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Pepperdine University
Graduate School of Education and Psychology

THE IMPLICATIONS OF MORAL INJURY AMONG AFRICAN AMERICAN FEMALES
WITH A HISTORY OF SUBSTANCE ABUSE: A PRELIMINARY STUDY

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Jaimee Silvera Hartman

July, 2015

Daryl Rowe, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Jaimee Silvera Hartman

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements of the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Daryl Rowe, Ph.D., Chairperson

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Chante DeLoach, Psy.D.

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DEDICATION

This research is dedicated to all the women who have suffered in silence through trauma and addiction and to the voice within struggling to be heard.

ACKNOWLEDGEMENTS

My family has been my rock and source of strength throughout my entire life and without them nothing would be possible. Thank you to my grandparents who emphasized values, a strong work ethic, and respect above all else. To my formidable mother who has always demonstrated the importance of speaking my voice. To my father whose loss has humbled me and has made me strive to make him proud in everything I do. To my brother who has been my savior through countless trials and tribulations, never faltering in his reassurance, guidance, and love. To my uncle who has been by my side every step of the way and remains my loudest supporter. To my aunt who has consistently demonstrated compassion for the less fortunate and emphasized the need for public awareness. To the extraordinary matriarchs of my family upon whose shoulders I have stood to attain my aspirations in an effort to commemorate our ancestors and bring awareness to the struggles of those ignored by so many. I am eternally grateful to the amazing family I was blessed to have and the lasting influences they have had on my life and those of our next generation.

I would like to thank my wonderful husband who has been patient and understanding despite late nights and stress, always there to hold my hand and offer encouragement. Thank you to my amazing group of friends especially Bird, Kelly, and Paige who have been by my side from the beginning demonstrating true sisterhood.

I would like to give special thanks to Dr. Rowe, my Dissertation Chairperson. Your patience, leadership, and vision have been instrumental in shaping my research, but also my path as a clinician. Dr. Himmelstein and Dr. DeLoach, thank you for the essential role you played in helping guide my research through deep intellectual discussion as well as the support and

encouragement you provided throughout my process. Dr. Rhonda Brinkley-Kennedy, thank you for being a mentor who has guided me through tumultuous times with reassurance and laughter.

None of this would have been possible without the strength and courage of the women who participated in this study who had the courage to make their voices heard. Far too often these women have been ostracized and shamed for their past. My only hope is that their narratives demonstrate the resilience and potential that they possess and the significance that appropriate treatment and resources can have on their future.

VITA

EDUCATIONAL HISTORY

Psy.D., Clinical Psychology

Pepperdine University, Graduate School of Education and Psychology, Los Angeles, CA
May, 2015

Dissertation Title: The Implications of Moral Injury Among Female Substance Abusers

Master of Arts in Clinical Psychology with an Emphasis in Marriage & Family Therapy

Pepperdine University, Graduate School of Education & Psychology, Irvine, CA
May, 2008

Bachelor of Arts in Psychology, Minor in Sociology, Concentration in Criminal Justice

Villanova University, Villanova, PA
May, 1999

HONORS

Pepperdine University Diversity Scholarship, 2008-2013

Psi Chi National Psychology Honor Society, 2007-current

PROFESSIONAL EXPERIENCE

Clinical Therapist

HealthRight360, Los Angeles, CA

August 2009- Present

HealthRight 360 offers a range of mental health services and integrated treatments for men and women with co-occurring substance use disorders and mental health problems. The program offers mental health services, assessment, individual, group, and family therapy, skills training, and crisis intervention.

- Intake: Conduct intake assessments for individuals seeking mental health services while in a residential program for substance abuse related criminal behavior, establish preliminary diagnoses, and formulation of treatment plans
- Therapy: Provide individual therapy, couples therapy, and family therapy using humanistic and cognitive behavioral therapy approached for the treatment adults with dual diagnosis
- Group Therapy: Facilitate psychotherapeutic groups regarding topics including depression, anxiety, mindfulness, music therapy, and anger management

- Supervisor: Clinical Site Coordinator of “Celebrating Families!”, an evidence based cognitive behavioral support group model for families in which one or both parents have a problem with addiction. Provide supervision for MFT and doctoral practicum students and assess supervisee progress through consultation with the supervising psychologist
- Presentations: Provide seminars to presentations to colleagues and supervisors on issues related to substance abuse and mental health

Pre-Doctoral Psychology Internship

Kaiser Permanente, Department of Psychiatry and Addiction Medicine, El Cajon, CA

August 2012-August 2013

The Department of Psychiatry and Addiction Medicine at Kaiser Permanente provides outpatient mental health services to Kaiser members seeking assistance for various mental health issues. The department provides services including individual, family, and group therapy, neuropsychological assessment and chemical dependency treatment for individuals of all ages.

- Assessment: Conduct psychodiagnostic evaluations for adults and children in order to provide individual cognitive behavioral therapy (including cognitive processing therapy) for members of the San Diego community requesting mental health services for treatment of diagnoses including Posttraumatic Stress Disorder, a history of physical and sexual trauma, depression, anxiety, and bereavement. Conduct intake interviews and neuropsychological assessments for adults and children requesting evaluation of symptoms associated with ADHD, learning disability, and cognitive impairment
- Therapy: Provided psychotherapy to a broad range of individuals including children, adolescents, adults, and geriatric populations, as well as couples and family therapy for the treatment of a variety of psychiatric disorders
- Groups: Co-facilitate groups focused on the treatment of anxiety, depression, emotional regulation, anger, couples communication, ADHD, behavioral modification, and skill building for adults as well as children and their parents
- San Diego Family Justice Center: Conduct intake evaluations for women and their children requesting assistance for domestic violence through the Family Justice Center. Provide weekly case management, referrals and resources for families requiring legal, psychological, military, housing, and police assistance
- Chemical Dependence Recovery Program: Co-facilitate a processing therapy group for individuals in treatment for substance and alcohol abuse. Interview and assess patients requesting services for substance abuse treatment as well as evaluating appropriate referrals and resources for treatment
- Specialized Trainings: Attended various trainings and seminars focusing on topics relevant to clinical psychology

Pre-Intern Doctoral Practicum

VA Los Angeles Ambulatory Care Center, Los Angeles, CA

August 2011-August 2012

The VA Los Angeles Ambulatory Care Center provides outpatient mental health services to veterans in need of services. The center provides individual and group treatment for various mental health issues and provides specialized treatment for issues related to Posttraumatic Stress Disorder, Military Sexual Trauma, and substance use disorders.

- **Assessment:** Conduct psychodiagnostic assessments and provide individual cognitive behavioral therapy (including cognitive processing therapy) for veterans with Posttraumatic Stress Disorder, a history of military sexual trauma, depression, and substance abuse
- **Group Therapy:** Lead a weekly Posttraumatic Stress Disorder and depression psychotherapy group for Filipino WWII Veterans
- **Psychosocial Rehabilitation and Recovery Center:** Co-facilitate a therapeutic process group for veterans with severe mental illness participating in the clinic's multidisciplinary Psychosocial Rehabilitation and Recovery Center
- **Alcohol and Substance Abuse Program:** Co-facilitate a family issues processing therapy group for veterans participating in the Alcohol and Substance Abuse Program
- **Specialized Trainings:** Attend didactic seminars focused on multicultural issues, legal and ethical issues, Posttraumatic Stress Disorder, military sexual trauma, and high-risk patients

Pre-Intern Doctoral Practicum

LAC-USC Rand Schrader Health and Research Center, Los Angeles, CA

September 2010-August 2012

The LAC-USC Rand Schrader Clinic provides comprehensive care of persons infected with HIV or other infectious diseases. The clinic facilitates neuropsychological evaluations on patients in an effort to improve the medical care of those being treated by the interdisciplinary team including psychiatrists, physicians, and psychologists.

- **Intake:** Conduct intake interviews with patients and their family members referred for psychological testing
- **Neuropsychological Assessment:** Conduct intake interviews and neuropsychological assessments for individuals experiencing cognitive impairment as a result of HIV and other infectious diseases. Administer, score, and interpret neuropsychological assessments and write integrative reports of patient results and clinical presentation

- Specialized Trainings: Attend seminars and grand round presentations related to psychiatry and infectious disease

Pre-Intern Doctoral Practicum

Pepperdine University Community Counseling Clinic, Los Angeles, CA

July 2010-August 2012

The Pepperdine University Clinic is located on the West LA Campus and provides affordable mental health services to students, individuals in the community, couples and families in need of psychological treatment.

- Intake: Conduct intake interviews in order to gather contextual and diagnostic information and formulate appropriate treatment plans
- Therapy: Provide couples therapy and individual therapy for adults with a wide range of psychological disorders
- Assessment: Administered, scored, and interpreted psychodiagnostic assessments to assist in treatment planning and determine the level of emotional and cognitive functioning
- Supervisor: Provide peer supervision for 1st and 2nd year doctoral students including oversight of records and clinical preparedness. Address case management issues, provide resources, and clinical skills training to supervisees. Conceptualize treatment and manage student progress through consultation with supervising psychologist

Pre-Intern Doctoral Practicum

Union Rescue Mission's Hope Gardens Family Center, Sylmar, CA

September 2009-August 2010

Hope Gardens Family Center is a residential program that provides mothers and children experiencing homelessness counseling, training, and support they need to escape homelessness and gain the tools and resources necessary to improve their lives.

- Intake: Conducted intake interviews for women in residential program in order to gather contextual information, diagnose, and formulate appropriate treatment plans
- Therapy: Provided individual and family therapy for adults and their children using cognitive behavioral therapy
- Group Therapy: Facilitated group psychotherapy implementing mindfulness, mediation, and play therapy

Marriage and Family Therapist Trainee

Orange County Youth and Family Services, Garden Grove, CA

September 2007-July 2009

Orange County Youth and Family Services serve children and adolescents who require mental health services for issues including disruptive behavior disorder, mood disorders, anxiety, adjustment or personality disorders. In addition, the program has a residential facility for women on parole for substance abuse and criminal behavior.

- **Therapy:** Provided individual therapy and family therapy to women incarcerated for substance abuse- related criminal behavior. Assisted in providing referrals for further treatment and coordinated client care with other treatment providers within the community
- **Group Therapy:** Created curriculum and facilitated group psychotherapy focused on anger management, grief and loss, and codependency issues

ABSTRACT

Moral injury is a concept that has been applied to the challenges facing veterans returning from combat due to the discrepancy between their moral values and the behaviors they engaged in due to war. In recovery women have expressed similar challenges due to the illicit behavior they engaged in while in their addiction as well as the prevalence of trauma that has impacted their transition into substance use. Thirteen female participants in treatment for substance abuse participated in this qualitative study. The majority of the women experienced a history of childhood and/or adult trauma that perpetuated their use of substances as a means of coping, created a sense of social isolation, and shame. The concept of moral injury was identified by the participants as a process that deepened with each subsequent transgression.

Chapter 1: Research Objective and Review of Literature

Introduction

Humankind has internalized values and norms that define us as individuals, establish our worldview, and help navigate our relationships with others, which collectively determine our moral identity. Morality is viewed as a means of conforming to a standard of what is right and good in accordance with established sanctioned codes or accepted notions of right and wrong (Morality, 2013). The question of moral judgment has come into question in various areas of research including criminal activity, addiction, and more recently in terms of morally compromising actions in theater (Greene, Ball, Belcher, & McAlpine, 2003; Husak, 2004; Longshore, Chang, Hseih, & Messina, 2004; Wolf, Addad, & Arkin, 2003). Moral casualties, as studied in veteran populations, have been defined as, “suffering debilitating remorse, guilt, shame, disorientation, and alienation from the remainder of the moral community, as a consequence of participation in war” (Bica, 1999, p. 81). The concept of moral injury has been attributed to perceived transgressions from one’s moral conviction and integrity resulting in guilt, alienation, and shame due to failure to live up to personal expectations. The construct of moral injury assumes the disruption of an individual’s sense of personal morality and her/his capacity to behave in a just manner consistent with her/his pre-existing values and belief system, due to acts of omission and commission, resulting in inner conflict (Bica, 1999; Drescher et al., 2011). Moral injuries of soldiers returning from war have been ignored in the past while the focus has been placed on stress and trauma for veterans re-acclimating to their civilian lives. Although moral injury has been restricted to the evaluation of distress placed on male veterans following combat, the implications of mental and physical deterioration resulting from profound discrepancies between one’s morals and behavior has the potential to be extended to other

distinct populations who have also engaged in negative behavior, due to environmental circumstances, requiring eventual reconciliation of their actions in light of their personal values and beliefs.

