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Understanding the treatment experiences of African American women

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has been found to be complete and satisfactory in all respects,
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2025

Abstract

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MSW, University of Michigan, 1999

BSW, Savannah State College, 1995

Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

Social Work/ Addictions

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Abstract

African American women experience trauma at disproportionately higher rates than any other group, yet limited studies focus specifically on African American women with self-reported co-occurring substance use disorder and PTSD and their experiences in seeking and remaining in outpatient treatment. The purpose of this qualitative study was to examine how this group defines trauma, its impact on their treatment experiences, and the sociocultural factors that influenced their decisions to seek help and remain in treatment. The research questions posed asked about the experiences of African American women over 31 years of age with co-occurring substance use and PTSD, how they defined trauma and the role trauma plays in their treatment, and the sociocultural factors that impact their decision to seek help and remain engaged in treatment. This study was guided by contemporary trauma theory, which suggests that individuals who have experienced trauma may struggle to manage its effects, making it challenging to stay engaged in treatment. Data was collected using purposive sampling and semi-structured interviews with five African American women over 31. Atlas.ti web qualitative data analysis software was used to identify codes that resulted in three main themes, including psychological and emotional responses to trauma, the role of trauma in treatment mistrust, and treatment preferences. Additionally, four subthemes emerged, including a broad definition of trauma, help-seeking and treatment engagement, mental health diagnosis, and therapist matching. This study has the potential to contribute to positive social change by adding to the limited body of literature on how trauma can influence this population's ability to remain engaged in treatment and improve treatment completion.

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Chapter 1:

Introduction to the Study

African American women with substance use disorder histories are more likely to have experienced trauma than other groups (Blakey & Grocher, 2020). This population also experiences poor treatment outcomes, shorter stays, higher relapse rates, and ongoing substance use. Meshberg-Cohen et al. (2016) suggest that African American women who do not disclose their trauma histories are at greater risk of experiencing trauma. Studies by Isobel et al. (2020), Tull et al. (2018), Ruglass et al. (2017), Giordano et al. (2016), Blakey and Grocher (2020), and Watson et al. (2016) support this assertion. However, despite their vulnerability, African American women are least likely to seek help and remain engaged in treatment due to mistrust of providers, bias, and stigma (Hammarlund et al., 2018; Browne et al., 2016), social and self-stigma (Crapanzano et al., 2018; Hammarlund et al., 2018), and structural stigmas (Adams et al., 2021; Priester et al., 2016). Studies by Reif et al. (2021) and Jones et al. (2015) report that this population has a low usage rate. Furthermore, Lacey et al. (2021) and Burkett (2017) assert that African American women are the least likely to seek help. Dillon et al. (2020) and Yang et al. (2018) suggest that a lack of trust in providers is a significant barrier to engagement in treatment.

Researchers have investigated women and coed studies related to experiences with trauma and self-reported co-occurring disorders from qualitative, quantitative, and mixed methodologies (Bailey et al., 2019; Ruglass et al., 2019; Sullivan et al., 2016; Giordano et al., 2016; Lopez-Castro et al., 2015; Gillespie et al., 2009). In addition,

limited research examines the relationship between substance use disorders and post-traumatic stress disorders among African American women specifically (Blakey & Grocher, 2020; Isobel et al., 2020; Tull et al., 2018). Further investigation is needed on how treatment providers can better serve the needs of African American women. Finally, researchers have used different theoretical frameworks to examine the interplay between SUDS (substance use disorder) and PTSD (Post Traumatic Stress Disorder) and trauma among women in general, such as the intersectionality theory (Redmond et al., 2020), emotional regulations theory (Bailey et al., 2019), grounded theory (Jones et al., et al.,2015), and Contemporary Trauma Theory (SAMHSA (Substance Abuse and Mental Health Services Administration), 2014). This study utilized the Contemporary Trauma Theory (CTT) as it incorporates the definition of trauma and understanding of the six tenets of contemporary trauma theory (SAMHSA, 2014; Herman, 1992). Contemporary trauma theory is a trauma-based change in basic assumptions that refrain from perceiving trauma survivors as psychologically and physically damaged to viewing the person as needing help and healing (SAMHSA, 2014). In this chapter, I provided an introduction, a brief overview of the study's background, the problem statement and purpose, and the research questions that guided the study. The chapter also presented the theoretical framework, the nature of the study, definitions of key terms, assumptions, the scope and delimitations, limitations, and the significance of the study. Finally, the chapter concluded with a summary.

Background

The evolution of substance abuse treatment from the moral model to the disease model has also led to the evolution in treating addictions. Dr. Benjamin Rush initially introduced the movement from the moral model to the disease model in 1784; he argued that alcoholism as an addiction was a disease, which led to the development of the temperance movement (Capuzzi & Stauffer, 2016; Henninger & Sung, 2014). During the temperance movement, women hid their substance use from family and friends due to the stigmatization of substance use (Henninger & Sung, 2014). The temperance movement was not focused on treatment but on drinking with moderate and socially approved drinking levels, which led to the Washingtonian Total Abstinent Society, where members went to taverns to recruit people into the movement, which later shaped the self-help recovery groups (Capuzzi & Stauffer, 2016; Henninger & Sung, 2014).

The moral model viewed individuals as having a character flaw, lack of willpower, and moral weakness. This approach *was adopted* by religious organizations and the legal system, who believed that punishing alcoholics and addicts would lead to their reformation rather than addressing the root cause and providing proper treatment (Capuzzi & Stauffer, 2016). The religious community ideology was that God gives man free will, and if a person cannot abstain from alcohol and drugs, it was seen as a sinful act, or the person was morally corrupt. The moral model view was discredited as scholars could not measure the "sinful nature of man" through research (Capuzzi & Stauffer, 2016; Henninger & Sung, 2014).

During the late 1950s, drug addiction was perceived as a lifestyle that only those who were unwilling or unable to change would adopt (Henninger & Sung, 2014). Addiction was seen as a social disease that could be transmitted to others, making it harmful (Henninger & Sung, 2014). Hence, those experiencing addiction were often institutionalized for one to three years to receive treatment instead of incarceration. Following their treatment, they returned to their community and continued receiving outpatient care (Henninger & Sung, 2014). In the 1960s, the federal government increased funding for developing Community Mental Health, anti-poverty, and criminal justice programs (Henninger & Sung, 2014).

Post the moral model, the Minnesota Model evolved throughout the 1950s, defining alcoholism as a progressive disease that requires a holistic and multidisciplinary approach, integrating mutual respect and professionalism (Moss-King, 2016; Henninger & Sung, 2014). In many instances, the early practitioners working in addiction were recovering people with an addiction, helping other addicts recover, and working to become licensed and credentialed professionals in substance abuse (Capuzzi & Stauffer, 2016). Initially, the social work profession was not well engaged in substance use services during the earlier stages of substance abuse treatment. However, it has evolved in developing local and national policies that impact prevention, intervention, and treatment (Capuzzi & Stauffer, 2016). The Hazelden model, formerly the Minnesota Model, is still commonly used for addressing alcohol and drug addiction (Henninger & Sung, 2014). The Hazelden approach to treating addiction involves a holistic and

respectful approach, abstaining from all substances, and building a supportive community where individuals can help one another in their recovery journey (Moss-King, 2016).

In the 1960s, hospitals started using a 28-day program for addiction treatment, which became the standard (Henninger & Sung, 2014). Patients were given detox medication and assigned a counselor to create a supportive environment that encouraged self-expression through group and individual counseling, lectures, working through the 12 steps, and planning for aftercare before returning to the community (Henninger & Sung, 2014). In the '60s, Methadone was considered a miracle drug for helping heroin-addicted veterans returning from the Vietnam War with detoxification and stabilization in outpatient clinics (Henninger & Sung, 2014). Over time, Methadone has been replaced by newer medications like Naltrexone and Suboxone, which are now commonly used for outpatient treatment (Henninger & Sung, 2014).

The approach to substance abuse treatment has shifted from a moral-based model to a disease-based model, resulting in diverse types of treatment, including outpatient programs. Outpatient treatment is designed to provide care and support to patients in a community-based setting. There are different forms of outpatient treatment available, such as intensive outpatient treatment (IOP), partial hospitalization programs (PHP), and traditional outpatient treatment (TOT) programs. According to the National Institute on Drug Abuse (NIDA), Outpatient treatment is effective for mild to moderate substance use disorders and can be used as a step-down treatment option for individuals who have already undergone residential or inpatient treatment.

Outpatient treatment allows patients to receive care while maintaining their daily routine, work, and family responsibilities. Intensive outpatient treatment (IOP) is a structured program providing a higher level of care than traditional outpatient treatment. IOP programs typically involve 9-12 hours of weekly treatment, including group and individual therapy, medication management, and other support services. Partial hospitalization programs (PHP) offer patients a more intensive level of care, similar to inpatient treatment, but on an outpatient basis. PHP programs typically involve 20 hours or more of treatment per week, including medical supervision, therapy, and other support services. Traditional outpatient treatment (TOT) programs are the least intensive and may include individual therapy, group therapy, or other support services. TOT programs are often used as a step-down treatment option after completing a higher level of care, such as IOP or PHP.

Research in the field of substance abuse has been shaped by social and political attitudes toward addiction (VanGeest et al., 2017). Over time, the research focus has shifted from a criminal perspective to a medical/disease approach (VanGeest et al., 2017; Henninger & Sung, 2014). The field continues to expand to include a broader range of vulnerable individuals, such as women, who were previously overlooked (VanGeest et al., 2017). Research on African American women's experiences and perceptions of barriers to mental health and substance abuse services is limited (Jones et al., 2015). Similarly, there is a lack of focus on racial and ethnic minorities in prevention and intervention studies (Blume, 2016). To address these gaps, it is crucial to explore how African American women define trauma during their treatment and understand how

trauma impacts their willingness to engage in services. Such a study can assist treatment providers in better addressing the needs of middle-aged African American women who have trauma and substance use histories while also identifying socio-cultural factors that affect their engagement in treatment.

Problem Statement

Studies have shown that African American women may experience more trauma than other groups (Blakey & Grocher, 2020) but may hesitate to disclose their trauma history when seeking help (Shields et al., 2015). However, the literature revealed that minority women with substance use disorder might not readily disclose their trauma history when seeking help due to cultural barriers, guardedness, shame, and mistrust of the provider, which can lead to poor treatment outcomes and a higher rate of addiction severity compared to those without trauma or post-traumatic stress disorder diagnosis (Blakey & Grocher, 2020; Danzer et al., 2016; Meshberg-Cohen et al., 2016; Carter & Sant-Banket,2015; Torchalla et al., 2012; Shields et al.,2016). Redmon et al. (2019) argued that there is a lack of focus on the role trauma plays in the lives of women who need treatment, which makes it difficult for African American women with substance use disorders to engage in and remain in treatment and the facility's ability to deal with their trauma.

Historically, substance abuse research in the United States excluded women as they have been overlooked in the substance use literature (Stenius & Veysey, 2005), especially African American women (Hunter et al., 2013). Additionally, women with trauma histories have been excluded from substance abuse treatment programs'

assessment process (Blakey & Bowers, 2014; Najavits et al., 2008). Individuals with substance abuse and trauma histories were not treated simultaneously because their issues were considered complicated (Blakey & Bowers, 2014). The intervention solely focused on addiction, and it was assumed that other issues would be resolved through recovery or by another treatment professional (Covington, 2008). However, treating addiction first and then addressing trauma or any other co-occurring disorder often leads to poor retention rates and treatment outcomes (Blakey & Bowers, 2014).

In the past, substance abuse was believed to be a problem that only affected men, leading to studies that primarily focused on male participants (Tuchman, 2010); hence, substance abuse treatment was designed to cater to the needs of men, which was ineffective with the complex needs of women (Covington, 2008). The recent literature from 1975 to the present day reveals that women were less likely to seek substance abuse treatment and more likely to experience treatment barriers than their male counterparts (Greenfield et al., 2010; Tuchman, 2010). However, until the early '90s, research on substance abuse treatment was based on male or mixed-gender samples, with little focus on gender differences, making the findings not generalizable to women (Greenfield et al., 2007; Boyd et al.,1993; Davis et al., 1997). Nonetheless, in 1993, the United States government guidelines expanded research to include women of childbearing potential, and the National Institutes of Health (NIH) guidelines in 1994 encouraged the inclusion of women and minorities in research (Greenfield et al., 2007).

When seeking help for substance abuse, African Americans tend to follow a culturally specific pattern influenced by socio-cultural factors (Bailey, 1987). However,

there is limited literature from the perspective of African American women who abuse substances on how socio-cultural issues contribute to the decision to seek help, what is needed to remain engaged in treatment and address the challenges they face in recovery. Women face different social expectations, and the expected role of nurturer and caretaker is affected by their addictive behavior, increasing the stigma of addressing their substance use problem (Briggs & Pepperell, 2009). Holden, McGregor, Blanks, & Mahaffey (2012) investigated the psychosocial, environmental, and socio-cultural factors that impacted help-seeking behaviors among African American men. Research studies on substance abuse seldom address explanatory variables such as gender, age, socioeconomic issues, race/ ethnicity, geographic locations, and cultural patterns, which can play a significant role in drug use patterns (Staff, M. N., 2013; Nayback, 2008; Curtis-Bowles & Jenkins-Monroe, 2000; Davis, 1997; Boyd, 1993). Recent studies have shown differences in gender, social factors, biological responses, progression to dependence, and barriers to treatment entry, retention, and completion (Tuchman, 2010).

In the past 30 years, there has been considerable progress in understanding drug and alcohol use, which has led to improved prevention and treatment of substance abuse. Researchers and treatment providers are increasingly concerned with substance use disorders and post-traumatic disorder (Torchalla et al.,2012). In addition, integrating trauma approaches into clinical work and considering gender differences when implementing trauma interventions (Giordano et al., 2016) can affect treatment outcomes for women differently (Hunter et al., 2013; Tuchman,2010; Stenius & Veysey, 2005; Davis, 1997). Additionally, the unique needs of African American women must be

addressed to assist them in overcoming substance use problems (Davis, 1997). The research problem in this study explored the narratives of African American women over 31 years of age with self-reported co-occurring disorders of substance use and PTSD, revealed how they defined trauma during their recurrent treatment experiences, how they perceived the relationship between trauma and recurrent admissions and sustained recovery, and the socio-cultural factors that impacted their decision-making to seek help and stay engaged in treatment.

Researchers have recommended conducting additional studies to understand better how cultural traditions, attitudes, values, and beliefs influence treatment engagement and access for African American women. Ahmedani (2011) suggests that exploring these factors can provide insights into the specific needs of this population. Redmon et al. (2019), Bailey et al. (2019), and Blakely & Bowers (2014) suggest conducting studies to identify the barriers to substance use treatment from the perspective of African American women. Stevens-Watkins et al. (2016) suggest examining the need for integrated treatment, while others, such as Blakely et al. (2014), Blakely & Grocher (2017), and Edmonds-Cady (2017), suggest exploring the relationship between African American women and their treatment as predictors of treatment engagement and completion. Masin-Moyer et al. (2020) and Glass (2012) suggest replicating help-seeking studies with larger samples. Lastly, Yang et al. (2018) and Jones et al. (2015) recommend conducting additional studies on urban minorities. Allen (1995) also recommends exploring the need for solid after-care programs and self-help groups in African American communities.

This study sought to gain insight into the experiences of African American women over 31 years of age with self-reported co-occurring substance use disorder and PTSD and how this population perceived trauma in general, what factors they reported that impacted treatment engagement, and what could be addressed in treatment environments that supported how they managed their substance use disorder as it related to trauma in the context of their diagnosis.

Purpose

This qualitative study explored the experiences with treatment for African American women over 31 years of age engaged in outpatient treatment services with self-reported co-occurring substance use disorder and PTSD. The study also delved into how this population defined trauma and the profound role it played during their treatment experiences. Furthermore, the study sought to identify the sociocultural factors impacting this population's decision to seek help and remain in outpatient treatment services.

Research Questions

The following research questions were posed to support the study's purpose of gaining insight into the experiences of African American women over 31 years of age with self-reported co-occurring substance use disorder and PTSD who were engaged in outpatient substance use treatment services perceived trauma and the factors that impacted their decision to seek help and stay engaged in treatment services.

1. What do the narratives of African American women with self-reported co-occurring PTSD and substance use disorders who are in outpatient

substance use treatment reveal about how they define trauma during their recurrent treatment experiences?

2. What do the narratives of African American women over 31 years of age with co-occurring PTSD and substance use disorders reveal about how they describe trauma during their recurrent outpatient substance use treatment experiences?
3. What socio-cultural factors do African American women over 31 years of age with self-reported co-occurring PTSD and substance use disorders describe as impacting their willingness and decision-making to seek help and stay engaged with outpatient treatment services?

Theoretical Framework

SAMSHA provides a consistent and comprehensive definition of trauma and essential principles and guidance to increase awareness and promote a trauma-informed approach across public institutions and service sectors (SAMHSA, 2014).

Contemporary trauma theory assumes that a person may have experienced trauma, that extreme behaviors may be how a person copes or adapts to the trauma, and that exposure to trauma is widespread among service users and providers (Sweeney et al., 2018). Through a trauma-informed lens, we can better understand trauma's prevalence, common signs, and widespread effects (Sweeney et al., 2018). Contemporary trauma theory recognizes that individuals may experience trauma differently; hence, the theory provides a framework to understand the impact of trauma based on five central

properties: 1) dissociation, 2) attachment, 3) reenactment, 4) long-term effect, and 5) impairments in emotional capacities (SAMHSA,2014).

SAMHSA's approach to understanding trauma and its impact on mental health and substance use involves identifying four key assumptions and six fundamental principles (SAMHSA, 2014). The four assumptions are recognizing that trauma plays a role in mental health and substance use, screening for signs of trauma, responding with understanding and promoting trust, and actively resisting re-traumatization. By incorporating these assumptions into an organization's culture, individuals with trauma experiences can receive the support and care they need without being triggered or re-traumatized. (SAMHSA, 2014).

SAMHSA's six fundamental principles are essential to creating a trauma-informed environment that prioritizes safety, trust, peer support, collaboration, empowerment, and cultural sensitivity. These principles help individuals cope with and become resilient to trauma, and they integrate trauma theory into treatment models for those with co-occurring trauma and substance use disorders (Goodman, 2017; Levenson, 2017; Shier & Turpin, 2017; SAMHSA, 2014). According to Goodman (2017), following these principles can also increase participants' willingness to stay engaged in treatment. Trauma-informed care is an approach in human services that acknowledges the prevalence of trauma in individuals' lives (SAMHSA, 2014). Charcot, Janet, Freud, Breuer, and Price were a few pioneers who contributed to the study of psychological trauma (Ringel & Brandell, 2011; Figley et al., 2017). For example, Janet's 1980 studies

of Vietnam veterans and victims of physical and sexual abuse lead to the diagnosis of post-traumatic stress disorder (van der Kolk & van der Hart, 1989).

The study of trauma theory originated from medical practitioners' examination of survivors of a railroad accident that caused "railway spine" (Figley et al., 2017). The term referred to physical or somatic complaints among the survivors of railway accidents with no visible physical injuries (Figley et al., 2017). However, their psychological and emotional times manifested weeks or months after the accident (Sutterlin, 2020; Figley et al., 2017).

Contemporary trauma theory originated from a study of the 1942 Cocoanut Grove fire, where 493 people died in a Boston nightclub. The survivors exhibited common reactions such as preoccupation with lost loved ones, guilt, disorganization, and somatic complaints (Ringel & Brandell, 2011; Figley et al., 2017). This study led to an understanding of the impact of trauma on a person, shaping contemporary trauma theory (Ringel & Brandell, 2011). In addition, contemporary trauma theory was advanced when supported by a solid and intense political movement that emerged into the public consciousness, shaping how trauma is currently viewed (Ringel & Brandell, 2011; Figley et al., 2017; Herman, 1997, p.9).

This study explored how African American women perceive trauma during their recurrent outpatient substance use treatment experiences and the sociocultural factors influencing their decision-making to seek help and remain engaged in treatment. These principles can help the researcher to better understand the narratives of African American women with self-reported co-occurring disorders of substance use disorder and PTSD,

the role trauma played in their outpatient substance use treatment experiences, and the sociocultural factors they perceived that impacted their willingness to stay engaged in treatment (Jones et al., 2015), lack of trust among treatment providers (Meshberg-Cohen et al.,2016), and continued use of substances to self-medicate, escape, cope, and feel safe (Gielen et al., 2016). Chapter 2 provided a detailed discussion of contemporary trauma theory.

