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Trauma Barriers to Substance Abuse Treatment Engagement Among Formerly Incarcerated Males

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Abstract

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Abstract

This study explored treatment engagement among formerly incarcerated adult males in a community-based substance abuse treatment program who experienced barriers related to sexual and violent trauma histories. Fully engaging in treatment requires a readiness to become and remain sober, and for those who suffer from trauma, such readiness may be absent, and continued substance use may be their way to cope with pain. This study explored a gap in the literature concerning how sexual and violent trauma might play a role as barriers to engaging in substance abuse treatment among formerly incarcerated males. Understanding how such traumas impact treatment engagement may allow mental health professionals to improve treatment and delivery, increase treatment engagement, and thus treatment success. Interpretative phenomenological analysis was the qualitative methodological design used for this study. Semi structured, one-on-one interviews were conducted with 9 participants who met the inclusion criteria to participate. The analytic procedures included coding data that were organized into themes. Findings indicated connections with family, friends, and healthy environments were critical elements in their sobriety. Participants also believed that substance abuse treatment providers could not help them unless they personally experienced addiction. This study's results add to the current literature, inform future research to further explore barriers to substance abuse treatment engagement, and promote positive social change to improve professional methods and processes, reduce relapse and recidivism, and enhance communities' health and safety.

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Dedication

For my husband, Chris, the love of my life: Your unconditional love, support, and encouragement helped me through the dissertation process. During the many years of my studies, you have been patient, including through late nights, weekends, and vacations. For this, I love you. For my two sons, who, in their unsuspecting ways, motivated my determination to work through my dissertation. For Dr. Larry Curry, my mentor whom I regard with tremendous respect, I appreciate your guidance, patience, and words of wisdom. You provided me with the courage and confidence to get my dissertation written.

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I thank the URR, the IRB, and my university advisor for their roles in supporting me through the dissertation process. I also thank the participants who graciously shared their personal experiences to help me with this study. Because of the courage to speak their truth and provide feedback through studies such as this, improvements to the professional addictions field are possible.

Table of Contents

List of Tables

Chapter 1: Introduction to the Study

Introduction

Drug addiction is a significant health and social problem in the United States. Approximately 90% of individuals who need drug use intervention do not receive it (Hardey et al., 2020). Understanding drug use and addiction treatment is essential in helping treatment providers offer the best possible care for substance use disorder (SUD). Trauma history plays a significant role in treating drug addiction; without healing from past traumas, recovering from drug addiction can be difficult. Understanding drug use, addictions, and the role that trauma plays in substance abuse treatment can provide insight into how to treat drug addiction problems more effectively.

According to Hari (2015), members of the general public hold inaccurate beliefs about drug addiction, and literature on addiction remains discorded between political, clinical, and the substance use disordered populations' perspectives and experiences. Members of the general population may believe that addiction results from dependency within weeks or even days of substance use, or that addiction occurs due to chemical hooks or prescribed medication. Hari asserted that this belief is wrong. Based on the Rat Park experiment and his research, Hari maintained that those with happy and connected lives do not become addicts, contending that a lack of connection with other people perpetuates addiction. Hari’s position is connected to an assumption underlying my study. In essence, trauma functions as a barrier to recovery treatment if the client has yet to connect with another and address trauma issues. In this way, trauma can perpetuate substance use.

As many as 75% of adults in substance abuse treatment report having experienced trauma (Rosenberg, 2011). Individuals who suffer from posttraumatic stress disorder (PTSD) or trauma histories are more likely to be diagnosed with SUDs (Ford et al., 2007; Rojas & Peters, 2016). SUDs afflict approximately 44.3% of formerly incarcerated adult males (Levenson, 2015). Rojas and Peters (2016) found that 90% of all formerly incarcerated individuals with substance abuse disorders suffer from PTSD or trauma histories. According to Mahmood, Vaughn, Mancini, and Fu (2013), 67.9% of formerly incarcerated males with SUDs suffer from PTSD or trauma histories. Knowing this information is important in helping SUD providers find ways to improve treatment delivery and recovery results.

Recidivism rates among formerly incarcerated individuals in the United States are high and often involve substance use problems. Researchers have also shown that relapse and recidivism rates are high among formerly incarcerated individuals with SUDs (Rojas & Peters, 2016). Drug-related offenses are the second leading reason that formerly incarcerated individuals return to correctional facilities, the first being property crime (Link & Hamilton, 2017). Gelb and Velázquez (2018) estimated that approximately 48% of formerly incarcerated individuals return to prison. In fact, according to the National Reentry Resource Center (NRRC, 2016), 67.8% of formerly incarcerated individuals return to prison within 3 years of release, and 76.6% return to prison within 5 years of release. These statistics highlight that most formerly incarcerated individuals return to prison, and many, if not most, may have ongoing substance abuse and trauma histories. By offering effective substance abuse and trauma treatments simultaneously to formerly

incarcerated individuals, it may be possible to reduce the recidivism rate. This study explored the experiences of formerly incarcerated individuals with substance abuse disorders and how sexual and violent trauma histories had impacted their engagement in substance abuse treatment. This study is important because SUDs continue to be a significant social problem that affects children, families, and communities.

Understanding whether trauma history is a factor in substance abuse treatment engagement may help treatment providers design better, more effective, and more efficient treatment delivery. Having the opportunity to learn clients' needs from clients' perspectives through interviews might help providers in the field gain richer insight into what changes may need to occur for better SUD treatment delivery. This chapter provides an overview of the study and how sexual and violent trauma barriers play a crucial role in substance abuse treatment engagement. Additionally, I briefly define the purpose and theoretical framework and explain the assumptions of this study.

Background

This section highlights selected articles related to substance abuse treatment and engagement in members of the formerly incarcerated population with trauma histories. The purpose of this information is to justify the need for this study. Understanding why and how substance abuse treatment providers can help is critical in reducing high relapse and recidivism rates among formerly incarcerated males.

Previous studies have identified that substance use and relapse are closely linked to reincarceration (Bartlett et al., 2005; Binswanger et al., 2012; Johnson et al., 2013; Kurbin, 2013). Even with programs providing community-based substance abuse

treatment to individuals after release from incarceration, substance use continues to be a problem (Mahmood et al., 2013). Formerly incarcerated individuals with SUDs are at high risk for drug overdose within the first several months of being released (Binswanger et al., 2012). Environments and lack of social and emotional support are the most powerful triggers for relapse. Upon release, many formerly incarcerated individuals return to their previous environments due to a lack of social and emotional support or housing, and many find themselves returning to drug use. Compared to the general population, the formerly incarcerated population has substantially higher rates of SUDs with co-occurring mental health disorders such as PTSD, depression, and anxiety (Mahmood et al., 2013). This information is important because this is a population whose members pose a higher risk to the community if they do not receive treatment. This population is less inclined to seek treatment due to a lack of support and resources.

Henden (2018) and Schaler (2000) found that trauma histories increase substance abuse risk. Trauma histories and SUDs only increase the risk of further use and relapse (Hari, 2015). Most people use drugs to cope with their emotional pain and trauma (Harden, 2018; Hari, 2015; Schaler, 2000). With continued use, the memory of a drug eases emotional pain, thus prompting increased use to the point of addiction (Inaba & Cohen, 2014). Understanding that trauma history plays an important role in substance use as a coping mechanism provided a foundation for this study to support how trauma histories can be barriers to substance use treatment engagement.

Incarceration, in itself, is often a traumatic event that formerly incarcerated individuals have experienced. The formerly incarcerated population also experiences

higher poverty rates, unemployment, housing problems, and lack of social support compared to the general population (Mahmood et al., 2013). These are additional problems that generally lead formerly incarcerated individuals to use substances to cope. Approximately 74% of parolees participate in substance abuse treatment as part of their parole plan (Bartlett et al., 2005). It is imperative to improve substance abuse treatment providers' efforts to ensure that members of this population receive effective treatment to improve their lives, families, and communities. For most, this would include integrating trauma treatment into substance abuse treatment to increase therapeutic effectiveness. Integrated treatment may prove practical in preventing relapse and recidivism (Johnson et al., 2013).

In this study, it was my intent to learn how sexual and violent trauma histories play a role in the level of engagement in substance abuse treatment programs among formerly incarcerated males. This study provided the opportunity to learn about the relationships between trauma histories and substance abuse treatment engagement. Researchers have found that individuals with SUDs and trauma histories self-medicate to cope with comorbid trauma, especially among vulnerable subgroups of populations such as formerly incarcerated individuals (Gielen, Krumeich, Tekelenburg, Nederkoorn, & Havermans, 2016). While trauma might present a barrier to engaging in substance use treatment, Gielen et al. (2016) asserted that feelings of impaired self-esteem, hopelessness, and shame can also be barriers to treating trauma.

Problem Statement

SUDs are substantial contributors to criminal activity and recidivism, especially among incarcerated populations (Mahmood et al., 2013). Formerly incarcerated individuals with SUDs also experience co-occurring and mental health disorders, including trauma (Kaag et al., 2018). Substance use is how many formerly incarcerated individuals cope with their trauma histories; it may be the only way they know how to gain relief from their anguish. Formerly incarcerated individuals may have never had the opportunity to address core trauma and learn to find reasonable and healthy ways to cope with traumatic histories. Helping members of the substance use disordered population address their sexual and violent trauma may help increase their substance use treatment engagement and lower their need to use substances as a way to cope (Begun, Early, & Hodge, 2016).

Substance abuse treatment programs positively impact recidivism rates (Begun et al., 2016). However, over 70% of formerly incarcerated adult individuals relapse due to substance use; 44.3% are dependent on illicit substances, and 23.6% are abusers of illegal substances (Mahoney, Chouliara, & Karatzias, 2015). Although substance abuse treatment programs positively impact recidivism rates, the percentages of recidivism are still relatively high.

More than 50% of adults with SUDs experience high levels of trauma, and substance use is their maladaptive way of coping with and managing their trauma symptoms (Hooley, Butcher, Nock, & Mineka, 2017; Mahoney, Chouliara, & Karatzias, 2015). Helping individuals heal from sexual and violent trauma histories might help them

recover from substance abuse use disorders. This study explored how substance abuse treatment engagement is challenging among those with unaddressed trauma histories. Understanding how sexual and violent trauma histories play a crucial role in substance abuse treatment engagement can help providers help the afflicted, change policies and procedures, and lower relapse and recidivism rates.

Purpose of Study

The purpose of this qualitative study was to explore substance abuse treatment engagement among formerly incarcerated adult males in community-based substance abuse treatment programs concerning the nature of sexual and violent trauma history barriers. Gaining a richer understanding of the barriers to treatment, particularly sexual and violent trauma, may offer substance abuse treatment providers the opportunity to improve treatment service delivery and increase engagement. In so doing, they may increase positive treatment results and decrease relapse, which may result in lowered recidivism rates. Implementing specific trauma treatment with clients in substance abuse treatment can translate into a specialized program structure, practice, and approach to increase treatment engagement and effectiveness (Blackey & Bowers, 2014; Sacks et al., 2013).

Improving substance abuse treatment effectiveness can increase client engagement and ultimately decrease recidivism rates. It is not routine for substance abuse treatment programs to consider detailed histories of trauma as part of the assessment process or implement tailored trauma treatment into substance abuse treatment plans. Offering a treatment plan to include substance abuse treatment and

trauma treatment concurrently can translate into increased effectiveness and efficiency in program approaches and practice when treating formerly incarcerated individuals with histories of addiction and trauma (Blakey & Bowers, 2014; Sacks et al., 2013). The formerly incarcerated population with SUDs is a poorly understood population, whose relapse and recidivism risks may increase if their trauma needs are not met (Johnson, 2013). Engagement levels in substance abuse treatment may increase if trauma needs are met (Johnson, 2013).

Unaddressed sexual and violent trauma and unhealed emotional wounds may only perpetuate substance abuse disorders, resulting in a lack of treatment engagement and potentially resulting in relapse and recidivism (Blakey & Bowers, 2014). This study offers insight into how incorporating trauma treatment into substance abuse treatment can increase client engagement among formerly incarcerated males in community-based programs, lower recidivism rates, and improve communities' safety.

Research Questions

The following research questions focused the study's collection of data:

Research Question 1: What do formerly incarcerated males believe can help them increase their engagement level in substance abuse treatment?

Research Question 2: How do trauma barriers affect engagement in substance abuse treatment among formerly incarcerated adult males in community programs?

Research Question 3: How do formerly incarcerated adult males in community-based programs feel about incorporating trauma treatment into their substance abuse treatment?

Theoretical Framework

The theoretical framework applied to this study was contemporary trauma theory (CTT). Theorists Elizabeth Loftus and Richard McNally are empirical clinicians who conducted numerous studies using this "anti-repressed memory" theory with participants with trauma histories (Suleiman, 2008). They argued that traumatic memories could not be repressed, but they are not always accurately recalled (Loftus, 1993; Sulieman, 2008). Furthermore, McNally (2007) argued that traumatic amnesia is a farce, and the more violent a traumatic event is, the more memorable the event becomes. McNally (2007) also argued that if an individual cannot clearly remember a traumatic event, then the traumatic event is not too intrusive. Contemporary trauma theory indicates that trauma histories left unaddressed may manifest in mental health disorders (Loftus, 1993; Suliman, 2008). This study found that if unaddressed, sexual and violent trauma histories may indeed manifest as mental health disorders, indicating that for those with substance abuse disorders, substance abuse may be perpetuated as a trauma coping mechanism.

In the present study, CTT offers a better understanding of how trauma impacts functioning based on dissociation, attachment, reenactment, long-term effects in later adulthood, and emotional impairment among individuals with trauma histories (Goodman, 2017; Piers, 1998). Researchers have shown an association between trauma and SUDs (Levenson, 2015). CTT provides a foundation for trauma-informed care to

understand better how traumatic experiences can cause coping difficulties (Goodman, 2017). CTT, as a theoretical framework in the current study, helps in arguing for the importance of therapeutic alliances between clients and substance abuse treatment providers and how such alliances can improve engagement and treatment outcomes. Goodman (2017) asserted that alliances are necessary to treat co-occurring trauma and SUDs. Goodman's assertion is consistent with the finding of Kaag et al. (2018) that there is an interrelationship between childhood trauma experiences and adult substance use. Sexual and violent trauma experiences in childhood lead to many poor outcomes later in life, such as substance abuse, involvement with the criminal justice system, and incarceration (Freeman, 2018). CTT was found to be the most appropriate theoretical framework to apply to this study. The CTT framework allowed this study to gain a rich understanding of the phenomenon of sexual and violent traumas and its impact on substance abuse treatment engagement.

Nature of Study

The nature of this study was qualitative. Interpretative phenomenological analysis (IPA) was the specific qualitative methodological framework used in this study. The IPA approach was appropriate for this study, in that it makes it possible to examine how individuals make sense of significant life experiences and what happens when their life experiences' normal flow takes on significance for them (Smith, Flowers, & Larkin, 2012). The IPA approach allowed me to explore the participants' experiences of substance abuse treatment and how their past sexual and violent traumas had created a barrier to their treatment engagement. The IPA approach allowed me to make sense of

their engagement level in treatment services as a feature of their unaddressed sexual and violent trauma histories.

I conducted individual, one-on-one interviews with formerly incarcerated adult males who participated in community-based substance abuse treatment programs that served adults on parole in Denver, Colorado. The participants were adult males over the age of 18 years with SUDs. The purpose of the interviews was to explore each participant's experience in substance abuse treatment and how their sexual and violent trauma histories may have impacted their engagement level. I detailed the participants' experiences and the themes among the individual data I collected. I advertised this study at community-based substance abuse treatment programs that provided services specifically to adults on parole in Colorado.