Traditional combat, reports of atrocities and abusive violence, subjective judgment of fear, and events reflecting malevolent discomforts in theater have been associated with PTSD symptom severity (King, King, Foy & Guadanowski, 1996). Killing has been found to be associated with PTSD symptoms, dissociation, functional impairment, and violent behaviors for war veterans who experienced and/or perpetrated violent crimes during war (Maguen et al., 2009). Killing another human being has been associated with traumatic dissociation due to the sense of unreality associated with the act as well as using dissociation as a coping mechanism to minimize the emotions related to this behavior. The disconnection from ethical foundations and the loss of frame of reference with which to structure the world results in loss of meaning in an incoherent world where relationships and duty to others have been altered (Bica, 1999). Those who participate in atrocious behavior and killing of other human beings have endorsed the re-experiencing and avoidance symptoms of PTSD, which limits recovery from a traumatic experience (Litz et al., 2009). The disconnect between an individual's moral and ethical teachings upon which they judge themselves and others can be in direct conflict to the actions demanded of them in times of war therefore damaging one's sense of morality and sense of self. The fear and stress experienced during violent acts are associated with mental disorders as well as being the hallmark of Posttraumatic Stress Disorder (Coyne & Downey, 1991; Golding, 1999). Dissociation and the inability to process traumatic experiences contribute to the development of PTSD and related symptoms including depression, psychological distress, and suicidal behavior (Litz et al., 2009; Maguen et al., 2009). As a society, we most commonly

associate these traumatic experiences with military personnel, due to media coverage of combat and the repercussions of combat on returning veterans and military families. However, experiences of fear and violence in traumatic circumstances can be attributed to other populations including, but not limited to, the experiences of those in their addiction, who frequently confront life and death situations due to their lifestyle and environment. The marginalization of this population by society results in a lack of significant research into the obstacles and potentially beneficial treatment interventions for those typically of lower socioeconomic status, poor education, decreased resources, and ethnic minority groups.

Although research on the effect of moral injury on female members of the military has yet to be published, PTSD research of female veterans has found that a significant number of those diagnosed with PTSD had a prior history of physical assault or sexual stress (Feczer & Bjorkland, 2009). Following combat, comparisons between male and female veterans have found poorer health and social functioning among women than men. This discrepancy has been attributed to female veterans having less social support, fewer economic resources, and greater exposure to different types of trauma such as sexual and noncombat, nonsexual trauma (Fontana, Rosenheck, & Desai, 2010). Women veterans are currently seeking care in record numbers as they return from serving in Operation Iraqi Freedom and/or Operation Enduring Freedom in Afghanistan, thereby increasing the clinical needs of women veterans in VA settings (Mattocks et al., 2011). Research has shown that women develop PTSD at twice the rate of men, which has been supported by the incidence of female veterans reporting symptoms of PTSD, outnumbering male veterans 2:1 (Breslau et al., 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Perkonig et al., 2005; Tolin & Foa, 2006). Although the concept of moral injury has been primarily researched in regard to male veterans, the significant proportion of women exhibiting

posttraumatic symptoms would suggest similar injury in women who internalize a shame response due to the personal responsibility they assume regarding a traumatic experience. Similarities in symptom presentation including depression, isolation, substance abuse, and shame found in both women veterans involved in violent or combative behaviors themselves and women engaged in addictive lifestyles, who are more likely to encounter sexual trauma and observe violence towards others, suggests the application of the construct of moral injury may be appropriate.

In the National Vietnam Veterans Readjustment Study (NVVRS), loss of meaning and control associated with PTSD was identified as an additional stressor due to exposure in a malevolent environment, which was found to contribute most strongly to PTSD (King, King, Gudanowski, & Vreven, 1995). Exposure to unpleasant physical conditions contributes to the inadequacy of supplies and constraints on freedom of movement (Fontana & Rosenheck, 1999). Although this was referenced in regard to veterans experience during war, similarities can be drawn relating these stressors to the experience of women engaged in substance abuse whose exposure to unpleasant conditions and increased vulnerability may exacerbate PTSD symptoms and their ability to manage additional cumulative trauma. The traumatic experiences of women during combat include enduring difficult living conditions, horrific sights, sounds, and smells. These experiences are similar to experiences by women in their addiction, living on the street, who endure poor living conditions, often due to poverty and homelessness, distressing sights (violence, sexual assault, death), sounds (sirens, gunshots, fighting, constant commotion), and smells (infection, blood, human waste). Insufficient environmental resources contribute to basic sense of meaning and when undermined it has been suggested that one's belief in her self-worth and safety is diminished, perpetuating a sympathetic reaction to trauma (Fontana & Rosenheck,

1999). The greater the exposure to death and injury, the greater the perception of threat to one's own safety and vulnerability which may lead to morally questionable behaviors as a consequence of the severity of the environment.

As an increasing amount of women enter the military, the complexity of military sexual trauma (MST) becomes an increasingly important issue as those who experience sexual assault in the military are at a greater risk for developing PTSD. Military sexual trauma is defined as severe or threatening forms of repeated, unsolicited, threatening acts of sexual harassment, or sexual assault sustained in military service (Haskell et al., 2010; Martin, Rosen, Durand, Knudson, & Stretch, 2000). Within the population of female veterans seeking treatment, approximately 14-43.1% report experiences of sexual assault while 55-63% report incidents of sexual harassment (Butterfield, McIntyre, Stechuchak, Nanda, & Bastian, 1998; Fontana & Rosenheck, 1999; Murdoch & Nichol, 1995; Rowe, Gradus, Pineles, Batten, & Davison, 2009; Sadler, Booth, & Doebbeling, 2005; Suris, Lind, Kashner, & Borman, 2007). This type of victimization leads to a sense of helplessness and vulnerability, further perpetuating symptoms of depression and substance abuse. Women who experienced sexual trauma during military service were more likely to identify themselves as being disabled and reported higher levels of symptoms and functional impairments than those who had not experienced MST (Rowe et al., 2009). In a study of women veterans coping with military sexual trauma, these women used common avoidance behaviors, including substance abuse, overeating, and shopping, in isolation (Mattocks et al., 2012). The correlation between sexual trauma and a woman's perception of disability and impairment implicates the pervasive consequences of trauma in a victim's life. The cycle of trauma, disability, mental and physical impairment, poverty, and substance abuse seems implicit to the impact of oppression and victimization of women. The shame accompanying

victims of MST has been found to result in maladaptive and unhealthy behaviors similar to those of women coping with their experiences during their addiction and the shame associated with their behavior.

Substances are a means to avoid or numb negative feelings associated with traumatic events, and have been implicated as a response to moral injury as substances can provide a means of escape from negative personal judgment and the assumed judgment of others. Models of posttraumatic stress have focused on issues resulting from severe deprivation, victimization, and personal life threat which can be applied to experiences encountered by individuals engaged in substance abuse, as well as by soldiers in war, due to the comparability of adverse and harsh conditions (Maguen et al., 2009). In researching the implications of moral injury in reference to combat veterans and its correlation to Posttraumatic Stress Disorder, it could be suggested that the concept is applicable to individuals impacted by the ramifications of similar moral dilemmas. Such individuals may include those in their addiction who are vulnerable to a maladaptive lifestyle, in which they are struggling with the adverse consequences of their actions following survival behaviors that are contraindicated by the moral compass that had previously dictated their conduct.

Self-forgiveness and empathy regarding malicious actions of the past can be a challenge to rectify. However, if utilized appropriately, forgiveness can be seen as a demonstration of goodwill toward the self, void of self-hatred and self-contempt for hurting another person, which can serve as an indicator of progress in treatment. Self-forgiveness includes recognizing one's intrinsic worth and separation from one's wrongdoing through restoration of self-respect and acceptance. It entails a resolution to change and behave differently, thus if this resolution is broken, self-destructive tendencies may reemerge (Enright, 1996; Hall & Fincham, 2005).

Substance abuse as a means of coping with negative feelings may be impacted by this cycle of self-forgiveness and self-destruction, making it more difficult to accept change and to separate one's self-worth from one's behavior. Furthermore, due to the negative thoughts and feelings associated with transgressions, this cycle can take an individual further into her addiction as a means of avoiding those she harmed, either self or others. The domain of self-forgiveness is particularly relevant in clinical populations as substance abusers may suffer from guilt and/or shame due to their inability to stop engaging in repeated self-destructive behaviors (Dillon, 2001). It is proposed that moral injury results from the shame associated with an action that conflicts with an individual's morality and sense of self. The substance abuse that typically ensues as a coping strategy for avoiding internal conflict has the potential to lead to further wrongdoings, creating a cycle of increased vulnerability to traumatic experiences, shame, and maladaptive coping.

When applying the concept of moral injury in treatment, engaging in a therapeutic dialogue about a veteran's experiences in war has been found useful for the individual to examine his/her personal responsibility to comrades and behavior dictated during battle. This approach is used in an effort to assist in the re-evaluation of moral responsibility and the ability to find meaning and acceptance of the past, and could be applicable to additional populations of those who have engaged in morally compromising behaviors and are seeking resolution of this cognitive dissonance (Bica, 1999). Failure to pay sufficient attention to the implications of moral and ethical transgressions during war or other hostile environments may prevent adequate assessment of guilt, shame, and associated mental health issues (Litz et al., 2009). Omitting questions regarding killing, purposeful harm, or witnessing of violence, and the subsequent impact on the perpetrator may prove counterproductive to evaluation and treatment by

implicating a sense of shame and inappropriateness to the discussion (Maguen et al., 2009). Re-education regarding appropriate values and behaviors for the purpose of reintegration into society may be a valuable component of treatment as individuals returning from war, or hostile environments, engage in moral self-evaluation of their behavior in unique circumstances (Bica, 1999). The battle between one's morality and aversive behavior resulting in the harm of others can be challenging due to the incongruence between beliefs and actions. Despite environmental factors and the motivation for survival, this discrepancy can result in significantly damaging effects on the individual and his or her sense of identity.

Posttraumatic Stress Disorder

Trauma is a response to an overwhelmingly negative experience, which can range from chronic oppression of an entire group to repeated sexual abuse of a child. Such negative experiences can result in erroneous processing of information of future events leading to negative behavior to create a sense of safety or decrease negative emotions (Covington, Griffin, & Dauer, 2011). Posttraumatic Stress Disorder (PTSD) has been defined as an anxiety disorder resulting from traumatic exposure characterized by symptoms including re-experiencing trauma through flashbacks, nightmares, intrusive thoughts, avoidance of stimuli associated with the traumatic experience, and increased arousal (American Psychiatric Association [APA], 2000). Events resulting in PTSD include military combat, war, disaster, criminal violence, or an event resulting in an intensification of fear, helplessness, or horror. The core features of PTSD consist of the stressor that defines the triggering event, characteristic symptoms of PTSD syndrome, re-experiencing of the trauma, numbing or avoidance of thoughts or environments related to the trauma, and excessive arousal reactions (Breslau et al., 1998). Research on combat veterans has identified exposure to atrocities, including extremely cruel, or brutal acts, as experiences that

increase the risk of psychological and behavioral disturbance in veterans while increasing the probability of developing PTSD. Witnessing or engaging in cruel acts has the capacity to provoke feelings of guilt and shame, depression, and internalized symptoms (Yehuda, Southwick, & Giller, 1992). While PTSD affects a significant portion of veterans, it has also been found to be highly correlated with individuals with a history of substance abuse due to childhood abuse, as well as domestic violence and assault. Moral injury has recently been correlated to the symptoms associated with trauma endured in the line of duty (Dokoupil, 2012; Drescher et al., 2011). In the same regard, the current study raises the possibility that moral injury could also be correlated with other experiences, such as addictive behavior, where similarly high rates of PTSD are associated with a cycle of avoidance through substance abuse and vulnerability to further trauma.