Nature of the study

This study used a narrative framework as part of a generic qualitative inquiry. The generic qualitative study design embraces many orientations and approaches that seek broad, inductive, richly descriptive, flexible, and emergent and is not bound by a specific method (Merriam & Tisdell, 2015). The data was collected through open-ended questions that asked participants to share their perspectives on how they perceived the world and the significance they gave to those experiences (Merriam & Tisdell, 2015).

This study applied Butina's (2015) narrative framework to explore the issues of treatment experiences through a generic research design. Narrative is a form of basic qualitative research that involves collecting stories from individual participants through face-to-face interviews, observations, and documentation (Patton, 2015). The participants' stories were captured through face-to-face semi-structured interviews that were transcribed and analyzed for patterns and themes (Patton, 2015).

This study applied the thematic analysis of Butina (2015). The method involved five phases: 1) transcribing audio recordings from the interviews and highlighting patterns or themes, 2) coding the data to gain an overall understanding of the data, 3)

identifying recurring words or patterns from reading and re-reading transcripts, 4) developing a master code list, and 5) interpreting the data (Butina, 2015). This approach helped me to understand the experiences and stories of the participants and identify themes within the data (Ravitch & Carl, 2019).

In this generic qualitative study, I sought to interview 10 to 12 African American women participants over 31 years of age, who were currently engaged in outpatient substance use treatment at a midwestern city treatment facility. Previous studies have focused on women of color, including African American women who have undergone substance use treatment and are around 40 years old on average (Watson et al., 2016; Carter & Sant-Barket, 2015; Jones et al., 2015). (Watson et al., 2016; Carter & Sant-Barket, 2015; Jones et al., 2015). However, there are limited studies focused on middle-aged African American women over 31 years of age as the main interest (Meshberg-Cohen et al., 2016; Torchalla et al., 2012; Davis, 1997). Therefore, I selected this age range as they were more likely to have multiple experiences with substance use treatment, be actively engaged in outpatient treatment, and have diverse perspectives and experiences with trauma.

Conducting a narrative framework was the most effective methodology for this study, as it provided a deeper understanding of how this population experienced trauma during their treatment and recovery by exploring and analyzing their stories, looking for insight and meaning, and connecting them. To collect this data, I conducted semi-structured in-person interviews using open-ended questions that focused on participants' experiences with trauma and its impact on their treatment and recovery. The data was

collected from participants who self-reported co-occurring PTSD and substance use disorders, had received treatment within the past 12 months, and had discontinued treatment before completing the episode. Additionally, demographic information was also collected for analysis.

This study employed a purposeful sampling approach with a homogeneous strategy to recruit participants currently engaged in outpatient substance use treatment at a facility that provided mental health and substance use outpatient treatment. Purposeful sampling is a non-random sampling of cases that meet specific criteria. The selected cases were information-rich and illuminative and offered insight into the research questions, allowing me to learn about the population represented by the selected participants (Patton, 2015). The homogeneous strategy allowed me to focus on a small selection of cases with a substance use history, self-reported trauma experiences and currently engaged in outpatient substance use treatment services.

Definitions

The following definitions of terms are used throughout the study:

African American: African Americans are citizens or residents of the United States who "have origins in the Black populations of Africa." The term is used to identify women born in the United States with African ancestry (Forson, 2018).

Co-occurring disorders: The term "co-occurring disorders" in this study will refer to a substance use disorder diagnosis and one or more mental disorders.

Middle Age: Middle age is generally defined as the period of life between young

adulthood and old age, typically considered to occur between the ages of 40 and 65 (Britannica, 2023). However, this study will define middle age as people between the ages of 30 and 65.

Post-traumatic stress disorder: PTSD is an incapacitating mental health disorder that may develop after exposure to a traumatic event and may be re-lived by the person through painful recollections, flashbacks leading to disturbed sleep, difficulty in concentration and guilt (APA.org, 2022; Roberts et al., 2016).

Socio-cultural factors: Sociocultural factors are environmental conditions that have a role in adaptive and normal behaviors as well as in maladaptive behaviors, or social pathology (APA, 2015). In this study socio-cultural factors will refer to a person's race, age, ethnicity, culture, religion, beliefs, values, demographics, income, mental illness, lifestyles, stereotypes, and attitudes of society which can influence behavior.

Substance use disorder: SUDs is a behavioral disorder in which the use of substances impairs functioning (Roberts et al., 2016).

Trauma: Trauma results from an identified event experienced by the individual as physically or emotionally harmful or threatening and has a lasting adverse effect on the individual's functioning and mental, social, emotional, or spiritual wellbeing (Goodman, 2017; Levenson, 2017; SAHMSA, 2014). The American Psychological Association defines trauma as an emotional reaction that follows an unsettling and negative experience (APA.org, 2022).

Assumptions

The assumption was that the participants felt safe openly discussing their trauma experiences, understood the interview questions, and responded truthfully (Creswell, 2017). The participants voluntarily discharged from their previous treatment before the completion of the episode and participated in the interview without any issues. They were informed that their participation was voluntary and were provided information on how the data would be used and what would happen after the study.

Scope and Delimitations

The scope refers to the specific boundaries that were placed on the study. This study invited African American women over 31 years of age born in the United States, who self-reported cooccurring post-traumatic stress disorder and substance use disorder, and who have experienced at least one traumatic event. In addition, to be eligible for the study, the participants must have been enrolled in treatment at least once in the past 12 months, be legal residents of a midwestern city, and acknowledge consent to participate in a face-to-face interview.

The inclusion criteria were based on purposive sampling to gain rich data since the participants had been identified and could answer the research questions. Only interested participants who met the abovementioned criteria were included in the study. Delimitation is a factor the researcher intentionally imposes to constrain the study's scope to make it manageable (Terrell, 2016). This study was limited to only one treatment center with approved access to this population, which limits the demographic sample to only African American women.

This study only focused on the experiences of African American women with the specified conditions. Therefore, the findings do not apply to individuals from diverse cultural backgrounds or ethnicities or those living in rural or suburban areas, as their experiences were not included in the study.

Limitations

The limitations are factors beyond control and can impact the external and internal validity of the study (Creswell, 2017). For example, this study's design included one outpatient substance use treatment facility located in a Metropolitan city in the Midwest; hence, the generalization of the results was limited. Additionally, since the study only focused on African American women born in the United States, the perspectives of other women were not represented due to its limited scope. It is essential to consider potential factors that may affect the study results, such as the severity of substance abuse, prior treatment experiences, and sociocultural factors. These variables were addressed in the study design to ensure accurate and valid results.

Due to COVID-19, the facility continues to implement the CDC-mandated guidelines for outpatient substance use treatment that include temperature checks, wearing a protective face mask to cover the nose and mouth, handwashing, sanitizing the area after each participant, social distancing and limiting the number of patients in the facility. In addition, the facility conducts telehealth and face-to-face sessions with consumers. The facility provided a private meeting space to conduct the individual interviews during business hours of operation; the flexibility with time was challenging as one participant canceled the day of the interview.

This study involved discussing sensitive trauma stories, none of the participants reported feeling triggered during or after the interview. I provided verbal and written information before the interview to ensure participants understood the risks and benefits. Additionally, each participant was given contact information for the midwestern city's 24-hour Crisis Center and Community Mental Health services to help them manage any symptoms after the interview.

I addressed researcher bias through reflexive journaling and peer debriefing to identify overlooked biases. The practice of bracketing was essential for withholding judgment and distinguishing my personal experiences from those of the participants. Peer debriefing helped me to build trust, enhance credibility and reliability, and investigate potential biases and other emerging issues (Spall, 1998). In addition, the peer debriefer was familiar with the selected method and subject matter.

Significance

This study was significant in that African American women with substance use disorders are more susceptible to the adverse effects of trauma compared to other groups (Salter & Breckenridge, 2014; Watson et al., 2016), yet PTSD is often under-diagnosed and under-treated among African Americans. Historically, there has been a lack of focus on prevention and treatment for racial, ethnic, and sexual minorities (Blume, 2016). Given the considerable influence of ethnicity on beliefs about seeking help, attitudes, and treatment barriers, it is essential to find ways to better support African American women in engaging with outpatient treatment services.

The findings of this study have the potential to enhance the knowledge of social workers who provide outpatient treatment to African American women with self-reported co-occurring disorders of PTSD and substance use. It offered an increased understanding of how these women experience trauma related to their repeated encounters with substance use treatment and insights into the factors that influenced their decisions to begin or continue treatment based on the participants' perspectives.

This study aimed to explore the experiences of African American women who have faced trauma and addiction. It sought to understand their perceptions of trauma, as well as the challenges they encounter when seeking help and participating in treatment. The outcomes of this study have the potential to contribute to positive social change by deepening our understanding of the unique experiences of African American women with trauma and advocating for culturally sensitive, trauma-informed services.

Summary

In Chapter 1, I presented the study's background, problem statement, purpose, research questions, theoretical framework, nature, definitions, assumptions, scope, delimitations, limitations, and significance of the study. Chapter 2 focused on the review of literature that referenced co-occurring disorders of PTSD and SUDs. This chapter covered treatment experiences, help-seeking attitudes, engagement/retention, and social work practice and interventions.

Chapter 2: Literature Review

Introduction

Research suggests that African American women are exposed to trauma at a disproportionate rate to other racial groups (Blakey & Grocher, 2020; Blakey & Bowers, 2014) and are likely to minimize symptoms when seeking treatment to address substance use (Shields et al., 2015; Danzer et al., 2016; Meshberg-Cohen et al., 2016). In addition, numerous studies support the premise that African American women with SUDs may be reluctant to disclose their trauma history due to cultural barriers, shame, mistrust of providers, and guardedness, which can lead to poor treatment outcomes and a higher rate of addiction severity (Blakey & Grocher, 2020; Danzer et al., 2016; Meshberg-Cohen et al., 2016; Carter & Sant-Banket, 2015; Torchalla et al., 2012).

This qualitative study aimed to explore the perceptions of African American women regarding trauma and its role in their treatment experiences, specifically those experiencing concurrent post-traumatic stress disorder and substance use disorder. Additionally, this study focused on how these women viewed trauma and its influence on their treatment, the factors they identified that affect their willingness to seek help and engage in treatment, and the aspects of treatment environments that could be improved to better support them in managing their substance use disorder about trauma.

There were limited studies on African American women as the primary focus in prevention and intervention research (Blume, 2016), and even fewer where these women got to share their experiences and perceptions regarding mental health and substance abuse barriers when seeking outpatient treatment services (Jones et al.,2015). There is a

need for research that specifically examines how African American women define trauma within their treatment experiences. Using a qualitative framework is needed to understand better how individuals diagnosed with co-occurring substance use disorder and post-traumatic stress disorder perceive trauma in the context of their diagnosis.

The literature review was divided into three sections. The first section covered the literature search strategy and the main search terms used. The second section examined the Contemporary Trauma Theory (CTT) theoretical framework, which served as the foundation for the study. The third section explored the research on the relationship between trauma and substance use disorders, African American women's involvement in outpatient substance use treatment, and the factors that influenced their engagement with those services.

Literature Search Strategy

Databases

In surveying the literature for this review, multiple databases were searched for relevant peer-reviewed journal articles through Walden University Library, including PsycArticles, PscychInfo, CINAHL Plus with full text, ERIC, MEDLINE Full Text, PubMed, ProQuest Central, Science Direct, SocIndex with full text, Social Science Citation Index, Social Work Abstracts, and Google Scholar. These databases were searched to identify research about African American women, trauma, the impact of trauma, help-seeking, coping strategies, and the theoretical foundation of contemporary trauma theory.

Key search terms

The key search terms started with the Boolean/phrase substance abuse and post-traumatic stress disorder, which yielded 11,825 articles while searching academic journals. Multiple combinations of keywords were used to search databases, including substance abuse, trauma, post-traumatic stress disorder, self-reported trauma, co-occurring disorders, treatment barriers, help-seeking, coping and resilience, substance use disorders, African American women and co-occurring disorders and trauma, African American women and trauma, African American women and help-seeking behaviors, African American women and treatment engagement and treatment outcomes. Next, the search was narrowed to include peer-reviewed scholarly journals that queried 11,000 articles and the last five years dating 2016 to 2020, which yielded 4,627 articles. Finally, the search was redefined to include "among African American women," which had 15 articles. This means that there was limited research on African women as the specific focus in the past ten years; hence, the search dates were extended to include 2012-2021, which provided 18 articles that were relevant to this study. After multiple keyword searches, 98 articles will support this study.

Theoretical Framework

Trauma can be defined in various ways, but it generally refers to an experience or series of experiences that causes physical or emotional harm and has a lasting negative impact on an individual's mental, physical, social, emotional, or spiritual well-being(Goodman, 2017; Levenson, 2017; SAMHSA, 2014; Herman, 1992). In addition,

the American Psychological Association also characterizes trauma as an emotional response to a disturbing event (APA.org). Trauma theory has shifted over time, with traditional theories emphasizing the question "What is wrong with you?" and newer theories adopting a more compassionate approach that asks, "What happened to you?" (Herman,1992).

The proposed study applied the contemporary trauma theory, focusing on understanding the connection between trauma and maladaptive behaviors. This approach offered a different framework for understanding the impact of trauma. In addition, contemporary trauma theory provided a foundation for trauma-informed care in social work practice with individuals with coexisting trauma and substance use disorders (Goodman, 2017).

The following paragraphs discuss the history and evolution of trauma theory, the development of contemporary trauma theory, its role in shifting how trauma is viewed, and the associated principles that have been developed to enable an improved understanding of the connections between trauma events and the impact on individuals, particularly those with a history of substance abuse and trauma.

History of Trauma

The study of trauma psychology dates back to the 19th century (Ringel & Brandell, 2011; Figley et al., 2017). Initially, the term "trauma" was used in medicine to refer to physical injuries caused by external sources resulting in shock or bodily harm. As time passed, the definition of trauma evolved to encompass the psychological and emotional effects of catastrophic events (Figley, 2017).

Trauma theory originated from Carruth's 1996 work, influenced by Freud's work on traumatic experiences (Osman, 2013). Janoff-Bulan (2010) further developed the theory by introducing the "just world hypothesis," which suggests that individuals hold three fundamental beliefs: 1) the world is kind, 2) the world has a purpose, and 3) they have inherent value, and trauma can occur when these beliefs are challenged by life events (Brown, 2008).

It is worth discussing the work of Charcot, Janet, Freud, and Breuer to provide historical context on trauma. During the late 19th century, Charcot studied hysteria and explored the connection between mental illness and trauma while working with women who had experienced trauma (Ringel & Brandell, 2012). He was the first to recognize that the origin of hysterical symptoms was not physiological but psychological and noted that hysterical attacks were dissociative problems resulting from enduring painful experiences (Ringel & Brandell, 2012).

Janet, a student of Charcot, studied dissociative phenomena and traumatic memories that influence the patients' traumatic experiences on personality development and behavior (Ringel & Brandell, 2011). Janet was the first to study and explain dissociation and obsessive-compulsive disorders as psychological defenses and observed traumatized people being attached to their trauma, asserting that mental disorders originate in traumatic experiences (Ringel & Brandell, 2011; van der Kolk, Brown, & van der Hart, 1989). In addition, Janet's 1980 studies of Vietnam veterans and victims of physical and sexual abuse revealed that traumatic experiences lead to the formal diagnosis of post-traumatic stress disorder (van der Kolk, Brown, & van der Hart, 1989).

Breuer is credited with developing the "talk cure" approach to treating nervous disorders, which later led to his collaboration with Freud to study hysteria. Freud built upon Breuer's concept that a direct relationship exists between traumatic events and hysteria, which he explored in his 1895 study (Piers, 1996). This study has become significant in trauma research, with scholars examining its findings, including literature, critical theory, history, social sciences, legal studies, psychology, and psychiatry (Osman, 2013).

The early theorists disagreed with what caused trauma. Janet asserted that the inability to integrate experiences led to dissociating the experience, whereas Freud opposed that forgetting unacceptable memories led to repression. Nevertheless, Freud, Breuer, and Janet each determined that hysteria was caused by psychological trauma (Ringel & Brandell, 2012). Freud's contributions to the study of traumatic experiences catalyzed various contemporary approaches, known as contemporary trauma theory, which emphasized dissociation in contrast to repression; years later, Freud redefined his theory while working with hysterical patients (Piers, 1996). Freud's trauma theory expanded on Breuer's conception that linear causality exists between a traumatic event and hysteria. Freud asserted that at the bottom of hysteria cases were one or more premature sexual experiences during childhood and later recanted this theory (Piers, 1996).

Trauma theory changed how people who have experienced trauma are perceived. Trauma theory began when medical practitioners investigated survivors of a railroad accident resulting in "railway spine" (Figley et al., 2017). The term referred to physical or

somatic complaints among the survivors of railway accidents that had no visible physical injuries, and their psychological and emotional symptoms manifested weeks or months after the accident (Sutterlin, 2020; Figley et al., 2017).

Contemporary trauma theory was developed following the 1942 Cocoanut Grove fire, where 493 people died in a nightclub in Boston (Ringel & Brandell, 2011). The survivors displayed common responses, including being preoccupied with lost loved ones, identifying with the deceased, expressing guilt and hostility, feeling disorganized, and experiencing physical symptoms (Ringel & Brandell, 2011; Figley et al., 2017). The contemporary trauma theory came about as a result of the findings of this study and thus provides an outline for understanding trauma symptoms and trauma's impact on a person (Ringel & Brandell, 2011). The following is an overview of the core components of this theory.

Contemporary Trauma Theory

The contemporary trauma theory is a new way of thinking about trauma survivors, focusing on helping and healing rather than viewing them as damaged (SAMHSA, 2014). The proposed study considered the trauma-informed care approach and its effectiveness in addressing the impact of trauma and substance use and contemporary trauma as a well-articulated theoretical framework for exploring the role of trauma in substance disorders and trauma-informed care practices to support improved client outcomes.

According to Herman (1997), the advancement in trauma resulted from political movements. Herman discusses three historical areas that have contributed to this progress

in her book. These include the study of hysteria, World War I (WWI) shell shock, the development of PTSD through the Vietnam War, and the feminist movement. The first study of hysteria, the psychological disorder among women, grew from an anticlerical political movement in France between the established religion and the secular form of government (Herman, 1997, p. 15). The Catholic church considered hysteria to be demonic possession, religious ecstasy, and based on witchcraft and was considered physiological, however; Charcot showed evidence that hysteria was psychological, and his investigation demonstrated the superiority of a secular framework rather than a religious one (Herman, 1997, p.15).

The First World War brought trauma into public awareness (Herman, 1997, p.15; Figley et al., 2017). When soldiers, who did not face combat, returned home from the war with symptoms of a nervous disorder, the medical professionals explained the phenomenon as hysteria commonly seen in women (Figley et al., 2017). The soldiers were shamed, punished, considered cowards, and blamed for weakness of character and mind (Herman, 1997, p.15; Figley et al., 2017). A new group of medical professionals that Freud influenced used the psychoanalytic approach to treat the soldiers, which was more humane successfully (Figley et al., 2017).

The second was shellshock or combat neurosis after WWI, which viewed soldiers as weak or "moral invalids" and peaked after the Vietnam War. British psychologist Charles Myers examined the war soldiers and discovered they presented with symptoms like hysteria, including exploding shells and a nervous disorder called "shell shock" (Herman, 1997, p. 24). The medical authorities asserted that combat neurosis was a

psychiatric condition that later led to the diagnosis of PTSD (Herman, 1997, p. 24). The political context was the antiwar movement in which veterans organized and retold their stories and relived the traumatic war experience (Herman, 1997, p. 24). The political pressure resulted in the mandate for treatment in the Veterans Administration based on the self-help and peer-counseling model (Herman, 1997, p. 24).

The third and most recent wave of the trauma movement focused on issues of sexual and domestic violence that were initially brought to light by the feminist movement. Rape was a vital issue that feminists highlighted as an example of violence against women, and it helped to provide a new framework for understanding the impact of sexual assault (Herman, 1997, p. 31). The National Organization of Women played a significant role in advocating for rape reform and conducting research on sexual assault. Through their efforts, feminist investigators confirmed women's experiences, previously dismissed by figures such as Janet, Freud, and Breuer (Herman, 1997, p. 29).

