, concluded that one can truly live only as long as one's life has meaning. He alleged that a lack of meaningfulness in life threatens contemporary human beings by creating an "existential vacuum" within. This existential vacuum manifests mainly in a state of boredom, which Frankl views as the main symptom of the "spiritual" illness of our time (pp. 96-97). He goes on to suggest that, when boredom becomes unbearable, depression, aggression, and addiction are often the result. The participants in this study all reflected similar experiences with regard to these very outcomes. Frankl (1962/1985) refers to the source of this process as a "frustration of meaning" (p. 138), a sickness rooted in the lack of meaning of one's existence. The basic premise of his therapeutic approach – logotherapy – is that all people have the freedom to find meaning in how they think, act, and experience life, especially in the wake of situations of unavoidable trauma and pain.

Clinical Recommendations

When working with the focal population of this study in the clinical context, it is important to recognize that clients are more than the diagnoses they are assigned. Ultimately, a diagnosis is primarily a subjective opinion arrived at by one individual (i.e., the therapist) about a set of symptoms manifested by another (i.e., the client) that appear to fit a set of predetermined diagnostic criteria. A diagnosis does not define who a client is as a person, nor does it describe and explicate what the client is experiencing as a human being. As Kierke-gaard believed, it is a scientific myth that, if we just observe something for long enough, we can determine

the causal factors that determine its appearance (in Warnock, 1970). In keeping with this idea, it behoves mental health professionals to guard against thinking that "If the client sits in front of me long enough, I can observe her and figure out what her problem is. In this way, I can then help in eliminating the problem." This kind of thinking severely limits our understanding of the presenting problem and, in turn, restricts how we treat the client. Our eyes and ears need to be open to the client's experience, and not centred on our own biased beliefs or limited understanding of how we see the client's condition.

Final Reflections

It warmed my heart that these women in a homeless shelter so willingly shared their experiences and stories with me. I sensed a deep level of support for my endeavour, especially when I shared my own story with them: that, despite having gone through my own personal struggles in life, I was able to earn a doctoral degree. These women recognized the strength I had in completing a degree programme. It was far from easy given my challenges of working full time, raising three children, and tending to a husband who had recently suffered a debilitating illness. I was honoured that they invited me into their shelter and into their personal lives, allowing me truly to be among them, trusting me – a complete stranger – with their personal stories.

Although I've worked with people from populations of this type for the past 10 years, this was a unique and special experience. The stories of these women were not only illuminating in their self-revelatory honesty, but at times both heart wrenching and deeply inspiring. Ultimately, the women in this study revealed themselves to hold the same belief as Frankl (1946/1986) in the possibility of finding meaning even in the most devastating situations and life experiences: "even a man who finds himself in the greatest distress ... even such a man can still give his life a meaning by the way he faces his fate, his distress" (p. xix). Each of these women, despite their dire circumstances, demonstrated this truth in the choices they made by recognizing that they did have the potential to change how they saw themselves and how they viewed the world.

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