Approximately 4.8 million incidents of rape and assault against women by an intimate partner occur each year in the United States (Mumola, 2000). One in every four women experience domestic violence in their lifetime with the majority of cases unreported to police (Covington et al., 2011). Women are two to three times more likely than men to report feeling unsafe during violent conflicts with intimate partners resulting in a high incidence of mental health problems including depression, suicidality, withdrawal, substance abuse, and PTSD symptoms. The lifetime prevalence of assaultive violence has been found higher in nonwhites with low education, low income, central city residents, and those previously married. Interpersonal traumatic events, especially intimate partner violence, have been found to have the strongest relationships to PTSD as these women are 2.9-5.9 times more likely to develop PTSD and 5.6 times more likely to engage in substance abuse compared to other women. Rates of drug abuse or dependence among battered women ranges from 7% to 25% in some studies (Golding,

1999; Morse, 1995; Sullivan & Holt, 2008). The National Comorbidity Survey indicates that among the victims of rape, 65% of men and 46% of women develop PTSD from this event. Other traumas associated with high rates of PTSD among women include childhood physical abuse (48.5%), sexual molestation (26.5%), physical assault (21.3%), and being threatened by a weapon (32.6%) (Charuvastra & Cloitre, 2008; Kessler et al. 1995). In a Swedish study investigating trauma types including robbery, physical assault, sexual assault, tragic death, war, and traffic accidents, only traffic accidents did not contribute to predicting PTSD diagnosis, with sexual assault most likely to predict PTSD (Frans, Rimmo, Aberg, & Fredrikson, 2005).

PTSD results from a highly stressful event that produces fear for one's life, or that of others, and helplessness resulting in re-experiencing of the traumatic event, avoidance, numbing, and hyperarousal. Family instability and unstable family background, including violence in the home, resulted in higher correlations with PTSD for those exposed to combat and malevolent environments (King et al., 1996). Social interaction and attachment, beginning with the parent-child relationship, have immediate and enduring influences on stress-regulation, which extend to experiences in adulthood at various interpersonal levels (Charuvastra & Cloitre, 2008). The theory of attachment asserts that early relationships with a healthy caregiver provides a source of safety through comfort and soothing as children rely on parents to help navigate emotional experiences. There are suggested links between attachment problems and internalized shame for children raised in environments of neglect, abuse, or rejection (Weichelt, 2007). In the same regard, child abuse has a resounding negative effect on one's sense of security and emotional regulation, resulting in poor interpersonal relationships, leaving victims at greater risk for PTSD following traumatic experiences later in life (Charuvastra & Cloitre, 2008). Women survivors of childhood sexual abuse report greater trauma-related distress than men while also indicating

higher levels of mental health issues including depression, anxiety, and PTSD symptoms (Sigmon, Greene, Rohan, & Nichols, 1996). Children raised in dysfunctional homes have poor coping skills and difficulty regulating their emotions due to lack of appropriate modeling or self-soothing behaviors.

Additionally, the intrinsic shame and personal responsibility assumed by a child who experiences trauma at a young age creates isolation and poor social support, which can lead to maladaptive coping as an adult. The association between childhood abuse and increased risk of PTSD has been found to result in feelings of shame as a means of working through internal conflict as the victim is unable to separate her value as a person from the negative act. Emotional responses such as shame, anger, dissociation, and acute stress disorder have been found to predict later PTSD due to the inability to manage heightened levels of distress and poor mental resources to cope with traumatic events (Brewin, Andrews, & Valentine, 2000). Individuals with persistent PTSD are unable to view the trauma as a time-limited event and instead the experience has global ramifications regarding various aspects of their lives, producing a sense of current threat (Ehlers & Clark, 2000). The compounding traumatic experiences and dysregulation creates a cycle of persistent anxiety due to the view that the world is unsafe as well as maladaptive coping such as substance abuse to diffuse the resulting unpleasant emotions, increasing the vulnerability to subsequent traumatic experiences.

Education and socioeconomic status are interrelated and can have further influence on intelligence in the presence of child abuse and early trauma, increasing one's vulnerability to psychiatric problems and PTSD. In addition, a family history of psychiatric disorder may be strongly correlated to an adverse home environment and potential abuse (Andrews, Brown, & Creasey, 1990; Brewin et al., 2000). Poverty, abuse, mental health problems, and victimization

are among the most common issues in the lives of incarcerated, substance-abusing women (Allen, Flaherty, & Ely, 2010). Statistics have indicated that as many as 80% of incarcerated substance-abusing women have a history of physical and sexual abuse (Bush-Baskette, 2000). The mental dissociation from traumatic events often leads to drug use as a means of regulating their internal emotional states and avoiding traumatic memories and experiences (Herman, 1992; Muzak, 2009). Individuals with a history of PTSD and substance abuse demonstrate less improvement in treatment, have poorer coping skills, increased levels of distress, and a more positive view of substance use as a means of numbing or avoiding uncomfortable emotions.

Exposure to traumatic events perpetrated at the hands of others, has a higher propensity for developing symptoms of PTSD partially due to perceptions about social support, which can assist in soothing trauma-driven fears (APA, 2000). The inability to regulate previously emotion-laden events leads to symptoms of re-experiencing, hypervigilance, avoidance, and dissociative behavior characteristic of PTSD (Charuvastra & Cloitre, 2008). Positive social interactions can help facilitate resolution of PTSD by mitigating the negative effects, while negative interactions may contribute to its maintenance as the perception of blame and unsupportive social responsiveness are strongly associated with psychological distress. Traumatic events that elicit negative responses, which reinforce the belief that the world and others are hostile and unsafe, are often unseen and associated with stigma and shame such as those including sexual assault and sexual or physical abuse (Charuvastra & Cloitre, 2008). Individuals may be unsure of how to respond to a trauma victim and accordingly, avoid talking about the event in order to alleviate distress. However, this can lead to the victim taking the blame or feeling as though others do not care, which in turn may lead to estrangement from others and social withdrawal, reinforcing emotional detachment from the trauma and problematic cognitive strategies (Ehlers & Clark,

2000). Poor social support has been associated with maladaptive coping skills such as avoidance, withdrawal, and emotional disengagement, which are behaviors correlated to substance use or other addictive behaviors that aid in the numbing of negative emotion (Charuvastra & Cloitre, 2008). Functional support has been defined as an individual's perception of social interactions and has been found more influential on posttraumatic distress as compared to structural support, which refers to the external aspects of one's social network including size, complexity, and actual support provided (Charuvastra & Cloitre, 2008). In a study of Vietnam Veterans, King, King, Fairbank, Keane, and Adams (1998) found that for both men and women, perceived social support was the most significant mediator for risk of PTSD and was negatively correlated with PTSD symptoms.

Peer support has proven to be a significant element of improved coping with mental illness and decreased substance use as evidenced by those who have participated in group treatment and 12-step programs (Magura et al., 2008). Substance abuse has been associated with PTSD symptoms due to the need for emotional dissociation from processing traumatic feelings. Ehrim (2001) used the term "escape alcoholism" (p.47) to describe the act of drinking excessively to numb the emotions associated with compounding grief experiences, has been found to be at a higher prevalence among African American women than other cultural groups (Battle, 1990). The significance of social support for psychological stability may be particularly relevant in terms of women with a history of substance abuse as they are frequently viewed negatively, due to the stigma of addiction and associated behaviors, by society. The high incidence of previous trauma in addition to poor coping skills increases the tendency for women suffering from substance abuse to withdraw from society due to the level of shame and hopelessness they feel in response to their actions.

Thus, based on the above brief review of literature, moral injury has been used to describe the challenge veterans encounter in trying to cope with the remorse, shame, and alienation from the community that they experience due to their participation in morally compromising behavior dictated by their environment. In attempting to broaden the conceptual application of moral injury, one population to whom it may be applicable is that of female ethnic minorities who have a greater incidence of having lower socioeconomic status, poorer education, victimization by abusive perpetrators, and fewer resources for coping with traumatic experiences in comparison to their male counterparts. This discrepancy seems to be associated with a higher rate of substance abuse for women with a history of PTSD and to that extent, it could be hypothesized that in their recovery, these women are challenged by the morally compromising experiences they engaged in during their addiction, proposing that moral injury has a broader implication in the realm of mental health.

PTSD, Women & Substance Abuse

In a study of female addicts, Daniulaityte and Carlson (2011) found that women viewed psychosocial stressors as having a strong link to all stages of their drug use including initiation, continuation, and escalation as well as relapse due in part to the women possessing very few positive coping resources and skills to deal with adversity and stress. Examination of female veterans have indicated a bidirectional relationship between PTSD and alcohol misuse which supports studies suggesting that women with PTSD are more likely to have substance-related disorders (Davis, Bush, Kivlahan, Dobie, & Bradley, 2003; Dobie et al., 2004; Nunnink et al., 2010). Repeated exposure to distressing experiences may perpetuate feelings of helplessness and numbness, leading to avoidant and dysfunctional coping. Dysfunctional and triggering environments have also been found to have a significant impact on the mental stability of

individuals and correlations can be made between the surroundings of war-torn areas and the environment of those fighting the battle of addiction.

Posttraumatic Stress Disorder and associated mental health problems, including depression, frequently result in isolation and social withdrawal from family and social support (Feczner & Bjorkland, 2009). High rates of trauma exposure and PTSD suggests that traumatic histories and posttraumatic stress sequelae are the norm rather than the exception for those in treatment for co-occurring substance abuse and posttraumatic symptoms leaving victims at greater risk for additional psychiatric comorbidities which may affect treatment and outcomes (Read, Brown, & Kahler, 2004). Gender has emerged as a significant risk factor for PTSD when other factors are controlled, with women's rate of PTSD being two to three times higher than those of men and their PTSD symptoms have been found to persist for a longer duration of time than for their male counterparts (Breslau et al., 1998; U.S. Department of Health and Human Services, Office on Women's Health, 2010). Women who perceive their behavior as immoral or damaging may have difficulty returning to their family system due to the shame they feel for disgracing their family and hopelessness regarding being able to regain the support and confidence of their loved ones. As previously indicated, the perception of social support is indicative of how traumatic experiences will be interpreted and level of disruption to an individual's cognitive schema.

A history of childhood sexual abuse has been hypothesized as a mechanism for mental health problems and shame due to early internalized transgressions of acceptable behavior, resulting in lower self-esteem, a defective view of self and failure to attain standards imposed by oneself, family, religion, or society (Feiring, Taska, & Lewis, 2002). Women with histories of childhood maltreatment (CM) incur higher rates of pain and poorer general health, in addition to

mental health problems, compared to women with non-traumatic histories (Lang et al., 2006). The prevalence of PTSD in survivors of CM range from 21% to 74% (Rodriguez, Kemp, & Foy, 1998). Challenges in various areas result from traumatic exposure such as relationship patterns, cognitions about self and others, and affective responses. Although these issues are often not immediately connected to one's history of abuse, the pervasive influence of these incidents signify the significant impact traumatic experiences have on biological, psychological, interpersonal, and spiritual aspects of the human experience (Fallot & Harris, 2002). Complex trauma has been applied to individuals who have endured multiple traumatic events, often originating in childhood. Individuals suffering from complex trauma manifest a broad range of symptoms including self-harm behaviors, relationship and sexual problems, poor personal boundaries, paranoia, brief psychotic symptoms, somatic symptoms, dissociation, re-enactments of abusive or violent situations, and loss of sense of self. Women with a history of abuse and, or complex traumatic experiences often utilize maladaptive coping in an effort to self-medicate, decrease mood symptoms, and avoid emotional triggers associated with the re-experiencing of trauma. Substance Use Disorders (SUDs) are highly comorbid with PTSD and other mood-related psychopathology in which the level of substance abuse is strongly correlated with the degree of childhood physical, sexual, and emotional abuse sustained by the individual (Khoury, Tang, Bradley, Cubells, & Ressler, 2010; Ouimette et al., 2010). Emotional abuse is an underlying factor in the breadth of abusive experiences encountered by women and has been shown to relate to physical health problems as well as mental health issues. The use of substances to anesthetize physical pain in addition to emotional distress is significant in understanding addiction and the continuance of maladaptive behaviors of individuals attempting to cope with various levels of desolation in an effort to dissociate from reality.