When contextualizing the movements mentioned above, one might argue that these movements shaped what is now known as contemporary trauma theory. Contemporary trauma theory was advanced when supported by a solid and intense political movement that emerged into the public consciousness, shaping how trauma is currently viewed (Herman, 1997, p.9). Contemporary trauma theory can assist clinicians in more effectively diagnosing and treating their clients' symptoms while also applying the key principles of trauma-informed care defined by SAMHSA (Goodman, 2017). The decision to select contemporary trauma theory was made because this theory offered a comprehensive understanding of the biological, psychological, and social impact of

trauma on individuals. It also offered insight into how a participant's treatment experience may be affected (Goodman, 2017).

The theory of contemporary trauma helps us to understand how trauma can affect a person's ability to function appropriately and refrain from viewing them as weak, morally deficient, or psychologically and physically injured but instead view them as needing healing and help (Goodman, 2017). Contemporary trauma theory assumes that a person may have experienced trauma and that extreme behaviors may be how a person copes or adapts to the trauma (Sweeney et al., 2018). The trauma-informed approach recognizes that many service users and providers have experienced trauma (Sweeney et al., 2018). Seeing through a trauma-informed lens acknowledges the common signs and widespread effects of trauma (Sweeney et al., 2018). Shifting towards a model that assumes participants might have experienced trauma and recognizing extreme behaviors may be how the participants have learned to adapt to past traumas (Sweeney et al., 2018). Being trauma-informed shifts how the staff perceives individuals who have experienced trauma and can benefit the client, staff, and the agency (Sweeney et al., 2018).

Contemporary trauma theory has become the focus of multiple service sectors, such as child welfare, criminal justice, and healthcare settings, which can alleviate or worsen an individual's ability to cope with traumatic experiences (SAMHSA, 2014). SAMSHA has developed a unified working definition of trauma, fundamental principles, and guidance to help public institutions and service sectors better understand trauma and adopt a trauma-informed approach (SAMHSA, 2014). In addition, contemporary trauma theory provides a framework for understanding clinical presentation and symptomology

and for trauma-informed care in social work (SAMHSA, 2014). This approach addresses the co-occurring disorders of trauma and substance use disorders to minimize the impact of trauma. Trauma-informed care is a human services approach that recognizes the likelihood of individuals having a history of trauma and its role in their lives (SAMHSA, 2014). In addition, SAMHSA's trauma framework has been adopted in other fields.

According to contemporary trauma theory, trauma can affect individuals differently. To better understand the impact of trauma, this theory identified five central properties: 1) dissociation, which is a defense mechanism used to cope with the traumatic experience; 2) attachment, which can affect the ability to form healthy relationships and trust others; 3) reenactment, which involves seeking out relationships and behaviors that replicate the original traumatic experience; 4) long-term effects, as childhood trauma can hinder appropriate development and diminish one's sense of self; and 5) emotional impairments, which can lead to emotional numbness and difficulty regulating emotions (SAMHSA, 2014).

SAMHSA's trauma-informed approach is based on contemporary trauma theory, which provides a framework for understanding trauma's impact on individuals (SAMHSA, 2014). SAMHSA has identified four trauma assumptions and six trauma principles to guide its approach. The four assumptions are: 1) having a basic understanding of trauma at all levels of the organization, 2) recognizing the signs of trauma through screenings and assessments, 3) responding with a physically and psychologically safe environment that promotes trust and transparency, and 4) implementing practices that will not re-traumatize individuals. The four assumptions

focus on having a basic understanding of trauma at all levels of the organization, recognizing the signs of trauma, responding with a safe and trusting environment, and resisting re-traumatization. Incorporating these assumptions into the organizational culture can actively resist re-traumatization and promote recovery.

SAMHSA (2014) has identified six fundamental principles for creating a trauma-informed environment: safety, trust, peer support, collaboration, empowerment, and cultural issues. SAMHSA defines each principle as 1) Safety means establishing a secure physical setting and interpersonal interactions that promote a sense of safety as the foundation for recovery (SAMHSA, 2014). According to Bloom (1999), physical and psychological safety is being safe with oneself, social safety is being safe with others, and moral safety is the organization's top priority. 2) Trust involves transparent decision-making that builds and maintains trust between staff and individuals (SAMHSA, 2014). 3) Peer support means building trust and using the individuals' lived experiences with trauma can promote recovery and healing (SAMHSA, 2014). 4) Collaboration and mutuality mean the staff members and the individual share power and decision-making, which levels the therapeutic relationship (SAMHSA, 2014). 5) Empowerment, voice, and choice mean the individual's decision-making and choices are supported by creating self-advocacy skills that reframe symptoms as adaptations and highlight resiliency instead of pathology (SAMHSA, 2014). Lastly, historical and cultural issues involve providing gender-responsive services that incorporate protocols to meet racial, ethnic, and cultural needs (SAMHSA, 2014).

These six principles are essential to promoting coping and resilience in trauma and help strengthen the main beliefs of contemporary trauma theory. Experts suggest that integrating these principles into a trauma-informed model can help treat co-occurring trauma and substance use disorders and can positively impact their willingness to seek or continue with treatment (Goodman, 2017; Levenson, 2017; Shier & Turpin, 2017; SAMHSA, 2014).

Applications of Contemporary Theory in the Research

There is a lack of research on contemporary trauma theory and trauma-informed care approach. Goodman (2017) conducted a study that examined the relationship between childhood trauma and the development of substance use disorders in adulthood, using contemporary trauma theory to analyze the experiences of seven African American women who sought help and reached a resolution. In another qualitative study, Shier & Turpin (2017) examined community residential addiction treatment programs that demonstrated trauma-informed principles, providing insights into how social service organizations can create a safe environment for individuals who have experienced trauma. The participants emphasized physical safety, confidentiality, rule enforcement, peer relationships, and reassurance as essential factors in feeling secure. They also highlighted the establishment of trust through staff availability, nonjudgmental interactions, positive relationships, and sharing, the expression of choice through opportunities for participation and meeting individual needs, collaboration through planning, goal setting, support, and feedback, and empowerment through trigger management, trauma awareness, and a comfortable environment for sharing. However,

the study did not address cultural issues or protocols for addressing racial, ethnic, or cultural needs.

The rationale for using contemporary trauma theory was to enhance the understanding of how African American women with a self-reported history of trauma and co-occurring disorders of SUD and PTSD defined the role of trauma in their treatment experiences. This study explored sociocultural factors influencing treatment engagement by examining the participants' narratives. The study participants' perceptions of how trauma experiences affected their engagement in treatment provided valuable insights.

Chapter 2: Literature Review

The research study's literature allowed the researcher to provide a thorough background of the topic to give the audience an overview of significant findings in existing scholarly work. This literature review discussed the research on substance use disorders and post-traumatic stress disorder and trauma, African American women's engagement with outpatient treatment services, and factors impacting treatment engagement. In addition, the following section covered specific themes like the connection between post-traumatic stress disorder/ trauma and substance use disorders, help-seeking intentions and attitudes, stigmas, treatment barriers, engagement and retention, and social work practices and interventions are discussed in the following section.

The connection between substance use disorder and post-traumatic stress disorder.

Experiencing traumatic events can result in post-traumatic stress disorder, a severe mental health condition (Fitzpatrick et al., 2020). Similarly, substance use disorders, caused by drug or alcohol abuse, can negatively impact one's functioning ability. These two disorders often occur together, with half of the people with substance use disorder also having a current or past diagnosis of PTSD (Fitzpatrick et al., 2020; Giddier et al.,2019; Wiechelt & Straussner, 2015) as patients with substance use disorders also have a high prevalence of PTSD. Individuals who have both PTSD and SUD often have a complex clinical condition, may not respond well to standard interventions for substance use disorder, and may have worse treatment results compared to those who only have one of these conditions (Gidzgier et al.,2019; Wiechelt & Straussner, 2015). Research studies have suggested that patients with concurrent substance use and post-traumatic stress disorders will return to using substances to manage their PTSD symptoms unless trauma issues are addressed in the context of their substance abuse (Brown et al., 1998). PTSD symptoms can lead to using substances to reconnect with others, exacerbating PTSD symptoms (Dass-Brailsford & Myrick, 2010).

Studies have shown that women with post-traumatic stress disorder (PTSD) are 15 times more likely to have drug and alcohol use and seven times more likely to use drugs alone (Sullivan et al., 2016). According to Fitzpatrick et al. (2020), half of individuals with substance use disorders have a current or lifetime diagnosis of PTSD, as PTSD is prevalent in patients with substance use disorders. In a study of 42 patients, Brown et al. (1998) found that patients perceived substance use and PTSD as functionally related, and improvement in one disorder often corresponded with improvement in the

other. Brown et al. (1998) argued that it is vital to identify and treat concurrent PTSD to avoid perpetuating negative emotions such as shame, blame, and mistrust.

Studies consistently show a significant correlation between substance use disorders and post-traumatic stress disorders (Ruglass et al., 2017; Dass-Brailsford et al., 2010). Therefore, it is vital to educate treatment staff on the connection between PTSD and SUDs and recognize the signs and symptoms of trauma (SAMHSA, 2014).

The relationship between trauma and addiction

People who have experienced trauma are more likely to engage in addictive behaviors, substance abuse, and other risky activities. Trauma can also impact how individuals with mental health disorders respond to illness and interact with healthcare services, as Isobel et al. (2020) noted. African American women have a higher risk of experiencing trauma and developing post-traumatic stress disorder and problematic substance use than the general population, as reported by Bauer et al. (2022) and Hien et al. (2020). Fitzpatrick et al. (2020) also noted that specific characteristics of traumatic experiences, such as the age of the first trauma and the number of traumas, can impede PTSD symptom reduction during treatment.

Edwards, Peterson, Chan, Anderson, & Helfand (2017) conducted a qualitative study with 28 women on the impact of interpersonal trauma and co-occurring substance use on recovery, identifying four key themes. The researchers suggested fractured foundations consist of childhood abuse and multiple forms of trauma, the pervasiveness of normalizing substance use and domestic violence, and identified intersections of substance use and domestic violence where substances were used as a coping mechanism

for domestic violence. The researchers argue that these critical themes can improve understanding of how substance use and trauma, specifically domestic violence, intersect and further impact how women with trauma and substance use engage in services designed to promote recovery. They argue for more trauma-informed services models where the principles of trauma-informed services are thoughtfully implemented (SAMHSA, 2014). Research shows that a trauma-informed care model is crucial for women with trauma and substance use issues to achieve sustainable recovery. This finding is supported by numerous studies, including Pemberton & Loeb (2020) and Wiechelt & Straussner (2015). Implementing trauma-informed care models and establishing positive therapeutic relationships between clients and professionals is essential to achieve this.

African American women and substance use disorders, PTSD, and trauma

Historically, prevention treatment has mainly focused on racial, ethnic, and sexual minorities, neglecting the perspective of African American women (Blume, 2016; Gielen et al., 2016; Jones et al., 2019; Curtis-Boles et al., 2000). Eighty percent of women who seek substance use disorder treatment do not reveal their history of trauma (Meshberg-Cohen et al., 2016; Torchalla et al., 2012; Brown et al., 1998). Traditional substance use treatment models cater to men (Covington, 2008), leaving the gender and cultural needs of minority women unmet. Women with post-traumatic stress disorder are 15 times more likely to have drug and alcohol use co-occurring and seven times more likely to use drugs alone (Sullivan et al., 2016). Some researchers have found that African Americans have

higher rates of post-traumatic stress disorder than their white counterparts (Alim et al., 2006).

A study by Alim et al. (2006) explored trauma exposure and prevalence in African Americans and discovered that post-traumatic stress disorders were often misdiagnosed or underdiagnosed. In another study by Meshberg-Cohen et al. (2016) involving 104 African American women, it was found that minority women experienced trauma at a higher rate and were less likely to share their trauma history due to mistrust of providers and their lack of sensitivity and cultural awareness. As a result, these factors led to poorer treatment outcomes.

Similarly, A study conducted by Giordano, Prosek, Stamman, Callahan, Loseu, et al. (2016) examined how common trauma is among women in substance abuse treatment. They found that 80% of the women they studied did not disclose a diagnosis of post-traumatic stress disorder, which suggests that this condition is often overlooked. In addition, Torchalla et al. (2012) claim that African American women are more likely to experience trauma, and post-traumatic stress disorder is often underdiagnosed in the African American community.

Each of these studies shows the importance of simultaneously addressing substance use, post-traumatic stress disorder, and trauma when serving African American women with SUD and co-occurring PTSD. Furthermore, the research reinforces the cultural principle of SAMHSA, where ethnic identity can protect against trauma. This knowledge can help healthcare professionals broaden their comprehension of the impact

of trauma on African American women (Watson et al., 2016), emphasizing the need for innovative treatments to help this vulnerable population.

Help-Seeking intentions and attitudes

African American women have been reluctant to seek treatment or underutilize mental health resources (Abrams et al., 2019; Burkett, 2017; Pullen & Oser, 2014). In some cultures, it may be discouraged or encouraged to share personal problems and seek help. Some may view personal problems as private matters and prefer to solve them independently to avoid outside interference due to feelings of pride, shame, or embarrassment (Lacey et al., 2021). Culturally relevant factors that impact health services have been understudied among marginalized groups (Pullen et al., 2014) may be why some ethnic groups do not seek help (Lacey et al., 2021).

There are several reasons why African American women may be hesitant to seek formal help, such as a history of discriminatory practices that have created a sense of distrust. Studies have also revealed that Black women experience higher rates of violence compared to other racial groups (Montgomery et al., 2017; Anyikwa, 2015), and yet they are less likely to seek help (Abrams et al., 2019; Montgomery et al., 2017; Abrams et al., 2019; Anyikwa, 2015; Pullen et al., 2014). When seeking formal services, African Americans often face systematic oppression and institutional and structural disparities, making navigating the process more challenging (Burkett, 2017).

A recent study by Lacey et al. (2021) investigated help-seeking habits and other factors affecting Black women. The researchers discovered that Black women often prefer to handle their problems independently, believing that the situation will eventually

improve or that treatment may not be effective. Additionally, the study found that sociodemographic factors can serve as obstacles to seeking help. In a 2015 study by Anyikwa, the intersectionality of race, ethnicity, class, and gender was examined to understand the help-seeking behaviors of 110 Black women. The study found that race hindered seeking formal help, while resiliency was a barrier to seeking informal help. Half the women worried about how they would be treated and the fear of failing. However, they received support from other women, engaged in prayer, attended religious services, and sought help from the minister's wife. Each study shows the need for responsive treatment considering gender and sociocultural factors that impact African American women's attitudes toward seeking help. These studies underline the significance of adhering to SAMHSA's cultural and peer support principles (SAMHSA, 2014).

Stigmas

Stigma refers to the negative perception or stereotype of individuals or groups who exhibit characteristics or behaviors that deviate from social norms (Ahmedani, 2011). Stigma is when someone is discredited, devalued, or shamed because of their characteristics or attributes, which can result in a person feeling isolated, rejected, marginalized, or discriminated against (Ahmedani, 2011; Crapanzano et al., 2018; Matsumoto et al., 2021). Furthermore, it is essential to note that professional stigma can negatively impact the care and treatment people receive, affecting their overall well-being and recovery (Crapanzano et al., 2018).

It is worth mentioning that substance use disorders are highly stigmatized and challenging to treat (Crapanzano et al., 2018). Individuals with substance use disorders co-occurring with post-traumatic stress disorder experience a lot of public stigma and discrimination (Matsumoto et al., 2021). Individuals who require substance use or mental health services may not seek treatment, start treatment, or remain in services due to personal or professional stigma, which can pose a barrier to treatment (Washington & Brown, 2019; Hammarlund et al., 2018; Ahmedani, 2011). It is important to note that addiction stigma can harm an individual's trust by making them feel judged, labeled, or treated differently (Cockroft et al., 2019); however, stigma can negatively impact a person's recovery process, depending on the substances used and the treatment sought (Crapanzano et al., 2018). According to Ward & Heidrich (2009), stigma is the biggest obstacle because it creates systemic and individual barriers.

Ahmedani (2011) study identified three levels of stigma: social, self-stigma, and professional, to help different disciplines understand specific stigma levels and how they may develop. The author noted that social stigma is a belief that a person is inferior, embedded in the social framework that creates inferiority, causing disparities in access to services. At the self-stigma level, the individuals internalize the stigma, which can cause the person to feel stigmatized and respond with embarrassment or anger. Finally, professional-level stigma is evident when the professionals do not provide adequate intervention, early detection, or community referrals because of personal stigmatizing beliefs.

In a study by Crapanzano et al. (2019), 18 empirical articles were analyzed to see how perceived social stigma and self-stigma impact recovery from substance use disorders with formal treatment services. The findings revealed that addiction professionals hold individuals with substance use disorders in higher regard than other professionals who may unknowingly increase stigma through treatment protocols.
In a study by Hammarlund et al. (2018), 64 articles were analyzed to understand how perceived social and self-stigma affect decisions to seek and enter treatment. The study revealed that stigma is not always directly perceived as worrying about others' opinions or feeling embarrassed. However, there was a connection between demographic factors that are often stigmatized and the decision to seek treatment.

The studies highlighted the need for treatment providers to mitigate the perception of stigma by providing more welcoming services and ongoing training on biases that can impact treatment outcomes. The fundamental principles of safety, trustworthiness, collaboration, empowerment, and culture outlined by SAMHSA can also help mitigate stigmas (SAMHSA, 2014).

Treatment Barriers

Concurrent mental illness and substance use disorders (SUDs) pose unique challenges for individuals seeking treatment, as symptoms associated with both conditions can exacerbate vulnerability and function as barriers to accessing appropriate care (Priester et al. et al., 2016). A literature review found that several factors contribute to treatment barriers, including access barriers such as geographic location, transportation, and insurance coverage (Redmond et al., 2020; Ward et al., 2009). Other

barriers to treatment include the availability of services, system-related issues, cultural factors, personal beliefs and attitudes, and professional barriers (Blakely et al.,2014; Browne et al., 2016). Structural barriers, such as limited resources and inadequate funding, also contribute to the challenge of providing adequate care for individuals with concurrent mental illness and SUDs (Priester et al., 2016; Schuler et al., 2015; Ward et al., 2009).

Financial constraints can further limit access to treatment, while Bias and stigma associated with mental illness and addiction can make it harder to access proper care (Jones et al., 2015; Browne et al., 2016; Schuler et al., 2015; Ward et al., 2009). Several factors can affect a person's ability to participate in treatment, including their readiness for change, access to technology for client services, agencies' functioning, conflicting views between wellness and illness, and mistrust (Schuler et al., 2015; Ward et al., 2009; Browne et al., 2016; Jones et al., 2015).

African American women are more likely to face obstacles to their readiness for treatment rather than issues related to accessing the treatment system. As a result, they may encounter difficulties when attempting to participate in and maintain treatment for substance use disorders (Redmond et al., 2020). A study conducted by Redmond et al. in 2020 focused on the obstacles African American women face when seeking treatment for substance use disorders. These themes emerged: treatment readiness, access, and system-related barriers. Treatment-related barriers were associated with personal and interpersonal reasons for delayed treatment; access-related barriers were linked with social-environmental issues, including financial or lack of nearby facilities. Finally,

system-related barriers were related to the treatment center's inability to address needs or a disconnect with the therapist/staff.

Similarly, a study conducted by Priester et al. (2016) found that people with co-occurring disorders face various obstacles when accessing treatment. These barriers include the availability of services, identification, service provision, and insurance coverage. The study identified two primary types of barriers: personal characteristics and structural barriers. The authors noted that people from low socioeconomic backgrounds and racial/ethnic minorities have high rates of under-identification of mental health and substance use disorders due to insufficient training in identification**.** Service provision had various barriers, such as long waitlists, complicated enrollment procedures, and unwelcoming environments for clients. Mental health services were more likely to be covered by insurance than substance use treatment, which puts those with substance use disorders at risk of being undiagnosed and untreated (Priester et al., 2016).

An earlier study by Schuler et al. (2015) found that the attitudinal barrier was the most reported barrier to seeking treatment. Schuler et al. (2015) examined factors associated with perceived need and treatment-seeking and found that attitudinal barriers were reported by 19% of the sample, 14% reported financial, and less than 10% reported structural barriers. The study conducted by Ward et al. (2009) focused on the beliefs of fifteen African American women regarding mental illness, coping, and treatment-seeking. The study revealed that barriers to seeking treatment included limited access to care, societal stigma, and inadequate awareness of mental illness. These barriers can be categorized into system-level barriers, such as lack of insurance, limited service

availability, social issues, inadequate quality of care, and cultural mismatches. Additionally, individual-level barriers include internalized stigma, feelings of shame and embarrassment, insufficient knowledge about mental illness, and cultural norms that could pose challenges for African American women seeking treatment.