Definition of Terms

The following are terms and definitions for reader clarification:

Addiction: A disease characterized by self-destructiveness, compulsion, and loss of control over the use and continued use of something, despite adverse consequences, often with denial that a problem exists (Inaba & Cohen, 2014; Schaler, 2000).

Formerly incarcerated individual: A person who committed a crime, served time in prison, and was then released (Prison Policy Initiative [PPI], July 2018).

Trauma: Persistent painful emotional response evoked after an individual experiences an event that is threatening or harmful (Little, Robinson, & Burnette, 2015).

Engagement: A level of commitment indicated by clients to treatment, as shown through attendance of several visits/sessions within a set time and participation in recovery activities (U.S. Department of Health and Human Services, 2019).

Community-based substance abuse treatment: The facilitation of substance use prevention and treatment and mental health services in a program outside of corrections once formerly incarcerated individuals are released into the community (U.S. Department of Health and Human Services, 2014).

Recidivism: Re-engagement in criminal offending (Taylor, 2016).

Sexual trauma: Any sexual act imposed on a man, woman, or child without their consent by another man, woman, or child. Sexual trauma may or may not be physically violent, but it can have lasting physical, emotional, or psychological effects on the victim (Yuan, 2006).

Substance use disorder (SUD): The continued use of a substance that causes significant distress or impairment in health, social, occupational, or other essential areas in a person's life that affect responsibility (Inaba & Cohen, 2014).

Violent trauma: Exposure to violence as a witness or victim. Violent acts may include threats, slapping/hitting/punching, beatings, knife attacks, and shooting (Song, Singer, & Anglin, 1998).

Assumptions

This study's primary assumption was that the participants were honest in discussing their trauma and substance use histories during the interviews. Another assumption I had was that lack of treatment engagement was due to unaddressed trauma

histories. Rosenberg (2011) asserted that one should not expect substance use disordered individuals to stop using without addressing their trauma first. Other causes for lack of treatment engagement are discussed in this study as well.

Scope and Delimitations

This study focused on formerly incarcerated adult males on parole. The participants were clients involved in community-based substance abuse treatment as part of their parole plan. To be eligible to participate in this study, individuals needed to be formerly incarcerated males aged 18 years or older who had been released from Colorado correctional facilities and paroled to the Denver city area. Participants were considered for inclusion if they reported a history of trauma experience and had participated in substance abuse programs at least twice (current or previous participation). Participants had a minimum of 2 years of substance use before incarceration. Although participants were not questioned about the details of the trauma they experienced, participants needed to have reported being a victim of sexual or violent trauma during childhood or adulthood to be eligible to participate in this study. This experience must have occurred before their previous incarceration. Participants met the criteria for "trauma experience" based on their reports of having experienced sexual or violent trauma. Examples of possible sexual or violent traumas included being a victim of rape or being involved in a gang-related incident, which were two common traumas often reported to me by formerly incarcerated individuals in the past. Given that there is little literature on formerly incarcerated males with sexual and violent trauma histories and their engagement in substance abuse treatment, males were chosen as the focus of this study rather than females. Based on the

required criteria, the participants provided a better representation of this misunderstood population's needs.

This study focused on participants' lived experiences with SUDs and how their histories of sexual and violent trauma might have impacted their engagement in substance use treatment. This study's results represent the participants' thoughts and behaviors around their substance use, their engagement in treatment, and their ways of coping with trauma.

Limitations

A limitation of this study was the size of the sample. This was a qualitative study that used a small sample size. The results may not represent the larger population of formerly incarcerated males with substance abuse and trauma history. Because this qualitative study used an IPA approach, the focus was on collecting individual experiences, and the concern was quality, not quantity (Smith et al., 2012). Data collected through the IPA approach can be especially powerful and provide useful findings for future research on SUD treatment.

Sample recruitment was a potential limitation. This study included the use of participants from one facility instead of several different substance treatment facilities. The participants might have discussed their participation in this study; however, study participation was kept private and confidential. Participants would only share their experiences in this study if they openly discuss it with others without judgement, which does not influence data collection. However, it was vital to have a homogenous sample of individuals to whom the research questions were meaningful (Smith et al., 2012).

Although a limitation could have had variation within the analysis, the topic explored defined boundaries among a relevant sample (Smith et al., 2012).

The sampling method could be considered a limitation. The participants who agreed to be interviewed for this study did not have enough time to gain rapport with me as the interviewer and may not have given true and accurate personal information. To address this possibility, I provided a safe environment to share and ensured that their identities and identifying information would not be revealed. I provided a comfortable and relaxed environment for them to build trust and share their personal experiences. I addressed establishing rapport efficiently in the little time we had together by facilitating semi structured interviews and continued to check in with the participants when I noticed any feelings of discomfort. Providing a safe space for participants was essential in helping them to feel safe enough to share. When participants felt safe in sharing their experiences, the opportunity was there to observe and capture both externally observable behaviors and internal states to understand the stories' context and perspectives (Patton, 2015). Participant information can be invaluable for future research.

A final limitation might have been my assumptions and personal beliefs about the data outcome. Because this was a study of interest, I had an idea that what I might believe might also be true. The premises came from being in the field and observing past behaviors or client engagement in treatment. Moreover, researching the facility included getting to know the program staff and participants on a somewhat personal level. However, many contributions to this field come from researchers' personal experiences (Patton, 2015). To a certain degree, this might be necessary. I addressed this by keeping

my bias and beliefs to the side. I maintained neutrality, meaning that I was nonjudgmental and sought to convey that participants could tell me anything and that I would not show favor or disfavor (Patton, 2015). I was open and did not ask participants any leading questions. I also performed member checking with participants during interviews to ensure that my reconstructions of participants' stories were adequate representations of their realities (Ravitch & Carl, 2016). I understood that collecting accurate and honest responses would be critical for presenting the findings in this study.

Significance

This study may be helpful in understanding how sexual and violent trauma significantly impacts clients' engagement in substance abuse treatment programs. Such understanding may provide insight into various ways to deliver substance abuse treatment to those who need to address sexual and violent trauma to move forward in their treatment. Orford (2008) asserted that addictions practitioners often fail to incorporate the client's perspective, instead relying on experimental or quasi-experimental designs. A client's perspective may offer providers a deeper understanding of potential trauma barriers to substance abuse engagement and how providers might change abuse treatment delivery. Changes in treatment delivery based on this understanding may increase substance abuse treatment engagement and ultimately decrease relapse and recidivism rates.

Summary

A lack of client engagement in substance abuse treatment is evident in low attendance, noncompletion of treatment, or client relapse. Client engagement in substance

abuse treatment may be increased if clients have the opportunity to address their sexual and violent trauma before treatment or concurrently with treatment. If formerly incarcerated individuals who most likely have experienced sexual and violent trauma are asked to quit using substances and begin sobriety without healing their sexual and violent trauma wounds, they may fail on their road to recovery. Substance use is a coping mechanism to ease pain and stress; if pain and stress are present, the individual will most likely use substances to cope. Unsuccessful substance use treatment often leads to relapse and may lead to recidivism, causing problems within communities and families.

Relapse and recidivism rates continue to be a problem among formerly incarcerated individuals, regardless of whether they attend substance abuse treatment. Offering trauma treatment concurrently with substance abuse treatment can help formerly incarcerated individuals cope without using substances. If trauma is left untreated, it may increase the risk of substance abuse. Suppose formerly incarcerated individuals do not address their sexual and violent trauma histories. In that case, it may not be possible for them to be ready to fully engage in substance abuse treatment, which is their way to cope with their trauma. Increasing substance abuse treatment engagement among members of the formerly incarcerated population can positively affect social change by lowering criminal recidivism rates and increasing community safety. Reducing recidivism improves public safety and helps formerly incarcerated individuals successfully reintegrate with their families and community responsibilities (Safe Streets & Second Chances, 2020).

In the next chapter, I review current research to support the existence of a gap in the literature. The literature review addresses substance abuse among the formerly incarcerated population and the context of substance use as a coping mechanism for sexual and violent trauma. I use literature to bridge the gap between substance use, sexual and violent trauma, and substance abuse treatment engagement among formerly incarcerated adult males in the community.

Chapter 2: Literature Review

Introduction

Trauma barriers to substance abuse treatment engagement exist among formerly incarcerated adult males. The phenomenon of trauma barriers to substance abuse treatment engagement is a topic less often discussed in relation to formerly incarcerated males than in relation to formerly incarcerated females. Although published research has assessed trauma barriers to substance abuse treatment engagement among formerly incarcerated females, there has been limited research exploring this phenomenon among formerly incarcerated males, especially concerning sexual and violent traumas (Blakey & Bowers, 2014).

Clients who have difficulties coping with past trauma may be less engaged in substance abuse treatment, as using substances is how many formerly incarcerated individuals cope with their problems (Begun, Early, & Hodge, 2015). Having a better understanding of how trauma histories might play a role in substance abuse treatment engagement among formerly incarcerated adult males in community-based programs may help providers deliver effective treatment to retain clients. Furthermore, recognizing common trauma features can help substance abuse treatment providers determine which clients may be at risk of disengaging from and dropping out of treatment. This study's purpose was to explore how trauma barriers might affect substance abuse treatment engagement among formerly incarcerated adult males in community-based programs. My goal was to bridge a gap in research by assessing the phenomenon of sexual and violent

trauma barriers to substance abuse treatment engagement. In this chapter, I discuss the literature search strategies, the theoretical framework, and CTT.

This study explored how trauma histories and engagement in substance abuse treatment may be interrelated. Studies of clients in substance abuse treatment programs have shown that over 50% of these individuals have high levels of trauma history, which may include threats of personal injury, experiences of witnessing injury, and/or experiences of sexual abuse (Hooley, Buthcher, Nock, & Mineka, 2017). If formerly incarcerated individuals with histories of sexual or violent experiences do not address their trauma, engaging in substance abuse treatment is difficult (Blakey & Bowers, 2014). For members of this poorly understood and high-risk population, engagement in substance abuse treatment may increase if their needs are met to address their sexual or violent trauma (Johnson, 2013).

Literature Search Strategy

Databases Used

To conduct my literature review, I searched multiple databases through the Walden University Library Portal. The search included peer-reviewed journal articles, published articles, online periodicals, websites, and books by experts in the field related to substance abuse, addictions, and sexual and violent trauma histories. The databases that I used included ProQuest Central, Google Scholar, SAGE Full-Text, PsycINFO, PsycARTICLES, PsycNET, SocINDEX, ERIC, PubMed, Science Direct, CINAHL Plus, Criminal Justice Periodicals, and Health & Psychosocial Instruments.

Keywords

I began my literature search with a narrow topic: trauma and SUDs. I found that there was a vast number of articles that addressed trauma and substance abuse. I then narrowed the search to trauma and substance abuse treatment. This search resulted in identifying articles about physical barriers to substance abuse treatment, trauma barriers in substance abuse treatment, trauma histories, and effective and efficient delivery of SUD treatment in the domains of psychology, substance abuse, and addictions. My search included studies published from 2013 through 2019. I did additional comprehensive searches to find foundational works related to the current study, which dated back to 1987. I conducted Boolean searches with several combinations of keywords in all of the search databases, including formerly incarcerated individuals, offenders, substance abuse, substance use disorders, trauma barriers, substance abuse treatment engagement, sexual trauma, violent trauma, and trauma histories. I conducted research online to identify relevant books and websites that provided me with literature, references, and statistics on the study topic. All referenced journal articles were peer reviewed.

Theoretical Framework

Trauma can be defined differently among individuals, depending on their understanding and experiences of trauma. However, the consensus is that trauma is defined as an event or series of events that is experienced by a person as physically or emotionally harmful, threatening, or overwhelming, and that interferes with emotional and physical functioning (Goodman, 2017). Trauma produces excess excitation in the

brain, which may inhibit the ability to process overwhelming events. Therefore, individuals respond to trauma in various ways, which may include showing an inability to function, disassociating, becoming numb, or shutting down emotional responses (Suleiman, 2008).

Trauma theory is a way to explain broad forms of human suffering and responses to suffering (Rodi-Risberg, 2015). Although trauma has considerable breadth, the focus of this study was sexual and violent trauma. The focus of the theoretical framework of this study was CTT. Although CTT has undergone various theoretical shifts, the progressive CTT camp of trauma theory discussed in this study was "anti-repressed memory." It was represented by empirical clinicians and psychological researchers (Suleiman, 2008). Two of the foremost CTT theorists, Elizabeth Loftus and Richard McNally, conducted numerous studies on individuals with trauma histories (Suleiman, 2008). Loftus (1993) conducted many studies on human memory's plasticity and argued that there is a lack of empirical evidence to support accurate recollection of repressed memories. CTT proponents contend that histories of trauma are ever-present and manifest in systematic mental distress. Those with trauma histories do not repress traumatic memories; those memories are manifested into mental disorders (Loftus, 1993).

Based on exhaustive research, McNally (2007) argued that traumatic amnesia is a myth. Furthermore, McNally argued that the more violent a traumatic event is, the more likely an individual is to remember the event. A single traumatic occurrence may cause individuals with PTSD to report details and vivid images comparable to those reported by individuals with PTSD from repeated trauma (Toth & Ciccetti, 1998). This phenomenon

may be caused by repeated exposure of trauma that becomes embedded and consolidated in memory with other everyday experiences.

Some trauma theorists believe that many childhood sexual abuse victims develop amnesia as a result of their abuse, while others develop cognitive skills that help them dissociate from ongoing abuse by mentally escaping it (McNally, 2007). McNally (2007) argued that repression, dissociation, amnesia, and memory are not phenomena triggered by sexual and violent trauma because these traumas' intense emotions tend to strengthen memory. This theory relates to the CTT model by explaining that sexual and violent traumatic experiences are stored in the memories of those with trauma histories and are not repressed or forgotten. If left unaddressed, traumatic histories may manifest into mental health disorders and lead individuals to substance abuse to cope with their traumatic memories.

In this study, CTT explains how trauma impacts an individual's functioning based on dissociation, attachment, reenactment, long-term effects on later adulthood, and emotional impairment (Goodman, 2017). The CTT model places a pathogenic significance on trauma. The model explains adult psychopathology, comprehension, retrieval, abreaction, and integration of traumatic experiences (Piers, 1998).

There are compelling associations between trauma and SUD and a substantial need for professionals in the addictions field to practice through the lens of trauma-informed care (Levenson, 2015). CTT provides a foundation for trauma-informed care (Goodman, 2017). Relating to a client's identity and trauma experiences, a trauma therapy framework such as CTT might provide an understanding of how traumatic

experiences can cause coping difficulties. Using CTT can provide a foundation for therapeutic alliances between clients and substance abuse treatment providers. Goodman (2017) asserted that CTT provides a foundation of trauma-informed care practice with co-occurring trauma and SUDs.

Furthermore, consideration of emotions, in addition to stress and coping, can provide a richer understanding of the perspectives of formerly incarcerated individuals who have difficulty in substance abuse treatment engagement (Lazarus & Folkman, 1987). For example, Kaag et al. (2018) found a negative interrelationship between childhood trauma and amygdala-striatum connectivity during reactivity in controls and cocaine users. The results of their study suggested that childhood trauma enhances the reward value of substance cues in users and decreases the reward value of substance cues in non-user controls (Kaag et al., 2018). By relating the CTT framework to this study, I sought to provide a better understanding of the phenomenon of sexual and violent traumas and of how they might impact engagement in substance abuse treatment.