Substance use disorders increase the likelihood of PTSD by their association with lifestyles that elevate the risk of exposure to traumatic events or by increasing one's vulnerability to PTSD-inducing effects of trauma. In addition, PTSD has been identified as a causal factor for substance use as a means of relieving distress (Breslau, Davis, & Schultz, 2003). Research has suggested that PTSD might be the cause of nicotine dependence and other substance use and dependence, or these disorders may share common risk factors including dysfunctional family environment, personality traits, early conduct problems, and a family history of antisocial behavior (Breslau et al., 2003). The study by Breslau, Davis, & Schultz (2003) demonstrated that individuals who experience traumatic events without the development of PTSD symptoms are not at a markedly high risk for depression and substance abuse. Individuals with substance use disorders and PTSD symptoms experience greater disability related to physical and mental health. The National Comorbidity Survey reported that for women, the odds of having co-occurring PTSD and a substance use disorder were 2.48 and 4.46 (Mills, Teesson, Ross, & Peters, 2006). Various reasons can be provided regarding the function of substance abuse for those attempting to cope with PTSD including a means to feel better or counteract dissociative symptoms, to stop the pain of feelings and memories associated with the traumatic event, to gain a sense of control against the abuser, as a re-abuse of self or self-defeating reaction to low self-esteem, a means of prolonged suicide, continuance of a learned coping behavior from childhood, or as protection against the chaos of one's lifestyle, providing a false sense of strength and courage.

Trauma exposure and PTSD have been found to be highly prevalent among substance use disorders, with the highest rates among opioid, sedative, and amphetamine use disorders. Research has indicated that almost 95% of individuals receiving treatment for substance use

disorders reported a history of trauma (Read et al., 2004). This trend may be attributed to the high-risk lifestyle associated with such addiction, creating a cycle of increased exposure to trauma and potential further PTSD and self-medicating behavior to disengage from the negative effects of PTSD, in particular hyperarousal and re-experiencing symptoms (Reynolds et al., 2005). Associated problems such as poor social skills and poor occupational functioning create greater clinical concern due to the lack of social and financial support available to these individuals, which create further barriers to accessing treatment and may increase the risk of relapse due to lack of resources following treatment (Mills et al., 2006; Najavits et al., 1998). Traumatic experiences have resounding implications on individuals, families, and communities. Although PTSD has most recently been publicized in relation to military combat, countless individuals are negatively impacted by the devastating cycle of abuse, trauma, shame, and substance abuse on a daily basis. Regardless of the precipitating event that triggered the maladaptive cycle, select veterans and addicts alike have engaged in behaviors contrary to their moral ethics due to the need to survive in an adverse environment. The resulting dissonance between their morality and conduct emerges as an inability to effectively navigate the world and reengage in the social constructs expected of them either when returning from war or entering recovery. The clinical ramifications of further assessment and treatment of moral injury as an essential component of trauma work, and potentially other areas including addiction, demands further inquiry.

Clinical Description and Comorbidity of Substance Abuse

The leading causes of morbidity and mortality in the United States are related to health and lifestyle factors, which include the impact of childhood abuse and dysfunction on disease risk factors, quality of life, and mortality. The prevalence and risk of alcoholism, illicit substance

use, high-risk sexual activity, and sexually transmitted diseases have been found to increase with the number of childhood incidents of abuse suggesting that the impact of adverse childhood experiences on adult quality of life and health is strong and cumulative. In the Adverse Childhood Experiences (ACE) Study conducted at Kaiser Permanente in San Diego and the US Centers for Disease Control and Prevention, scoring of categories of adverse childhood experiences found that women were 50% more likely than men to have experienced five or more categories of traumatic events including abuse, household dysfunction, and neglect. Higher ACE scores were found to have a strong relationship to chronic depression, suicide attempts, dissociative responses to emotional trauma, addiction (including smoking, alcoholism, and IV drug use), problematic work performance, high-risk sexual behavior, and adult biomedical disease. These results indicate the profound and long-lasting effect adverse childhood experiences have on emotional and physical state of the individual throughout one's lifetime (Lanius & Vermetten, 2010). Childhood distress due to abuse produces anxiety, anger, and depression in children, which is often perpetuated into adulthood. Research has suggested that early trauma is associated with global self-attributions for negative events, which relates to shame-proneness including negative feelings about the self as inadequate and increased vulnerability (O'Connor, Berry, Inaba, Weiss, & Morrison, 1994). Maladaptive coping devices such as smoking, alcohol and/or substance abuse, overeating, and high-risk sexual behaviors are often then employed for the psychological benefits of relieving stress related to household dysfunction (Felitti et al., 1998). Motivation for substance use is often to escape suffering, relieve anxiety and unbearable feelings, and to help cope with feelings of shame and inadequacy. Women in particular have been socialized to repress negative feelings of anger, inadequacy, shame, and guilt leading to the use of substances as a means of coping with unacceptable

feelings (Ehrim, 2001). The lack of emotional regulation and healthy self-soothing or coping skills leads to these more temporary coping behaviors that tend to be used chronically and therefore result in various health problems and life-threatening medical consequences.

Substance Use Disorders (SUDs) are divided into two groups including substance abuse and substance dependence. Substance abuse implies external consequences of use including interpersonal difficulty, legal problems, and physical deterioration. Substance dependence reflects more internal ramifications of use including physical withdrawal, increased tolerance, and the inability to control one's use (McHugh, Hearon, & Otto, 2010). Approximately 20.1 million Americans use illicit drugs, with 3.9 million endorsing substance use dependency, a devastating condition associated with distress and disability. Substance abuse is described as three or more severe symptoms including withdrawal, tolerance, high effort to obtain a substance, giving up of other activities, and unsuccessful efforts to reduce use (National Survey on Drug Use and Health, 2008; Waldron & Turner, 2008). The disorder is characterized by the recurrent use of psychoactive substances associated with significant distress and dysfunction to daily activities. Substance use in the United States continues to increase. In 2011, an estimated 22.5 million Americans aged 12 or older, 8.7 percent of this population, identified as current illicit drug users in comparison to 8.3 percent in 2002. Illicit drugs were classified as marijuana, cocaine, heroin, hallucinogens, inhalants, or prescription drug misuse. Lifetime rate of substance abuse or dependence is more than 30% for alcohol and upwards of 10% for other substances (Substance Abuse and Mental Health Services Administration, 2011).

High rates of substance abuse have been found with individuals diagnosed with anxiety disorder potentially due to self-medication of symptoms resulting in negative reinforcement effect due to physiological symptoms associated with chronic abuse and withdrawal (Courbasson

& Nishikawa, 2010). Comorbidity with other disorders such as depression and PTSD, as well as high incidence of criminal behavior, contributes to the arduous treatment of the disorder. From an operant learning perspective, substance use is developed and maintained in the context of antecedents and consequences of the behavior (Waldron & Kaminer, 2004). The physiological effects of substances serves as a powerful reinforcement for continued use, as well as effects such as enhancement of social situations, tension reduction, and dissociation from negative or emotionally distressing events, which reinforces use and increases the likelihood of establishing a repeated pattern of maladaptive behavior. Waldron and Kaminer (2004) assert that social learning conceptualizes substance abuse as being influenced by observation and imitation of models, social reinforcement, expected effects, and self-efficacy beliefs about one's ability to refrain from use and dependence while the stress coping model identifies substance use as a maladaptive means of coping with stress and emotional situations due to a lack of appropriate coping models. Substance abuse has been viewed to some degree as a learned behavior in that it may be a maladaptive coping strategy used within the family system and has also been seen as a means of numbing or dissociating oneself from emotional or psychological distress such as that related to traumatic experiences and abuse. The use of substances as a means of coping with unpleasant emotions is associated with Posttraumatic Stress Disorder and frequently results in a maladaptive pattern of behavior in which an individual engages in high risk behavior in an effort to sustain their substance use and becomes vulnerable to traumatic experiences, further perpetuating the need for a substance to disassociate from the pain and moral implications of their behavior.

Research by Dearing, Stuewig, & Tangney (2005) suggests that shame-prone individuals use alcohol and substances to cope with negative emotions and are at a higher risk for

dependency issues, as well as problems with daily functioning that accompany substance misuse, creating a cycle of pain and shame. Sources of shame may include cultural oppression, childhood abuse or neglect, family dysfunction, adult experiences of violence or trauma (Weichelt, 2007). The prevalence of substance abuse and the significant impact it has on society in terms of the cost associated with healthcare, mental health, and corrections, demonstrates the importance of addressing the treatment of addiction as it affects society as a whole despite the marginalized view of substance abuse as being a problem impacting a subset of the generalized population.

Morality and Substance Abuse

Drug consumption among addicts is significantly influenced by consequences. Addiction has been defined as the habitual consumption of a substance or performance of an activity, caused or sustained by a psychological or neurobiological dependency (Wasserman, 2004). “Addiction” to a substance describes a compulsive pattern of use, characterized by impaired control over the use of the substance and continued use in the face of negative consequences. The moral model of addiction asserts that the persistent intense cravings to seek and consume substances, as well as the associated maladaptive behaviors, indicates a moral failure (Morse, 2004). Simply speaking, addiction is associated with disinhibition, leading to higher incidents of impulsive and risk-taking behavior deemed inappropriate by conventional societal norms. The impairment to frontal lobe structures, as demonstrated in those dependent on addictive substances including alcohol, cocaine, and heroin, influence higher order executive functions and impulsivity leading to imprudent actions (Leeman, Grant, & Potenza, 2009). Drug use may be viewed as immoral due to its effect on behavior and the increased risk of harm to oneself or others as well as the unnatural psychological state it produces (Husak, 2004). Disinhibition and addictive behaviors are related in that they carry moral implications and involve diminished

consideration of negative consequences which may result in harm to self and others (Leeman et al., 2009). Empirical research has confirmed the relationship between social bonds and criminal behavior, delinquency, substance abuse, and smoking (Agnew, 1993). In the 2004 Survey of Inmates in State and Federal Correctional Facilities, 32% of state prisoners and 26% of federal prisoners said they had committed their offense while under the influence of drugs. Among state prisoners, drug offenders (44%) and property offenders (39%) reported the highest incidence of drug use at the time of the offense. Among federal prisoners, drug offenders (32%) and violent offenders (24%) were the most likely to report drug use at the time of their crimes (Karberg & Mumola, 2006). Decreased self-control, as seen in addiction, has been found to correlate with a lack of close emotional ties, less time spent engaging in conventional activities, and rejection of the belief that the prevailing moral values of society are binding or should be adhered to in regard to one's personal conduct (Longshore et al., 2004). Thus, there seems to be a relationship between childhood discord and trauma, poor maladaptive coping, and substance abuse, possibly resulting in compromised moral behavior that may be difficult for a woman to rectify in recovery. Rectifying the shame associated with certain conduct, deemed disrespectful to self or others, has been found to be an onerous task as evidenced by veterans in combat who have difficulty reconciling their actions.

There has been a correlation between addiction and antisocial behavior among individuals suffering from poverty due to social and economic marginalization in society. Stressors and limited resources experienced during poverty and substance use increases the likelihood of risky and maladaptive behavior in order to cope with various obstacles (Husak, 2004). During one's addiction, individuals are often given over to their compulsions and cravings, which decrease their ability to think and perceive things in a rational manner. In the

recovery stage of addiction, the impulsive behaviors, detrimental decisions, and the consequences their choices had on others frequently results in self-deprecating thoughts (Neff, 1988). The manner in which individuals perceive their actions may have a significant impact on their recovery and ability to re-engage in society due to the manner in which they attribute their actions in regard to their view of self. Guilt has been shown to motivate individuals to make reparations for their behavior whereas shame typically results in feeling negatively about oneself, which results in self-denigration and unhealthy coping skills including isolation and avoidance (Stuewig, Tangney, Mashek, Forkner, & Dearing, 2009).

Moral standards represent an individual's knowledge and internalization of norms dictated by universal moral laws and culture. Shame, guilt, embarrassment, and pride are self-conscious emotions elicited by self-reflection and self-evaluation and can influence one's morality and behavior by providing feedback of the anticipated behavior and consequences. Shame-prone individuals would be inclined to anticipate shame in response to various behaviors and would in the same regard experience shame as a consequence of failures and transgressions (Tangney, Stuewig, & Mashek, 2007). Individual differences in resilience, how an individual processes difficulties to regain satisfactory life, and vulnerability to extreme stress are determinants of the intensity and duration of PTSD symptoms and the effect it has on the individual's feelings of hopelessness and despair, behavior, and future actions (Peres, Moreira-Almeida, Nasello, & Koenig, 2007). In a study of war veterans, Fontana and Rosenheck (2004) concluded that morally compromising actions engaged in during combat resulted in weakened faith and their eventual focus on mental health appeared more driven by guilt than by their traumatic symptoms or social deficits as they searched for a meaning and purpose behind their traumatic experiences. In this regard, the emotional ramifications of one's negative actions and

self-judgment may have a more significant impact on an individual's mental health than the trauma itself, due to the shame associated with the event and the meaning attributed by oneself or others.