The studies highlight the need for identifying barriers to treatment when providing services to African American women dealing with SUD and co-occurring PTSD. In addition, these studies show how important it is to assess treatment barriers, particularly for African American women, when engaging them in treatment programs because these barriers can impact their remaining engaged in treatment, completion, and ongoing recovery progress (Redmond et al., 2020).

Treatment engagement

When co-occurring disorders are not treated or identified, engaging in treatment, building a therapeutic relationship, and following treatment plans become more challenging (Priester et al., 2016). In addition, Clients who are at a higher risk of dropping out of treatment programs often have more severe drug problems, lack legal pressure, experience more psychological problems, have greater psychiatric severity, lower motivation for treatment, and a lack of social support (Amaro et al., 2007).

In 2020, Dillon, Kedia, Isehunwa, and Sharma conducted a study to identify the reasons why 30 people with substance use disorders sought treatment. The study showed that people's decision to seek treatment was affected by their beliefs about how severe their addiction was, how effective the treatment program would be, and their ability to use the tools and resources provided. The authors also recommended using peer

graduates as positive examples to encourage people to participate in treatment. A study by Yang, Perkins, and Stearns (2018) analyzed the treatment engagement of 60 clients receiving SUD treatment. The study identified four key themes: perceived treatment needs, trust, rapport with the counselor, peer inspiration, and organizational barriers to treatment engagement. 1) Recognizing one's treatment needs can either help or hinder engagement in treatment. Recognizing a need resulted in more involvement, whereas not perceiving a need postponed involvement.2) Trust in the counselor and their support were critical factors in facilitating treatment engagement. 3) Building empathic bonds with peers can also lead to greater engagement in treatment. 4) Barriers to treatment engagement included organizational issues such as needing treatment options, gender-specific treatment, and ineffective communication with non-clinical staff.

According to Yang et al. (2018), treatment engagement can be improved by increasing motivation for treatment and building rapport with counselors, implementing gender-responsive programs, and providing staff training. Both studies highlighted the need for building rapport and improving motivation when providing intervention services for African American women dealing with SUD and co-occurring PTSD. In addition, SAMHSA's principles of safety, trust, peer support, and empowerment can enhance treatment engagement (SAMHSA, 2014).

Retention

According to a study by Reif, Stewart, Torres, Davis, Dana & Ritter (2021), individuals frequently drop out of treatment for substance abuse during the beginning stages. The study highlights the importance of implementing retention strategies.

Shockingly, half of those who start treatment leave early, putting them at higher risk of relapse (Amaro & Black, 2017). Women undergoing multiple substance abuse treatment episodes are likelier to drop out. In contrast, those mandated for treatment and those with moderate prior treatment episodes tend to have higher retention rates (Amaro et al., 2007). Blume's (2016) study among racial, ethnic, and sexual minorities revealed that intervening at the level of treatment is promising for improving treatment outcomes with minorities. Cultural sensitivity among treatment professionals has also been associated with higher retention rates and less service wait time (Blume, 2016).

A study conducted by Black & Amaro in 2019 assessed the effectiveness of Moment-by-Moment in Women's Recovery (MMWR) on 200 women who had a substance use disorder. The study aimed to determine the impact of MMWR on treatment retention and discovered a positive correlation between MMWR class attendance and improved mindfulness and distress tolerance. The study defined retention differences as the time a patient takes to complete treatment only after progressing toward achieving their goals. Additionally, the study looked at self-reported changes in mindfulness, perceived stress, distress tolerance, emotion regulation, distress, affect, and drug craving as mechanisms of action for the intervention (Black & Amaro, 2019). By day 150, 74 (37%) people had completed treatment, 42 (21%) were still in residential treatment, 26 (13%) did not complete but made satisfactory progress, and 58 (29%) did not complete and did not make satisfactory progress.

Montgomery et al. (2017) conducted a coed study with 194 African Americans to examine whether changes in readiness to change (RTC) over time affected retention.

Their findings revealed a significant relationship between changes in RTC and retention. They also explored whether gender played a moderating role in this relationship. In addition, the findings revealed that participants who were more willing to change stayed in treatment for a more extended time. However, the researchers were primarily concerned with improving treatment retention rates for men rather than women.

Impact of sociocultural factors in help-seeking and treatment engagement

Sociocultural factors shape how individuals view and perceive the world and other people around them. They are synonymous with the traditions, patterns, and beliefs unique to a community or any other population group. They drive decision-making, influence people's behavior, and respond to different circumstances and contexts. Culture played a role in shaping the participant's decision-making process to enter and remain in treatment. There is limited literature explicitly targeting African American women that focuses on sociocultural issues related to help-seeking, motivation for entering and remaining in treatment, and challenges in recovery.

Campbell and Long's (2014) study investigated the impact of cultural beliefs on help-seeking behaviors and the use of mental health services in four specific areas: perceptions of depression, whom individuals confide in about depression, beliefs about help for depression, and views on treatment options. The study found that these cultural beliefs often discourage African Americans from seeking mental health services. The authors emphasized the significant role of culture and culturally shaped beliefs in

shaping mental health, help-seeking, and treatment behaviors, emphasizing the need for a culturally sensitive approach in mental health care to foster empathy and understanding.

Watson-Singleton, Black, & Spivey's (2019) qualitative study modified Brigg's (2011) mental health utilization logic model to develop a culturally responsive mindfulness-based intervention. The study focused on three primary factors that contributed to the underutilization of services: factors internal to the mental health system (e.g., lack of culturally relevant services); factors external to the mental health system (e.g., limited financial resources for services); and individual level factors (e.g., cultural mistrust). The study underscores the underutilization of services and engages them in behavioral health interventions to address African American women. Modifications included using African American facilitators, incorporating cultural values into the content, employing terminology that resonates culturally, and providing resources tailored to their specific cultural context to improve the effectiveness of these interventions. The findings regarding internal factors revealed a need for African American facilitators, a curriculum that reflected cultural values and culturally familiar language, and culturally relevant supplementary aids. For external factors, the study found that interventions provided in culturally familiar spaces, like churches, can increase engagement. On the individual level, respondents suggested addressing religious concerns and focusing on holistic health.

Similarly, a study by Mays, Caldwell, & Jackson (1996) explored the role of sociodemographics, social support, and sociocultural characteristics in African American women's use of community mental health centers and private psychotherapists. The study

examined the importance of sociocultural factors such as religiosity, ethnic group consciousness, preference for Black therapists, and cultural sources of social support, which are the culturally specific ways African American women seek and receive support from their communities.

Research suggests a need for culturally responsive treatment alterations to improve engagement among African Americans (Watson-Singleton, Black, & Spivey, 2019, Campbell & Long, 2014, Mays, Caldwell, & Jackson, 1996).

Interventions along the continuum of substance use disorder treatment

Outpatient Treatment

Addiction treatment has four levels of care, ranging from outpatient services (Level I) to intensive inpatient care (Level IV). Clinicians use the American Society for Addiction Medicine (ASAM) criteria to assess which level of care is best for an individual. This study will specifically focus on outpatient treatment services (Level I). Community-based outpatient treatment is the most popular form of addiction treatment. It involves weekly counseling sessions that can be done individually, in a group, or with family members. The treatment program is tailored to the specific needs of each individual and includes a range of therapies such as 12-step programs, life skills training, anger management, and relapse prevention. Different therapeutic techniques are also used, including cognitive-behavioral therapy, contingency management, motivational enhancement therapy, and self-help/mutual-help groups based on the twelve-step program.

A pilot study was conducted by Carswell, Gordon, Gryczynski & Tangires in 2018, which involved 15 substance use disorder clients enrolled in outpatient substance abuse treatment. The study examined the feasibility of a telephone-based software program called Daily Progress System (DPS), which used interactive voice response (IVR) to track substance use and involvement in recovery support activities. The results showed that 65% of the participants completed daily call-ins, indicating that DPS was feasible in addressing relapse and treatment engagement. Both clients and counselors were satisfied with the system. The authors believe this approach could change basic assumptions, improving the quality of care and client outcomes in outpatient treatment. This study can potentially inform clinical service delivery in substance abuse treatment.

According to recent research, outpatient treatment is effective for treating substance use disorders. A 2018 study showed that individuals who received outpatient treatment were more likely to achieve abstinence than those who did not receive or receive inpatient treatment (Hser et al., 2018). Additionally, another study demonstrated that outpatient treatment effectively reduced substance use and improved mental health outcomes for adolescents with substance use disorders (Substance Abuse and Mental Health Services Administration, 2017). However, according to Carswell, Gordon, Gryczynski & Tangires (2018), It is common for individuals to experience relapse and stop attending outpatient substance use treatment.

Integrated Treatment

There is a need for integrated treatment to address substance use, post-traumatic stress disorder, trauma, and recovery (Sullivan, Weiss, Flanagan, Willie, Armeli &

Tennen, 2016). Integrated trauma treatments that address women's co-occurring concerns are more effective than treatments that focus separately on trauma, substance use, or mental health (Masin-Moyer, Kim, Engstrom & Solomon, 2020). There is a consensus that integrated treatment is the most appropriate model for treating co-occurring disorders as opposed to traditional treatment (Amaro et al., 2007; Hien et al., 2020). Most studies found that integrated treatment programs reduced substance use, post-traumatic stress disorder, and other mental health symptoms from baseline to follow-up (Torchalla et al., 2012).

Sullivan et al. (2016) study explored integrated programs that supported women's health, prevented substance use, facilitated post-traumatic stress disorder and substance use recovery, and found that women with a history of post-traumatic stress disorder and trauma will benefit from gender-specific integrated treatment and programs. Torchalla et al. (2012) investigated if integrated treatment programs effectively reduced trauma symptoms and substance use more than traditional programs and found that several integrated treatment programs had greater intensity, frequency, and duration than non-integrated treatment programs. However, the reviews did not find evidence that integrated treatment programs were superior to non-integrated treatment programs. Gielen, Krumeich, Havermans, Smeets & Jansen (2014) argued that clinicians should be trained to provide integrated treatment for trauma and substance abuse disorders simultaneously. Research shows that addressing substance use, post-traumatic stress disorder, trauma, and recovery through integrated treatment is necessary (Sullivan et al., 2016).

Integrated trauma treatments that address women's co-occurring concerns are more effective than treating trauma, substance use, or mental health separately (Masin-Moyer et al., 2020). Experts agree that the most appropriate model for treating co-occurring disorders is through integrated treatment, as opposed to traditional treatment (Amaro et al., 2007; Hien et al., 2020). Studies have found that integrated treatment programs significantly reduce substance use, post-traumatic stress disorder, and other mental health symptoms from baseline to follow-up (Torchalla et al., 2012). Ward et al. (2009) noted a shortage of specialized services for individuals with co-occurring disorders and that practitioners may unintentionally overlook the co-occurrence of mental health and substance use disorders.

When African American women seek substance use disorder (SUD) treatment, practitioners should conduct assessments to screen for trauma exposure, substance use, and PTSD symptoms. These assessments should be followed by referrals to integrated treatment services catering to their specific needs (Meshberg-Cohen et al., 2016; Kobulsky et al., 2016; Torchalla et al., 2012). Research indicates that gathering trauma-related details during the initial client interview is crucial. It is also essential to treat both disorders in a gender-specific environment.

Trauma-Informed Care

Social workers who practice trauma-informed care prioritize the needs of their clients by building trust, promoting safety, showing respect, collaborating, instilling hope, and sharing power (Levenson, 2020; Pemberton & Loeb, 2020; Giordano et al., 2016). By recognizing the impact of trauma, understanding its symptoms, and integrating

this knowledge into their services, social workers can effectively address client problems and promote healing (Levenson, 2020). Trauma-specific services aim to treat the after-effects of sexual or physical abuse by meeting the needs of individuals aware of their trauma history rather than just treating their symptoms (Harris & Fallot, 2001).

Harris & Fallot's (2001) identified five requirements to create a trauma-informed care system. These include integrating knowledge about violence and abuse into service delivery, conducting universal screenings of individuals seeking services to determine if they have a history of trauma, training and educating all staff members on information about trauma, hiring workers and clinicians who have a basic understanding of trauma, and reviewing policies and procedures that may be harmful or hurtful to consumers. These five requirements align with SAMHSA's guidance for implementing a trauma-informed approach, which involves training, screening, and integrating policies to reflect trauma-informed principles (SAMHSA, 2014).

Similarly, Levenson's (2020) article outlines ten trauma-informed practices to implement trauma-informed care. This involves understanding the client's struggles, strengths, and ways of coping and responding to avoid re-traumatization. By viewing and responding to the problem through a trauma lens, trauma-informed care fosters trust, respect, collaboration, compassion, and genuineness. This approach cultivates self-efficacy and promotes healthy psychosocial functioning (Levenson, 2020). According to Gielen et al. (2014), coping skills are crucial for recovery, but women with post-traumatic stress disorder and substance use disorder do not benefit from treatment when the trauma is not addressed.

Many agencies have adopted trauma-informed care initiatives but found infusing the concepts into service delivery challenging (Levenson, 2020). Blakely & Bowers (2014) pointed out obstacles that prevent substance abuse treatment providers and professional staff from adopting an integrated approach to treating substance abuse and trauma. They also noted that failure to provide integrated treatment may result in low retention and poor outcomes. These studies emphasize the importance of providing integrated treatment to African American women to ensure their engagement in treatment. Clinicians may not screen for trauma because they lack awareness of its impact. PTSD and SUD often occur together, making them difficult to treat and associated with poorer outcomes. While several psychological therapies exist to treat comorbidity, there is no agreement on the most effective approach.

Cognitive Behavioral Treatment

One of the most effective interventions for substance use disorders and post-traumatic stress disorders is cognitive-behavioral treatment (CBT). This treatment aims to reduce anxiety and avoidance related to trauma memories by correcting dysfunctional thoughts, which in turn reduces intrusive symptoms (Dass-Brailsford & Myrick, 2010; Vujanovic et al., 2020; Black & Amaro, 2019; Amaro & Black, 2017). In addition, Giordano et al. (2016) note that trauma-informed care fosters Safety, trustworthiness, choice, collaboration, and empowerment. There are various methods of treatment available, including Seeking Safety, Trauma Recovery and Empowerment Model (TREM), Addictions and Trauma Integration Model, 12-step programs, motivational

interviewing (Livingston et al., 2012), Cognitive-behavioral treatment (Black & Amaro, 2019; Amaro & Black, 2017), and Mindfulness (Vujanovic et al., 2020).

The mindfulness model suggests that individuals with substance use disorders and post-traumatic stress disorders may develop symptoms related to substance use and trauma to avoid negative emotions and physical symptoms associated with withdrawal and traumatic events (Vujanovic et al., 2020). Amaro & Black (2017) developed and piloted a mindfulness-based intervention, Moment-by-Moment in Women's Recovery (MMWR) was created to assist women with substance use disorder while they are receiving residential treatment. The goal of this program is to reduce the rate of dropout and relapse among ethnically diverse women. In a study conducted by Vujanovic et al. (2020), it was suggested that mindfulness may predict post-traumatic stress disorder outcomes. The study found that those with higher levels of mindfulness before treatment had less severe PTSD symptoms after treatment. However, it was noted that participants could not maintain abstinence from substance use. In addition, mindfulness was not related to post-traumatic stress disorder avoidance.

Treatment programs specific to gender focus on the unique issues faced by individuals of that gender and utilize approaches based on feminist principles. The Helping Women Recover program (HWR) is designed specifically for women and can be used in residential and outpatient settings. It combines treatment for trauma and addiction with a focus on developing the self, building healthy relationships, exploring sexuality, and nurturing spirituality (Covington, 1999). According to a study conducted in 2020 by Hien et al., community treatment programs were advised to train their staff to identify

and provide trauma-related services. Seeking Safety was included in the treatment programs of four out of five sites. Despite limited resources, these agencies continued to use Seeking Safety—three of the sites provided Seeking Safety training to other agencies and committed to delivering skills-based trauma treatment to female patients with substance use disorders, trauma histories, and other affected groups. Seeking Safety by Najavits (2002) is a popular integrated treatment program utilized in substance abuse agencies to promote clients' Safety while managing SUD and PTSD. Gender-based programs are crucial to ensure women remain engaged in services, as those treated in a women-only program tend to have higher completion rates than those in diverse settings.

Treating members of specific groups, we sometimes fail to acknowledge their diverse identities, such as age, social class, ethnicity, religious beliefs, and sexual orientation. This "one-size-fits-all" approach can be ineffective (Brown, 2008). Brown (2008) analyzed trauma definitions using culturally aware practice models and proposed alternate ways of defining and understanding trauma. The Betrayal Trauma (BT) model explains how interpersonal and psychosocial dynamics can cause a traumatic event, regardless of whether physical Safety is threatened. Brown emphasized the importance for practitioners to feel safe and supported as allies so that their ability to cope with painful experiences is not disrupted.

TREM is a group therapy method created for women that simultaneously targets interpersonal trauma, mental health issues, and substance use disorders. It is based on feminist and relational theories and relies on four key beliefs about trauma and recovery (Masin-Moyer et al., 2020; Fallot & Harris, 2002). Fallot, McHugo, Harris & Xie's

(2011) study evaluated the TREM Model with 250 women trauma survivors compared with a group that received the usual services. The investigators discovered that participants in the TREM program could significantly reduce the severity of their alcohol and drug abuse and their symptoms of anxiety and exposure to stressful events. Additionally, they reported feeling safer and experiencing positive improvements in recovering from trauma.

A similar study by Masin-Moyer et al. (2020) revealed that the Trauma Recovery and Empowerment Model (TREM) effectively improved PTSD and psychological distress in adult women. The number of TREM sessions attended positively correlated with enhanced trauma recovery skills, reduced post-traumatic stress, mental health, and drug severity. Additionally, it has been discovered that TREM adaptations based on spiritual attachment effectively produce multiple positive outcomes.

Spirituality

Spirituality is a personal quest to discover answers to life's profound questions, such as the meaning of one's existence, purpose, and relationship with a higher power or divine force (Hipolito et al., 2014). Research indicates that spirituality is an essential aspect of the lives of African American women. It has been shown to function as a protective factor in post-trauma situations. Despite this, there has been limited exploration into how this process happens (Stevens-Watkins et al., 2014). The 12 Step recovery program focuses on spirituality. It encourages individuals to develop a stronger connection with a higher power through prayer and meditation, reading recovery literature, and engaging in spiritual beliefs and practices (Williams et al., 2019). In

contrast, Herman (1997) stated that Alcoholics Anonymous recovery programs focus on powerlessness rather than choice, which can worsen trauma symptoms because powerlessness and loss of control are common reactions to abuse.

A study conducted by Williams-Woodson et al. in 2019 analyzed the religious and spiritual practices of 106 African American women living in urban areas. The study revealed that women were more inclined to engage in religious practices and utilize spirituality to cope with emotional pain. Similarly, Blakey (2016) studied 26 African American women who had experienced trauma and substance abuse. The findings showed that all women had undergone two or more traumatic events. The study also identified four spiritual strategies facilitating healing and recovery, including reclaiming spirituality, finding meaning, trusting the process, and active faith. These strategies aimed to help women reconnect with their spiritual practices, find purpose, develop trust, and surrender, and rely on their faith instead of turning to drugs.

According to Blakey (2016) and Stevens-Watkins et al. (2014), some women use spiritual practices like prayer, meditation, and worship to manage their trauma. In a study by Ward et al. (2009), participants preferred prayer and counseling as coping strategies instead of medication. Similarly, in the study by Hipolito et al. (2014), counseling was preferred as a treatment strategy over medication. The investigators examined private religious practices, daily spiritual experiences, and daily interaction with a higher power and recommended supporting the inclusion of spirituality.

These studies identified the importance of including and supporting spirituality as an intervention in practice protocols. African American women rely on spirituality to

cope with different forms of trauma (Hipolito et al., 2014; Stevens-Watkins et al., 2014). Social workers need to recognize that clients' spiritual beliefs can impact their recovery, either positively or negatively. However, it is also important to acknowledge that not all women are interested in pursuing a spiritual path (Blakey, 2016).