Literature Review

Trauma

Trauma is an ancient Latin and Greek term for “wound” or “hurt,” which became recognized in the 1800s as referring to a “psychic wound” that resulted from bad experiences and mental pain (Little et al., 2015). Trauma is an emotional response that individuals experience after a terrible event that is threatening or harmful (Little et al., 2015). Trauma is a drama; the brain cannot fully process traumatic events and may cope by psychological numbing or shutting down normal emotional responses (Suleiman,

2008). Lifton (1980) described trauma as having both positive and negative consequences, noting that it can undermine individuals. It can be a powerful motivation for behavior. Individuals affected by trauma, especially sexual and violent trauma, suffer negative consequences, perhaps due to a limited ability to cope, depending on their resilience to their trauma.

Today, trauma and its devastating long-term effects are receiving more attention than ever before. Individuals exposed to severe stressors are prone to psychological disorders later in life (Brown, Fulton, Wilkeson, & Petty, 2000; Bryant et al., 2010; Popovic et al., 2019). For example, Popovic et al. (2019) asserted that childhood trauma affects individuals by impairing memory, executive and global functioning, learning, attention, and cognitive performance, indicating that it often causes mental health illnesses, including depressive symptoms and anxiety. Health professionals conceptualize traumatic experiences as dissociation more often than repression (Sletvold, 2016). Anxiety, inner conflict, aggression, stress, and depression are mental health problems that individuals experience due to trauma. Many of those who suffer from trauma histories have experienced trauma in childhood. According to the National Center for Mental Health Promotion and Youth Violence Prevention (2012), approximately 26% of children in the United States experience some form of trauma within their first 5 years of life. There is an association between childhood trauma and impaired working memory, executive function, and verbal learning, and there is an increased risk of the development of psychosis in those who have experienced childhood trauma (Popovic et al., 2019). Many individuals with trauma histories go undetected while in treatment. For example,

approximately 71% of individuals in outpatient psychiatric treatment have histories of sexual or violent trauma not previously reported (Carlson et al., 2011).

Trauma assessments are not routinely offered in substance abuse treatment due to time constraints. They are also not often recognized as being important data in substance abuse treatment and are therefore addressed as a separate disorder. However, assessing trauma when clients seek substance abuse treatment may help to increase treatment success. Today, more substance abuse treatment providers recognize the importance of assessing trauma to incorporate interventions for trauma symptoms in treatment (Sanford, Donahue, & Cosden, 2014). Recent studies support the need for the integrated treatment of substance abuse and trauma symptoms in clients who report a history of trauma (Sanford et al., 2014). Studies show positive outcomes of treatment approaches that integrate SUD and trauma treatments (Amaro et al., 2007).

Substance Abuse

Addiction is a disease. Substance abuse negatively affects cognitive functioning and behaviors; it damages relationships and interferes with daily activities such as school and work. The consequences of substance abuse can be devastating for individuals with SUDs. According to the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 28.6 million Americans aged 12 years and older have used illicit drugs or prescription drugs for non medical reasons (Wulffson, 2019). Over 90% of individuals with substance use problems began smoking, drinking, or drugging before turning 18 years old (Center on Addiction, 2019). According to the Center on Addiction (2019), one in seven individuals

over age 11 has a substance abuse problem. If left untreated, substance abuse may contribute to a variety of severe health conditions. Substance abuse often co-occurs with mental health disorders, including depression, anxiety, bipolar disorder, and conduct disorders (Center on Addiction, 2019). The Center on Addiction reported that alcohol and drug use cause over 20% of deaths in the United States each year.

According to the Treatment Episode Data Set (TEDS, 2017), the most frequently used and abused substances in 2017 were opiates (34%), alcohol (29%), marijuana/hashish (13%), stimulants (12%), and cocaine (5%). Approximately 93% of those admitted were age 12 years and older (TEDS, 2017). Anyone can become addicted to substances. Psychological and environmental factors play a significant role in substance abuse. Furthermore, according to the Center on Addiction (2019), genetics play a significant role in predisposing those who might become addicted. Physical, sexual, or emotional abuse or trauma experiences often encourage substance abuse. However, experiences of trauma do not necessarily indicate that an individual will abuse substances. Many factors encourage substance abuse, and the more factors that are present, the greater the likelihood of substance abuse.

Trauma and Substance Abuse

Trauma and substance abuse are often linked. Kaag et al. (2018) investigated the neurobiological connection between childhood trauma and amygdala-frontostriatal activity in frequent cocaine users. They found that trauma is associated with increased anxiety levels, increased risk of SUDs, and increased neurodevelopmental abnormalities (Kaag et al., 2018). Neural mechanisms of trauma and anxiety often contribute to

substance use and addictions (Kaag et al., 2018). In addition to increased mental abnormalities and substance use and addictions, cumulative childhood trauma increases behavioral and physical health problems (Wu, Schairer, Dellor, & Grella, 2010). Individuals with mental health disorders and substance abuse are often vulnerable individuals with a high prevalence of past traumatic experiences.

There are compelling associations between trauma and substance abuse (Levenson, 2015). There is often a link of comorbidity between SUD and trauma. SUDs among clients with cooccurring disorders (SUDs and posttraumatic stress disorders) are significantly higher than those with SUDs alone (Ouimette & Read, 2013). Wieferink, de Haan, Dijkstra, Fledderus, and Kok (2017) compared substance use disordered patients with high levels of PTSD who received standard, nonintegrated treatment to those with lower levels of PTSD who received the same treatment. After 6 months of substance treatment, the researchers found that patients with higher PTSD levels did not always have poorer treatment outcomes. Instead, they found that anxiety and PTSD symptoms predict relapse (Wieferink et al., 2017). This study demonstrated that individuals with SUDs who abstain from alcohol and drugs often had improved negative trauma symptoms (McGovern et al., 2015; Wieferink et al., 2017).

Trauma underlies stimulus-response or habit behavior and poorer cognitive control (Kaag et al., 2018). Habit behavior and poor cognitive control partially explain why those who suffer from trauma have SUDs. Individuals with SUDs and mental health disorders endorse a history of trauma or post-traumatic stress disorder (Kaag et al., 2018). Driessen et al. (2008), Elwyn and Smith (2013), Levenson (2016), and Levenson and

Grady (2016) found similar results linking childhood trauma to underlying mechanisms that contribute to the development of SUDs. Also, Jung et al. (2014) and van der Kolk (2014) also found that exposure to sexual or violent trauma in childhood will increase the risk of alcohol and drug abuse in adulthood. Substance use is often how many individuals may cope with their unresolved trauma histories.

Those with a history of trauma and SUDs have increased suicidal thoughts and suicide attempts and correlates with maladaptive emotional and behavioral patterns (Keyser-Marcus et al., 2015). Brucker (2007) asserted that there are detrimental consequences of co-occurring trauma and SUDs among the substance-abusing population. Understanding the association between trauma and substance abuse disorders might contribute to better substance abuse treatment procedures. Professionals who are trauma-informed in the addiction treatment field and mental health professionals assess for trauma histories might provide more efficient treatment if working with both issues concurrently.

Formerly Incarcerated Adult Males and Substance Abuse

Substance abuse and the formerly incarcerated population. Substance use and abuse are prevalent among adult male criminal formerly incarcerated individuals. Substance abuse persists after release from incarceration into the community mental health system (Mahmood et al., 2013). Formerly incarcerated individuals are at high risk for drug overdose during the period of their immediate release from incarceration (Binswanger, Nowels, Corsi, Glanz, Long, Booth, & Steiner, 2012). Formerly incarcerated individuals often return to the environments they came from before

incarceration; those triggered may relapse to drug use. Compared to the general population, the formerly incarcerated population has substantially higher SUDs with co-morbid mental health disorders, including post-traumatic stress disorder, depression, and anxiety (Mahmood et al., 2013). Compared to the general population, formerly incarcerated populations have higher poverty rates, unemployment, housing, instability, and experience sexual and violent trauma. (Mahmood et al., 2013). Mahmood reported that of formerly incarcerated males with substance abuse disorders, 44.3% are dependent on illicit substances, and 23.6% are abusers of illicit substances. Criminal justice, mental health, and social services systems are inevitable in the formerly incarcerated population with SUDs. Addressing the challenges of substance abuse can increase positive outcomes in community re-entry into their communities.

Formerly incarcerated individuals often face biases in many areas in their lives. They experience stigma from the general population regarding their legal background, mental health disorders, and SUDs. They experience obstacles to successful re-entry in employment and skills, education, poverty, housing, legal representation, public benefits, and healthcare (Mahmood et al., 2013). Finding employment that enables formerly incarcerated individuals to sustain a reasonable living is often complicated and discouraging, especially among men who have child support responsibilities. Many formerly incarcerated individuals also struggle with family reintegration (Taylor, 2016). Child support is a common obstacle for formerly incarcerated individuals in re-entry; they often do not earn the same amount of money they made before being incarcerated and have little to no money to modify child support (Taylor, 2016; Kurbin, 2013). With

these challenges, it is no wonder that nearly two-thirds of formerly incarcerated individuals are arrested again within 3 years of their release (Taylor, 2016).

SUDs are a significant factor contributing to criminal activity and recidivism among formerly incarcerated individuals (Mahmood et al., 2013). Formerly incarcerated individuals with SUDs and mental health disorders endorse a history of trauma or post-traumatic stress disorder (Kaag et al., 2018). Addressing trauma barriers and helping formerly incarcerated individuals find reasonable and healthy ways to cope with their trauma histories may help increase their treatment engagement and lower their need to use substances as a way to cope (Begun, Early, & Hodge, 2016). Furthermore, Begun et al. discussed the evidence of substance abuse treatment programs positively impacting, reducing the recidivism rate. Sexual and violent traumas experienced in childhood are associated with significant psychiatric morbidity, alcohol, and drug use (Cardoso, 2018). Over 50% of adults with SUDs have histories of high trauma levels (Hooley, Butcher, Nock & Mineka, 2017). The role of substance abuse is a maladaptive coping mechanism used to manage trauma associated with adverse and abusive life experiences (Mahoney, Chouliara, & Karatzias, 2015). Suppose formerly incarcerated individuals with histories of sexual and violent experiences do not address their trauma. In that case, it could make engaging in substance abuse treatment difficult and could result in relapse and potentially recidivism (Blakey & Bowers, 2014). Asking formerly incarcerated individuals with SUDs to quit using substances is equivalent to asking them to quit coping with their pain in the only way they know how.

Gaining knowledge of clients' trauma histories during their intake assessment can translate into specialized program structures, practices, and approaches when treating formerly incarcerated individuals with histories of addiction and trauma (Blackey & Bowers, 2014; Sacks et al., 2013). Assessing trauma barriers to substance abuse engagement might offer mental health professionals an understanding of ways to develop more efficient and effective substance abuse treatment delivery, increasing substance abuse treatment engagement, and ultimately decreasing recidivism rates. Substance abuse treatment programs do not routinely consider histories of trauma as part of the assessment process, which can otherwise offer critical knowledge to translate into program practice and approaches when treating SUDs (Blakey & Bowers, 2014; Sacks et al., 2013). With this poorly understood and high risk-population, formerly incarcerated individuals with sexual and violent traumas may have increased substance abuse treatment engagement if their needs are met to address their trauma barriers (Johnson, 2013).

Substance abuse and poor cognition and behavior. Substance abuse is the persistent use of substances that cause problems in social, vocational, interpersonal, and legal areas (Mahmood et al., 2013). Substance dependence is the loss of control over substance use, cravings for the used substance, the inability to stop or reduce using the substance, which often results in harm and physical changes to the brain and increases tolerance (Mahmood et al., 2013). Prolonged substance use induces neurodevelopmental changes in the prefrontal cortex (Kaag et al., 2018). The frontostriatal circuit controls the drug-reward anticipation and inhibitory control, and the amygdala plays a role in negative reinforcement in SUDs (Kaag et al., 2018). The amygdala becomes hypersensitive to a

negative emotional stimulus after repeated abuse and dependence. Eventually, continued use of psychoactive substances becomes normalized after continued use and tolerance increases. Trauma can hinder personality development and may increase psychopathology and increase the risk of substance abuse problems (Handley, Rogosch, Guild, & Cicchetti, 2015). With continued use of a drug, the cognitive control and response inhibition disrupts the anticipation that the drug becomes a craving, and the self-control process is inhibited, therefore becoming what we call addiction (Becker, Kirsch, Gerchen, Kiefer, & Kirsch, 2017).

Substance abuse is associated with mental health problems, poor performance, and involvement in violence and the criminal justice system (Rahdert et al., 2017). Impaired cognition is associated with formerly incarcerated individuals with SUDs. Negative behaviors are also associated with individuals with SUDs and cravings related to negative reinforcement (Kaag et al., 2018). Individuals with SUDs may feel conflicted in their social worlds, biases, and their own moral decisions and behaviors. Many individuals with SUDs often struggle with individual and environmental factors, belonging, and acceptance by others, producing psycho-emotional disabilities (Semb, Tjora, & Borg, 2019). Psycho-emotional disabilities may produce mental health issues, feelings of rejection, lack of engagement in social environments, and possibly continued the use of substances. In his book, *Chasing the Scream*, Hari (2015) describes the opposite of addiction is a connection; if a user does not connect to their social environment, they will find a connection in a drug community, where others understand them. Through their research, Tjora and Borg (2019) found that participants reported that

the drug-user community was a place that provided a sense of belonging. Eventually, they began experiencing additional, different problems resulting from engaging in drug communities. This problem includes reclusive behaviors to eliminate the chances of exposure to their substance use. Countries, especially the United States, punish individuals with addictions and have the worst substance use recovery rates (Hari, 2015). Harm reduction services that support punishment do not help substance use disordered populations; however, addiction treatment services and compassion can.

Substance abuse and relapse. The formerly incarcerated population is at high risk for drug relapse after release from incarceration (Binswanger et al., 2012). Although several factors contribute to relapse, the primary factor is poor social support and resources to get treatment (Binswanger et al., 2012). Formerly incarcerated individuals who present treatment challenges, treatment dropout, and elevated substance use rates often relapse (Horsfall, Cleary, Hunt, & Walter, 2009; Kaag et al., 2018). Furthermore, clients with histories of SUDs are associated with poorer treatment outcomes and have an increased risk of relapse compared to those without substance use histories (Wieferink et al., 2017). Treatment outcomes are measured in different terms, depending on each facility's substance abuse treatment models and requirements. For example, treatment intervention outcomes can be difficult if there is little or no post discharge follow-up to determine the long-term effects (DuPont, 2014). Also, a single follow-up post treatment might not determine if treatment successfully produced lasting recovery change. Individuals with addiction histories may relapse due to specific addiction motives. Addiction motives for use include coping, poor impulse control, loss of control,

substance cues, obsessive behavior, withdrawal, taste, and smell (Gielen, Krumeich, Tekelenburg, Nederkoorn, & Havermans, 2016). Destructive behaviors may also contribute to poorer treatment outcomes and increased risk of relapse. Substance abuse treatment programs are a strategy to assist in decreasing substance use relapse and to prevent recidivism.