Women, Crime & Addiction

The population of individuals incarcerated in the United States has increased 500% over the past 30 years with female incarcerations increasing at an unprecedented rate (Allen et al., 2010). Analysis of female incarcerations has demonstrated an increase of arrests more than double the rate of men, women have been found to be 10% more likely to serve sentences for drug-related crimes, and a large proportion of inmates have reported frequent substance use and associated problems in the year prior to incarceration (Dearing, Stuewig, & Tangney, 2005). In a large study comparing female offenders within a 30-year period, research indicated little change in personal characteristics and experience of those incarcerated however, there was a significant shift from 37% to 77% of arrests being related to substance abuse problems. Evidence also indicated that recent female offenders were more likely to have a family member with a criminal background and a two-fold increase of violence against other women in the penal system. In comparison to incarceration rates in the past, female offenders have been found to be significantly older at their age of first arrest and more likely to report substance addiction in crimes including homicide, assault, robbery, and property damage (Kruttschnitt & Gartner, 2008). Substance abuse is a major public health problem in need of effective interventions for diverse populations including women and ethnic minorities (U.S. Department of Health and Human Services Public Health Services, 2000).

Trends in criminal activity may indicate the influence of substance use on impulse control and judgment. Economic motivations are common indicators of women's violent crimes

and may reflect the feminization of poverty as well as the greater involvement of women in street drug economy. The overrepresentation of African American women in poverty increases their risk for addiction and places additional restrictions on their access to adequate treatment and resources (Rhodes & Johnson, 1997). The structural changes in current economic circumstances and changing gender roles are significant factors in female violent offences, as women are acting alone and indicating the primary motivation for criminal activity as the need for monetary gain or attainment of substances (Kruttschnitt & Gartner, 2008). In comparison to male prisoners, females in the penal system have been found more likely to use substances to cope with stress and traumatic experiences. In addition, their socioeconomic status is significantly affected by discrepancies in education, employment, and compensation (Bloom, Owen, & Covington, 2003; Nedderman, Underwood, & Hardy, 2010). This discrepancy further limits access to resources for adequately coping with previous trauma, addressing mental health issues, and receiving substance abuse treatment that would allow them to resolve the maladaptive cycle of addiction and incarceration.

Women who identify as being a part of both the criminal community and the larger society as a whole have been found to demonstrate elevated levels of psychological distress due to cognitive dissonance between the dual affiliation (Tangney, Mashek, & Stuewig, 2007). Findings related to moral judgment in the criminal population indicate that prisoners' morality is multidimensional and complex which contradicts the conventional tendency to label those with criminal backgrounds as morally inferior (Wolf et al., 2003). The significant percentage of female, child, and acquaintance victims may relate to feelings of guilt and shame during a perpetrator's recovery as they are faced with the implications of their behavior. Women in the penal system are poorly served by the system and are among the most marginalized and

vulnerable members of society. The vast majority of women involved in criminal justice are poor, single mothers serving sentences for nonviolent drug-related offences (Allen et al., 2010; Moe & Ferraro, 2006). A third of the women parents in state prison reported committing their current offense while under the influence of drugs. Mothers were most likely to report the influence of cocaine-based drugs (16%) and marijuana (15%) while committing their crime. About equal percentages of mothers in state prison reported the use of opiates (6%) and stimulants (5%) at the time of their offense, while 2% used depressants or hallucinogens. Thirty-two percent of mothers in state prison reported committing their crime to get drugs or money for drugs, compared to 19% of fathers (Mumola, 2000).

The role of women in our society contradicts the behavior attributed to crimes of violence, which is reflected in the societal stigma placed on female offenders (Kruttschnitt & Gartner, 2008). The view of others is often held in high regard as individuals do not want to be thought of in a negative manner or thought of by others as capable of committing certain morally questionable acts (Forest, 2005). The social disadvantages and stigma of society demonstrate the moral implication of substance use in regard to the potential harm to women, children, and the family system (Barnard, 2005). Despite the belief that women who engage in substance abuse are selfish and without concern for their family and children, research has found that addicted and non-addicted mothers generally have similar beliefs regarding the sanctity of motherhood (Ehrmin, 2001; Kearney, Murphy, & Rosenbaum, 1994; Wellisch & Steinberg, 1980). Throughout the course of one's addiction and even when in treatment, they often find themselves in situations where they have to award the custody of their children to family members or foster care, further contributing to the mothers' shame. Regardless of whether or not this is a temporary or permanent position, the loss of a child magnifies the existing negative beliefs about oneself,

feelings of inadequacy and hopelessness, as well as the guilt and shame associated with the perceived failure of being able to care for one's own child (Ehrmin, 2001). Substance abuse problems are associated with significant stigma within society and are influenced by the public view of substance use and addiction as incompatible with effective parenting, leading to a discrepancy in traditional gender roles for women in recovery (Barnard, 2005; Hogan, 1998; Klee, Jackson, & Lewis, 2002). Emotions have been indicated as the core of motivation for continued abuse and may provide the driving force and direction for maladaptive behavior in women in the penal system, further contributing to the cycle of addiction and criminal behavior (Barnard, 2005; Tangney et al., 2007). The magnitude of this strain, in addition to the myriad of additional issues facing an individual in treatment for substance abuse, can seem unmanageable and hopeless, leading to relapse and perpetuation of the negative pattern of behavior associated with addiction.

Those in recovery not only have to confront their actions, but also the ramifications of their actions on their family and the time lost with loved ones during their addiction and/or incarceration. In comparison to guilt, which is associated with the negative evaluation of a specific behavior, shame involves the negative evaluation of the global self, indicating a sense of worthlessness, powerlessness, and eventual desire to escape as an avoidance response, which often results in continued substance abuse in order to alleviate painful emotions (Tangney et al., 2007). Research has found shame-proneness to be associated with PTSD, obsessive-compulsiveness, psychotic symptoms, anxiety, depression, and low self-esteem (Tangney et al., 2007). In an analysis of interviews regarding women and alcohol abuse, alcohol consumption was primarily indicated as a source of recreational pleasure, self-medication and a means of coping with emotional pain, depression, and stress. Isolation from others can be a serious

problem for individuals in recovery for addiction and is especially true for those simultaneously struggling with mental health issues such as Posttraumatic Stress Disorder and depression (Magura et al., 2003). Unhealthy coping skills such as isolation can perpetuate a pattern of abuse due to lack of social support and negative thinking as well as an inability to cope with memories of the trauma and using self-medication as a means to address the problem. Thus, the stigma from society associated with substance abuse may be an obstacle for many women accessing treatment services due to the possible implication of being an addict, loss of control, and failure of attending to established gender roles.

Individuals engaged in chronic criminal behavior frequently externalize their attributions for behavior and view a broad range of crimes as victimless without giving significance to the psychological pain associated with crime. Guilt-inducing, shame-reducing rehabilitation may help reduce the significant recidivism and relapse rate of women in the criminal justice system by encouraging individuals to take responsibility for their behavior, acknowledging negative consequences, empathizing with the victims' experience, and feeling guilt and remorse for one's behavior rather than applying negative emotions to oneself (Tangney et al., 2007). Offender's ability to shift between the moral languages of criminal behavior and normative society may be a beneficial area to address in correctional and rehabilitation programs as a means of reinforcing moral modularity and an individual's ability to shift their moral direction. The concept of the moral-judgmental modularity suggests that one's morality can fluctuate as a function of one's goals at the time (Wolf et al., 2003). Women encounter various barriers when seeking mental health treatment due to the stigma associated with mental illness and substance use, limitations to healthcare coverage, lack of transportation and resources, as well as potential cultural barriers (Stacciarini, 2008). Utilizing the research of moral injury treatment with veteran populations may

provide a beneficial structure for treating other populations suffering from moral crises. In this regard, adapting empathic treatment to decrease shame in an effort to improve the patient's ability to process the consequences of their actions while addressing previous trauma, acknowledging their values, and strengthening one's sense of self-worth may allow for more effective, withstanding results.

Guilt and Shame Proneness in Relation to Substance Abuse

Women enter drug and alcohol treatment at a lower rate than men which may be a result of greater stigma and shame associated with chemical dependency, increased risk for women who enter treatment, including losing custody of children, and the possibility that women seek assistance for addiction-related problems from mental health agencies more readily than treatment centers. Thus, women often enter treatment with a greater sense of guilt and shame and have emotional needs different from those of men due to an exaggerated sense of responsibility, low self-esteem, and depression (O'Connor et al., 1994). Western culture reflects the tendency to suppress shame and keep the experience hidden by negating the concept of shame in social discourse (Weichelt, 2007). Women have typically been socialized to make internal attributions for failures and not reward themselves for their successes, leaving them vulnerable to feelings of shame in response to misdeeds (O'Connor et al., 1994).

Shame and guilt are commonly used interchangeably despite their distinctly different implications for motivation and adjustment. Guilt has been deemed a trait involving tension, remorse, and regret regarding the effect of one's actions on others and results in empathic concern and motivation for the offender to apologize or make amends as a means of seeking forgiveness. Guilt-prone individuals tend to be more empathic, accepting of responsibility, and able to manage their anger (Weichelt, 2007); and guilt-proneness is more positively correlated

with adaptive characteristics in which the individual takes responsibility for their actions and seeks atonement, which fosters healthy interpersonal relationships. Guilt focuses on the negative nature of a specific act or behavior whereas shame assumes a negative and judgmental view of the self in response to a behavior.

Feelings of shame in response to one's actions can result in a self-defeating cycle of negative affect and substance abuse to avoid painful emotions; while guilt, although painful, is less debilitating and more likely to motivate an individual to change their dysfunctional behavior (Dearing et al., 2005). The chronic life stress of developmental experiences frequently remain unnoticed as time progresses and the experiences are concealed by shame, secrecy, and social taboo, which impede the appropriate treatment (Lanius & Vermetten, 2010). Shame is an internalized focus of one's conduct, promoting self-destructive behavior due to the perception of the offensive act being a negative reflection of the global self and one's self-worth. Shame focuses on the self, including concern with other's view of the self, and results in denial, escape, avoidance and lack of self-forgiveness (Hall & Fincham, 2005). Shame is associated with poorer mental health and is coupled with a sense of worthlessness and powerlessness, which promotes defensiveness, interpersonal separation, and distance. This acutely painful emotional response is more closely tied to ethical, social and spiritual violations and arises from public exposure and disapproval of some transgression whereas guilt arises from more private distress within the conscience resulting in a sense of worthlessness, powerlessness and isolation (Tangney & Dearing, 2002; Tangney et al., 2007). Shame is a complex construct supported by the expectations of the self, family, peers, society, and the media. When an individual does not seem to adhere to or meet the expectations of others, they are left vulnerable to intense pain and feelings of unworthiness (Brown, 2006). This concept is especially salient in regard to those who

have a poor sense of self and are confronted by the judgment of others as they are more susceptible to accepting negative beliefs as reflections of who they are as a person rather than assigning the sense of failure to transgressions.

In a study by Benetti-McQuoid and Bursik (2005) exploring the individual difference in guilt and shame responses across genders, women who endorsed a feminine gender role identity reported a higher propensity for guilt and shame feelings in comparison to men. Western culture sensitizes girls to shame-prone reactions promoting a sense of powerlessness and internalized failure whereas male counterparts develop externalization behaviors with a negative assessment of the specific action, which protects them from shame reactions (Ferguson, Eyre, & Ashbaker, 2000). Gender role stress may be a greater indicator of shame-proneness as men have been found to experience more shame in relation to instances such as intellectual inferiority, failure in work, or intimacy problems. Whereas women shame-proneness has been implicated in victimization and failure to attain social expectations of gender roles such as nurturing (Benetti-McQuoid & Bursik, 2005). The social emphasis on women as nurturers and heightened negative implications of harming others in comparison to men is proposed as a significant indication of the detrimental effects of internalizing these experiences that would resonate for women in their addiction who have acted in a manner ego-dystonic to their self-identity (Ferguson et al., 2000).