Summary and Conclusion

The literature identified significant themes related to substance use disorders and post-traumatic stress disorders among African American women. These themes included the impact of trauma, stigma, help-seeking intentions, treatment retention, and social work practices. It is vital to delve deeper into African American women's trauma experiences and why they may not seek services or struggle to stay in them. Understanding these barriers is crucial for providing adequate support.

The literature identified numerous barriers to treatment that included the availability of services, personal, professional, structural, readiness for change, financial, treatment readiness, and cultural factors that can impact African American women from seeking treatment and remaining engaged in treatment services (Priester et al., 2016; Redmond et al., 2020; Ward et al., 2009; Browne et al., 2016; Blakely et al.,2014; Schuler et al., 2015; Jones et al., 2015; Matsumoto et al., 2021). Not seeking help may be a cultural factor for some ethnic groups; however, according to Anyikwa's (2015) study, no evidence supports the belief that Black women are less likely to seek help. Therefore, social workers should allow women to identify the treatment barriers they experience, providing insight into increasing admission rates and changing underrepresentation (Allen, 1995).

Integrated treatment practice is effective for women with co-occurring disorders (Blakey & Grocher, 2020; Blakely & Bowers, 2014) and should begin by identifying the program's structure, milieu, assessment, treatment, staffing, training, and continuity of care (Blakely & Bowers,2014). Dillon et al. (2020) suggest that helping clients understand the severity of their substance use disorder using an integrated treatment approach can simultaneously address trauma and comorbidities. Several integrated treatment programs have been developed over the years that offer evidence of reducing the symptoms of both disorders, such as motivational interviewing, cognitive-behavioral therapy, contingency management, relapse prevention, and Self-help groups.

In Chapter 2, I presented a brief introduction, an overview of the database, and key search terms utilized in the literature search strategy. Additionally, I discussed the theoretical framework, the history of trauma, applications of contemporary trauma theory, and included a literature review.

In Chapter 3, I will discuss the methods, including the introduction, the researcher's role, instrumentation, recruitment procedures, participation, data collection, and the plan for data analysis. I will explain the rationale for selecting a generic qualitative design using a narrative lens. In addition, this chapter will discuss the components of trustworthiness in qualitative research, including credibility, dependability, confirmability, and transferability, which are essential in evaluating the authenticity of the study (Bloomberg & Volpe, 2018). I will also address the ethical procedures.

Chapter 3: Research Method

Introduction

Studies have shown that African American women are more likely to experience trauma than any other group (Blakey & Grocher, 2020) and may minimize symptoms when seeking treatment (Shields et al., 2015). However, numerous studies have supported the premise that cultural barriers, guardedness, shame, and lack of trust in healthcare providers can prevent African American women with substance use disorders from disclosing their trauma history (Blakey & Grocher, 2020; Danzer et al., 2016; Meshberg-Cohen et al., 2016; Carter & Sant-Banket, 2015; Torchalla et al., 2012). This reluctance to share can lead to poorer treatment outcomes and a higher severity of addiction, especially when post-traumatic stress disorder (PTSD) is present.

Research focusing specifically on African American women as the main subject of prevention and intervention studies (Blume, 2016) or their experiences and beliefs of trauma when seeking outpatient treatment services (Jones et al., 2015) is limited. To better understand how trauma impacts African American women's ability to engage in and complete treatment, it is essential to examine the perspectives of those who have undergone treatment multiple times.

This study aimed to examine the beliefs of trauma and the role of trauma during treatment experiences among African American women over 31 with self-reported co-occurring post-traumatic stress and substance use disorders. Furthermore, the study identified sociocultural factors that influenced this population's decision to seek and remain in treatment.

This study sought to better understand how African American women with substance use and post-traumatic stress disorder perceived their trauma and willingness to engage in treatment. This study explored how trauma affected their access to treatment, sustained recovery, and the need for culturally sensitive trauma-informed services. Through this qualitative inquiry, practitioners can gain a broader understanding of the impact of trauma on culture and co-occurring disorders in African American women.

In this chapter, I introduced the method for this generic qualitative approach framed through a narrative lens. I explained the reasoning behind the research design, the role of the researcher, the research questions, the study participants, the setting, data collection methods, analysis strategies, ethical considerations, and potential ethical concerns.

Research Design and Rationale

Qualitative research delves into how people interpret and assign meaning to a social problem (Creswell & Creswell, 2017). Qualitative studies explore how individuals perceive and interact with a phenomenon (Creswell & Creswell, 2017). Qualitative research involves collecting and analyzing data to understand how people experience the world (Terrell, 2016). Generic qualitative research involves collecting stories from individual participants through interviews and observations (Terrell, 2016). The generic qualitative study design is broad, inductive, richly descriptive, flexible, emergent, embraces many orientations and approaches, and is not bound by a specific method (Marriam & Tisdell, 2015).

This specific research design used the generic qualitative inquiry framed through a narrative lens. Using a narrative lens allowed me to tell the participants' stories in their own words and how they make meaning of their experiences. This generic qualitative inquiry was explored from the perspective of five African American women participants over 31 years of age, currently receiving outpatient substance abuse treatment in a midwestern city. This approach is appropriate for this study to understand how the participants experienced trauma during their treatment experience and recovery by exploring and analyzing their stories, looking for insight and meaning, and interpreting the data. In addition, the women's stories provided insight into how they defined trauma during their experiences in outpatient substance abuse treatment services.

The participants' narratives were captured through face-to-face semi-structured interviews that were transcribed and analyzed for patterns and themes (Patton, 2015). The data was collected through open-ended questions to capture the participants' perspectives on how they perceived the world and the significance they attached to their experiences (Marriam & Tisdell, 2015).

Research Questions

The following research questions were intended to explore how African American women with concurrent substance use and post-traumatic stress disorders defined trauma to understand better how trauma impacted them from engaging in and completing treatment. This study sought to answer the following research questions:

1. What do the narratives of African American women over 31 years of age with self-reported co-occurring PTSD (Post Traumatic Stress Disorder) and substance

use disorders reveal about how they describe trauma during their recurrent outpatient substance use treatment experiences?

2. How do African American women with self-reported co-occurring PTSD and substance use disorders perceive their experiences with trauma and its relationship to recurrent substance use admissions and sustained recovery?
3. What socio-cultural factors do African American women with self-reported co-occurring PTSD and substance use disorders describe impacting their willingness and decision-making to seek help and stay engaged with outpatient treatment services?

Role of the Researcher

When conducting qualitative research, the researcher directly interacts with the participants from their perspective, known as an emic approach (Terrell, 2016). This type of research is personal because the researcher is the main instrument used in the inquiry process (Patton, 2015). In this study, I was the instrument of the researcher and the observer-participant while collecting and analyzing data. I utilized interview guidelines, recordings, and notes that were essential in gathering the data. The reflexive approach involves attentiveness to the research process and acknowledging potential biases (Ravitch & Carl, 2016).

To avoid prejudices or preconceived notions, I utilized reflective journaling. Bracketing was used to avoid judgment and distinguished my personal experiences from those of the participants, which helped to mitigate biases (Weatherford & Maitra, 2019). Peer debriefing and reflexive journaling aided me in staying impartial and acknowledging

any biases that I may have overlooked. As a research instrument, I had no personal or professional relationship with the participants. They were recruited through flyers posted in the facility's common areas or referred by the substance use disorder/trauma therapist. As a thank you, participants received a $10 Kroger gift card for participating in the study.

Methods

Participant Selection Logic

The inclusion criteria for this study included African American women over 31 born in the USA, a legal resident of a midwestern city, self-reporting a diagnosis of post-traumatic stress disorder and substance use disorder. They acknowledged consent to participate in the study. The cases were similar in their common characteristics, including a self-reported co-occurring disorder of post-traumatic stress disorder and substance use disorder, having at least gone for treatment in the last twelve months, and previously terminated treatment against staff advice before completion of the intended episode. Participants with similar experiences or characteristics were recruited for the study. Any potentially interested individuals that did not meet the criteria were excluded from the study.

This study used the purposeful sampling approach with a homogeneous strategy to recruit the five participants who were currently engaged in outpatient substance use treatment at a facility that provided mental health and outpatient substance abuse treatment services. Purposeful sampling is a non-random sampling of cases that meet specific criteria; are information-rich and illuminative and offer insight into the inquiry questions being investigated which allows the researcher to learn about the population

obtained from the selected participant (Terrell, 2016; Bloomberg & Volpe, 2018; Patton, 2015).

The homogeneous strategy allowed for a small selection of cases with similar trauma experiences while engaged in treatment (Patton, 2015). The recruitment of participants was deliberate as the identified population being served at the intended agency could provide information that addressed my research question and was the focus of my study. Participants over 31 years of age were more likely to engage in treatment more than once and have diverse experiences and beliefs about trauma.

Recruitment Strategy

Flyers were used to recruit participants for this study, and they were posted at an outpatient center in a midwestern city. In addition, the invitation to participate in the study was posted in the facility's public areas that consumers can access, such as hallways, the therapist's office, the group room, the waiting room, and the communication board. The researcher contacted local outpatient substance use treatment facilities that were listed as trauma-informed and received Women Specialty Program funding. The site's Chief Executive Officer permitted me access to post flyers and to interview consumers interested in participating in the study.

The facility primarily serves African American women, which provided me with a suitable platform for recruiting participants. The clinical supervisor and the Chief Executive Officer permitted the researcher to interview their stakeholders. However, these intentions were contingent on the approval of the Walden University Institutional Review Board.

Instrumentation

The narrative interview was organized into four phases: preparation, initiation, main narration, questioning phase, and concluding talk (Jovchelovitch & Bauer, 2000). The preparation stage included securing a quiet room to meet with the participant privately. The initiation phase asked the participant for permission to record the interview, which led to a self-introduction stating the purpose of the study and how long the interview would take. Informed consent was discussed with the participants, and they provided verbal acknowledgment to participate, and we addressed confidentiality to ensure that their privacy would be protected throughout the study.

The interview questions were derived from the review of literature by Redmond, Smith, & Collins (2019), a 1995 to 2018 study that explored various treatment barriers that affect the use of services among African American women seeking treatment for substance use disorder. Hien, Kropp, Wells, Campbell, Hatch-Maillette, et al. (2020) study questioned if post-traumatic stress disorder symptoms severity led to improvements in substance use disorders and whether improvements in suds led to improvements in PTSD severity. The study supported the understanding that women were disproportionately exposed to high-impact trauma and more vulnerable to developing PTSD and moving from first-time use to problematic substance use. Blakey and Grocher (2017) examined the types of relationships that African American women with trauma histories and substance use disorders had with their treatment counselors and how those relationships affected their engagement in substance abuse treatment. Blakely and Bowers (2014) conducted a study with counselors to investigate what barriers exist in

simultaneously addressing women with trauma histories and substance use. My professional experience working with African American women in residential and outpatient substance use treatment programs and community mental health agencies informed the interview questions. The interview questions elicited rich narratives and supported the women in telling their stories in their own words and making meaning of their experiences through those stories.

The following are examples of the interview questions that were developed based on the purpose of the study and the proposed research questions.

RQ1. What do the narratives of African American women over 31 years of age with co-occurring PTSD and substance use disorders reveal about how they describe trauma during their recurrent outpatient substance use treatment experiences?

1. How do you define trauma?
2. Can you tell me some examples of how you experienced trauma recently or in the past?

RQ 2: How does African American women over 31 years of age with co-occurring PTSD and substance use disorders perceive their experiences with trauma and its relationship to recurrent substance use admissions and sustained recovery?

1. Can you tell me about your last substance abuse treatment experience?
2. Can you tell me how trauma affects your ability to remain engaged in outpatient treatment?

RQ 3: What socio-cultural factors do African American women over 31 years of age with co-occurring PTSD and substance use disorders describe impacting their willingness and

decision-making to seek help and stay engaged with outpatient substance use treatment services?

1. Can you tell me about your experiences in seeking help when deciding to enroll in outpatient substance use treatment?
2. What, if any, factors made it difficult for you to remain engaged in outpatient treatment?

As part of the interview process, I provided each participant with the Community Mental Health Authority contact information if they showed the need for additional support, given the nature of the issues to be addressed during the interview and the possibility that some might be triggered emotionally. None of the participants indicated emotional distress during the interview. No incomplete interviews were used in this study.

Data Collection

I recruited five African American women over 31 years of age, residing in a midwestern city, who had enrolled in outpatient substance use treatment at least once in the past 12 months. Based on the research, many studies include African American women with other groups, the vast age range with an average of 40 years (Watson, DeBlaere, Langrehr & Zelaya, 2016; Carter & Sant-Barket, 2015; Jones, Hopson, Warner, Hardiman, & James, 2015). There are limited studies that focus on middle-aged African American women as the main interest (Meshberg-Cohen, Presseau, Thacker, Hefner & Svikis, 2016; Torchalla, Nosen, Rostam, & Allen, 2012; Davis, 1997). The middle-aged participants are more likely to engage in treatment more than once and have

diverse experiences and beliefs about trauma. This study conducted semi-structured interviews in person containing open-ended questions that focused on the participants' experiences with trauma and how it affected treatment and recovery.

The participants' stories were captured through face-to-face semi-structured interviews that were transcribed and analyzed for patterns and themes (Patton, 2015). Saturation occurred when there was no new or additional data that had already been learned or talked about in previous interviews (Guest, Bunce, & Johnson, 2006). The research questions, interview questions, and follow-up prompts provided the data.

Data Analysis Plan

The first step in analyzing narratives is to read the transcripts and identify significant experiences and details. Afterwards, a written summary was created. According to Butina (2015), the thematic analysis plan is comprised of five steps that include transcribing the audiotapes post-interview, identifying patterns or themes in the margins, manually coding to comprehend the data, and recognizing recurring words or patterns by re-reading the transcripts. Lastly, a preliminary code list is created to interpret the data.

This study used the thematic analysis process, allowing me to examine the data and identify recurring themes and meanings. The most generic form of thematic analysis includes six steps. Following the six steps can avoid confirmation bias: 1) I familiarized myself with the data, which included reading the text, taking notes, and then transcribing the audio file immediately. 2) I generated initial codes through Atlas.ti qualitative data software. 3) I generated themes by searching for patterns and grouping them into themes.

4) I reviewed the themes for accuracy. 5) I defined the themes by making a list and assigning names to the themes to analyze later. 6) I prepared a write-up based on my analysis (Caufield, 2022). This approach made sense of the participants' stories, analyzed them, and sought insight and meaning. I kept a reflective journal throughout the process, with notes and reflections connected to the data.

Issues of Trustworthiness

Credibility

When evaluating qualitative research, it is vital to consider its credibility, dependability, confirmability, and transferability as the essential criteria for determining its trustworthiness (Bloomberg & Volpe, 2018). Credibility is the confidence that the study is authentic and accurately represents the participant's perspective (Bloomberg & Volpe, 2018; Terrell, 2016). Member checks were conducted to ensure the credibility of the research. This process clarified participants' statements to ensure their responses were accurately recorded, allowing them to correct discrepancies (Bloomberg & Volpe, 2018; Terrell, 2016). Additionally, ongoing debriefing sessions were held with the chairperson to maintain the integrity of the overall process.

Transferability

Transferability applies research findings to different populations or situations (Terrell, 2016). To achieve transferability, the study provided detailed descriptions of the participants and the context in which the results were obtained. This approach ensures that the findings can be relevant in various settings. For instance, social workers, substance abuse counselors, and other providers working in women's specialty programs

can use this study's results to understand better how this population perceived trauma and what factors influenced their decisions to seek treatment or remain engaged in outpatient services.

Dependability

Dependability refers to the reliability of data over time and the ability to replicate results (Terrell, 2016). To achieve dependability, it is essential to provide a complete procedure for replicating the study, including a description of the research design, detailed data collection procedures, and documentation of any changes made during the research process (Bloomberg & Volpe, 2018; Terrell, 2016). In addition, the chair conducted an external audit verifying the accuracy of the results. This process was supported by maintaining an audit trail consisting of process logs documenting all activities and decisions made throughout the study.

Confirmability

Confirmability is how the researcher ensures neutrality in the study, and the results are based on the participant's responses and not outside influence or potential bias of the researcher (Terrell, 2016). I achieved confirmability by utilizing an audit trail to keep a step-by-step account of the study and traced activities to understand the results of the study (Bloomberg & Volpe, 2018; Terrell, 2016). Also, reflexibility aided in the continued awareness that my actions may affect the study's outcome (Bloomberg & Volpe, 2018; Terrell, 2016). Confirmability was demonstrated in the findings, which were the participants' actual experiences and were established using audit trials, which

were transparent from the data collection phase to the interpretation of the data (Bloomberg & Volpe, 2018; Terrell, 2016). The analysis is described in Chapter 4.

Peer debriefing enhances trust, boosts the project's credibility and trustworthiness, and examines potential biases and emerging issues (Spall, 1998). The peer debriefer should possess some understanding of the selected method and topic. Peer debriefing provided opportunities for learning, teamwork, and issue resolution (Spall, 1998).

Ethical Procedures

The ethical obligation is to the participant, who has a right to know the nature of the study and that their participation is voluntary (Patton, 2015). Therefore, as part of the interview procedures, I explained the following to each participant:

1. The purpose of the research and the expected duration.
2. The interview is voluntary, and the participants have a right to decline to participate or withdraw from the research at any time.
3. Potential risks and benefits of the research
4. The collected data will be treated with confidentiality.
5. The transcripts will be destroyed after the study.
6. Whom to contact for any additional questions.
7. Copies of the transcribed interview will be available upon request.

Sharing experiences of trauma during the study may be triggering for participants due to the sensitive nature of the topic. Therefore, each participant was given mental health resources to get additional support during or after participation.

The privacy of the participants, the agency's location, and other identifying information were protected by using a unique code/number throughout the interview, for example, P001, P002, P003, etc. All personal data, including analysis, was safely guarded on a password-protected computer to which I was the only person with access. The data was shared with my chair/committee and followed institutional guidelines for protecting human subjects' data. The participants were allowed to ask questions for clarity if needed before the interview questioning began. The main narration phase, interview questioning, allowed the participants to speak uninterrupted, the researcher actively listened and asked follow-up questions. The questioning phase addressed the research questions. The concluding talk was the last phase of the interview, where questions were asked.

Summary

In Chapter 3, I provided an outline for the method that included the introduction, the researcher's role, instrumentation, recruitment procedures, participation, data collection, the plan for data analysis, and the rationale for selecting a generic qualitative design using a narrative lens. This chapter discussed the components of trustworthiness in qualitative research, including credibility, dependability, confirmability, and transferability, which are essential in evaluating the authenticity of the study (Bloomberg & Volpe, 2018).

The sample consisted of five African American women over 31 years of age with self-reported diagnoses of post-traumatic stress and substance use disorders. Participants were recruited via a flyer at the facility informing them about the study with contact information. Individuals who met the inclusion criteria were contacted by the researcher

and scheduled for an interview. The participants were informed about the study's purpose, risks, benefits, and the right to stop participation during the informed consent process. The participants' privacy was protected using a unique identifier, and I stored the data on a password-protected computer that only the researcher had access to. The interview protocol was used to gather data from the semi-structured interview that was transcribed and analyzed for patterns and themes. The thematic analysis is consistent with this generic qualitative inquiry (Butina, 2015).

In Chapter 4, I will present the introduction, describe the setting, the demographic characteristics of the study participants, the data collection and analysis methods, the trustworthiness of the findings, and the results.

Chapter 4: Results

Introduction

The purpose of this qualitative study was to explore the treatment experiences of African American women over the age of 31 who self-reported co-occurring substance use disorder and PTSD while engaged in outpatient treatment services. The study aimed to understand how this population defines trauma, their perceptions of the role of trauma in their treatment experiences, and the sociocultural factors that influence their decisions to seek help and remain engaged in outpatient treatment services.

The following research questions were designed to support the study's goal of understanding the experiences of African American women over the age of 31 who self-report co-occurring substance use disorders and PTSD and who are engaged in outpatient substance use treatment services. The study focused on how these women perceived trauma and the factors that influenced their decisions to seek help and remain engaged in treatment. The specific research questions addressed in this study are:

RQ1: What do the narratives of African American women with self-reported co-occurring PTSD and substance use disorders who are in outpatient substance use treatment reveal about how they define trauma during their recurrent treatment experiences?