Forty percent of formerly incarcerated individuals attend substance abuse treatment during incarceration (Mahmood et al., 2013). Approximately 74% of formerly incarcerated individuals on parole are mandated to participate in substance abuse treatment as part of their parole plan (Bartlett, Dinsmore, Gilbert, Kornblum, Latham, Oliff, 2005). To effectively treat formerly incarcerated individuals with SUDs, providers need to know and understand each client's needs. For example, for those with specific mental health needs, addressing and integrating those needs in substance abuse therapy can increase treatment effectiveness. A full understanding of substance abuse relapse, barriers to treatment, and client rapport are essential in collecting information from formerly incarcerated individuals in substance abuse treatment (Johnson, Yael, Nargiso, Kuo, Shefner, Williams, & Zlotnick, 2013). The course of substance use relapse and sobriety maintenance among formerly incarcerated individuals are critical to developing effective substance abuse strategies to prevent relapse and recidivism (Johnson et al., 2013).

Trauma from sexual and violent abuse adversely affects men and women and is identified as an independent risk factor for drug and alcohol relapse among the SUD population (Driessen et al., 2008). Within six months of incarceration, 75% of formerly

incarcerated males use illegal substances (Mahmood et al., 2013). SUDs can inhibit an individual's ability to find stable and long-term employment for formerly incarcerated individuals. Employment is a substantial factor in preventing relapse among formerly incarcerated males (Mahmood et al., 2013). Substance abuse treatment is also a substantial factor in preventing relapse prevention. It can help formerly incarcerated individuals not use while working, decrease calling in sick to work, and help maintain a healthier lifestyle, leading to better decision making (Mahmood et al., 2013).

Formerly incarcerated individuals with co-occurring disorders are at an increased risk for recidivism. Anxiety is associated with cravings related to negative reinforcement, suggesting that anxiety is relevant to continued substance use and may reduce the ability to regulate the emotional response to substance cues, increasing the risk or relapse (Kaag et al., 2018). Relapse occurs when an individual with serious and persistent problems with drugs initiates the use of drugs (Shoaib, Mansoor, & Saeed, 2018). Shoaib, Mansoor, and Saeed (2018) found that stress and anxiety often are leading factors to relapse due to the individual's inability to cope with stress. Their study is consistent with previous studies that stress, anxiety, and depression predict drug dependence and relapse among previous users (Shoaib, Mansoor, & Saeed, 2018). This information is important to this study because it explains the leading factors of substance abuse and predictors of relapse. Economic and social climates are affected by incarceration. Improving criminal justice and community-based treatment systems by assessing risks and addressing formerly incarcerated individuals' needs through treatment interventions can reduce relapse and recidivism (James, 2018). Understanding these factors and predictors can

help mental health professionals manage client treatment by tailoring each client's specific needs to increase or maintain client engagement in treatment and decrease relapse chances.

Trauma Barriers to Substance Abuse Treatment Engagement

Trauma might contribute to the most common barriers to substance abuse treatment engagement in community-based programs among adult formerly incarcerated males. If formerly incarcerated individuals with histories of sexual and violent experiences do not address their trauma, engaging in substance abuse treatment may be difficult, as using is often the only way they know how to cope with their pain (Blakey & Bowers, 2014). Knowing clients' trauma histories can translate into specialized program structures, practices, and approaches when individuals with histories of addiction and trauma (Blakey & Bowers, 2014; Sacks et al., 2013). Many community-based substance abuse treatment programs may not address trauma histories in the intake assessments or treatment curriculum. However, trauma history could be vital information in treatment approaches in treating clients with addictions. It is possible for formerly incarcerated individuals with sexual and violent traumas to fully engage in substance abuse treatment by addressing their needs for coping with their trauma barriers (Johnson, 2013). Greater engagement in substance abuse treatment may increase positive outcomes and decrease recidivism rates among formerly incarcerated adult males. Community-based substance abuse programs that offer integrated services can offer more effective interventions than substance abuse treatment alone (Mahmood et al., 2013). Examples of services that might increase substance abuse treatment effectiveness may include case management,

contingency management, social support, employment resources, and evidence-based self-esteem and improvement approaches.

While there are many barriers to substance abuse treatment engagement, Blakey and Bowers (2014) assert that trauma is a secondary barrier to substance abuse treatment, and addiction is the primary barrier. How is it that formerly incarcerated individuals become addicted to substances in the first place? Does addiction come from experimentation? Can it be a series of use when coping with pain, which can eventually lead to addiction? Wieferink et al. (2017) found no evidence showing better outcomes between treatment with trauma-focused SUD treatment than SUD treatment alone. However, more research is needed to compare substance abuse treatment with trauma-focus and substance abuse treatment without trauma-focused among the population with sexual and violent trauma histories. Some professionals and researchers argue core issues that create barriers to substance abuse treatment engagement. Formerly incarcerated individuals are more likely to benefit from substance abuse treatment from facilities that offer supportive peer-relationships with similar cultural backgrounds (Mahmood et al., 2013). Offering additional support to clients with complex needs can increase their treatment engagement.

Trauma as a Barrier to Treatment Engagement

Trauma histories can present as a barrier to substance abuse treatment if symptoms are misinterpreted as substance abuse symptoms rather than trauma symptoms (Center for Substance Abuse Treatment, 2014). If this occurs, clients may appear to lack the motivation to engage in treatment. Further, trauma may present as a barrier to

treatment engagement. Researchers have consistently found that the client-counselor relationship predicts treatment engagement (Yang, Perking, & Stearn, 2018). Without establishing a trusting rapport with the client, the client may not open-up to discuss their trauma histories. If a mental health provider can quickly ascertain the client's needs, establish trust and rapport, and encourage inspiration and motivation, the chances of client engagement substantially increase (Yang et al., 2018). The addiction treatment field does not often include the client's perspective regarding treatment engagement; instead, it focuses on quantitative methods (Orford, 2008). The consideration of client emotions, in addition to stress and coping, can provide a deeper understanding of the perspectives of formerly incarcerated individuals who have difficulty engaging in substance abuse treatment (Lazarus & Folkman, 1987). Researchers have found high correlations between trauma and SUDs, which signifies an essential need to integrate trauma-informed care into substance abuse treatment (Goodman, 2017).

While sexual and violent traumas are substantial factors in substance abuse treatment barriers, there are many other factors to consider. For example, health insurance can be a barrier to substance abuse treatment. Health insurance can be expensive, and many formerly incarcerated populations might not afford the out-of-pocket cost for treatment nor afford the cost of many insurance premiums. Implementing affordable insurance or free services to the substance use disordered population can help reduce the financial burden. Medicaid offers mental health coverage to formerly incarcerated individuals on parole status. Not all formerly incarcerated individuals have Medicaid coverage, mostly because they do not know that they qualify for free health

insurance. If there is no transition link between prisons to community-based treatment programs, clients are at a disadvantage and may not seek immediate treatment. Begun, Early, and Hodge (2015) suggested that community treatment programs should offer priority services to those released from incarceration to increase their attendance and treatment engagement. However, this study argued that trauma, specifically sexual and violent traumas, is the most substantial barrier to treatment engagement.

Treating Formerly Incarcerated Individuals With Histories of Trauma and Addictions

Formerly incarcerated individuals with SUDs and trauma are associated with poorer treatment outcomes and have an increased risk of relapse than those without trauma histories (Wieferink et al., 2017). Studies on clients in substance abuse treatment programs indicate that over 50% of clients have high trauma levels in their past. Exposure to trauma such as physical abuse, sexual abuse, and violence is associated with significant psychiatric morbidity and alcohol and drug use (Cardoso, 2018). Substance abuse is often a maladaptive coping mechanism when trauma is present.

Trauma increases the risk of transitioning from recreational use to compulsive substance use, decreasing the motivation to abstain from use and engage in substance abuse treatment. Increased substance use increases withdrawal symptoms, decreasing motivation to abstain from use (Shoaib, Mansoor, & Saeed, 2018). Trauma and negative emotional states are associated with SUD (Kaag et al., 2018). Forming formerly incarcerated individuals with trauma histories can help mental health professionals understand their clients' presentation and symptoms. Discounting the role of trauma with

this population, they may be misdiagnosed and assessed for inaccurate treatment, thus leading to relapse and the potential of recidivism. There is, however, a lack of agreement between research and mental health professionals on what ideal treatment is for SUDed individuals with prior traumatic experiences. While many mental health professionals often treat trauma and SUDs as one entity, research shows that trauma and substance abuse treatment should be addressed in multiple ways, and at the same time, to optimize an individual's recovery (National Child Traumatic Stress Network, 2008). An integrated treatment approach to substance abuse and trauma may substantially increase the chances of success in individuals who suffer from trauma histories.

Client disclosure of trauma history, especially among formerly incarcerated males with sexual trauma, can be difficult, and therefore a client's perceived safety in a therapeutic environment is crucial (Mhaoney, Chouliara, & Karatzias, 2015). Designing and implementing effective substance abuse processes in community-based treatment programs specific to formerly incarcerated individuals with trauma histories can help the population re-enter the community and prevent s relapse and reincarceration (Johnson et al., 2013). Since using psychoactive substances is a coping mechanism for many formerly incarcerated individuals with trauma histories and mental health problems, substance abuse treatment is critical in improving their lives. Those with trauma histories may often experience depression, anxiety, anger, and mood swings, which stem from mental health problems rooted in their traumas. Formerly incarcerated individuals have a better chance for successful treatment if trauma treatment is integrated with SUDs treatment compared to SUDs treatment alone. Exposure to people, places, and things may trigger substance

use. Substance abuse treatment should address how to handle different triggers and cope when they occur and to remind individuals that they are moving further away from trauma histories into healthier coping (Johnson et al., 2013). Asking for help is not a weakness and should be considered a highlighted strength for all individuals with trauma histories entering substance abuse treatment.

Summary

Trauma barriers to substance abuse treatment engagement in formerly incarcerated males is a phenomenon that should be more thoroughly explored. Most males do not often discuss trauma histories unless addressed explicitly in treatment with their provider. Specifically, sexual and violent traumas are less explored among males than females (Blakey & Bowers, 2014). While there are many more formerly incarcerated males than formerly incarcerated females, it is essential to address trauma among males during and after incarceration in substance abuse treatment to increase positive treatment outcomes. If formerly incarcerated males do not have the opportunity to address their trauma histories, they may be less engaged in substance abuse treatment (Begun, Early, & Hodge, 2015).

Further, some clients in substance abuse treatment may begin to experience emerging trauma symptoms only after abstinence or decrease stressors in their lives (Center for Substance Abuse Treatment, 2014). Addressing trauma histories can decrease substance abuse treatment engagement barriers, thus decreasing relapse and recidivism among formerly incarcerated adult males. In the next chapter, I will review this study's methodology and design, participant recruitment, data collection, and data analysis.

Chapter 3: Research Method

Introduction

In the previous chapter, I discussed current literature on formerly incarcerated males' engagement in substance abuse treatment and the need for further research to understand the phenomenon of how unaddressed sexual and violent trauma histories might influence engagement in substance abuse treatment. The purpose of this study was to explore how sexual and violent trauma barriers might affect substance abuse treatment engagement among formerly incarcerated adult males in community-based programs. Understanding trauma histories and their role in substance abuse treatment engagement can help substance abuse treatment providers find more effective ways of delivering treatment to clients. If providers could assess clients who were at potential risk from disengaging from treatment, they might have an opportunity to address the issue and re-engage clients in treatment. In this study, I aimed to bridge a literature gap by assessing the phenomenon of sexual and violent trauma barriers to substance abuse treatment engagement. In so doing, I sought to help professionals find ways to increase effective treatment delivery methods and engagement in community-based treatment programs.

This chapter outlines the research methodology, which involved the use of a phenomenological approach. In this chapter, I describe this qualitative study's phenomenon and context. Additionally, I provide details on the processes used for participant selection and interviewing, describe participant protection measures, outline processes of data collection, and explain data management and analysis procedures.

Research Design and Rationale

Research Method of Study

In this study, I examined the phenomenon of individuals experiencing sexual and violent trauma as barriers in substance abuse treatment engagement. The phenomenological research method was used to examine and understand the phenomenon and themes of trauma as a barrier to engagement in substance abuse treatment among formerly incarcerated adult males in community-based treatment programs. The IPA approach provided the opportunity to examine the participants' experiences and perceptions with rich detail. Through this phenomenological study, I attempted to find meaning in the lived experiences of formerly incarcerated males who attempted substance abuse treatment, in order to find what had worked for them in the past in terms of engagement, as well as what had not. This study allowed formerly incarcerated males with trauma histories to voice their experiences with substance abuse treatment engagement, expressing what they found to be most helpful and what they believed should be added to treatment to increase engagement.

Research Design

Developed by Edmund Husserl, phenomenology is a method of interpretation that helps people identify the essence of unique experiences (Pietkiewicz & Smith, 2012). Phenomenology is a philosophical approach to individuals' lived experiences and what matters most (Smith et al., 2012). Phenomenological questions focus on the meaning, structure, and essence of people or groups (Patton, 2015).

Interpretive phenomenological analysis. IPA is a relatively new qualitative methodological framework that is gaining popularity in American psychology (Pietkiewicz & Smith, 2012). It is a specific conceptual, phenomenological approach used in qualitative research studies (Smith et al., 2012). Using IPA, researchers examine how individuals make sense of significant life experiences and what happens when their life experiences' normal flow takes on significance for them (Smith et al., 2012). IPA was used in this study to explore the participants' experiences of substance abuse treatment and how their past traumas might have created a barrier to their engagement in treatment.

IPA was an appropriate approach for this study because it allowed the opportunity to understand lived experiences related to how past traumas might affect participants' engagement in substance abuse treatment. I used IPA to understand the participants' perceptions of substance abuse treatment, treatment engagement, and trauma histories, as well as these factors' relationship. IPA offers a way to learn how participants make meaning (Pietkiewicz & Smith, 2012). Using IPA in this study allowed me to focus on the participants' meaning- and sense-making concerning how their engagement in treatment services might have been a feature of their unaddressed trauma histories.

The IPA feature that I used for the study was the idiographic approach. With this approach, researchers focus on individuals' detailed examinations instead of groups' average experience (Smith et al., 2012). I detailed the participants' experiences and themes based on the individual data that I collected.

Research Questions

The following research questions guided the collection of data for this study:

Research Question 1: What do formerly incarcerated males believe can help them increase their engagement level in substance abuse treatment?

Research Question 2: How do trauma barriers affect engagement in substance abuse treatment among formerly incarcerated adult males in community programs?

Research Question 3: How do formerly incarcerated adult males in community-based programs feel about incorporating trauma treatment into their substance abuse treatment?

Role of the Researcher

In a qualitative study, the researcher's role is to collect data, state assumptions, identify participants' values, and explain biases (Patton, 2015). In IPA, the researcher explores and collect details of participants' personal experiences in naturalistic settings and makes sense of combined meanings (Pietkiewicz & Smith, 2012). My role as the researcher in this study was to gain insight into the participants' feelings and perceptions about their lived experiences to understand this study's focus better. Throughout the study, I reflected on assumptions and processes to provide context for the data. I had no personal or professional relationship with any participant. The participants had no relationship with me; they met me during our telephone interviews. I introduced myself to participants as a doctoral student looking to gain information through research with their help.

I reflected on the position of my own biases. I recognized that as a researcher interested in and conducting a study on the topic of engagement in substance abuse treatment among those with histories of sexual and violent trauma, I had assumptions that could lead to bias and could affect data collection. Although I could not avoid bias altogether, I alleviated bias by acknowledging my assumptions throughout data collection and analysis (Patton, 2015). I documented my reflections on my biases to ensure transparency and to decrease bias in data collection and analysis. I understood that specific personal questions might be difficult for participants; therefore, I was mindful of the questions I presented.