Shame-prone individuals exhibit symptoms including psychological problems, anger, low self-esteem, and impaired empathy, which result in interpersonal problems (Dearing et al., 2005). Intimate partner violence, including aggressive acts that are physical, psychological, and sexual in nature, have been implicated in mental health problems such as anxiety and depression, as well as shame, and feelings of worthlessness and humiliation (Shorey et al., 2010). Healthy shame contributes to the development of conscience and allows individuals to monitor

themselves, recognize limits, and adjust behavior. However, problematic shame occurs when individuals are exposed to frequent, long-lasting or intense experiences resulting in the internalization of shame as part of one's identity (Weichelt, 2007). Those engaged in substance abuse may form an identity associated with their environment including being dirty and worthless which leads to their experience of social marginalization due to circumstances such as a nomadic existence. Occupying unsanitary places often shared by multiple individuals using substances contributes to the sense of being dirty and disgusting, which is linked to expressions of self-shame (Rhodes et al., 2007). Shame proneness and illegal, risky, or problematic behaviors including substance abuse and lower probability of practicing safe sex, have been shown to have a positive relationship (Tibbets, 1997). Clinicians have found that victims of abuse or trauma often experience shame potentially due to the secretive nature of the events as well as the stigma which promotes internalized shame-inducing thoughts of self-blame and helplessness (Tangney et al., 2007). Predisposition for shame proneness has been found to originate in middle childhood (Tangney & Dearing, 2002). This suggests that abuse during childhood could have an enduring impact on an individual's mental health due to psychological and/or physical aggression therefore leaving an individual at an increased risk for future victimization as they internalize interpersonal conflict as their fault and a reflection of their own negative self-assessment (Shorey et al., 2010).

Decreased guilt has been associated with self-forgiveness. The motivational shift that characterizes self-forgiveness is driven by changes in emotional, social-cognitive, behavioral, and perceived transgression severity (Hall & Fincham, 2008). Belief in a higher power and the assumption of forgiveness may be attributed to higher levels of self-forgiveness; however, in terms of morality and one's values or beliefs, the perceived lack of forgiveness from a higher

power and the internalized self-hatred and shame that results for some individuals inhibits their ability to make amends due to the intensity of the moral injury.

Populations of men and women in substance abuse treatment exhibit elevated levels of shame-proneness and externalization, and lower levels of guilt when compared to non-drug addicted populations (O'Connor et al., 1994). Shame based individuals feel vulnerable, disconnected, and isolated which frequently is demonstrated by symptoms including downcast eyes, lowering of the head, blushing, and averted gaze (Weichelt, 2007). Underlying issues of shame have been indicated in accounts of public shaming including demeaning interactions with police, healthcare professionals, drug dealers, other drug users, and the public.

When comparing men and women with substance abuse related issues, research has indicated that women score higher on indices of shame, self-blame and depression (O'Connor et al., 1994). Thus, the reduction of shame-proneness and enhancement of guilt-proneness may be a significant treatment intervention for those with substance abuse problems, because persons who are more guilt-prone tend to respond more positively to treatment interventions. Distorted cognitions regarding one's behavior as a result of substance abuse without shameful self-devaluation may help clients shift their reactions toward more adaptive guilt responses (Dearing et al., 2005). In a study by Ehrmin (2001), women in treatment described the overwhelming challenges they faced reconciling their feelings of guilt and shame about themselves as women and mothers in regard to their inability to be trusted with their own children due to negligence and poor decision-making including prostitution and substance use during pregnancy. Additionally, these women found it difficult to rectify the pain they had caused their family members throughout their addiction and their family's, especially their children's, difficulty to trust their ability to remain sober and responsible members of society. Culturally sensitive

treatment for women may need to specifically counter shame, helplessness and depression to empower women and decrease the tendency to attribute blame for negative events to one's self (O'Connor et al., 1994). Shame-inducing confrontation may be detrimental to the treatment of women in treatment programs as they may contribute to acceptance of blame and further intensification of shame leading to abandonment of treatment and possible relapse (O'Connor et al., 1994).

Shame and addiction appear to be cyclical in nature, as substances are used to sedate emotional pain. In the process of developing an addiction, individuals feel increasing shame and humiliation associated with their loss of control. In an attempt to sedate shame, a cycle of addiction and increasing shame emerges due to the behaviors and emotions associated with substance abuse (Weichelt, 2007). Perceptions of inferiority, alienation from others, and being afraid of revealing oneself as vulnerable have been described as motivation for substance use and allows a means to escape psychological pain (Wiklund, 2008). Research has indicated links between environment, health, and the embodiment of social conditions, including perceptions of self-worth, autonomy, and efficacy (Rhodes et al., 2007). Shame is associated with one's inability to solve personal problems and the additional aspect of being mandated to treatment by authorities may further reinforce one's shame when entering treatment. Educating individuals on the difference between guilt and shame, including social skills training techniques, promotes a shift from making negative attributions about self to negative judgments about specific behaviors. The power differential in a therapeutic relationship is also important to consider as it leaves patients vulnerable to experiencing shame and requires clinical consideration for those working with substance-related issues (Weichelt, 2007). Encouraging vulnerability in treatment through empathy and processing of previous trauma while providing consistent nonjudgmental

support may provide the foundation for healing necessary to promote change. Separately, behavior in the context of the environment while empowering women through improved self-efficacy and self-worth is an adaptation of moral injury treatment for women suffering from moral dilemmas that may perpetuate healthy coping to ideally alleviate shame.

Use of Focus Group Methodology

Qualitative research is utilized to promote the enrichment of understanding regarding the experienced meaning attributed to various phenomena through the viewpoint of the specific population being studied (Elliot, Fischer, & Rennie, 1999). When Robert Merton first utilized focus groups during World War II, he found that the non-directive interview technique was a cost-effective and efficient means of gathering qualitative data to illustrate individual patterns observed in cumulative analyses as people revealed sensitive information when they felt they were in a safe, comfortable environment with people who had similar experiences. Focus groups provide an interactive environment that allows individuals to contemplate and reflect on the issues addressed, while encouraging self-disclosure of the participants to express their perspectives in their own voices without limitations or constraints (Krueger & Casey 2009). The open response format of focus groups provides the opportunity for deeper levels of communication between participants, resulting in more detailed data regarding connection, expression and meaning attributed to the area of discussion (Stewart, Shamdasani, & Rook, 2007). The focus group method facilitates targeting a select group rather than a random sample to control for group characteristics, and a local sample will be used to provide a convenient location and thereby increase participation.

The use of focus groups allows for dynamic interaction between members that provides more detailed discussion and clarification of experiences in the participant's own words and

context that may be difficult to elicit with individual interviews (Stewart et al., 2007; Tufts, Wessell, & Kearney, 2010). Participant observation and interviewing is a means of social action, which allows the researcher to observe the socialization between participants in an effort to understand how people think about an issue (Halkier, 2010; Krueger & Casey, 2009). This method of qualitative analysis allows for discussion and interaction among participants with similar experiences, as a means of obtaining individuals' cognitive and emotional perceptions regarding sensitive information in a relaxed environment (Heary & Hennessy, 2002). Analysis of focus group data can then be applied beyond the conversational situation of what is discussed, but also to the interaction between group members, and interpretations across different contexts (Halkier, 2010). Applying this research method in the proposed preliminary study regarding the relationship between addiction and moral injury among African American women will allow the perspectives of participants to define the experience through first-hand accounts. A fundamental strength of focus groups is the ability to examine applied meaning and terminology from the perspective of the target audience by allowing the participants to act as the experts (O'Donnell, Lutfey, Marceau, & McKinlay, 2007). The themes and patterns of the narrative may contribute to the clinical treatment of women in recovery for substance use, by providing information regarding how women construct their world and the meanings they attribute to their experiences while in recovery and attempting to sustain their sobriety and reunify with family. Narratives provide insight into women's sense of self, as well as her role in the family system and society. In addition to personal experiences, discussion among participants will include expressions of more external and global views of society toward those ostracized due to addiction and associated behavior.

Utilizing a focus group as the means of information gathering provides the participants with the opportunity to listen to others who have endured similar experiences and have been able to successfully manage high-risk situations, therefore giving participants the confidence that they also have the ability to cope with their addiction and associated unpleasant feelings regarding their behavior. Having the opportunity to voice their experience in an emotionally supportive, nonjudgmental environment of peers has the potential to elicit more open communication about their true experiences as they observe other group participants speak candidly (Magura et al., 2003). Allowing the women to engage in a discussion with their peers in a safe, open environment may also allow the women to express the experiences surrounding their addiction and negotiation of recovery from their perspective as African American women. This type of forum could likewise provide a sense of empowerment for the female voice and emphasize shared experience, as well as identify the barriers women have endured to achieve their goals. In addition to the personal narrative, or accounts of one's individual experience of addiction and recovery, the proposed research study also includes a collective narrative of the shared story of the specified population of women.

Analysis of the collective narrative can generate information regarding the influence of gender, race, and socioeconomic class on their roles in their communities and the context of their experiences within society. Grounded theory emerged from the work of Glaser and Strauss (1967) and allows for the data collected to inform the construction the foundation of the theory, which provides the foundation for the concepts. Grounded theory allows for the revision of the data collected as the research progresses. This method can be useful in focus groups as information gained in one session can lead to the refinement of questions posed in following groups to gain clarity. In the application of grounded theory, initial interview questions can elicit

more detailed discussions of the topic to gather specific data for further development of the theoretical framework. Analysis of the data using grounded theory involves discovery of a theory through the analysis of data in which key factors are coded and then grouped into similar concepts and categories for the formulation of a theory that can justify the subject of the research (Carey & Ashbury, 2012; Charmaz, 2006).

Based on previous literature, the current study proposes to explore the potential relationship between the experiences of women with a history of substance abuse to those reported by male veterans who have experienced what has been defined as moral injury, as a result of the moral transgressions they engaged in during combat. Focus groups provide the opportunity for the women to explore accounts of their experiences related to trauma and addiction in relationship to moral injury and their perspective of the interplay between psychosocial stressors and moral values. Using qualitative research methods to provide a safe environment for women with a history of addiction to discuss their experiences and identification with some of the concepts related to moral injury could provide additional clinical information for addiction treatment and relapse prevention. Moral injury might be identified as an integral component of an individual's transformation as they confront the shame and guilt associated with their previous behavior. The social interaction and connection elicited by a focus group is a significant aspect of the data analysis that would not be possible through individual interviews.

Chapter 2: Methodology

Participants

The study will include two focus groups of 6-10 women in the Los Angeles area, currently in recovery for substance abuse including alcohol, cocaine (crack), heroin, and/or methamphetamines. The selection criteria include that participants be at least 18 years old and able to read English at a 6th grade level. The subjects must have abstained from substance use for the past month and must be actively participating in their recovery, which can consist of in-person residential treatment, outpatient treatment, or a 12 Step Program. Participants will include African American women who are not actively reporting or demonstrating psychotic symptoms. In terms of recruitment and contact with participants, personnel at identified drug and alcohol treatment centers including HealthRIGHT 360, Jenesse Center, Weingart Center, Clare Foundation, AADAP, and The Lighthouse as well as local Narcotics Anonymous and Alcoholics Anonymous meetings will be approached by mailing a permission letter to determine their willingness to have a graduate student request volunteers from their agencies (see part one of Appendix A). In the letter, the researcher will introduce herself, her intentions, and provide information about the study. The requests will include allowance for the researcher to contact participants from intact groups within the agency. Due to the delicate nature of the discussion, requests will be made to get volunteers from individuals participating in treatment, which will allow for the researcher to access participants from intact groups within the agency. Existing groups will have the established, underlying support and resources of the agency that may help address any issues that may surface following the focus group. The sensitive nature of information discussed may prove challenging with a group of strangers and accessing groups of participants within the agency would make use of the relationships between the women to

optimize the discussion. In addition, by entering an existing group, the researcher would be utilizing the familiar model of group interaction to facilitate a more specialized and focused conversation around a topic pertinent to women, which would be congruent with recovery treatment. These potential benefits seem to outweigh the risks of familiar groups inhibiting Donnaisclosure. The voluntary aspect of participation will be emphasized and participants will be reminded that their participation will not negatively or positively influence their involvement with the agency.