RQ2: How do African American women over 31 years of age with self-reported co-occurring PTSD and substance use disorders perceive their experiences with trauma and its relationship to recurrent substance use admissions and sustained recovery?

RQ3: What sociocultural factors do African American women over 31 years of age with self-reported co-occurring PTSD and substance use disorders describe as impacting their willingness and decision-making to seek help and stay engaged with outpatient treatment services?

In this chapter, I will outline the study's setting and the demographics and characteristics of the participants. I will describe the data collection process and the specific approach I used for thematic analysis. Additionally, I will provide evidence to demonstrate the study's trustworthiness, addressing aspects such as credibility, transferability, dependability, and confirmability. I will address the research questions by presenting supporting evidence for the findings, and I will conclude with a summary of the findings.

Setting

The participants were given the option to be interviewed either via Zoom or in person at the agency. All five women participated in in-person interviews at the agency, as they were familiar with its location. The outpatient substance use treatment agency is located downtown in a Midwestern city and primarily serves African American women. The CEO granted me access to the agency and provided private office space for meetings with the participants to ensure confidentiality. Additionally, complimentary parking was offered to make the process more convenient for them. None of the five participants reported experiencing distress before, during, or after the interviews.

Demographics

I interviewed five African American women living in a Midwestern city. The participants provided detailed demographic information, including age, education, marital status, number of treatment admissions, mental health status, substance use history, PTSD diagnoses, and utilization of services. Their ages ranged from 34 to 60: one participant was 34, two were 38, one was 46, and one was 60. Three of the women had never been married, while two were married. Four women had at least 13 years of education, and one held a bachelor's degree. Four participants had undergone at least two treatment episodes, while one had participated in treatment three times. Three participants had been diagnosed with PTSD; two of these were self-diagnosed.

Additionally, all five reported having a substance use disorder and a mental health diagnosis. Currently, all participants are enrolled in outpatient treatment, with four of them addressing trauma in this episode. All participants had previously terminated treatment against staff advice before completing their episodes.

Table 1

Participant Demographics

Participants **Date of Interview**	**P002** **May 5**	**P003** **May 12**	**P004** **June 29**	**P005** **July 21**	**P006** **July 29**
Age	34	60	46	38	38
Education	BA	14	14	13	14
Marital Status	Never married	Divorced	Married	Never Married	Never Married
Employment	FT	FT	FT	FT	FT
Dependent children	No	Yes	No	No	No
Insurance	Yes	Yes	Yes	Yes	Yes
# Outpatient treatment admissions	2	3	2	2	2
Substance Use Disorder DX	Yes	Yes	Yes	Yes	Yes
Mental Health DX	Yes	Yes	Yes	Yes	Yes
PTSD DX	Yes	Yes	Self DX	Yes	Self DX
Utilized mental health services in the past 12 months	No	No	No	Yes	Yes
Addressed trauma during the last treatment episode	Yes	Yes	No	Yes	Yes
Addressed trauma during the current treatment episode	Yes	Yes	No	Yes	Yes
Terminated from substance use treatment in the past	Yes	Yes	Yes	Yes	Yes

Data Collection

I conducted in-person, semi-structured interviews with six African American women to explore their experiences with trauma while enrolled in outpatient treatment. To collect data and ensure an accurate representation of their experiences, I used an interview protocol, an interview guide, and follow-up questions.

The study underwent a comprehensive review by the Institutional Review Board (IRB) because the identified population is particularly vulnerable, and the research involves more than minimal risks due to the sensitive nature of the data collection. As a result of this review, Forms C and D were completed, leading to amendments in the initial recruitment plan. These changes included adjusting the age range from 31-49 to individuals over 31, providing detailed explanations to avoid any conflicts of interest, and ensuring participant privacy.

The Institutional Review Board (IRB) requested clarification regarding the timing of the consent forms, recruitment procedures, and member checking. The consent form was revised to state that if a recipient does not respond within seven days, it will be interpreted as a decision to decline participation in the study. It was also updated to reflect that the entire consent process is conducted via email without physical forms or signatures. The consent email was also modified to include a statement indicating that participants have seven business days to respond; otherwise, their lack of response will be viewed as a lack of consent or interest in participating. To save participants' time, they will no longer be asked to document their consent a second time. The recruitment procedures were adjusted to eliminate follow-up communication after sending the initial

consent form. For member checking, instead of asking participants to review a transcript for redactions, additions, or changes, the consent form indicates that a summarization and confirmation process will take approximately 15 minutes following the interview. IRB also requested additional information on the inclusion questionnaire to reflect the 6 inclusion criteria and to include that the potential participant must have terminated treatment in the past. The recruitment flyer was changed to address this concern.

The interviews were conducted at the outpatient substance use treatment facility in a Midwestern City. The agency provided a private office outpatient substance use treatment facility located in downtown Midwestern City. To ensure participants' privacy during the face-to-face interviews, the agency provided a private office. Each participant was scheduled for a 60-minute interview, allowing them freedom to speak openly and without interruption. After each interview, I promptly transcribed the audio recording verbatim and assigned an alpha-numeric code to each transcript to maintain confidentiality. All materials, including audio recordings, transcribed interviews, and notes, were stored securely on a password-protected computer that only I could access.

I encountered challenges that deviated from the data collection plan described in Chapter 3. The initial objective of the study was to interview between 10 and 12 participants enrolled in outpatient substance use treatment. However, after six months of recruitment, I was only able to recruit five participants. Due to these challenges, I revised the target number of participants from 10-12 to 5.

During the data collection process, I encountered two unusual situations. One participant chose to withdraw from the study on the day of their scheduled interview.

Additionally, another participant had to be excluded after I consulted with the committee about their presentation, which raised concerns regarding their substance use status. This issue was brought to the committee's attention, leading to the participants' removal from the data set. In response to these occurrences, I began with Interviewee P002 by adding a preliminary question to inquire whether the participant had used any mind-altering substances within 24 hours before the interview. This measure was implemented to enhance the trustworthiness of the data provided by the participants.

Data Analysis

I collected the data through open-ended questions that captured the participants' perspectives on constructing the world and what meaning they gave to those experiences (Merriam & Tisdell, 2015). I used thematic analysis to examine the data and identify recurring themes and repeated meanings. I captured the participants' narratives through semi-structured interviews, which were transcribed and analyzed for patterns and themes (Patton, 2015). Patton's six-step approach was employed to mitigate confirmation bias in my research process. 1. I familiarized myself with the data by thoroughly reading the text, taking preliminary notes, listening to audio recordings for additional clarity, and promptly transcribing the audio files into text. 2. I utilized Atlas.ti web qualitative data analysis software to identify codes and analyze the data effectively. 3. Atlas.ti web generated three targeted questions aligned with my initial research objectives. These questions facilitated the extraction of relevant insights from the data, with each question assigned a category code to enhance the coding results. The software then identified themes based on patterns within the data and grouped them accordingly. 4. I meticulously

reviewed the themes to ensure their accuracy. 5. I defined the themes by compiling a comprehensive list for analysis. This involved reviewing the codes and categories while eliminating repetitive or irrelevant codes. 6. I prepared a write-up reflecting my analysis, which allowed me to make sense of the participants' narratives, analyze them, and seek deeper insight and meaning.

Throughout the research process, I kept a reflective journal to examine my assumptions and biases, ensuring that my notes and reflections aligned closely with the data. Maintaining a journal enhanced the researcher's ability to sustain a reflexive stance (Tufford & Newman, 2012). Table 2 presents the initial codes, categories, and final themes derived from my data analysis process. This table begins with the initial codes and concludes with the final themes. It also provides examples of the initial codes, categories, and themes that emerged from those initial codes.

TABLE 2

RESEARCH QUESTIONS, INITIAL CODES, CATEGORIES, THEMES AND SUBTHEMES.

RQ1: What do the narratives of African American women with self-reported co-occurring PTSD and substance use disorders who are in outpatient substance use treatment reveal about how they define trauma during their recurrent treatment experiences?			
Codes	**Categories**	**Themes**	**Subthemes**
lack of coping skills, societal misconception, sticks with you, haunting, prevents healing, abuse, mental, verbal, and physical abuse domestic violence, impact on relationships, traumatic	definition of trauma, impact of trauma, perception of trauma, coping skills	psychological and emotional responses to trauma	trauma broadly defined

RQ2: How do African American women over 31 years of age with self-reported co-occurring PTSD and substance use disorders perceive their experiences with trauma and its relationship to recurrent substance use admissions and sustained recovery?			
Codes	**Categories**	**Themes**	**Subthemes**
major depression, PTSD, ADHD, trust issues, treatment process, treatment engagement, trauma acknowledgment, unhealthy behaviors, substance use, perception, seeking help	Help-seeking attitudes, maladaptive coping, treatment experiences	trauma's role in treatment mistrust	help-seeking and treatment engagement mental health diagnosis

RQ3: What sociocultural factors do African American women over 31 years of age with self-reported co-occurring PTSD and substance use disorders describe as impacting their willingness and decision-making to seek help and stay engaged with outpatient treatment services?			
Codes	**Categories**	**Themes**	**Subthemes**
Recognition of the need for help, stigma, shift in perception, awareness of the impact, realization of need, non-judgmental attitude, personal experience, therapist connection, embarrassment, self-assessment, therapist matching, blame, feeling misunderstood, frustrated, therapist relatability, the importance of understanding	non-judgmental attitudes, needs are unaddressed, self-reflection, support	treatment preference	Needs addressed, therapist matching, safe space

Themes

The research and interview process identified three main themes and resulted in 267 codes using Atlas.ti web software. Research Question 1 (RQ1), which included five interview questions, generated 113 codes. The first theme identified psychological and emotional responses to trauma, with a subtheme of trauma being broadly defined. Research Question 2 (RQ2) comprised three interview questions, yielding 98 codes. The second theme addressed trauma's role in treatment mistrust, with the subthemes of a) help-seeking and treatment engagement and b) mental health diagnosis. Research Question 3 (RQ3) comprised three interview questions, resulting in 56 codes. The third theme identified treatment preferences, with the subtheme of therapist matching.

Evidence of Trustworthiness

Credibility, dependability, confirmability, and transferability are essential criteria for evaluating the trustworthiness of qualitative research (Bloomberg & Volpe, 2018).

Credibility

Credibility is the confidence that the study is authentic and accurately represents the participant's perspective (Bloomberg & Volpe, 2018; Terrell, 2016). I adjusted the credibility strategies outlined in Chapter 3. Member checks involved sharing a typed transcript with the participants, asking them if their input was accurate, and allowing them to correct any discrepancies (Bloomberg & Volpe, 2018; Terrell, 2016). After each interview, I summarized the information gathered and requested clarification from the participant to ensure accuracy. This approach served as the primary member-checking procedure instead of asking participants to read the entire transcript and suggest

redactions, additions, or changes (Bloomberg & Volpe, 2018; Terrell, 2016). Throughout the study, I engaged in reflective journaling and held debriefing sessions with my chairperson to uphold credibility.

Transferability

Transferability applies research findings to different populations or situations (Terrell, 2016). This study utilized a demographic questionnaire to describe the participants, thereby enhancing transferability accurately. For example, all five participants were African American women aged between 34 and 60 who had enrolled in treatment at least twice and lived in a Midwestern city. By providing detailed descriptions of the participants, readers can better evaluate the relevance of the findings to similar contexts, ultimately improving the study's overall transferability (Ahmed, 2024).

Dependability

Dependability refers to the consistency of data over time and the ability to replicate results (Terrell, 2016). To achieve dependability, researchers must provide a detailed procedure for replicating the study, describe the research design, outline the data collection processes, and document any changes made (Bloomberg & Volpe, 2018; Terrell, 2016). In this study, dependability was ensured by maintaining an audit trail, which included process logs documenting all activities and decisions made throughout the research. Additionally, the chair conducted an external audit to assess the accuracy of the results.

Confirmability

Confirmability is how the researcher ensures neutrality in the study, and the results are based on the participant's responses and not outside influence or potential bias of the researcher (Terrell, 2016). I used an audit trail to keep a step-by-step account of the study and trace activities to understand the study's results and achieve confirmability (Bloomberg & Volpe, 2018; Terrell, 2016). Confirmability was demonstrated in the findings, which were the participants' actual experiences. These were established by using transparent audit trials from the data collection phase to the interpretation of the data (Bloomberg & Volpe, 2018; Terrell, 2016). Writing memos throughout data collection and analysis as a means of examining and reflecting engagement with the data is a method of bracketing (Tufford & Newman, 2012). Bracketing is setting aside one's own beliefs and assumptions to avoid misrepresenting the participant's intended meaning, perception, or experience (Weatherford & Maitra, 2019).

Bracketing is essential for withholding judgment and distinguishing my personal experiences from those of the participants. This practice helps mitigate biases (Weatherford & Maitra, 2019). By maintaining this approach, I can enhance data collection, research findings, and interpretation while remaining self-aware throughout the ongoing process. Reflexibility aided in the continued awareness that my actions may affect the study's outcome (Bloomberg & Volpe, 2018; Terrell, 2016).

Results

In analyzing the narratives of African American women who identify as experiencing co-occurring post-traumatic stress disorder (PTSD) and substance use

disorders while receiving outpatient treatment, three primary themes and six subthemes emerged. The insights gathered from these narratives highlight the complex interplay between their lived experiences and recovery challenges. Refer to Table 2 for a presentation of the research questions, initial coding, categorized findings, overarching themes, and related subthemes.

Research Question 1

RQ1: What do the narratives of African American women with self-reported co-occurring PTSD and substance use disorders who are in outpatient substance use treatment reveal about how they define trauma during their recurrent treatment experiences?

Theme 1: Psychological and Emotional Responses to Trauma.

Trauma has a profound impact on individuals, leading to a range of psychological and emotional symptoms that can vary in intensity, from mild discomfort to severe distress. Four participants defined trauma as adverse experiences that not only changed their lives but also significantly shaped their coping abilities. All the participants reflected on the impact of their family backgrounds, particularly emphasizing experiences with parental addiction and abuse. These challenging circumstances significantly shaped their self-esteem and influenced their coping strategies to handle life's challenges. P005 stated, "My mom was very abusive, I want to say maybe because her dad was abusive and he did anything under the sun, so she carried it over in raising us." For instance, one participant reflects on their mother's drug addiction and the absence of their biological father. P004 disclosed her mother struggled with addiction and that she did not grow up

with her biological father. She revealed that her mother was addicted to drugs during her early childhood, from elementary school until the 6th grade. P006 shared a similar experience. "Growing up I dealt with abandonment; my sperm donor was not involved in my life. I wanted him present and needed him present but he did not give me that option. I had abandonment issues with my mother, she wasn't there all my life. She made a way for me financially but then again financially meant nothing. I need her present the entire time, but I understand that you know life happens. Then my grandma, even though she was present, was abusive, and that wasn't the best because with physical abuse I became angry. Anger has become a part of me and isolation."

> P003: I thought I was strong. The embarrassing part, maybe it is embarrassing to me, I thought I was stronger, I thought I was over it, so to sit here and tell you, it is like damn, I am not over it. I never cried because he committed suicide. I was relieved. I am crying about what I went through, and I am still beating myself up.

These responses illustrate the broad and complex nature of trauma experienced by the participants.

Subtheme 1: Trauma is all-encompassing and was broadly defined by participants.

The participants described trauma based on their personal experiences, highlighting its profound impact on individuals' lives. They acknowledged that trauma often stems from various distressing events, such as childhood abuse, neglect, abandonment, and betrayal. Furthermore, they noted that different forms of mistreatment—whether emotional, physical, or verbal—can leave lasting scars. These experiences can significantly alter a person's self-image and influence their beliefs and

feelings about themselves. P002 defined trauma as anything that hurts you, and you may not necessarily know how to overcome it. You may tend not to have good coping skills. P005 and P006 echoed this sentiment. P005 defined trauma as "Something that sticks with you and Something that can haunt you. Trauma is very hurtful, and trauma can allow you not to heal. Anybody can go through trauma whether it's abuse whether is mental or verbal or physical." P006 defined trauma as "Past experiences that change your perspective in life. Trauma is hard. It's Something that comes up like triggers, you like to avoid or block out in your mind, and Something can trigger that which can result in a response." P003 described her experience with childhood maltreatment and domestic violence. "In the past as a child what happened to me, was domestic violence with my ex-fiancé- he tried to kill me that was maybe about five years ago. Abuse." One of the participants' descriptions of trauma was different from the other as she identified betrayal as traumatizing. P004: I would have nightmares after it happened, it's been a few years and we've been trying to work through it and there are times that I have to revisit, and I feel that I need to clarify things. I feel like he's a pathological liar.

Research Question 2

RQ2: How do African American women over 31 years of age with self-reported co-occurring PTSD and substance use disorders perceive their experiences with trauma and its relationship to recurrent substance use admissions and sustained recovery?

Theme 2: Trauma's role in treatment mistrust.

Challenges in trusting others can greatly hinder an individual's ability to seek necessary treatment, often arising from past traumatic experiences that have left lasting

emotional wounds. These trust issues may create barriers, making it difficult for the person to confide in healthcare professionals or fully engage in the therapeutic process. Participants shared mixed feelings about their treatment experiences as three of the participants found trust as a major barrier to seeking help. P005 stated “it’s hard to seek help because you don’t know who to trust. You don’t know who’s a listening ear or just for a paycheck.” P003 shared a similar experience. “It was a trust factor, I didn’t know the person, I thought that they would be judgmental, and I didn’t think that they would understand me. It was important that when I went into treatment it had to be someone that I felt was like me, a female. It had to be someone from my culture or background who could maybe understand the family dynamics because of my first treatment. It was someone who couldn't relate and I felt judgement. I did know seeking help had to be someone similar to my background and what made me feel comfortable.

> P006: Because, at the time, they didn’t have an African American therapist on board they never disclosed that to me which I found out after the fact, later, they hired an African American therapist, but I still went 7 months without therapy.

Subtheme 2: Help-seeking and treatment engagement

The participants express a strong desire to seek help but often struggle with complex emotions that make them hesitant to engage in treatment. A familiar feeling among them is shame, which can stop them from reaching out for assistance. Additionally, there is a notable tendency to avoid discussing their struggles due to concerns about the stigma associated with seeking help. These challenges create significant barriers to accessing the support they need. P002 shared the difficulties of

being a black woman and seeking help due to stigma. “It was tough, especially as a black woman you know the stigma. I don’t want to be judged but after a while, you realize that you need help”. P006: “I avoid when things get uncomfortable, I avoid situations, and avoiding treatment is like a coping mechanism for me to just avoid it. You know so like oh I’m ok. But in actuality, I’m not ok and I need help.”

One of the participants did not perceive any barriers to help-seeking and shared a different experience. P004 stated “I don’t feel like it impacts you know I’m able to seek the help I need. Sometimes I think it helps but I want to make every effort to make sure I’m doing everything to take some corrective action for my mental health issue.”

Subtheme 3: Mental health diagnosis.

The mental health symptoms experienced by the participants created significant obstacles to seeking help. In this study, all participants had been diagnosed with a range of mental health conditions, including depression, attention-deficit/hyperactivity disorder (ADHD), substance use disorder, and post-traumatic stress disorder (PTSD). These diagnoses highlight the challenges individuals face when trying to navigate the mental health system, making the process even more daunting. Two of the participants were currently utilizing mental health services to address their mental health needs. Four of the participants currently address trauma while in outpatient treatment. Depression was common among the participants, along with maladaptive coping mechanisms. P006 stated “depression just keeps me in my bubble. I used alcohol and food to soothe my needs because food and alcohol do not talk back to you, that was one of my coping mechanisms.” P002 stated depression and trauma she believes “is the reason why I drink

to numb the depression, and once you are numb, you don't care about anything anymore."

> P003: I agreed with what my therapist told me about PTSD when I did the research. I know I go through depression because of it. I get sad and I get in my moment where I stay in bed, and I don't want to bathe. When I get depressed, I want to get up in bed and eat, and just be left alone.

Research Question 3

RQ3: What sociocultural factors do African American women over 31 years of age with self-reported co-occurring PTSD and substance use disorders describe as impacting their willingness and decision-making to seek help and stay engaged with outpatient treatment services?