It was my responsibility to ensure that the participants were not harmed in this study. A step I took to safeguard sensitive questions was to have the Institutional Review Board (IRB) review and approve the interview questions. Data collection occurred through a face-to-face, semi structured interview method. I interviewed one participant at a time. To maintain ethical practices, I reflected on ethical issues throughout the data collection and analysis processes (Smith et al., 2015). All questions were predetermined and screened before I conducted the interviews. I ensured that all participants understood that they could discontinue the interview at any time should they become uncomfortable or no longer wish to continue the interview. I told them that they would still receive the participation incentive even if they withdrew from the interview.

Methodology

Participant Selection

Participants included in this study were formerly incarcerated males on parole who were 18 years or older. Participants included in this study reported a history of sexual and violent trauma experiences. Additionally, all participants reported that they had participated at least twice in substance abuse programs. I excluded those who were not currently participating in a substance abuse program, as well as those who had not participated in substance abuse treatment at least twice in their lives. In addition, I excluded those with no history of sexual or violent trauma, males under 18 years, and females.

Procedures for Recruitment, Participation, and Data Collection

Sample size. Because IPA is concerned with detailed accounts of participants' experiences and is time consuming, IPA studies' samples are usually small (Pietkiewicz & Smith, 2012; Smith et al., 2012). Because quality and not quantity was the goal of this study, the sample size benefited from a concentrated focus on a small number of participants. Three to six participants are typically presented as a reasonable sample size for IPA research (Smith et al., 2012). There have been published IPA studies that have used sample sizes between one and 15 participants, and larger samples are acceptable but not as common (Pietkiewicz & Smith, 2012). It was not appropriate to use a large sample size for this study due to the qualitative method chosen. For a study of this type, it is preferred to use a sample size small enough to enable data richness and depth (Pietkiewicz & Smith, 2012). In this study, I intended to learn about each participant, in

order to understand each participant's specific experience in substance abuse treatment and treatment engagement level. Ten participants were recruited, one of whom did not meet the criteria to participate in this study. The study still had the qualifying sample size of nine needed to analyze data. Due to IPA's nature, which often involves the use of homogeneous samples, British clinical psychology doctoral programs recommend six to eight participants to fully explore participant experiences (Pietkiewicz & Smith, 2012; Turpin et al., 1997). I interviewed participants until saturation was reached, at which point no new information was evident and there was nothing new to learn (Patton, 2015; Rubin & Rubin, 2012). Patterns emerged as being similar. I explored the participants' responses and summarized the interviews.

Participant recruitment. Flyers were posted at substance abuse treatment programs that served formerly incarcerated individuals. The flyers presented all of the participant inclusion requirements and indicated a $10 gift card incentive to participate in a confidential, face-to-face interview lasting 1 to 2 hours. The inclusion criteria listed indicated that the invitation was open to adult males aged 18 or older who were on parole and were currently enrolled in a community-based substance abuse treatment program. To enable prospective participants to contact me, I listed my name and email address on the flyers. When contacted, I screened potential participants by asking the preliminary questions that were required for their participation in this study, including the following:

- Are you over the age of 18?
- What is your gender?
- Are you currently or previously on parole?

- Are you currently participating in substance abuse treatment?
- How many times have you participated in a substance abuse treatment program?
- Have you ever experienced sexual or violent trauma?

Ten potential participants called, and nine met the participant criteria for this study. I then closed the invitation for participant recruitment. By mutual agreement, I determined a time to meet with each participant by telephone to conduct the interview. I reminded the participants that the interview would be recorded before it began.

Instrumentation. The research questions were in the context of the phenomenological method. Predefined, semi structured interview questions were the primary tool for collecting data. Interview questions allowed me to gather rich information on the participants' experiences and perceptions. Interviewing the participants allowed me to ask questions about their substance abuse, treatment, and trauma history; perspectives on treatment; and engagement in treatment in community-based programs. The questions were designed to engage participants to feel comfortable in discussing their substance use and trauma experiences and their perspectives on current treatment. I offered open-ended questions, which tend to be less threatening when asking sensitive questions as well as less leading, offering participants the opportunity to answer openly and expansively (Rubin & Rubin, 2012). Semi structured interviews enabled the participants to discuss their experiences in real time, offered participants the flexibility required to describe their experiences in detail, and permitted me to ask further questions when needed (Pietkiewicz & Smith, 2012). The one-on-one format also allowed

participants to discuss their private experiences with one person; this was important, given that the open-ended interview questions were personal and sensitive. I used an electronic audio recording device to record the interviews for data analysis. No other specific instruments were used in this study.

The following were the specific questions that I asked in the interviews:

1. How old are you?
2. Tell me about your experiences with relapse.
3. How does alcohol or drugs play a role in your life today?
4. What contributes to your continued use of alcohol in your life?
5. Sometimes people have experienced sexual or violent traumatic events in their lives. Tell me about how sexual or violent trauma that you have experienced in your life affects you today.
6. How do you cope with your trauma history?
7. What role do alcohol and drugs play in your ability to cope with your past trauma?
8. Tell me about your participation in substance abuse treatment.
9. How do you feel mentally and physically after attending substance abuse treatment (including thoughts, associations, and fantasies)?
10. How do you decide whether or not to attend substance abuse treatment?
11. How is substance abuse treatment helpful to you?
12. How is substance abuse treatment not helpful to you?

13. How would you describe the role your trauma history plays in your substance abuse treatment?
14. What would you change in your substance abuse treatment program to help increase your participation in treatment?

Data collection. The researcher is the primary data collection instrument in a phenomenological qualitative study (Patton, 2015). Data collection included conducting in-depth, confidential, and personal interviews. As the researcher, I collected and analyzed the data simultaneously by classifying participants and experiences, characterizing their properties (Creswell, 2015). Because the interviews were conducted by telephone, I did not have the opportunity to observe the participants' body language. Although I allowed for 1 to 2 hours per interview, the interviews took approximately one hour each. The interview included trauma-sensitive questions and questions about prior substance abuse programs and participants' engagement levels and perceptions of treatment. With each participant's consent, the interview was recorded on a small Olympus digital voice recorder, which allowed me to listen to it later and code. Once the interviews were finished, I thanked the participants for their time and mailed them their consent and their $10 gift card to McDonald's.

There were no participant follow-up interviews in this study. However, I did do member checking with the participant at the end of each interview. Member checking allowed me to increase the accuracy of the collected data (Creswell, 2014). Before I concluded each interview, I discussed the notes I had written during the interview and asked the participant to provide feedback on the notes' accuracy. Providing me feedback

on my notes allowed the participants the opportunity to correct errors and clarify vague data. At the end of each interview, I debriefed the participant. During the debrief process, I thanked the participants for their participation. I also asked them if they had any further comments or information that they would like to add.

Data Management

To manage and store the collected data, I provided appropriate security for all participant information safekeeping. I protect all the participant data by storing the data on a personal computer with a secure password. My computer is stored in a locked home office. After transcribing the audio recorded interviews, the audio recordings were deleted from the recording device. The interview transcriptions are stored in my home office in a locked cabinet. I will keep the data for five years before deleting electronic transcripts and shredding all paper documents. It is my goal to ensure the protection of the participants of this study. I will adhere to privacy and ethical issues on behalf of all the participants in this study.

Data Analysis

The interviews were digitally recorded to capture the actual words from participants. I took notes during the interviews. Taking notes during interviews enabled me to formulate additional questions as we moved along the interview process. Taking notes enabled me to ensure the interview inquiries unfolded in the planned direction, helped me analyze the data, and provided a back-up should the recordings have failed (Patton, 2015). My goal was to produce comprehensive and detailed field notes and comments on the data while maintaining a clear phenomenological focus and explicit

meaning of participants' narratives (Smith et al., 2012). Having kept a clear focus helped me to understand and interpret the thoughts and feelings of the participants. I read and re-read through the interview responses and identified common themes and patterns to transcribe the data. I looked for words and phrases that participants repeated in the interviews (Alase, 2017). I found common themes and patterns and then narrowed the data scope for analysis. I transcribed recorded interviews. Finally, I re-read the transcripts and confirmed the themes and patterns of participants' responses that helped me capture the essence of the participants' lived experiences (Alase, 2017).

After I collected the data, I coded and transcribed the information. I read and re-read the transcripts to "get the feel of the interviews" which helped me identify the overall theme of the data I collected (Storey, 2007). I analyzed exploratory comments to identify emergent themes. Having analyzed the data involved the my focus on the transcripts to recall what I learned from participants in the interviews (Smith et al., 2012). I turned my notes and voice recorded data into themes, I produced a concise and combined statement of participant experiences and perceptions. I searched for connections across the collected data's emergent themes and organized it to identify thematic clusters (Storey, 2007). The themes formed rich structural descriptions of the of the participants' experiences (Creswell 2014). I connected the data back to the research questions. I produced a summary table of superordinate and sub-themes, which included illustrative quotations. I then presented the analysis in a narrative form.

Issues of Trustworthiness

Controversy surrounds qualitative research over assessing research quality. Qualitative research is judgment dependent, as analysis depends on researchers' insights and integrity (Patton, 2015). However, validity is a strength in qualitative research, based on participants and researchers (Creswell, 2014). Assessing validity in qualitative research employs guidelines and checklists to help researchers produce quality research. This study addressed trustworthiness by identifying credibility, transferability, dependability, and confirmability. To ensure this study's validity, I provided a detailed account of data collection, triangulation of the data, and recorded the data to accurately picture the methods used in this study (Creswell, 2014).

Credibility

Credible analysis needs to use appropriate psychological concepts derived from theory (Storey, 2007). To enhance this study's credibility, I generated alternative conclusions of findings, looked for contrary or disconfirming evidence, and compared the data (Patton, 2015). The analysis aligned with the purpose and design of this study. Theoretical interpretation of the data is clear and stated from the text of the interview notes or digital recordings. I triangulated the data by comparing and cross-checking the consistency of the data of interviews, observations, and literature reviews, which are consistent with the qualitative design used in this study (Creswell, 2014). I compared what I heard between interviews, listened for consistencies of what participants told me in the interviews, compared the participants' perceptions and experiences, and compared the statements to other data on the phenomenon. Consistency in data patterns across

different sources can increase the credibility of findings (Patton, 2015). I approached the analytical triangulation by asking participants for feedback on my understandings and accuracy of the data I collected during the interviews (Patton, 2015).

Transferability

Data collected from each participant was provided to allow readers to establish similarity between cases. In qualitative research, transferability is synonymous with generalizability. Generalizability provides readers with evidence of the study and assures that findings are consistent with participants' perceptions and the reconstruction of data incorporated into this study (Patton, 2015). Although I cannot prove the study's findings, I have provided sufficient data to establish a degree of similarity between the cases to show how the findings are transferred. I provided a contextualized analysis of the data to show transferability among participant experiences.

Dependability

For dependability, I ensured that this study's processes are logical, traceable, and documented (Patton, 2015). I took care to avoid mistakes in collecting data, interpreting the findings, and writing the findings. The results are reported clearly and as accurately as possible. The observations and interview process are consistent with the population, subject, and reason for this study. Field notes and audio recordings are documented in the report.

Confirmability

For confirmability, this study established a link between the data and the assertions, findings, and interpretation of this study's participants and researcher (Patton,

2015, p. 685). I established an audit trail of field notes and audio recordings and collected field notes in a dissertation journal. To keep my biases in check, I asked participants to provide me with feedback on whether my interpretations are representative of their accounts. Also, I received peer feedback upon their review of my conclusions.

Ethical Procedures

I requested Walden University's Institutional Review Board (IRB) approval for approval to conduct my study and access the participants of interest. I addressed important ethical considerations in my request to IRB, including participant recruitment, confidentiality, study availability to participants, and participant consents, including rights, interests and wishes, anonymity, and storing collected data (Creswell, 2014). I sought permission to post flyers at substance abuse treatment programs in Denver and Aurora, Colorado, to recruit participants for this study.

During the entire process of data collection and analysis, I was mindful of ethical practices. The most crucial element of an ethical study is to avoid harm to the participants. I assured the participants that their identity would not be disclosed, would be kept confidential, and that the interviews they participate in would be edited for anonymity (Smith et al., 2012). All participants were assigned a code name in the transcriptions. With this study's sensitive nature being trauma and addictions among the participants, I continuously evaluated the extent of discussions around sensitive issues that might harm the participants (Smith et al., 2012). I gained informed consent from each participant. I first read the informed consent to each participant then explained what they can expect from participating in the interview (Smith et al., 2012). In addition to

written consent, I provided oral consent, stating the same due to the interview questions' sensitive nature. All participants were offered the right to withdraw from participating in the study at any time during the interview. The data collected through the interviews were handled with sensitivity and care, and the participants were offered access to support if needed after the interview. Per the American Psychological Association (1992) Ethical Standards *5.04 Maintenance of records,* I will maintain appropriate confidentiality in storing, accessing, transferring, and disposing of all written and digital records under my control. Also, in accordance with the law and per the requirements of the APA Ethics Code, I will dispose of records appropriately in compliance.

Summary

While many research studies focus on trauma and treatment engagement among incarcerated females, few studies are related to formerly incarcerated males with trauma barriers (Blakey & Bowers, 2014; Mahmood et al., 2013). Most research on formerly incarcerated males focuses on substance abuse treatment barriers and recidivism as education, employment, social and familial environments, and addictions. There is little research discussing formerly incarcerated males with sexual and violent traumas barriers that decrease engagement to substance abuse treatment. This chapter discussed the design methods, data collection, and analysis relating to this qualitative phenomenological study. This chapter included the ethical considerations for the safety of participants and complied with Walden University's IRB.

The next chapter focuses on the results of this study. Through confidential, one-on-one interviews, the phenomena of engagement in substance abuse treatment among previously incarcerated men are explored.

Chapter 4: Results

Introduction

Drug addiction has a significant impact on health and social problems in the United States. Statistics show that approximately 90% of individuals who suffer from drug addiction do not receive drug intervention (Hardey et al., 2020). It is imperative to offer the best possible care to the substance use disordered population. Substance abuse treatment providers should better understand addiction treatment barriers from the client-perspective to offer a level of care specific to each client. Trauma history plays a significant role in drug addiction; without healing from past traumas, commitment to and engaging in addiction treatment can be difficult for clients.

The following research questions guided this study:

Research Question 1: What do formerly incarcerated adult males believe can increase their engagement level in substance abuse treatment?

Research Question 2: How do trauma barriers affect engagement in substance abuse treatment among formerly incarcerated adult males in community programs?

Research Question 3: How do formerly incarcerated adult males in community-based programs feel about incorporating trauma treatment into their substance abuse treatment?

The purpose of the IPA approach in this study was to explore how sexual and violent trauma barriers might affect substance abuse treatment engagement among formerly incarcerated adult males in community-based programs. The goal was to bridge

a gap in literature by assessing the phenomenon of sexual and violent trauma barriers to substance abuse treatment engagement. This study adds to the existing literature and may help professionals find ways to increase effective treatment and engagement in community-based treatment programs.

In this chapter, I review the study's setting and participant demographics. Additionally, I describe the data collection and data analysis procedures. Finally, I present the results and discuss evidence of trustworthiness.