Once gatekeepers of the agencies grant permission to provide potential participants additional information about the study, agency personnel will be asked in a second letter (see part two of Appendix A) to distribute information including a recruitment flyer about the study to members of their group who are interested in participating (see Appendix B). Additional information regarding the study will be contained within a research study brochure that will also be provided to potential subjects describing the nature of the study and eligibility criteria for those who participate (see Appendix C). This brochure will contain information regarding: inclusion criteria for participation, intent and brief description of the study, voluntary participation, information regarding scheduled group meetings where the researcher will present additional information regarding the study, and the researcher's contact information.

The researcher will then visit the agencies to review the study details with the agency community, to identify potential participants (see Appendix D). Those interested in participating in the study will be asked to contact the researcher and will be provided a Letter to Participants (see Appendix E). The first agencies with an adequate number of interested participants will be identified for the study. If an individual is interested in participating in the study, but is not able to be scheduled for a focus group, a letter will be mailed to the individual thanking them for their

interest (see Appendix F). Subjects will be volunteers from agencies and programs that have agreed to participate in the study and they will be eligible to enter a raffle for a Visa gift card of \$50 to be awarded at the end of each focus group. The researcher will work with the agency/agencies to determine a comparable prize should they recommend a different form of compensation. Once a subject is identified, the researcher will review the inclusion criteria with her to ensure that she meets the following selection criteria, in which she:

- is at least 18 years old;
- is able to read English at a 6th grade level;
- has been abstinent from substance use for the past month;
- is actively participating in her recovery, consisting of in-person residential treatment, outpatient treatment, or a 12 Step Program;
- self-identifies as an African American woman; and
- is not actively reporting or demonstrating psychotic symptoms.

The focus groups will be scheduled to take place in group rooms at the agencies with their permission and at times deemed appropriate for the agencies to minimize disruption to the agency's services. If utilization of a room within the agency is not possible, the researcher will discuss potential options close to the agency where staff is comfortable having participants meet. A list of potential times for the groups will be discussed with the participants and the time most feasible for the majority will be scheduled. Participants will be called to inform them of the date and time of the scheduled focus group and will be given a reminder call the day prior to the group. A maximum of 12 women will be identified as participants to increase the likelihood of having the ideal number of participants attend. If fewer than four women attend the focus group, the raffle will be held however, the group will be rescheduled.

Prior to the start of the focus group, eligibility will be confirmed by review of self-report information indicated on the demographic questionnaire (see Appendix G). The questionnaire will request background information such as age, level of income, educational attainment, religious affiliation, and history of alcohol/substance use. The participants will be offered the option of completing it on their own or if they have challenges regarding the questionnaire, it will be completed privately via interview in which the questions are read aloud by the researcher who records the participant's responses. The purpose of homogeneous sampling will be explained to individuals interested in participating in the research, but do not meet eligibility criteria due to ethnicity. The benefits of including participants with similar backgrounds and experiences presents a more clear understanding of the information shared as well as promotes a more comfortable environment for participants to discuss their thoughts in a safe environment. Once eligibility has been established, the researcher will review and explain the informed consent verbally and in writing with the participants prior to conducting the focus group and will explain they may discontinue their participation in the focus group at any time or refuse to answer questions they prefer not to answer, without any negative consequences. Participants who choose to discontinue participation or refuse to answer questions will still participate in the raffle. During the consent process, the researcher will reiterate that the focus groups will be audio-recorded and will review the handling of confidential data collected. A copy of the signed informed consent will be provided to the subjects for their records (see Appendix H). The potential for distress will be discussed during the consent process, and a list of potential resources regarding further mental health services will be provided to all subjects upon completion of the group (see Appendix I). As previously described, the existing resources and

support offered through the agencies will also contribute to the safety and stability of the participants who are in treatment.

Joining with the group is an integral part of focus group research that enables the participants to feel safe, with the researcher and others, and trust that details regarding their personal experiences are treated with respect and dignity. Prior to the start of the group, refreshments will be served as the researcher welcomes the participants, to encourage pre-group conversation and help break the ice socially. The researcher will explain the purpose of the study and briefly share her personal motivation for exploring the proposed topic, in an effort to establish trust and an appropriate comfort level among the participants (see Appendix J). Different creative arts will be used during the introduction and close of the groups to enhance the group dynamic and establish an environment of safety and comfort. The benefit of using music in therapeutic settings has been supported by research for the improvement of social, emotional, physical, and cognitive areas. Music has been shown to improve various mental health symptoms including tension, stress, and mood enhancement (Choi, Lee, & Lim, 2008; Nayak, Wheeler, Shiflett, & Agostinelli, 2000; Standley & Prickett, 1994). Music is an integral part of African American culture and allowing a moment at the beginning of group to allow for reflection and connection between group members through a valued medium may serve to decrease tension and further establish a sense of community among the participants and elicit deeper discussion. As an initiation to the group, the song *Sometimes I Feel Like a Motherless Child* performed by Sweet Honey in the Rock will be played to set the tone of the group. Sweet Honey in the Rock is an a cappella group that celebrates music incorporating spirituals, gospel, and the Civil Rights Movement with womanist undertones appropriate for the discussions posed and the challenges of the women in attendance.

Following the introduction, the researcher will initiate an audio-recorded focus group of 90 minutes in length. The questions posed to the focus groups will be offered as discussion points from a list of predetermined questions regarding the participant's substance abuse history, actions or behaviors engaged in while in their addiction, as well as traumatic experiences encountered during their addiction that may have resulted in shame (see Appendix K). Interviews are semi-structured as per previously prepared questions to allow for informal, conversational data collection in which participants are offered the forum to discuss their perception of the research question in relation to their personal experiences and life events. A portion of the focus group questions have been adopted from a study by Drescher et al. (2011), in which health and religious professionals, with experience treating veterans, provide their assessment of moral injury. Additional questions were developed based on the research related to the connection between moral injury and substance abuse as well as treatment implications.

Focus groups will be conducted with participants to obtain information regarding their experiences with substance abuse and the moral implications of their behavior. The focus group format may allow the subjects to establish rapport with others who have survived similar experiences, with the expectation of eliciting an open dialogue regarding sensitive topics that may not be generated by individual interviews or questionnaires. The structure of the focus group will allow the researcher to pose open-ended questions to the group to evoke candid discussions regarding their unique experiences while providing a nonjudgmental space for the participants to be heard while forming connections between other women.

Research Objective and Specific Aims

Although there has been an increase in the amount of research attending to the issue of moral injury in relation to traumatic experiences, there remains a dearth of research examining

how this concept has been applied to other moral dilemmas as it has primarily been investigated in terms of the relevance for military personnel. This dissertation aims to examine the implications of the behaviors performed by women in their addiction and how the concept of moral injury may be applied to demonstrate further understanding of the moral dilemmas endured by these women.

Specifically, the dissertation will examine the following questions:

1. Among women with a history of substance abuse, do they identify with the theory of moral injury in application to their experiences and behavior when actively involved in their addiction?
2. Among women who identify the moral implications of their addiction as problematic, are there similar themes or salient differences between the female participants and the research regarding moral injury in regard to those in the military?
3. Among the participants, how do they conceptualize their pattern of substance abuse and to what extent do they relate their use to moral injury regarding the disparity between their behavior and the moral teachings and values upon which they judge themselves?
4. How do the experiences of women recovering from substance abuse relate to moral injury due to vicarious, observed, and perpetuated violence and trauma?
5. What are the dominant themes of substance abuse for women as they confront their addiction and maladaptive behaviors?

A focus group will be utilized to elicit stories of the experiences of women recovering from substance abuse and facing the implications of their actions. This approach will provide further elaboration of the women's experiences and insight they have gained in recovery. The

questions posed to the focus groups will be offered as discussion points from a list of predetermined questions regarding the participant's substance abuse history, actions or behaviors engaged in while in their addiction, as well as traumatic experiences encountered during their addiction that may have resulted in shame (see Appendix K). Throughout the group, observations will be made regarding the subjects' affect, level of discomfort, and nonverbal information.

Following the focus group, a couple questions will be asked of the group regarding their experience, a video of Maya Angelou reciting her poem *Still I Rise* (Mohitbahi, 2007) will be viewed, and a copy of the poem distributed to each group member in an effort to emphasize the resilience and strength of the collective voice of the group. The use of poetry to signify the close of the group provides a space for reflection through the use of the spoken word, which is a respected and foundational aspect of the African American culture as poetry, prose, and music are an integral part of the oral tradition (Fisher, 2003). In addition, the participants will be informed that the researcher will return, following analysis of the data, to discuss the findings of the study and how the information may be applicable to their treatment and recovery (see Appendix L). The participants will be debriefed in an effort to discuss their experience and address any issues that may have resulted from the discussion. A list of potential resources regarding further mental health services will be provided to all subjects upon completion of the group (see Appendix I). At the conclusion of the focus group, a bag of raffle tickets will be passed around to all the participants. A ticket will then be drawn by the researcher, and the winner will be awarded a \$50 gift certificate at the end of each focus group (or a gift of comparable value according to the agency standards).

Focus groups will be recorded and transcribed. Coding techniques will be used to apply grounded theory to the data in an effort to generate underlying concepts to support the theory. The researcher will generate notes about recurring themes and concepts presented among the participant's narratives following which the information will be coded and analyzed. Use of coding and identification of themes and patterns will be managed by the primary researcher through the use of Atlas.ti computer software (Friese, 2011) in an effort to collect, organize, and analyze content from the focus group discussions. Detailed analysis of the data will help identify if the larger research questions regarding the application of moral injury to women in recovery for substance abuse is supported by the subjects' responses. Detailed process notes regarding the focus group including observations of nonverbal communication, interactions between participants and the researcher as well as with one another, and the researcher's internal process will be documented. Consideration of the group process and the influence it has on the data provides a greater understanding of the group dynamic in terms of what it felt like in the room and how it impacted the content of what was disclosed.

Chapter 3: Results

Group Facilitation

The introduction of each group began with a half hour socialization period where participants and the researcher were provided the opportunity to enjoy food and get acquainted with one another. Despite the researcher's attempt to enter intact groups, due to the nature of rehabilitation programs, many of the participants who were initially present for the announcement of the study and request for participation were not present on the date of the focus groups. This was a result of some enlisted participants having conflicts with appointments as well as having left the program prior to the group facilitation. As a result, some of the women who participated in the focus groups had not met the researcher until the day of the group and had been informed of the study by program staff. In addition, although each focus group was restricted to women from the two perspective programs in which the groups were facilitated, some of the women had never been in groups with one another. The provision of ample food was a means of nurturing these women and conveying a sense of respect and appreciation for their participation and willingness to share their experiences as breaking bread and sharing meals are an integral part of the African American culture. The origins of soul food in the African American culture began with the enslaved for whom cooking was tied to one's culture, community, and pride. These traditions remain today as food unites families, generations, and communities (Regelski, 2014). During this period of socialization with the participants, there was a jovial spirit in the room as the women delighted in the treats, joked with one another, and had a chance to get to know one another and the researcher on a superficial level. The communalism – a cultural orientation emphasizing interdependence - exemplified by the group reflects the significance of connection within the African American culture where

interconnectedness plays a monumental role in social-emotional bonds (Abdou et al., 2010; Brown et al., 2013). In this regard the group found safety and a kinship with one another that promoted an environment of sharing and appreciation for each other's stories.

Once everyone had an opportunity to eat and the nature of the focus group was discussed, the song *Sometimes I Feel Like a Motherless Child* by Sweet Honey and the Rock was played. The particular song was chosen as it is a traditional Negro spiritual that originated when children of enslaved Africans were sold and removed from their parents, and conveys the agony and despair of a child separated from their loved ones (Burleigh, 1917; Marcos, 2009). Considering the focus of the group was to discuss experiences of women removed from their families due to their addiction, the song seemed an appropriate segue to set the tone of the discussion. The women sat in silence, reflecting on the words and their lives as evidenced by the emotion demonstrated after the last notes were sung. The particular song played seemed to resonate for the women as they engaged in a lively discussion for the remainder of the sessions, making reference to it and how it related to their lives as well as the injuries they had endured in their addiction. Initially there had been some concern about the participant's ability to be vulnerable and divulge stories that could potentially elicit shame however, the steps taken to prepare a safe environment that was culturally sensitive to the group participants seemed to alleviate the potential barriers that could be expected.