Theme 3: Treatment Preference

The preference of the participants to engage in gender-specific services with a supportive, understanding, and judgment-free provider was essential for them to develop rapport and remain in services. Such an environment fosters trust and encourages individuals to open up, making it essential in developing rapport. When individuals feel accepted and free from judgment, they are more likely to remain committed to the services, leading to more effective and meaningful outcomes. Three of the four participants shared their past treatment experiences, in which they identified the need for support and the ability of an agency to meet their needs with a culturally competent provider, and a safe space that would allow them to build trust with the provider, which was a motivating factor to stay engaged in treatment. P003 stated "I stress you have to

have to right person. I didn't have the right person many years ago and that's why it was so far in advance I couldn't link to them, and they couldn't link to me. It was as if they were reading from a book, and it just didn't fit me at all. I would say one thing and it was to the point where I said how my brother molested me, and they didn't want to hear. So, I felt embarrassed talking about it because I thought it was my fault that I was promiscuous."

P005 stated "I had a good treatment experience, I guess it depends on where you go and who you are with. I feel like some people in treatment need to understand the culture. It's not what you say, it's how you say it. You have to understand that this is a vulnerable moment for people just because you didn't experience it, it doesn't mean it hasn't happened. Sometimes people need to put themselves in other people's shoes and not be so quick to judge."

The common responses from the participants led to the subtheme of finding a therapist that they could relate to as an African American woman without feeling judged.

Subtheme 4: Therapist Matching

Finding a therapist that fit their needs was challenging. They identified factors such as gender and culture. Participants shared their challenges of connecting with therapists, often making them feel disconnected. Many expressed that they found it difficult to relate to their therapists, leading to experiences of feeling misunderstood or judged. The search for a therapist who understands their unique perspective can be frustrating and disheartening for individuals seeking support. Participants in a study expressed feelings of disconnection, a lack of relatability, and experiences of being

misunderstood or judged. Three participants shared similar experiences of not finding the right match for their therapy needs. P003 stated “I didn’t have the right person many years ago and that's why it was so far in advance I couldn’t link to them, and they couldn’t link to me. It was as if they were reading from a book, and it just didn’t fit me at all. I would say one thing and it was to the point where I said how my brother molested me, and they didn’t want to hear. So, I felt embarrassed talking about it where I thought it was my fault that I was the promiscuous one.” P005: “I had a Caucasian female and anything I would tell her about my life it was like she was judging me. I’m like, so it was my fault to be molested. It was like everything I went through was my fault making it seem like it's wrong for me to be black or being born into my circumstance. I also didn’t come here to be judged either. If you don’t have a safe space, where can you go?” P006 shared a similar experience stating “I fell through the cracks because I requested for an African American therapist, someone that looks like me that can understand me and can relate to me, but I kept getting Caucasians male and females, and it angered me. Because for a female version, she kept asking me how that makes you feel when I told you in the beginning that I was mad. So, asking me multiple times made me angry. For the male therapist, he couldn’t relate because you are a male. So, you can’t relate to a female difficulty, especially with relationships in the dating world, and did not understand my feelings in how I dealt with my relationships or my thought pattern.”

The role of community and shared experiences were identified by two participants who benefited from hearing others' stories and were motivated by their support. P002 stated “It's strengthening to be around people that don’t judge you. That know that I

know what you are going through. Because it's nothing worse than going through something and you get someone looking at you and asking why you keep going through that. It hurts. A broken ankle is almost the same as a broken heart. I don't have any kids, but I know." P005 stated, "Everyone has their own struggles, and if I can help someone else with their struggles meanwhile helping myself with my struggles then I'm ok with that."

Summary

In this chapter, I discussed the setting, demographics, and data collection. At the participants' request, I conducted five semi-structured interviews at an outpatient substance use treatment agency. The participants were African American women, ages 34 to 60, who were currently enrolled in outpatient services and resided in a Midwestern city. There were no discrepant cases in this study. I discussed the data analysis, identified themes, and presented evidence of trustworthiness, which included credibility, dependability, confirmability, and transferability.

The study revealed three main themes and four subthemes. For RQ1: What do the narratives of African American women with self-reported co-occurring PTSD and substance use disorders who are in outpatient treatment reveal about how they define trauma and how they experienced trauma during their recurring treatment experiences? I identified the first theme as psychological and emotional responses to trauma. The first subtheme that emerged from the data was that trauma is all-encompassing. For RQ2: How do African American women over 31 with self-reported co-occurring PTSD and substance use disorders perceive their experiences with trauma and its relationship to

recurrent substance use admissions and sustained recovery? The second theme was the role of trauma in the mistrust of treatment. Two subthemes emerged from the data: help-seeking, treatment engagement, and mental health diagnosis. For RQ3: What sociocultural factors do African American women over 31 with self-reported co-occurring PTSD and substance use disorders describe as impacting their willingness and decision-making to seek help and stay engaged with outpatient treatment services? I identified the third theme as treatment preference, with the fourth subtheme being therapist matching.

In Chapter 5, I will provide an overview of the purpose and nature of the study, articulating the motivations that inspired me to undertake this research. I will compare my findings with the existing literature to evaluate whether my results align with or challenge previous studies. Additionally, I will outline the limitations encountered during the research process, identify potential areas for future exploration, and discuss the implications of my findings for promoting positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

There is a notable lack of research specifically examining the experiences of African American women with co-occurring substance use disorders and PTSD in outpatient treatment (Blume, 2016). This qualitative study aimed to explore the experiences of African American women over the age of 31 who self-reported having both substance use disorders and PTSD while participating in outpatient treatment. This study also investigated how this population defined trauma, the role trauma played in their treatment experiences, and the sociocultural factors that influenced their decisions to seek help and remain in outpatient treatment, what can be addressed in treatment environments to support how they manage their substance use disorder.

While previous studies have predominantly centered on women of color, particularly African American women, who have undergone substance use treatment and are around 40 years old on average (Watson et al., 2016; Carter & Sant-Barket, 2015; Jones et al., 2015), there is a noticeable gap in research focusing on middle-aged African American women over 31 as the primary interest (Meshberg-Cohen et al., 2016; Torchalla et al., 2012; Davis, 1997). This study therefore targeted this age group, which was more likely to have had multiple experiences with substance use treatment, be actively engaged in outpatient treatment, and have diverse perspectives and experiences related to trauma. The data was collected from five African American women who received treatment in the last 12 months at an outpatient treatment facility in a

Midwestern city. Their stories were captured through transcribed, semi-structured interviews and analyzed for patterns and themes (Patton, 2015).

This study adopted a narrative framework as part of a generic qualitative inquiry. The generic qualitative study design is characterized by its broad, inductive, richly descriptive, flexible, and emergent nature, not bound by a specific method (Merriam & Tisdell, 2015). The narrative framework was chosen as the most suitable method for understanding how these participants experienced trauma during their treatment and recovery. This approach involved exploring and analyzing their stories, seeking insight and meaning, interpreting the data, and making connections.

The data was examined using thematic analysis to identify recurring themes and repeated meanings. Patton's six-step approach was employed to mitigate confirmation bias in the research process. The data was familiarized by thoroughly reading the text, taking preliminary notes, listening to audio recordings for additional clarity, and promptly transcribing the audio files into text (Patton, 2015). The Atlas.ti web qualitative data analysis software was used to identify codes and analyze the data effectively. The software identified themes based on patterns within the data and grouped them accordingly. The themes were defined by compiling a comprehensive list for analysis, which involved reviewing the codes and categories while eliminating repetitive or irrelevant codes (Patton, 2015).

The analysis revealed three primary themes and three subthemes that addressed the three research questions guiding this study. The first theme focused on the psychological and emotional responses to trauma, with the subtheme addressing the

broad definition of trauma. The second theme was the role of trauma in the treatment of mistrust, and the subtheme was help-seeking and treatment engagement. The third theme was treatment preference, and the subthemes were therapist matching.

The study's key findings offered valuable insights from the participants' perspective. These insights include how the participants defined trauma, the role trauma played in their decision to seek help and engage in treatment, and the sociocultural factors that influenced their decision to seek help and stay engaged in treatment. These findings shed light on the complex interplay of trauma, treatment engagement, and sociocultural factors in the experiences of African American women with substance use disorder and PTSD.

In this chapter, I will interpret the findings and compare them to the literature from Chapter 2 to confirm or challenge previous research. I will also discuss the study's limitations, provide recommendations for future research, and highlight the implications for social workers and social change. I will conclude with key points.

Interpretation of the Findings

African American women with histories of substance use disorders experience trauma at a disproportionate rate than any other group and have poorer treatment outcomes, shorter lengths of stays, higher rates of relapse, and continued use of substances (Blakey & Grocher, 2017). In this study, the key themes identified as psychological and emotional responses to trauma, help-seeking and treatment engagement, and treatment preference suggest varying reasons for why poor treatment engagement and outcomes are the case. As this study's findings show, having co-

occurring PTSD and substance use disorder seems to exacerbate the challenges this population faces with engaging in and staying in treatment.

Research question 1, which asks about how they define trauma during their recurrent treatment experiences, I identified one primary theme, namely, psychological responses to trauma, as well as a subtheme of trauma is broadly defined. Each participant was asked to define trauma, provide examples of their traumatic experiences, explain the role trauma played in accessing services, and describe how their mental health diagnosis affected their willingness to engage in outpatient substance use treatment.

Theme 1: Psychological and Emotional Responses to Trauma.

Participants talked about trauma as mental, verbal, and physical abuse, haunting, sticking with you, triggering, and preventing healing. Four participants described trauma as negative experiences that have impacted their lives and shaped their coping mechanisms. They highlighted the effects of trauma within their families, especially concerning parental addiction and abuse. They reported that these experiences have affected their self-esteem and how they cope with life. For example, two participants explained that they engaged in self-soothing through maladaptive behaviors as a coping **s**trategy. The participants highlighted the influence of trauma within their families, highlighting experiences related to parental abuse and addiction. Four of the participants disclosed that they experienced childhood maltreatment. P003 noted a long history of abuse as a child and shared that her mother would beat her naked, and a brother and cousin molested her as a child. P005 shared that her mother was very abusive, as her

grandfather was also abusive to her mother, and her mother repeated the abusive behavior while raising the participant.

Three of the participants share abandonment issues with their parents as being traumatic. P006 dealt with abandonment by her father and mother and was raised by her physically abusive grandmother, which led to her being angry and isolated. P002 shared a similar experience with the loss of her father and the absence of her mother. P004 disclosed that her grandmother raised her as her mother struggled with addiction and that she did not grow up with her biological father. She revealed that her mother would go through stints, maybe days or weeks when she did not see her mother.

Researchers define trauma as an experience or series of experiences that cause physical or emotional harm, resulting in a lasting negative impact on an individual's mental, physical, social, emotional, or spiritual well-being (Goodman, 2017; Levenson, 2017; SAMHSA, 2014). Similarly, the APA (2020) defined trauma as an emotional response to a distressing event (APA.org). When considering how the participants describe trauma, their perceptions align with what researchers suggest and further offer some insight regarding the role of trauma when it comes to factors that impact a person's ability to engage in and stay in treatment.

The literature argues that trauma can be perceived and defined in different ways (Giordano et al., 2016), and further, if a person perceives their trauma as negatively impacting their lives such that they are not able to act in ways that support their mental stability, the person is far less likely to engage in meaningful or helpful activities like

therapy that might improve their mental health outcome (Tull et al., 2017). When considering the research question about how they define trauma during their recurrent treatment experiences, the noted theme of psychological responses to trauma and the subtheme of trauma is broadly defined is aligned with the literature and seems to capture what the participants describe when speaking about how they experience and make sense of their trauma.

Subtheme: Trauma is All-Encompassing and Broadly Defined

The participants defined trauma as a significant part of their personal experiences, highlighting its profound impact on their lives. They noted that trauma often stems from various distressing events, such as childhood abuse, neglect, abandonment, and betrayal. Furthermore, they emphasized that several types of abuse—whether emotional, physical, or verbal—can leave lasting scars. These experiences can significantly alter an individual's self-image and influence their beliefs and feelings about themselves. For example, P002 defined trauma as anything that hurts you, don't know how to overcome it, and poor coping skills. P005 and P006 echoed this sentiment. P005 defined trauma as something that sticks with you and can haunt you; it won't allow you to heal; the abuse can be mental, verbal, or physical. P006 defined trauma as past experiences that change your perspective in life and trigger. P003 described her experience with childhood maltreatment and domestic violence with my ex-fiancé, abuse. One of the participants shared a distinct perspective on trauma, emphasizing the profound impact that feelings of betrayal had on her. Unlike the other participants, who focused on various aspects of their

experiences, she highlighted that the sense of being deceived by someone she trusted was especially traumatic for her.

Brown's (2008) study examined the concept of trauma beyond the definitions offered by the DSM-IV. The study explored alternative definitions and provided insight into understanding trauma by deconstructing and reanalyzing the DSM-IV using culturally informed models of practice. Brown (2008) emphasized that betrayal of trust can be considered traumatic, especially when the full extent of the betrayal becomes apparent. Considering the research question about how the participants perceive the relationship between trauma and their recurrent admission and sustained recovery.

For research question 2, which asks about how they perceive trauma and its relationship to their recurrent admissions and sustained recovery, I identified one primary theme as trauma's role in treatment mistrust, as well as two subthemes of help-seeking and treatment engagement and mental health diagnoses. Each participant was asked about their treatment experiences, how those experiences impacted their ability to remain engaged in treatment or end treatment, and what they found supportive to manage their recovery.

Theme 2: Traumas' role in treatment mistrust.

The participants in this study had damaging relationships with their past counselors, which led to feelings of judgment and a lack of trust. As a result, they terminated treatment prematurely. Four participants noted that trust was a significant barrier to seeking help. This observation highlights the vital role of building trust in

therapeutic settings in promoting healing and recovery. One participant described a past relationship with a counselor as transactional, which did not allow her to have a connection, which hindered her ability to trust the provider. P006 stated that trust issues were a barrier to engaging in treatment and states she is learning how to open up with a new therapist as she is feeling safe. P003 shared the same sentiment and stated it was a trust factor as she did not know the person and thought they would judge her and not understand her. It was evident that this population had issues with trusting their providers. One of the participants stated she did not disclose her history of trauma during her treatment episodes and disclosed that she continues to drink copious amounts of wine alone at home. She recently noticed an increase, and she noticed she was having blackout spells and did not remember things. On the other hand, four of the participants disclosed their trauma history and did not sustain their recovery as they were enrolled in their second treatment episode.

Challenges in trusting others can significantly hinder an individual's ability to seek the necessary treatment, often arising from past traumatic experiences that have left lasting emotional wounds (Blakey & Grocher, 2017; Jones et al., 2015). Blakey & Grocher's (2017) study examined the types of relationships that African American women with extensive trauma histories and substance use disorders had with their treatment counselors and how those relationships affected their engagement in treatment. Their study revealed three types of relationships: reparative- empowering and mattering, which supports an environment that fosters trust; damaging-unimportant and untrustworthy, which leads to feelings of judgment and lack of trust, often resulting in

premature termination of treatment; and transactional-task-focused and superficial, which are short-term and do not allow for the processing of trauma. Transactional relationships are short-term and task-focused as the counselors do not get personal with the women, which does not allow the women to process and work through trauma and substance use histories (Blakey & Grocher, 2017). Studies by Jones et al. (2015) and Meshberg-Cohen et al. (2016) found that minority women with SUDs might not disclose trauma history due to cultural barriers, shame, and mistrust of the provider, which can lead to poor treatment outcomes and a higher rate of addiction severity. According to Reyre, Jeannin et al. (2017), the therapeutic alliance is a bonding process between the provider and the client that requires mutual trust, which plays a crucial role in the healing process. These trust issues can create barriers, making it difficult for the person to confide in professionals or fully engage in the therapeutic process (Blakey & Grocher, 2017). This study highlights the urgent need for a more personal approach in counseling, one that fosters trust and allows for the processing of trauma.

Considering the research question about the relationship between trauma and recurrent admissions and sustained recovery, the noted theme of trauma's role in treatment mistrust aligns with the literature as it is captured through the participant's experiences.

Subtheme: Help-seeking and treatment engagement

Participants expressed a strong desire to seek help but often struggled with complex emotions that made them hesitant to engage in treatment. Common feelings among them included stigma, isolation, embarrassment, and shame, which hindered their

willingness to reach out for support. These challenges created significant barriers to accessing the help they needed. Four participants identified avoidance, isolation, and difficulty in managing their symptoms as barriers to help-seeking. One participant mentioned that avoiding uncomfortable situations and treatment was a coping mechanism. Another participant shared that when she becomes frustrated, she isolates herself, as some people are not receptive to her needs. In contrast, two participants had more positive attitudes toward seeking help and felt comfortable reaching out for formal support. One participant discussed the challenges she faces as a Black woman, citing stigma and the fear of judgment associated with seeking assistance

Historically, African American women have faced societal barriers that discourage them from seeking help, a trend in the literature that can be traced to an interplay of societal expectations, cultural stigmas, and institutional challenges that discourage these women from seeking support (Abrams et al., 2019; Montgomery et al., 2017; Burkett, 2017; Anyikwa, 2015; Pullen et al., 2014). In a study conducted by Redmon, Watkins, et al. (2017) investigated ethnic and gender differences in the type of providers sought for substance use disorder treatment and reasons for avoiding and leaving treatment. The findings revealed that most respondents did not seek help because they felt their problem was not serious, the situation would improve independently, or they did not think they needed help. According to SAMHSA TIP 57 (2014), stigma acts as a barrier to treatment and recovery, which is influenced by ascribed roles and gender expectations. The societal stigma placed on women discourages them from seeking help,

which can lead to further stigmatization and challenges, particularly faced by women of color, older women, and lesbian women (SAMHSA TIP 57, 2014).

The importance of being a "strong Black woman" was revealed by two participants who experienced childhood trauma. This adoption of being a strong woman may have led to them not seeking formal help for fear of being seen as "weak." For example, in a study, Hampton-Anderson, Carter, Fani, et al. (2021) found that African American women with ACE utilized culturally relevant coping mechanisms such as the "Strong Black Woman/Superwoman" schema. The Superwoman schema is a cultural expectation that African American women should be strong, independent, and free of emotions, and it is often used to cope with stress. Participant P003 stated, "I must be strong and provide for myself. I struggle to let someone in who wants to love me and share responsibilities." Her experiences reflect the Superwoman schema, which has made her hesitant to seek help. She noted that women of her generation had to run households, leading to a strong sense of independence. Participant P005 agreed that this independence makes it difficult for women to submit to anything, as they have always had to manage independently. There have been studies that have defended the influence of the "strong Black woman" schema on the mental health and treatment-seeking behaviors of Black women (Hampton-Anderson, Carter, Fani, et al., 2021; Abrams, Hill & Maxwell, 2019).

Considering the research question about how the participants perceived trauma in their relationship to recurrent treatment experiences and the subtheme of help-seeking and treatment engagement aligns with the literature and is captured through the participants' experiences.

Subtheme: Mental health diagnosis

The participants in this study shared how their mental health symptoms hindered their ability to engage in services actively. Four of the participants had been diagnosed with mental health disorders, with major depression being the most common, alongside ADHD and PTSD. One participant discussed her struggles with depression and trauma, explaining that she drinks to numb her feelings. Once she is numb, she feels indifferent to everything. P003 shared that she was diagnosed with depression and PTSD five years ago. She described her experience of depression, stating, "I recognize it as depression because I do not feel the desire to bathe." Another participant, P006, discussed her struggles with depression, self-diagnosed PTSD, and ADHD. She stated that during depressive episodes, she tends to stay in bed, eat, and isolate herself. Notably, two participants resorted to religious coping to deal with their mental health symptoms instead of seeking help.

Mental health issues and substance use pose unique challenges for people seeking treatment, as symptoms can exacerbate vulnerability and function as a barrier to accessing appropriate treatment (Priester et al., 2016). A study conducted by Meshberg-Cohen et al. (2016) found that African American women with comorbid post-traumatic stress disorder (PTSD) experienced higher levels of depression than those without PTSD. Their study supported previous research showing that women who had both substance use disorders (SUDs) and PTSD faced greater psychological distress compared to those who did not have PTSD. Ward et al. (2009) conducted a coed study focused on African Americans' beliefs about mental illness, attitudes toward seeking mental health services,

preferred coping behaviors, and whether there were differences by gender and age. According to Ward et al. (2009), depression was the most common mental illness; the participants in the study knew their symptoms but were concerned about the stigma that was associated with mental illness and help-seeking, which they often preferred religious coping. In this cultural practice, individuals turn to their faith and spiritual community for support and healing. Stigmas associated with mental illness and treatment-seeking are prevalent among African Americans; they tend to cope with mental illness through informal support networks (family, friends, church leaders) and experience numerous barriers when seeking treatment (Ward, Clark & Heidrich, 2009).