Research Setting

Flyers were left at three participant organizations that offer substance abuse treatment and service to the formerly incarcerated population. Due to the nature of the current COVID-19 pandemic, these organizations presented the study's recruitment flyers to clients before or after their online sessions, and flyers were distributed by these Denver and Aurora-based community-based substance abuse treatment programs. I had no prior affiliation with these treatment program centers or the research participants. The clients were offered the opportunity to contact me via telephone or email to participate in the study. Ten potential participants called me to volunteer their participation. Nine of the 10 participants met the criteria for this study. The participants were screened and then scheduled a specific time convenient for them to interview for this study. The study took place during a pandemic; therefore, I conducted interviews virtually from my home office in Denver, Colorado.

The interviews were conducted by telephone to reduce the risk that the participants or I would contract COVID-19. The participants had the opportunity to take

part in the interviews in the privacy of their homes. Each interview was recorded through the telephone on a voice-recording device, with the participant's permission. Because of the nature of the pandemic and having to conduct the interviews by telephone, I read the consent form in its entirety and obtained verbal consent from each participant. I mailed each participant the virtually signed consent form with my signature, along with a $10 gift card to thank the participant for contributing to the study. I then shredded each participant's mailing address.

Demographics

The volunteer research participants were recruited from and lived in the Denver area in Colorado. Nine of 10 potential participants met the criteria for this study. One of the potential participants who called to express interest in this study did not meet the criteria for the study because he had never been incarcerated. The purposive sampling criteria specified that participants needed to be formerly incarcerated adult males over the age of 21 years who had a history of sexual or violent trauma and had been in substance abuse treatment at least twice in their lives. Although all participants admitted to having histories of violent traumas, none discussed nor admitted to sexual traumas, which might have been an omission due to a lack of trust and rapport that takes time to build. They had all experienced continued alcohol and drug use into adulthood and had participated in several drug and alcohol treatment programs. All participants had committed violent or drug-related crimes, which had led to time in prison. Most of the participants experienced abusive childhood traumas, which included drug and alcohol use. All participants reported that they experienced their first traumas in childhood, between the ages of 11

and 17 years. The participants all reported childhood drug and alcohol use. The majority of the participants had experienced physical abuse and personal neglect during their childhood. Of the nine participants, four were African American, three were Caucasian, one was Hispanic, and one was biracial African American and Hispanic. All nine participants reported that they had been involved with the criminal justice system since their teenage years, had been incarcerated more than once as an adult, had experienced addiction problems since childhood, had committed drug-related crimes, and had experienced multiple violent traumas since childhood.

Data Collection

All nine interviews were conducted by telephone due to the COVID-19 pandemic. I read the consent form in its entirety to each participant, and each participant verbally consented to the terms of the consent form, which I then signed and mailed to them. The consent form specified that appropriate and free mental health support resources were available if needed after interview participation.

I recorded all of the semi structured interviews using a device next to my telephone. I conducted the interviews using speakerphone in a private room in my home office. I designated 1 to 2 hours for each interview. Each interview took approximately 1 hour. I established a safe environment for each participant by not asking for personal or identifying information, letting the participant know how important the study was, and expressing my appreciation for the participant's willingness to share personal experiences. I informed participants that they could quit the interview at any point if they wished, for any reason.

Because the IPA method is subjective, I conducted member checking with participants during and at the end of each interview for accuracy of the data I collected. (Creswell, 2014). I kept my bias and beliefs to the side. I maintained neutrality by offering a nonjudgmental environment and allowed participants to share their experiences without showing favor or disfavor (Patton, 2015). Additionally, I avoided asking participants leading questions.

Participants' responses appeared to be honest. In most cases, the participants were passionate about sharing their experiences and feelings around substance abuse treatment and their engagement. A couple of participants began talking about racial disparities in light of the racial conflict and protests that were currently happening. When this occurred, I gave them space to share and redirected them back to the study's focus without any difficulties. The answers varied only slightly from one participant to the next, and the responses expressed similar themes, suggesting shared experiences. Because there were strong similarities between the participants, I felt that the nine participants were representative of the population interviewed.

Data Analysis

IPA studies provide rich and contextualized analysis of participants' experiences (Smith et al., 2012). Because of this, IPA studies usually benefit from a concentrated focus on smaller sample sizes. Smith et al. (2012) suggested three to six participants as a reasonable sample size for such a study. This study used nine participants, and there appeared to be sufficient saturation. I took notes as I was conducting the interviews. After completing the interviews, I read and reread the notes that I had taken during the

interviews. I then transcribed the recorded interviews and printed them. I wrote comprehensive field notes and transcribed the audio-recorded interviews. The statements included processes and values and the meanings that I extracted. I noted and transcribed slang words and figures of speech. Participants' emotional responses were also recorded. I created a separate spreadsheet, writing line-by-line answers to each correlating question for coding.

I went through the transcripts and coding and highlighted that which appeared necessary. As I mapped connections and patterns in the data, I made sure that the data and the research questions came together to form a synthesized analysis (Smith et al., 2012.) These emergent patterns led to the development of an interpretive account of participant experiences.

I imported the interview transcripts into NVivo software to code. The codes that I obtained using NVivo were similar to those developed in my manual coding effort. I did not find it helpful to use NVivo to analyze themes due to the type of rich analysis that I was looking for in an IPA study. I found it more meaningful to group the codes into themes manually and make sense of the data based on codes and observational data I collected from the participants.

After transcribing and coding each data set for themes, I compiled transcript extracts into a file of emergent themes to further develop and organize the analysis. The data delivered themes presented in all nine interviews and subthemes presented in at least three or more of the interviews, as shown in Table 1.

Table 1

Themes and Subthemes

Connection	Providers	Treatment Needs
Talk	Empathy	Address trauma (to help alleviate co-occurring disorders)
Hearing others with similar addiction experiences	No judgment	Cost/Insurance
Support	Provider to have experienced addiction to understand it	

Evidence of Trustworthiness

The evidence of this qualitative study's trustworthiness was established through the strength of validity based on the accounts of this study's research participants. I provide evidence of trustworthiness by identifying credibility, transferability, dependability, and confirmability. In assessing this study's validity, I employed a guideline and a checklist to help me produce quality research and support the IPA analysis's appropriateness. I took great care to demonstrate sensitivity to the context of this study's substance use disordered population by conducting the interviews with awareness and dedication. I showed empathy and sensitivity to context, was able to put the participants at ease, recognized interactional difficulties, and maintained focus on the interview questions (Smith et al., 2012). To support the validity of this study, I provide a detailed account of data collection, describe the triangulation of the data, and offer an accurate picture of the methods used in this study (Creswell, 2014).

Credibility

Credible analysis needs to use appropriate psychological concepts derived from theory (Storey, 2007). Therefore, these concepts were implemented in this IPA inquiry. To do this, I established rapport with the participants to put them at ease during the interviews and generate rich data. Triangulation was used to explore multiple perspectives and detail multifaceted accounts of this study's phenomenon, thereby making it possible to reach saturation (Smith et al., 2012). I triangulated the data by comparing and cross-checking the participants' experiences and perceptions, as they expressed them to me in the interviews, with my observations of them during the interviews as well as with the literature reviews. This triangulation effort was consistent with the qualitative design used for this study (Creswell, 2014). Consistency in data patterns across different sources can increase the credibility of findings (Patton, 2015). I also approached the analytical triangulation by member checking or asking the participants to provide feedback on my understanding and accuracy of the data that I collected during the interviews (Patton, 2015). After each interview, I summarized the collected data to the participant to ensure accuracy, offering the participant the opportunity to correct or add to the information shared with me.

After collecting the data through interviews, I coded the field notes. I coded a second time as I transcribed the notes. I coded a third time while rereading the prepared transcripts. I constructed files of emergent themes that consisted of compiled transcript extracts. This helped me to cut and paste relevant sections into appropriate files easily. Within each file, I listed the frequency of the theme. This process helped me to look at

and analyze the internal consistency of each emergent theme (Smith et al., 2012). To enhance this study's credibility, I generated alternative conclusions concerning the data findings, looked for contrary evidence, and compared the data collected from the participants (Patton, 2015). The analysis aligned with the purpose and design of this study.

Transferability

Through semi structured interviews, I collected detailed and thick descriptions of experiences from the participants' perspective. The participants varied in age, though all were over 21 years old. Additionally, they reported various cultural backgrounds and ethnicities. The data reflected their personal experiences, concerns, understandings, and perspectives, including what they believed could increase engagement in substance abuse treatment. The data that I collected are provided in such a way as to allow readers to establish similarity between cases. For transferability, the study results section below includes evidence from literature appropriate to this study and shows generalization of my data to other groups. The findings concerning participants' perceptions and the reconstruction of data incorporated into this study are consistent with literature (Patton, 2015). In the Study Results section, sufficient data are provided to establish similarity between cases to show how the findings might be transferred. I provide direct participant quotes and a transparent and contextualized analysis of data to show data transferability among participant experiences, both similar and not.

Dependability

To ensure this study's dependability, I took careful steps to show the accuracy of the methods and language and construct detailed audit trails that demonstrated triangulation. In the process of triangulation, I asked each participant the same research questions and collected responses to compare to reliability to other sources. Throughout each interview, I conducted member checking as appropriate by reviewing the data with the participant, asking the participant to confirm, correct, or add to my interpretation of the interview responses. I ensured that this study's processes were logical, traceable, and documented (Patton, 2015). The results are reported clearly and as accurately as possible. This study's observations and interview process were maintained in a manner consistent with the population, methods, and purpose of this study. Showing these methods in detail may allow for other researchers to replicate and add to this study's data.

Confirmability

For confirmability, this study's data are linked to assertions, findings, and interpretation of this study's participants and researcher (Patton, 2015, p. 685). I established a detailed audit trail of field notes. I used an audio recording device, with participant approval, to record each interview. I used the subsequent recordings for transcription and documentation purposes. Field notes, including my thoughts during data collection, were documented in my dissertation journal. My dissertation journal included my thoughts on the coding rationale and my potential biases, which I wrote down to ensure self-awareness. Additionally, I asked participants to provide me with feedback on whether my interpretations were representative of their accounts through the process of

member checking. My documentation processes should enable anyone to determine if my interpretations and conclusions are traceable and that my data are supported and confirmable.

Study Results

The semi structured interview questions used in this study were designed to understand the participants' lived experiences, thoughts, and ideas. The purpose was to gain rich data into the lives of formerly incarcerated adult males with SUDs and their experiences of trauma barriers to their substance abuse treatment engagement. The questions I asked the participants explored how they perceived substance abuse treatment from past programs, how they believed they were and were not helpful, and what determined their decision to attend therapy. The questions also explored past and current substance use and its relation to their trauma histories. Each of the nine interviews took approximately 1 hour.

Through careful data analysis of reading, transcribing, re-reading, and coding the transcripts and field notes three times, I found three common themes and their subsequent subthemes across all data sets; please see *Table 1* above. The three themes include connection to others, treatment needs, and provider experience. The following are the interviews' results by themes and subthemes to reflect the participants' experiences and meanings.

Theme 1: Connection

The theme most prevalent in this study was the need for connection with others. All participants reported that connection with others was a major significant influence in

their substance abuse treatment engagement. They noted that their connection with others could be with their therapist, with others in a group therapy, or with family or friends. Connection with others can provide SUDs individuals with support and motivation to change. The participants discussed that connections with others as a fundamental need to belong and increase positive mental health. Most participants described how substance abuse treatment was helpful for them in that they were able to talk about their problems, hear how others solved and coped with their problems, and felt that their place of treatment was a great support through their recovery. P5 stated that an emotional connection helped him in therapy and knowing that others have been through the same experience or recovery.

Subtheme 1.1: Talk. Participants reported that talking to others was the most beneficial aspect of their motivation to engagement in their recovery. They said that talking to others helped them cope with their stress, anxiety, and depression, thus helping them deal and cope with stress and trauma. P2 described the anguish he lived with each day because he didn't talk about his trauma. He described his pain as "I couldn't tell nobody, I had to live with all that inside, for years with night sweats, I would soak the bed, I'd wake up every night. I had nightmares. I was not always functional. I started using meth. After 18 years, I finally got a chance to get this off my chest. I felt so good to let it go." Talking, whether to a therapist, friend, family, or stranger can help relieve stress. Having the opportunity to talk about weighting issues can benefit mental health and lessen the burden of trauma. P7 stated, "Anyone can help someone. It can be an addict, a high school kid; you can talk to a little kid." The point being, talk is helpful in

stress relief, which could lower anxiety and depression as found in most individuals with trauma histories. P7 stated that he learned a lot about himself through working with a therapist and talking has been a tremendous help in his recovery. Talking can be therapeutic for some. P8 stated, “I like talking, I like conversations.”

Participants described that the feeling of being listened to was vital in motivating them to engage in group or individual therapy. Genuinely being listened to was important to the participants. A couple of the participants complained that they felt their therapist did not listen to them or hear what they were saying. P7 stated that he feels that most counselors do not listen to what he says, therefore, they cannot help him. P6 noted that he engaged in treatment because it was a safe place to talk about his feelings that he suppressed and that talking about his trauma helped him cope with it. P9 liked to talk about his trauma to “clear the air.” Most of the participants felt that talking about their trauma helped them cope with their negative memories.

Subtheme 1.2: Hearing others with the same addiction experiences. Many of the participants discussed how it is helpful to hear others talk about their addiction experiences. They described how hearing others having the same problem or same addiction experiences has help them feel like they are not alone. They reported that sharing their stories and hearing others’ experiences help them feel like they have a shared connection with others. They also learn from others how to cope with their addictions if different ways. P1 described group therapy as a place for him to “hear how other people did things that helped them. How other people have tried this or have tried that.” P3 talked about how he learned a lot in group therapy: “I learned that many other

people are pretty much the same way. It helps to listen and hear other people are the same way as me. I learned by hearing other people's stories of success." P4 said, "In treatment, I've always learned a new perspective of what has helped other people when they are triggered to use alcohol or drugs, that has been really helpful." P7 stated that sharing in group therapy "helped me learn a lot about the way I was behaving." P8 said, "I participated a lot. I like talking and participating in conversations, to hear where others were coming from and how they dealt with their addiction." P5 described how he enjoyed attending treatment groups, "It's a good place to express and hear other like-minded people express similar situations. It's kinda like a link and able to express how we cope." On the other hand, P9 stated that he felt that once he heard a story, he has heard them all and found that hearing others talk about their experiences did not help him connect. He thought that his relationships outside of group treatment were more helpful for him in terms of connection. P9 stated, "In group treatment, once I heard a story, I heard 'em all. It's like, I get it already. So again, it's about helping the other person to become normal in thinking. If you can change the way of thinking, then behaviors will start to change. Change the thought, and then you can change the behavior."

Subtheme 1.3: Support. Most of the participants discussed the importance of support from others in their recovery success. The support they found helpful through their recovery were providers, family, friends, peers, and groups. For P1, group therapy provided a place for him to feel connected with others, "challenge my use and their use at the same time, to help each other take ownership of our addiction. Peer support works." For P2, group therapy has helped him connect with others through a way of similar

experiences, “You get to know about addiction to help someone with an addiction, to talk to another addict about addiction, they understand it. You talk to them about it and just start to feel better.” P3 found that group therapy helped him engage and “get things off their chests. I always engaged in treatment and told the truth all the time. I was a good participant. I would share in group therapy.” P5 stated, “I participated a lot to help me with my addiction, to help me in my sobriety.” There are different types of support, however, the feeling of belonging is critical in the addiction recovery process, as stated by P8: “Everybody wants to be part of something, part of a community.” P9 described group treatment as “part of a team.” For P6, connection with others helped him cope with his trauma and helped him in his recovery, “I talked [to others] about my feelings. I wrote letters to people. It helped me cope with my trauma.” P6 stated that he would not be where he is today without the support of his treatment program.

Theme 2: Substance Abuse Treatment Providers

While most of the participants reported that talk therapy helped them, one participant said that talk therapy was never helpful for him. He just went through the motions because he was not interested in the mandated treatment. P7 said, “providers would challenge us in group and have arguments with us, and I didn’t want to participate in something crooked.” P7 also believed that “the treatment providers would rather get rid of those people with problems rather than help them.” Establishing rapport is essential to client success outcomes. For example, P8 stated, “I wonder about the providers. I wonder why they get involved in wanting to do the treatment. Because I don’t believe they understand the people they work with.” P8’s statement was the underlying tone

across most participants. P9 stated. “I don’t think they [substance abuse treatment providers] were prepared to help clients pull out of homelessness and help address the recidivism of substance abuse. I mean, they get to a certain point, and I think that they don’t really go into the behavior and thinking and the characteristics of addictions and the rebuilding process, the maintaining process.”

Subtheme 2.1: Empathy. Empathy is essential to the participants interviewed in this study. Participants reported that substance abuse treatment providers who show empathy are easier to trust and engage with. Most participants reported that they felt like their substance abuse treatment providers did not show empathy and did not understand them. For example, P7 stated that he never trusted his substance abuse treatment providers. He believed that most substance abuse treatment providers are merely doing a job for a paycheck. One comment that P7 made was, “treatment providers would rather get rid of those people with problems rather than help them; it was like this is a job.” P7 also commented, “When they don’t listen. It doesn’t work.” P7 further stated, “When you talk about some trauma in life when someone listens, that is treatment, that's all it takes for someone to listen, it helps. When you listen to someone’s problems, you are helping them. Anybody can help someone.” P7 explained his belief that empathy is important and that it is done through active listening. P8’s experience with substance abuse treatment providers are similar, “they haven't dealt with their issues, they are not open to hearing my issues, and there is a lot of countertransference.” However, other participants discussed how empathy from their therapist was essential to their treatment outcome. P2 stated, “You talk to them [therapists] about it [trauma] and just start to feel better.” P6

confirmed the importance of provider empathy, “As far as participation, you have to make your client feel like you care. If a therapist is just nodding and agreeing and not showing any empathy, um, I don’t think you don’t get as far with clients than if you are genuinely empathic with clients."

Subtheme 2.2: No judgment. P1 uses alcohol to cope with trauma and is “not comfortable walking into addiction treatment for help.” P1 stated, “I always feel ashamed afterwards [drinking].” Nobody likes to be judged by others. Most of the substance use disordered population feels judged and some stigma tied to them for their “choices” of addiction and incarnation. Most of the participants discussed how they had been judged in the past. Many still feel as if they are still judged by others today. P1 simply stated, “When you're in a substance abuse program, you don’t want to be judged.” P7 said, “People with mental health issues are stigmatized as being weak. When you go to jail or prison, all that is contributing, all of that is stigmatizing.” It is no wonder that P7 often feels judgment in substance abuse treatment programs, as evidenced by the comment, “Treatment providers would challenge the people and have arguments with them.” P8 perceives judgment from most substance abuse treatment providers as he described his experience when he stated, “providers feel like that are better than their clients.” P4 described group therapy as “support for me; it’s a safe place.” No having the feeling of safety and support can play a tremendous barrier to treatment engagement. P9 commented, “A lot of clients relapse, and they [substance abuse treatment providers] are always there with open arms to take us back.” This example portrays nonjudgment from providers. P6 stated, “They [substance abuse treatment providers] encourage you [him].”

P6 also feels shame every time he looks in the mirror; he said, “Of course your single [speaking to himself], nobody wants to be with a drunk.”

Subtheme 2.3: Substance abuse treatment providers to have personal experience addiction to understand. Most of the participants discussed their belief that in order for therapists to know what they are going through in terms of addiction and recovery and to have the ability to help them in treatment, therapists should have personal experiences of addiction. Many participants stated, “how can they know what it’s like for us if they haven't experienced addiction themselves.” Examples of participant comments made regarding his belief include:

P1: “Some counselors were addicts, and so they were helpful because the used the same lingo we use on the street. It’s easier to open up to counselors who have been addicts because they understand” and “having a counselor who had similar issues are easier to talk to.”

P2: “You got to know about addiction to help someone with an addiction. But to talk to another addict about addiction, they understand it. How can you talk to me about my addiction without having experienced it yourself? There’s a lot you can relate to if you have that experience” and “have a counselor on an equal platform.”

P4: “I would add more counselors with more life experiences of coping with addiction.”

P5: “The emotional connection they know that this person has been through the same experience or recovery and to share their remedy, for me, it’s the

emotions part versus someone that doesn't understand the aches and pain of what it's like to be addicted to drugs and alcohol. To have a therapist who understands stuff and went through the same thing and to be able to connect with the therapist. A lot of therapists don't understand the experiences of addiction."

P7: "Counselors would be more effective if they were addicts themselves. Not all counselors, but more."

P8: "I don't believe they [substance abuse treatment providers] understand the people that they work with. It wasn't' until I met counselors that experienced the same thing I experienced and could relate before I felt treatment helped."

Only 3 of the 9 participants did not discuss having a therapist with personal addiction experiences. P3 stated, "What's not helpful is putting drug addicts around other drug addicts." Again, it is most likely empathy and nonjudgment that was missing for some to feel that they need a counselor with addiction experiences.

Theme 3: Treatment Needs

In this study, the third major theme being a barrier to participant treatment engagement was not having their treatment needs met. The subthemes of treatment needs were addressing trauma and the cost of treatment. Participants reported that when they do not have their treatment needs met, they find it difficult to fully engage in their treatment because "it does not work."

Subtheme 3.1: Address trauma. Trauma is a common experience among those with SUDs. With trauma often comes depression and anxiety. Those with SUDs must often deal with depression and anxiety. All of the participants interviewed for this study reported that they are still dealing with their trauma histories. Some participants reported being able to cope with it better today compared to before treatment. Most reported that trauma histories are still significant enough to cause them continued use and depression or anxiety. The following are all example responses from participants in this study regarding their trauma histories:

P1: "I still see his face today, the desperation. I still see him. His eyes with fear." This was an event the participant described as a man who was shot and bled to death in front of him as a young child.

P2: "After the first murder, huh, the first one was murder. She kept saying, please don't let him kill us. I still see it clearly to this day, the trauma, it's there every day, still like the day it happened. I still hold on to it. I think about it all the time. This was an event the participant described as two women were shot point-blank in front of him as a teenager."

P3: "I had a lot of violent trauma in my life, all kinds of crazy stuff."

P4: "I'm on parole now for killing my best friend by drinking and driving. I drink to help me forget the bad things that happened in my life."

P6: "I had a pretty broken childhood. I lost my mom, my dad, and my partner of 14 years to suicide, all within a year. My support system was gone."

P7: "I had trauma, crazy situations, a lot of detentions, having been abused by staff, trauma on top of trauma. All the trauma built up and built up and not getting any treatment whatsoever, so when you go to prison, it's all contributing. I went through things that were not normal. "

P8: "I have experienced trauma. I got angry with a world that doesn't get it, and still don't get it."

P9: "I still look for approval. I think about my trauma history about the shower. It's there. My mother not wanting me. My mother tried to kill me. It has crippled me throughout my life."

The above responses to trauma histories as being ever-present today reiterates why it is imperative to address trauma in addiction treatment. In response to having trauma addressed in therapy, P8 stated, "They [substance abuse treatment providers] didn't address my trauma; they didn't' assess me for trauma, it wasn't on the table at all. I don't think that substance abuse treatment providers get deep into the trauma about why a person uses. It's more like, oh, you use alcohol, let's get you a medication to help you with it, and hopefully, it works. They Don't actually deal with the trauma that has you use in the first place." P1 states, "I still drink. I experience a lot of anxiety because of trauma, so I drink." P4 attended substance abuse treatment most of his life, yet he stated, "The incident really made a big impact on my life, and it still affects me today. I drink to help me forget the bad things that happened in my life. They [drugs] help me forget about my childhood, just basically helps me forget and makes me feel better." For P4, substance abuse treatment was not useful for him, and he continues to use substances to

cope with his trauma history today despite all his prior treatment." P7 stated: "They [substance abuse treatment providers'] not addressing trauma in treatment. Hah, they not addressing trauma. They tell people about trauma."

On the other hand, a couple of the participants reported having addressed their trauma in treatment. For P9, he was able to address his trauma in treatment however found that it wasn't the level he needed: "They [substance abuse treatment providers] did talk to me about my trauma, but I don't feel like treatment centers addressed my level of need, it doesn't help." For P6, treatment addressed his trauma and was helpful: "Treatment helped me by talking about my trauma while I was sober and to talk about my feelings that I was suppressing."

Subtheme 3.2: Cost and insurance. Some of the participants reported that substance abuse treatment is costly. Three of nine participants brought up the high cost of substance abuse treatment. One participant suggested that he would skip treatment to buy the food if he had to decide between buying food or paying for treatment. Clients reported that they sometimes find themselves opting not to attend treatment because they would rather spend that money on another, more pressing need. P5 finds that treatment is too costly. P6 stated, "Most treatment centers are expensive, and they should offer treatment on a more economical level, if not, free." P1 said that "treatment is like super expensive, and I can't afford it." He said that substance abuse treatment is so expensive that people would go if it were more affordable or free. One participant suggested that most treatment centers do not have available hours suitable for him because of his work schedule.

Summary

All nine participants reported that they are still coping with their trauma histories today. Eight of nine participants specifically reported childhood trauma histories. Most participants admitted to continued drug and alcohol use today but have reduced use to cope with their trauma histories. Some participants reported keeping busy with work, school, and religious activities to cope with trauma history and help them recover. Most of the participants admitted having continued to co-occurring disorders, including feelings of depression, anxiety, stress, and anger, in addition to substance use.

The theme I found most significant in this study is a connection with others. Connections with family, friends, and healthy environments are responses I have heard from the participants as critical elements in their sobriety. Connection ties back to the primary theme of this study.

The second significant theme was that participants believe that substance abuse treatment providers cannot help them unless they have personally experienced addiction. Participants believe that substance abuse treatment providers cannot understand the feelings, cravings, withdrawal symptoms, and other consequences of use unless they have first-hand experiences. For some participants, providers who show genuine empathy without judgment and personal addiction experience are not as important. These participants reported that empathy and non-judgment from their therapist are helpful and therapeutic. This ties back to the most important element that participants believe are most helpful to their engagement to treatment and recovery success: connection with others, to be able to talk, to be listened to, and having the support of others.

The next chapter summarizes the study's results, detailing interpretations of the findings. Chapter 5 also discusses the limitations and implications of this study and provides recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative phenomenological study was to explore how formerly incarcerated adult males with barriers of trauma histories engage in substance abuse treatment. Participants' experiences and perceptions of substance abuse treatment factors are critical in considering how substance abuse treatment providers may deliver treatment more effectively. Substance abuse treatment providers can learn from clients about their specific needs to better support them through successful outcomes. Understanding how sexual and violent trauma histories may function as barriers to treatment engagement among adult males can help substance abuse treatment providers offer more effective substance abuse treatment delivery. Addressing trauma in substance abuse treatment may improve client engagement and treatment outcomes while decreasing recidivism rates. Addressing trauma in substance abuse treatment can increase substance abuse treatment engagement and effectiveness (Blackey & Bowers, 2014; Sacks et al., 2013).

The phenomenological method was appropriate for this study to explore the personal experiences of participants. The following research questions were developed to examine the phenomenon of interest in this study. The participants addressed the research questions through a list of semi structured interview questions.

Research Question 1: What do formerly incarcerated adult males believe can help increase their engagement level in substance abuse treatment?

Research Question 2: How do trauma barriers affect engagement in substance abuse treatment among formerly incarcerated adult males in community programs?

Research Question 3: How do formerly incarcerated adult males in community-based programs feel about incorporating trauma treatment into their substance abuse treatment?

Nine research participants were recruited from community-based substance abuse treatment facilities in Denver and Aurora, Colorado. Participant criteria specified that participants needed to be formerly incarcerated adult males over the age of 21 who had a history of sexual or violent trauma and had been in substance abuse treatment more than once in their lives. All nine participants admitted to trauma histories, had experienced alcohol and drug abuse, and had been incarcerated for violent or drug-related crimes.

The interviews were conducted by telephone due to the COVID-19 pandemic. I recorded the semi structured interviews with a voice recording device. Each interview took approximately one hour. The open-ended questions allowed participants to share their unique yet common interpretations of their lived experiences with substance abuse treatment engagement related to coping with trauma histories. The interviews allowed me to collect meaning and shared themes that the participants collectively shared. To enhance the study's credibility and accuracy, I conducted member checking with participants during and at the end of each interview (Creswell, 2014). I avoided asking participants leading questions and avoided showing bias, favor, or disfavor (Patton, 2015). Participants appeared to be honest and passionate in describing their perceptions

regarding substance abuse treatment and engagement. The patterns and strong emerging themes led me to believe that the participants were representative of the population that I researched.

The IPA method was used in this study because it was most appropriate, in that it is a method that provides a rich and contextualized analysis of participants' experiences (Smith et al., 2012). Additionally, IPA studies often benefit from a concentrated focus on smaller sample sizes, supporting three to six participants as a reasonable sample size (Smith et al., 2012). This study used nine participants, and there appeared to be sufficient saturation. I took notes as I was conducting the interviews. After completing the interviews, I read and reread the notes and transcripts several times for coding purposes to find themes. I mapped patterns, ensuring the data and research questions align to form a synthesized analysis (Smith et al., 2012). I imported the interview transcripts into NVivo software for coding, receiving results that were similar to my manual coding. The transcripts were filed into emergent themes and analyzed.

Interpretation of the Findings

There were three emergent themes from the research questions of this study. These themes fill a gap in the literature regarding barriers to substance abuse treatment engagement. The participants addressed the following three research questions regarding their accounts of their lived experiences and perceptions.

Research Question 1

Research Question 1 explored what formerly incarcerated males believed could help increase their engagement level in substance abuse treatment.

Connection. Connection to others is the prevalent theme that supports what can help to increase engagement levels in treatment. Connection with others was the dominant theme throughout this study as a critical factor in all life areas, especially in the participants' recovery. Hari (2015) asserted that those with happy and connected lives do not become addicts and that lack of connection with others perpetuates addiction. Participants reported better treatment engagement when they felt a connection with their treatment provider and treatment group. The participants' responses in this study are consistent with the study results reported by Johnson et al. (2013), who found that client rapport is essential in preventing substance abuse relapse and overcoming treatment barriers. Yang et al. (2018) also consistently found that client-counselor relationships predict treatment engagement. Substance abuse treatment providers who establish rapport with clients can help them trust and open up to discuss their trauma histories. Additionally, substance abuse treatment providers who establish trust and connection may encourage inspiration and motivation to substantially increase the chances of client engagement (Yang et al., 2018).

Talking helps to feel connected. Participants shared that talking to people helped them to feel connected with others. Participants discussed how talking about their stress and past traumas helped alleviate depression, reduce anxiety, and cope better with stress. For the participants, talking was one of the most helpful tools for engaging in substance abuse treatment. Talking about thoughts and feelings related to trauma histories can alleviate problem behaviors, interpersonal problems, and mental illnesses and decrease substance disorders (Skeffington & Browne, 2014). If substance use disordered

individuals do not connect to their social environment, they may find relationships through the drug community, a place where they can connect with others (Tjora & Borg, 2019).