The research question about the relationship between trauma and recurrent admissions and the subtheme of mental health diagnosis aligns with the research suggesting that individuals recognize their symptoms but are reluctant to seek help due to the stigma of mental illness. The participant's responses confirm depression as the most frequent diagnosis among this population.

For research question 3, which asks what socio-cultural factors impact their willingness and decision-making to seek help and stay engaged in outpatient treatment services. I identified one primary theme as treatment preference and a subtheme of therapist match. Each participant was asked about their experiences in seeking help when deciding to enroll in outpatient treatment, the factors that prevented them from seeking help, and the factors that influenced their decision to remain engaged in outpatient substance use treatment.

Theme: Treatment preference

Participants identified challenges such as limited availability of programs, mismatches in cultural understanding between providers and clients, and negative attitudes towards seeking treatment, which discouraged them from accessing the help they needed. Participants expressed preferences for various treatment models, from evidence-based to individualized approaches. For instance, one participant preferred a personalized engagement like a life coach, while another participant needed cognitive behavior therapy to deal with past traumas. Another participant emphasized the importance of gender-specific treatment, as she felt more comfortable in environments with other women. Engaging in gender-specific services with a supportive, judgment-free provider was crucial for this population to develop rapport and remain in service.

This study focused on outpatient treatment services, which involved weekly individual and group therapy and were tailored to meet the needs of the participants. Four participants attended group and individual therapy, whereas one only attended individual therapy. One participant disclosed participating in a community women's self-help mutual group. Hser et al. (2018) study found that individuals in outpatient treatment were more likely to achieve abstinence than those who did not receive outpatient treatment, and confirms it is common for individuals to experience relapse and stop attending outpatient treatment. A study by Shield, Delany, & Smith (2015) found that limited organizational resources impacted the availability of trauma services in SUD treatment and highlighted providers' potential lack of awareness regarding trauma's impact on the SUD treatment population. Ward et al. (2009) noted that there is a shortage of services

for individuals with co-occurring disorders and that practitioners may unintentionally overlook co-occurring mental health and substance use disorders.

When considering the research question about the sociocultural factors that influenced this population's willingness to seek help and stay engaged in outpatient treatment, the theme of treatment preference aligns with existing literature based on the participants' responses.

Therapist match

The participants emphasized the need for relatable providers who do not judge them. Four participants preferred gender-specific treatment, stating they felt more comfortable with other women. One participant shared the importance of working with a female provider from her cultural background who could understand her family dynamics, as she did not have that option during her last treatment episode. Another participant shared a similar experience, stating that she chose not to seek treatment because the facility did not have an African American therapist on staff. A different participant had negative experiences with Caucasian therapists, feeling unheard and subsequently terminating treatment. Overall, participants noted that a provider's race, nationality, and gender played a significant role in their decision to discontinue treatment during their last experiences. It is essential to recognize and address stereotypes and biases to ensure individuals receive gender-responsive services that are tailored to their racial, ethnic, and cultural needs (Goodman, 2017; Levenson, 2017; Shier & Turpin, 2017; Meshberg-Cohen et al., 2016; SAMHSA, 2014).

In a study conducted by Ruglass et al. (2014), they examined the effects of racial and ethnic matching between clients and therapists on session attendance and treatment outcomes. The findings revealed that racial and ethnic matching did not influence session attendance; patients continued to engage in treatment regardless of whether their therapist matched their racial or ethnic background. A study conducted by Bauer, Ruglass, et al. (2022) found that education levels and prior treatment attempts predicted early therapeutic alliance among Black women undergoing group treatment for PTSD and substance use disorders (SUD). The study emphasized the need to address educational factors when culturally adapting interventions for PTSD and SUD. However, the researchers did not analyze the race or ethnicity of the therapists as a predictor of alliance, nor assess the racial or ethnic identities of both therapists and patients. As a result, the potential influence of therapists' race/ethnicity on the development of alliance among Black women may be an area for continued investigation, considering the diversity within Black/African American and multiracial populations. In another study by Davis, Ancis, & colleagues (2014), it was found that the likelihood of establishing a strong working alliance with African American women who use substances increases when therapists demonstrate multicultural competence, including empathy, unconditional positive regard, and genuineness.

The research question regarding the sociocultural factors that influence willingness, decision-making, and therapist matching is consistent with the research conducted by Shier and Turpin (2017) and Meshberg-Cohen et al. (2016), as they reflect the participants' experiences. However, the findings from this study do not align with the

study by Ruglass et al. (2014) as the participants' attendance was based on the providers who shared their cultural values.

Theoretical Framework and Findings Interpretations

Trauma is any event or series of events perceived as physically or emotionally harmful. These experiences can negatively affect an individual's well-being (Goodman, 2017; Levenson, 2017; SAMHSA, 2014). This concept informs trauma-informed care (TIC) in social work, particularly for those with trauma and substance use disorders (Goodman, 2017; SAMHSA, 2014). This study utilized the trauma-informed care approach (TIC) and its effectiveness in addressing the impact of trauma and substance use and contemporary trauma as a well-articulated theoretical framework for exploring the role of trauma in substance disorders and trauma-informed care practices to support improved client outcomes.

SAMHSA's trauma-informed approach consists of six core principles that address cultural, historical, and gender-related issues across various settings: Safety: creating an environment where clients feel both physically and psychologically safe to minimize potential triggers in their surroundings; 2) Trustworthiness and Transparency: establishing a culture of trust and openness allows clients to understand what to expect as they work towards building a trusting relationship with their caregivers; 3) Peer Support: building trust and enhancing collaboration by utilizing the stories and lived experiences of peers promotes recovery and healing; 4) Collaboration and Mutuality: emphasizes partnering with clients and addressing power imbalances between staff and clients; 5) Empowerment, Voice, and Choice: recognizing and building upon individuals' strengths

and experiences; 6) Responsiveness to Cultural, Historical, and Gender Issues: ensures access to gender-responsive services and the incorporation of policies that are responsive to the racial, ethnic, and cultural needs of individuals (Brent-Goodley, 2018; Goodman, 2017).

This study focused on three of the six key principles of the trauma-informed approach to effectively work with African American women who have experienced trauma. The participants' shared experiences resonated with three of the essential principles of Trauma-Informed Care (TIC), which include the importance of establishing trustworthiness and transparency in relationships and having a safe space for healing; the necessity of peer support to draw strength from other's experiences; and recognizing and addressing cultural, historical, and gender-related issues that uniquely shape the experiences of African American women (Brent-Goodley, 2018; Goodman, 2017; SAMHSA, 2014).

Trustworthiness and Transparency

Four participants identified trust issues and fear of judgment as barriers to their engagement in treatment. Their previous experiences with providers left a sense of mistrust when accessing services. One participant did not reveal her trauma history during her past or current treatment experience. As a result, she remained undiagnosed, highlighting a significant gap in the diagnostic process. The participants in this study reported they experienced trauma from people that they once trusted, which complicated their ability to trust providers when seeking help. This mistrust can lead to reluctance to disclose traumatic experiences, resulting in misdiagnosis (Pemberton & Loeb, 2020). The

lack of trust can damage therapeutic relationships, which can cause a person to question whether to remain or terminate treatment (Blakey & Grocher, 2017). Redmond, Smith, & Collins's (2019) study connected to this principle of trust as they revealed that the participants in their study felt uncomfortable with providers who had a negative attitude toward them, which led to terminating treatment prematurely. They noted that for African American women with substance use disorders, engaging in and maintaining treatment is a complex challenge (Redmond, Smith, & Collins, 2019).

Trustworthiness and transparency are promoted when the organization is focused on building and maintaining trust between the individual and the staff (Goodman, 2017; Levenson, 2017; Shier & Turpin, 2017; Jones, Hopson, Warner & James, 2015; SAMHSA, 2014). This study aligns with SAMHSA's (2014) trauma-informed approach, with trust as a core principle.

Peer Support

Three participants expressed the importance of connecting with peers to share personal experiences and recognized that they are not alone in their struggles. One participant felt empowered by being with non-judgmental individuals who understood her. Another was motivated to help others avoid similar struggles due to her lack of support. The third participant found peace in assisting others while managing her issues. Peer support is crucial in encouraging individuals to connect through groups and networks, fostering validation, and helping to alleviate feelings of shame and isolation. Peer support is essential for establishing safety, building trust, fostering collaboration, and using lived experiences to promote recovery (SAMHSA, 2014).

Lacey et al. (2021) found that half of the women in their study reported obtaining support from other women, engaging in prayer, and attending church. Dillion, Kedia, Ishehunwa, and Sharma (2020) recommend using peer graduates to encourage peers to participate in treatment. The participants' responses indicated the importance of peer support in creating safety, building trust, promoting collaboration, and utilizing lived experiences to facilitate recovery and healing (Goodman, 2017; Shier & Turpin, 2017; SAMHSA, 2014).

Cultural, Historical, and Gender Considerations

Participants verbalized a desire for gender-specific and culturally competent services that acknowledged their unique experiences. Four participants desired treatment tailored to women, as they felt more comfortable with other women. Three participants expressed reluctance to enroll in services due to a lack of therapists they could identify. Addressing ethnic and geographical disparities in trauma exposure rates is essential (Pemberton & Loeb, 2020). Cultural and gender issues help frame the understanding and treatment of trauma by creating environments that respect and embrace diversity. It is imperative to recognize and address stereotypes and biases and ensure that individuals receive gender-responsive services tailored to their racial, ethnic, and cultural needs (Goodman, 2017; Levenson, 2017; Shier & Turpin, 2017; Meshberg-Cohen et al., 2016; SAMHSA, 2014). For example, one of the participants shared past challenges of not being able to relate to an assigned therapist as the therapist was not of her culture and did not understand her experiences or family dynamics. The responses of the participants indicated they felt understood and connected with female providers who related to their

cultural nuances around trauma, leading them to stay in treatment and have their needs met.

The participants' stories illustrated the three principles of Trauma-Informed Care (TIC): trustworthiness and transparency, peer support, and an awareness of cultural, historical, and gender issues (SAMHSA, 2014). The TIC framework allowed me to explore how African American women perceive trauma in their treatment experiences, as well as the factors that influence their decisions about seeking help and staying engaged in treatment. Implementing these trauma-informed principles can improve treatment experiences for African American women who have faced trauma. Implementing these trauma-informed principles can improve treatment experiences for African American women who have faced trauma in the context of substance use.

Limitations of the Study

This study's limitations may affect the internal and external validity (Creswell, 2017). One of the challenges I encountered was recruiting participants. The sampling method resulted in fewer participants than I had predicted. All participants opted to meet at the agency, which required me to travel downtown for the interviews. The facility offered a private meeting space for individual interviews. However, scheduling could have been more flexible; one participant canceled on the day of her interview, and another arrived more than 30 minutes late. While these challenges affected the study's process, they also provided valuable insights into the difficulties of conducting research in this field.

The focus of this study was on the experiences of five African American women from a metropolitan area in the Midwest, specifically those over 31 years of age who self-reported co-occurring disorders of substance use and PTSD and who were actively engaged in outpatient treatment. The small sample size, while a limitation, allowed for a deep exploration of these specific experiences. As a result, the findings do not capture the perspectives of women from other racial and ethnic backgrounds living in different regions of the United States. While I achieved saturation with these five interviews, I cannot extend the conclusions beyond this group. According to Fusch and Ness (2015), saturation is reached when enough information is obtained to replicate the study, and there is no additional information.

I collected data from multiple sources to strengthen internal validity, including interviews, observations, and notes. To address potential researcher bias, I practiced reflexive journaling to identify and minimize any biases I may have held or overlooked. After each interview, I clarified statements with the participants to ensure accuracy and further examined my biases through self-reflection (Creswell, 2017).

Given the sensitive nature of trauma, I carefully designed the study to minimize the risk of triggering participants while they shared their experiences. This approach involved open-ended questions, allowing for a deeper exploration of personal stories that quantitative measures might not capture. Each participant was provided contact information for a local 24-hour community mental health service to ensure they had access to additional support for managing their symptoms if necessary. Participants were fully informed about the risks and benefits of participating in the study through a consent

form emailed before scheduling the interview and verbally in person before the interviews began. This careful design was implemented to ensure the ethical treatment of the participants and to provide a safe environment for them to share their experiences.

Recommendations

Recommendations for future research must investigate the trauma experiences of women of color, particularly those from diverse backgrounds such as African, Caribbean, East Indian, Asian, and Latino cultures. This nuanced approach is crucial in gaining essential insights into how these women perceive and define trauma within their cultural contexts. Moreover, it is a necessary step in understanding the unique challenges and barriers that hinder their access to mental health treatment and trauma-related care. As Jones et al. (2015) have rightly pointed out, studies of women of different ethnicities, ages, social and economic statuses, and geographical regions are urgently needed.

Additionally, future studies should specifically focus on the experiences of African American women within the LGBTQIA community who have cooccurring disorders of substance use and trauma. Two of the participants shared that their choice to wear men's clothing often provokes societal judgments about their femininity, a reflection of the pervasive stereotypes and biases they encounter when engaging in services. Exploring and understanding the lived experiences of African American women is crucial for practitioners, as it will equip them with the knowledge and tools necessary to provide more effective support to this often marginalized population.

Researchers have suggested the need to replicate additional studies on African American women who are exposed to different types of trauma and strategies for coping

with symptoms are needed (Sullivan et al., 2018), as well as studies exploring barriers to treatment from the perspectives of African American women (Redmon, Smith & Collins, 2019; Blakely & Bowers, 2014; Allen, 1995). Understanding these coping strategies is necessary to support these women more effectively.

Further research is needed to shape policies and practices to ensure African American women receive appropriate and effective care tailored to their unique circumstances and challenges (Redmond, Watkins, Broman, et al., 2017).

Implications

Implications for social workers.

Social workers can benefit from training to simultaneously provide integrated treatment for trauma and substance use disorders (Gielen et al., 2014). Improving the knowledge base and education of social workers about substance use disorders and trauma can increase interest in working with this population. Allen's 1995 study suggested that practitioners should allow women to identify the treatment barriers they experience. This approach can provide insight into increasing readmission rates, which can change the underrepresentation of African American women in treatment. The study also emphasized the necessity of strong aftercare programs and self-help groups within African American communities, underlining their critical role in recovery.

Screening assessments should include evaluations for trauma experiences, substance use, and PTSD symptoms, followed by referrals to integrated treatment services tailored to the specific needs of African American women (Meshberg-Cohen et al., 2016; Kobulsky et al., 2014; Torchella et al., 2012). Interventions should be revised

to target the relationship between current PTSD and substance use to achieve favorable treatment outcomes (Sullivan et al., 2016). Social workers can advocate for policy changes and develop interventions and strategies to reduce personal and institutional stigma (Ahmedani, 2011).

Social workers can increase their understanding of how trauma can impact culture, treatment readiness, sustained recovery, and the need for culturally sensitive trauma-informed services for African American women with co-occurring substance use disorders and PTSD, which may decrease health disparities in the African American community.

Implications for positive social change

There are limited studies explicitly focusing on African American women with co-occurring substance use disorders and PTSD, sharing their experiences and perceptions regarding their decision-making to enter treatment and the type of support that is needed to remain in treatment (Jones et al., 2015; Blume, 2016). This study aimed to contribute to the limited body of literature on this topic by exploring the experiences of African American women over 31 with co-occurring substance use disorders and PTSD.

Service providers should support long-term recovery by recognizing the significant impact of culture on treatment readiness. The lack of African American women as treatment providers in the Midwestern city poses challenges in addressing this need. This study can potentially influence social change for social workers providing services to African American women who have been underserved due to traditional services that do not adequately respond to their needs.

The findings of this study can enhance social workers' understanding of how African American women experience trauma, empowering them to advocate for policies that promote culturally sensitive trauma-informed services. By shedding light on the experiences of African American women in the context of their treatment, this study has the potential to foster positive social change.

Conclusion

In Chapter 5, I reiterated the study's purpose and explained why it was conducted. I summarized the key findings and analyzed and interpreted them within the theoretical framework used in the study. Additionally, I compared the findings to the literature reviewed in Chapter 2. I also discussed the study's limitations, recommended future research, and outlined the implications for social workers and social change.

This study explored how African American women over the age of 31 with a self-reported history of trauma and co-occurring disorders of substance use disorder (SUD) and post-traumatic stress disorder (PTSD) perceived trauma. It explored factors that influenced their decision to engage in treatment and identified what could be incorporated into treatment settings to better support them in managing their substance use related to their trauma experiences. By analyzing the participants' perspectives, this research provided valuable insights into the effects of trauma on treatment engagement.

I developed three research questions to collect data on how African American women over 31 who self-reported co-occurring substance use disorders and PTSD define trauma, perceive their experiences with trauma and its relationship to recurrent admissions, and what influences their willingness to seek help and stay engaged in

treatment. The interview questions revealed three primary themes: 1) psychological and emotional responses to trauma, 2) the role of trauma in treatment mistrust, and 3) treatment preferences. The subthemes identified were: 1) a broad definition of trauma, 2) help-seeking and treatment engagement, 3) mental health diagnosis, and 4)therapist matching.

This study utilized three of the six principles of trauma-informed care: trustworthiness and transparency, peer support, and consideration of cultural, historical, and gender issues (Goodman, 2017; SAMHSA, 2014). The participants expressed a strong desire for gender-specific therapy from professionals who understand their cultural backgrounds. The lack of culturally competent services tailored to address their unique experiences and challenges worsens their difficulties, leaving them without the necessary support to manage their mental health and substance use issues. Notably, the participants' deep mistrust of service providers, along with the absence of culturally relevant and gendered treatment options, arose from their previous negative experiences with treatment providers. However, the stigma associated with shame and the lack of adequate community and social support continues to create significant barriers for African American women with co-occurring disorders of substance use and PTSD in this metropolitan Midwest city. The findings of this study provide valuable insights for social workers who offer outpatient treatment to African American women with self-reported co-occurring disorders of substance use and trauma.

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Appendix A

Demographic Data

1. What is the highest level of education that you completed: [] Some high school [] Highschool diploma [] GED [] AS degree [] Bachelors [] Masters [] Technical school [] Certification: _____
2. What is your marital status? [] Never married [] Married [] Divorced [] Widowed [] Partnership/SO/LTP
3. Do you have dependent children: [] Yes []No Ages of children: _____
4. What is your current employment status: [] Unemployed [] Full-time [] Part-time [] Self-employed [] Disabled [] Full time student
5. Do you have insurance? [] Yes [] No
6. Have you enrolled in outpatient treatment in the past? [] No [] Yes If yes, Number of times: _____
7. Do you have a substance use disorder? [] Yes [] No
8. Have you utilized any mental health services in the last 12 months? [] Yes [] No
9. Have you addressed trauma during your last treatment episode? [] Yes [] No
10. Have you addressed your trauma during your current treatment episode? [] Yes [] No
11. List any noteworthy events or situations that you view as traumatic in your life?

_____

Appendix B

Face-to-Face Interview

Participant Masking #: P#_____ Time: _____ Date: _____

RQ1: What do the narratives of African American women with co-occurring PTSD and substance use disorders reveal about how they define trauma during their outpatient substance use treatment experience?

1. How do you define trauma?
2. Can you tell me some examples of how you experienced trauma recently or in the past?
3. What role if any does your trauma play in getting services?
4. Can you tell me about your mental health diagnosis?
5. How does your mental health diagnosis impact your willingness to engage in outpatient substance use treatment?

RQ2: How do African American women perceive their experiences with trauma and its relationship to recurrent substance use admissions and sustained recovery.

1. Can you tell me about your last substance abuse treatment experience?
2. Can you tell me how your experiences with trauma impact your ability to remain engaged in treatment or end treatment?
3. Is there anything about outpatient substance use treatment that you found less supportive or difficult to manage in your recovery?

RQ3: What socio-cultural factors do this population describe as impacting their willingness and decision making to seek help and stay engaged in outpatient treatment services?

1. Can you tell me about your experiences in seeking help when deciding to enroll in outpatient treatment services?
2. What if any, factors prevent you from seeking help?
3. What factors influenced your decision to remain engaged in outpatient substance use treatment services?

Is there anything else that you would like me to know about your experience with treatment and your past traumas before closing?

I would like to thank you for your time in sharing your story with me today.