Feeling listened to helps to feel connected. Participants reported that they felt the connection needed to engage in treatment when they felt heard. Participants said that they could tell when a provider was actively listening to them. When participants think substance abuse treatment providers do not actively listen to them, they do not feel connected with them, making engaging with them difficult. Participants also reported that being heard in group therapy helped them feel like they had a connection with others, helping them further engage in treatment.

Support from others helps to feel connected. Support is an essential contributing factor in substance abuse treatment engagement and increases recovery chances (Hanif & Riaz, 2019). Participants reported support from family, friends, providers, and groups that assisted their recovery treatment. Support provides participants with a connection to others. Additionally, group therapy was reported by the participants to be an essential support system for them regarding feeling connected with others and providing them with a sense of community. Group therapy is vital to helping those with trauma histories to heal through resiliency (Manyam & Davis, 2020). Although professionals may argue over what core issues create barriers to substance abuse treatment engagement, formerly incarcerated individuals are more likely to benefit from treatment when offered supportive peer relationships with others from similar cultural backgrounds (Mahmood et al., 2013). This finding is consistent with the participants' responses in this study. The

participants discussed how group therapy helped them engage in treatment and support other group members as a community in their recovery journey. If clients do not feel that they have support from their social environment, they may find it where they feel connected—the drug-user community may become a place that provides them with a sense of belonging (Tjora & Borg, 2019).

Substance abuse treatment providers. The relationship that participants have with their substance abuse treatment providers are important in their treatment engagement. Like any relationship, a healthy connection requires certain elements to be influential and beneficial. Below are what participants reported as being essential traits in their substance abuse treatment providers. Clients must have a perceived connection with their therapist before they are willing to engage in substance use treatment (Hall, 2016). Establishing rapport with clients is critical in treatment outcome (Kaag, 2018; Goodman, 2017). The theoretical framework of CTT demonstrates the importance of therapeutic alliances between clients and substance abuse treatment providers and how it can improve engagement and treatment outcomes in substance use treatment (Goodman, 2017). The participants stated that to engage in substance abuse treatment, substance abuse treatment providers must show empathy and be nonjudgmental.

Empathy. All participants discussed the importance of empathy from their substance abuse treatment providers to establish rapport. They indicated that when a substance abuse treatment provider is empathetic toward them, they feel that their provider understands them and cares about them. Hall (2016) contended that empathy is the most critical tool in establishing a connection with clients. Empathy helps clients trust

their substance abuse treatment providers. Many participants talked about the importance of perceived empathy in encouraging them to share their addiction and trauma experiences.

No judgment. Members of the formerly incarcerated population often face biases because of the choices they have made for addiction. They frequently feel conflicted, experience biases, and feel a lack of acceptance from others due to their decisions and behaviors around addiction (Semb, Tjora, & Borg, 2019). Many experience shame and guilt. They often experience stigma from the general population regarding their legal background and mental health disorders. When they feel judgment from a provider, it inhibits their ability to engage in treatment. Participants discussed the importance of feeling that they are not judged by their substance abuse treatment providers, which is critical to engagement in treatment and success in treatment. In my experience working with the substance use disordered population, I have not met many clients who come in for treatment trusting substance abuse treatment providers from the start; providers must form trust in the relationship first. Building trust must come from a place of nonjudgment. Most participants in this study expressed the importance of nonjudgment from therapists and other clients in their therapy for better treatment outcomes.

History of addiction. All participants reported that they believed that their treatment provider should have a personal account of addiction to help them with their treatment. Most participants felt that to understand addiction, substance abuse treatment providers should have experience in addiction. However, in further explanation, participants also commented that when they are listened to, they feel like the other person

cares, providing them with a connection. After all, they seek a connection, maybe not so much to share similar addiction histories. Otherwise, there would not be a separation of substance abuse treatment providers and peer specialists. Participants believed that substance abuse treatment providers could not understand the feelings, cravings, withdrawal symptoms, and other substance use consequences unless they have firsthand experience. When a substance abuse treatment provider presents an environment of empathy, showing no judgment, and expressing genuine care for a client, the provider's personal addiction experience might not be so important to the client. This notion ties back to an essential element that participants perceived are most helpful: connection to others, to be able to talk, be listened to, and have the support of others. Some clients reported that substance abuse treatment providers who provided a safe and non-judgmental space to talk were helpful and therapeutic.

Barriers to treatment needs. Engagement levels in substance abuse treatment may increase if trauma needs are met (Johnson, 2013). However, if their treatment needs are not met, participants experience barriers to their treatment, as the participants in this study reported. Most participants reported that they had experienced barriers to treatment most of their lives, thus their multiple years and occurrences of participation in treatment.

Trauma. All participants in this study reported having trauma histories. All participants also reported co-occurring disorders: In addition to SUDs, participants had experienced depression, anxiety, anger, and PTSD. Formerly incarcerated individuals with sexual or violent trauma histories may have increased engagement in substance abuse treatment if their needs are met to address their trauma (Johnson, 2013). Most

participants reported that they had not had the opportunity to address their trauma in substance abuse treatment. Because unaddressed trauma often causes other symptoms, such as depression and anxiety, co-occurring disorders are prevalent in the formerly incarcerated population with SUDs (Kaag et al., 2018).

Substance use disordered individuals with trauma histories may have increased suicidal thoughts and suicide attempts due to maladaptive emotional and behavioral patterns (Keyser-Marcus et al., 2015). Participants discussed how their use is typical when triggered, stressed, depressed, anxious, or angry around daily stressors and trauma histories. People use drugs to cope with their emotional pain and traumas (Harden, 2018; Hari, 2015; Schaler, 2000). More substance abuse treatment providers are beginning to recognize the importance of assessing for trauma and addressing clients' needs through integrated treatment; however, this is not standard practice in substance abuse treatment (Sanford et al., 2014). There is evidence showing positive treatment outcomes with integrating SUD and trauma treatments (Amaro et al., 2007).

Cost/insurance**.** Approximately 71% of males incarcerated in Colorado state prisons need SUD treatment (Colorado Criminal Justice Reform Coalition, 2016). Among justice-involved people in the United States, 70% to 90% are uninsured (Colorado Criminal Justice Reform Coalition, 2016). About half of the participants discussed how the cost of substance abuse treatment or lack of health insurance presented a barrier to treatment. Although many justice-involved individuals quality for Medicaid insurance, there are qualifying criteria. Formerly incarcerated individuals are entitled to Medicaid insurance during their parole status (Colorado Criminal Justice Reform Coalition, 2016).

However, many do not know about Medicaid or understand that they are eligible for Medicaid. Once they are off parole status, depending on their income level and household size, they may no longer meet Medicaid's eligibility threshold. Without health insurance, the cost of substance abuse treatment can be a financial burden.

Research Question 2

Research Question 2 addressed how trauma barriers might affect substance abuse treatment engagement among formerly incarcerated adult males in community-based programs. Eight of the nine participants in this study reported that trauma history posed a barrier to substance abuse treatment engagement because of their ongoing need to use substances to cope. Of these eight participants, six said they addressed their trauma histories with their substance abuse treatment providers and were still in recovery and sober. PTSD, depression, anxiety, anger, and triggers are common symptoms of sexual or violent trauma. Unaddressed trauma histories were reported to be the most common reason for continued substance use by participants. With continued use, the memory of a drug eases emotional pain, and increases use to the point of addiction (Inaba & Cohen, 2014). Many participants shared a need to use illicit substances to cope, describing a need to feed their addiction.

Research Question 3

Research Question 3 addressed how formerly incarcerated males in community-based programs feel about incorporating trauma treatment into their substance abuse treatment. Trauma histories and SUDs only increase the risk of further use and relapse (Hari, 2015). Most participants stated the importance of incorporating trauma treatment

into substance abuse treatment because trauma and substance use often go hand in hand. Most of the participants discussed that they often used substances to cope with their trauma histories, and if they were able to address their trauma in treatment, it might reduce their need to use. All of the participants stated that talking about their trauma helped them to cope with it better. They indicated that they needed to address trauma and move toward healing and not turn to substances to cope. Most suggested that trauma treatment should be part of substance abuse treatment. Researchers Carless and Douglas (2016) found that sharing allows people to express and communicate complex traumas and may help them to understand what they have not yet grasped. Hari (2015) stated that "the opposite of addiction is not sobriety; the opposite of addiction is human connection" (p. 293), which is consistent with most participant responses to the interview questions in this study.

An area that should be studied is the clients' perceived need to work with substance abuse treatment providers who have personally experienced addictions to understand it. Eight of the nine participants believed that to understand addiction and help others heal from it truly, the substance abuse treatment providers should have personal experience. The participants want a treatment provider to connect with, empathically and without judgment, listen to them based on the interview responses. Group treatment is an excellent opportunity for clients to share their addiction experiences. However, a treatment provider is a trained professional who offers a different kind of support than peer support. Exploring in-depth why clients believe they need a provider with a personal history of addictions to help them through treatment could provide a useful study.

The theme of trauma barriers to substance abuse treatment engagement can be applied to contemporary trauma theory (CTT). While trauma theory explains the broad ways of human suffering and its responses (Rodi-Risberg, 2015), CTT explains that trauma histories are persistent and present in systematic mental distress. Those with trauma histories have lingering memories that are manifested into mental disorders (Loftus, 1993). McNally (2007) argued that the more violent the traumatic event, the more likely one remembers it. This relates to CTT by explaining that sexual and violent traumatic experiences are stored in memories as trauma histories.

Further, there is evidence of an association between trauma and SUD (Levenson, 2015). The results of this study demonstrated that the participants who had unaddressed trauma histories continued to have persistent mental health disorders and most likely continued to use during their substance abuse treatment. Also, those who said they addressed their trauma histories in therapy reported that they engaged in treatment, which was helpful. This study's results relate to CTT based on the participants' responses, demonstrating that violent trauma experiences are stored in our memories. The more violent the incidents were, the more persistent the mental disorder symptoms were. Based on CTT, left unaddressed, traumatic histories may manifest into mental health disorders that often lead to substance abuse to cope with those traumatic memories (McNally, 2007).

Limitations of Study

This study has limitations, just as all research studies do. One limitation might have been the sample size. The nine participants in this study do not generalize the

population of formerly incarcerated males with SUDs and trauma histories. Because IPA is concerned with detailed accounts of individual experiences and not the number of samples, IPA studies usually benefit from a small number of participants (Smith et al., 2012). IPA focuses on quality, not quantity (Smith et al., 2012).

Another limitation may have been the place of recruitment. This study included participants from facilities that provide services to men on parole. The participants are mandated to participate in substance abuse treatment as opposed to voluntary participation. Participants may feel differently about treatment engagement compared to those to willingly choose to attend therapy.

Another limitation may have been that participants who agreed to interview for this study did not have sufficient time to gain rapport with me, their interviewer, thus not sharing true and accurate personal information accounts. When participants feel safe enough to share their experiences, the opportunity is there to capture internal states and understand the context and perspectives of the stories being told (Patton, 2015). Also, COVID19 may have been a limitation because I could not conduct face-to-face interviews, which may have affected the rapport's level of rapport with the participants.

Finally, my assumptions and personal beliefs about data outcome may have been a limitation since this was a study of interest. The premise came from my observations of being in the field. Many contributions to our professional field come from researchers' personal experiences (Patton, 2015). I addressed this by keeping my own bias and beliefs at bay, maintained neutrality, and avoided leading interview questions. I also member-

checked with participants during and after interviews to confirm the accuracy of participants' responses (Ravitch & Carl, 2016).

Recommendations

This study added to the existing research literature on formerly incarcerated males' engagement in substance abuse treatment. There is limited literature addressing trauma as a barrier to treatment among males compared to females. Recommended future research should focus on the limitations of this study and how trauma treatment might be implemented in substance abuse treatment to increase best practices and treatment outcomes.

The participants in this study acknowledged that trauma is forefront in substance abuse treatment, often decreasing their engagement in treatment. Substance abuse treatment may become more manageable for those who address trauma histories, thus increasing their engagement in treatment. Further exploring trauma barriers in treatment may increase how substance abuse treatment is delivered to clients more effectively and improve their treatment engagement. Substance use is a tool for coping with trauma among many individuals. With over 50% of substance use disordered adults having high levels of trauma, their substance use is a maladaptive way to cope with and manage their trauma symptoms (Hooley, Butcher, Nock & Mineka, 2017; Mahoney, Chouliara, & Karatzias, 2015). Helping the substance use disordered population addresses their trauma may help increase their level of engagement in treatment, thus decreasing their need for continued substances to cope (cope (Begun, Early, & Hodge, 2016).

Another recommendation includes a more in-depth exploration of why the substance use disordered population perceives that having a provider with a personal account with addiction history might be more effective in their treatment than substance abuse treatment providers with no history of addiction. Peer support is available for those in addiction treatment. If substance abuse treatment providers can make connections (establish rapport, show empathy, and avoid judgment), would that be sufficient in terms of useful treatment provider traits?

Implications

The findings of this study may provide many implications for substance abuse treatment outcomes and positive social change. Substance abuse is often a tool for coping with trauma. If trauma is not addressed in SUD treatment, the likelihood of clients seeking addiction treatment outside of substance abuse therapy decreases.

As discussed by participants in this study, substance abuse treatment is costly. If they were to seek additional treatment for trauma, that would only incur additional cost and create possible barriers to finding extra time for more treatment and finding a facility that provides trauma treatment. Developing a substance abuse treatment to include addressing trauma histories may increase positive treatment outcomes by lowering co-occurring disorders and decreasing substance abuse.

The findings also suggest that incorporating trauma treatment in substance abuse treatment could be beneficial. There is literature addressing trauma as a barrier among females. Blakely and Bowers (2014) assert a disparity in literature addressing sexual and violent trauma histories as barriers to treatment studies among males compared to

females. Many research studies focus on trauma and treatment engagement among incarcerated females; however, it is not the case for studies related to formerly incarcerated males with trauma barriers (Blakey & Bowers, 2014; Mahmood et al., 2013). The participants described that treatment could be stigmatizing for them, especially in certain cultures. Many males may have difficulty in asking for trauma treatment because of the stigma. Including trauma in substance abuse treatment can provide an opportunity for males to address their traumas without having to ask for additional treatment and eliminate potential stigma.

Finally, this study confirms that group therapy is effective. Group therapy is essential in helping those with trauma histories to heal through resiliency (Manyam & Davis, 2020). The participants discussed how connecting with others through group therapy engages them in treatment and provides them an opportunity to talk about their problems and how to solve their problems collectively. This ties back to this study's most common theme: connection. Connection with others provides a safe place to engage and heal.

Summary

The purpose of this qualitative study was to explore how trauma histories play a factor as a barrier to substance abuse treatment engagement among formerly incarcerated adult males. There was a gap in literature among males with trauma histories and their engagement in substance abuse treatment. This provided an opportunity for this study to address this gap with this study's participants. The nine participants shared their detailed life experiences of participating in multiple treatment programs, their addictions,

how they have, or have not, coped with their trauma histories, and how it affected their engagement in treatment. This study's emergent themes were that connection with others, rapport with their substance abuse treatment providers, and having their trauma addressed in substance abuse treatment are significant roles in their treatment engagement. This research's findings can provide a foundation for future research to establish effective treatment delivery methods to increase treatment engagement. Increased treatment engagement can increase positive treatment outcomes, decreasing costs of ongoing and ineffective treatment programs.

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