The feeling of communalism and sisterhood was apparent throughout each of the groups as the women were able to truly hear each other's stories, reflect how they related to themselves, and provide hope and support to one another as a result. The comfort and fellowship of the group were illustrated in two meaningful ways as I reflected on the group dynamics. The first came in terms of the participant's reaction to the researcher. During the introduction of the study an

explanation was provided to the groups regarding the reason why the study was specified to African-American women. Although I phenotypically resemble more of my Caucasian heritage, the participants were informed that my strong matriarchal family of African-American descent had an instrumental impact on my development as a woman, in addition to having worked largely with African-American women in my clinical training, which peaked an interest in further improving the understanding and treatment of this particular population. The responses from the personal disclosure suggested a connectedness between the group and the researcher. Lighthearted banter such as “You’re black?”, “Are you adopted?”, “I just would have never thought you was raised by a black lady,” and “That’s why I said you can’t judge by the cover,” suggested that the group welcomed me as part of the group. Due to the diversity within the African American community, there is an acceptance of members with varying complexions when there is a common culture, history, and ancestry (Basu, 2012). The women in the group were able to appreciate my heritage and were comfortable enough to ask more prying questions and make comments that may have been deemed impolite in a different context, yet were welcomed and laughed about in the intimate setting established. One participant’s comment, “So you relate to us real well” indicated the similarities not only between the group members, but also acceptance of the researcher as being a part of and the establishment of a common thread and appreciation for one another.

The second indication of group cohesion was made evident at the end of each group. Compensation for participation had been discussed in the announcements about the group as well as described in the consent and in the introduction, which would include a \$50 gift certificate to the winner of a raffle at the end of the discussions. The participants universally expressed excitement about the prize with comments such as, “I’m going to win” and discussions about

what would be purchased with the gift card. However, after two hours of bonding through laughter, tears, and shared stories, the women shifted from individuated to a collective unit. When the raffle was announced the participants expressed how they wish everyone could get a prize and in one group it was actually voted on if they would prefer to have the prize broken up into smaller donations for everyone. Raucous cheering erupted in each group when the winners were announced and comments were made by group members about how happy they were that the particular woman had won. Whereas initially, the participants may have been lured in by the promise of food and a gift card, at the end everyone left emotionally full.

The closing of the group included an audio recording of Maya Angelou reciting *Still I Rise*, a poem speaking to the strength and tenacity of the female spirit. Every group member was provided a framed copy of the poem in appreciation for their candor and willingness to share their personal journey. One woman expressed her appreciation for the group by stating,

I just want to say that I appreciate you listening to me and like [she] said, I feel a little better, you know, getting some of that off my chest. I feel a lot lighter. I can go in here and I can probably do this program a lot better now that I've done that.¹

Another group member shared,

What I got out of the group is that I'm making progress and I still have some emotional scars, you know when I still talk about the things that I've experienced and at times it still hurts I can tell in my voice. But I'm thankful that I am making progress and I'm not going to give up, you know. I think all of us should allow ourselves the opportunity to um to heal and just move forward.²

¹ All quoted material was obtained through personal communication from participants in the study.

² All quoted material was obtained through personal communication from participants.

A palpable transformation had occurred during the discussions as the women were provided a space of respect, appreciation, and support where they were allowed to heal.

Description of Participants

The sample for this study included two focus groups consisting of a total of 13 African American women in recovery for substance abuse. The women represented were between the ages of 26 and 49 and were currently participating in substance abuse treatment programs in Southern California. Pseudonyms have been used in place of the participant’s names to maintain the anonymity and confidentiality of all participants, their friends, and family members.

Table 1

Patient Demographics

Participant	Age	Ethnicity	Education	Religion	Employment	Number of Children
Antonia	26	African American, Other	High School graduate	Christian	Unemployed	2
Benilda	28	African American	High School graduate	Christian	Unemployed	4
Caroyln	32	African American	High School graduate	Christian	Unemployed	0
Donna	33	African American	10+ years of high school without diploma	Christian	Unemployed	5
Evie	34	African American	10+ years of high school without diploma	Christian	Unemployed	3
Farrah	40	African American	High School graduate	Christian	Unemployed	2
Gwen	38	African American	7-9 years of school	Spiritual, but not religious	Unemployed	Unknown

(continued)

Participant	Age	Ethnicity	Education	Religion	Employment	Number of Children
Holly	39	African American, Caucasian	One or more years of college, without degree	Spiritual, but not religious	Unemployed	3
Iris	44	African American	10+ years of high school without diploma	Christian	Employed Part-time	8
Jewel	46	African American, Native American	10+ years of high school without diploma	Christian	Employed Part-time	6
Kenya	46	African American	High School graduate	Christian	Employed Part-time	2
Lisa	49	African American	Less than 1 year of college, business or trade school	Christian	Unemployed	3
Marlise	49	African American	Two year college degree	Christian	Unemployed	1

Table 2

Biopsychosocial History

Participant	Intimate Partner Violence	Verbal Abuse	Physical Abuse	Trauma History	Comorbid Disorder
Antonia	No	Yes	No	Yes	No
Benilda	Yes	Yes	Yes	No	Yes
Carolyn	No	No	No	Yes	Yes
Donna	Yes	Yes	Yes	No	Yes
Evie	No	Yes	Yes	Yes	No
Farrah	Yes	Yes	Yes	Yes	Yes
Gwen	Unknown	Yes	Yes	Unknown	Yes
Holly	Unknown	Yes	No	Yes	Yes

(continued)

Participant	Intimate Partner Violence	Verbal Abuse	Physical Abuse	Trauma History	Comorbid Disorder
Iris	Yes	Yes	Yes	Yes	Yes
Jewel	No	Yes	Yes	Yes	Yes
Kenya	No	No	Yes	Yes	Yes
Lisa	No	Yes	Yes	Yes	Yes
Marlise	Yes	Yes	Yes	Yes	Yes

Table 3

Demographic Questionnaire Responses

Education	
7-9 years	8%
>10 years without diploma	31%
High school graduate	38%
<1 year of college	8%
>1 year of college without degree	8%
2 year college degree	8%
Religion	
Christian	85%
Spiritual, but not religious	15%
Victimization	
Intimate Partner Violence	38%
Physical Abuse	77%
Verbal Abuse	85%
Trauma	77%
Mental Health	
Existing Mental Health Diagnosis	85%
Depression	38%
Schizophrenia	23%
Bipolar Disorder	38%
PTSD	23%
Anxiety	8%
Family History	
Have Children	85%
Children removed from mother's custody	8%
Children reside with other family	46%
Children reside with father	15%
Children adopted outside of family	8%

(continued)

Substance Use	
Crack cocaine	62%
Club drugs	8%
Methamphetamines	15%
Marijuana	69%
Alcohol	54%
Prescription Medication	8%
Recovery	
Desire to stop substance use	92%
Attempted to stop substance use	92%
Motivation for Treatment	
Just did it	38%
Friends and family	31%
Incarceration	15%
Support meetings	38%
Substance Treatment Programs	62%
Prayer, faith, church	54%
Self-help books	15%
Wanted it bad enough	8%
Previous Length of Sobriety	
1-3 weeks	15%
1 month	8%
4-6 months	15%
7-12 months	15%
1-2 years	23%
>2 years	15%
4 years	8%
Number of Treatment Programs	
1	31%
2-3	38%
>3	31%
Number of Programs Completed	
None	31%
1	54%
2-3	15%
Length of Current Sobriety	
1-3 months	46%
3-6 months	8%
6-12 months	23%
>1 year	23%
Substance Use Has Affected	
You	69%
Family	100%

(continued)

Substance Use Has Affected	
Finances	62%
Education	46%
Housing	62%
Work	62%
Physical health	54%
Friendships	54%
Mental Health	62%
Safety	62%
Children	69%
Substance Use Has Affected	
Children's education	23%
Children's health	31%
Children's safety	15%

Participant Profiles

Antonia is a 26 year-old female of African American and Haitian descent. She graduated high school and identifies as a Christian. Her income is below \$12,000 annually and she is unemployed. The participant reports being a victim of emotional or verbal abuse as an adult and has been a victim or witness to trauma. She has two children including a 2 year-old son and a 7 year-old daughter who reside with family members. Her primary drugs of use are crack cocaine and club drugs. She is on parole and in treatment at the request of her parole officer. The participant indicated that she has wanted to cut back on her substance use and in the past has tried through self-motivation and assistance from friends and family for which she was successful for 1 month. She has participated in one substance abuse treatment program and has been sober for over one year. The participant indicated that her addiction has negatively impacted her family, mental health, safety, and her children.

Benilda is a 28 year-old African American, Christian female with her high school diploma. Her annual income is below \$12,000 and she is unemployed. She reports being a victim of Intimate Partner Violence, verbal, and physical abuse. The participant has been diagnosed

with depression. She has four children including 7 and 9 year-old sons and two daughters ages 6 and 8 years old. Her children have been removed from her custody and currently reside with family who have guardianship. The participant primarily uses methamphetamines, is on parole, and is currently participating in treatment as required by her parole officer. She reported that she has wanted to stop her substance use and has tried in the past by herself and by going to prison. She has previously maintained a change in her lifestyle for 1-2 years. She has attended substance abuse treatment 2-3 times in the past and has successfully completed treatment once. At the time of the group, she had been sober over one year. The participant indicated that her substance use has been problematic for her family, finances, housing, physical health, friendships, mental health, safety, and her children.

Cynthia is a 32 year-old African American, Christian female who has graduated high school. She is unemployed and has an annual income of less than \$12,000. The participant reports having been a victim or witness to trauma in the past and has been diagnosed with depression, Schizophrenia, Paranoid type, and Bipolar Disorder. She does not have any children. Marijuana is her primary drug of choice. She is currently on parole and is mandated to substance abuse treatment by her parole officer. The participant indicated that she has wanted to stop her substance use in the past and has attempted to decrease her use by attending support group meetings through which she was able to maintain a change for 1-3 months. She has attended and completed substance abuse treatment 2-3 times in the past and has been sober for 1-3 months. The participant indicated that her addiction has created problems for her family and her education.

Donna is a 33 year-old African American, Christian female who attended 10 or more years of school without her diploma. She is unemployed and makes less than \$12,000 annually.

The participant reported that she has been a victim of Intimate Partner Violence, verbal abuse, physical abuse and has been diagnosed with Bipolar Disorder. The patient has 5 children including three daughters and two sons who are currently in the custody of their father. Her primary drug of choice is marijuana, she is on parole, and is required to attend substance treatment by her parole officer. The participant reported that when she has tried to cut back on her drug use she has done so with the help of friends and family and maintained the changes for 1-2 years. She has participated in a treatment program once without completion and has been sober for over one year. The participant indicated that her addiction has negatively impacted her family, finances, housing, work, friendships, children, children's education, and children's health.

Evie is a 34 year-old African American, Christian female who completed 10 or more years of school without gaining her diploma. She is unemployed and has an annual income of less than \$12,000. The participant has been a victim of verbal abuse, physical abuse, and has been a victim or witnessed trauma. She has three children including a 6 year-old son and daughters ages 17 and 19 years old. Her children have been removed from her custody and are living with other family. The participant's primary substance use included crack cocaine, marijuana, and alcohol. She is currently on parole and is mandated to treatment by her parole officer. She expressed that she has wanted to stop her substance use and has tried through attending substance abuse treatment programs, prayer/faith, and reading self-help books. Through previous efforts she had been able to maintain a change in her lifestyle for 1-3 weeks. She has previously attended substance abuse treatment 2-3 times in the past, but has never completed a program. The participant has been sober for 1-3 months. She indicated that her

addiction has been problematic for her, her family, finances, education, housing, work, physical health, friendships, mental health, safety, her children and their health and safety.

Farrah is a 40 year-old African American, Christian female who graduated high school. She is unemployed and has an annual income of less than \$12,000. She has a history of Intimate Partner Violence, verbal abuse, physical abuse, and has been a victim or witness to traumatic experiences. She has been diagnosed with Bipolar Disorder. The participant has two children including a 14 year-old son and a 20 year-old daughter who have been removed from her custody and are currently in the care of other family members. Her primary substance use includes alcohol, crack cocaine, methamphetamines, marijuana, and prescription drugs. She is currently on parole and is required to attend substance abuse treatment by her parole officer. She indicates wanting to stop her substance use in the past and has attempted by participating in a substance abuse treatment program through which she was able to maintain a change in her lifestyle for 7-12 months. The participant has attended 2-3 treatment programs with one successful completion and has been sober 1-3 months. She indicated that her addiction has created problems for her, her family, finances, education, housing, work, physical health, friendships, mental health, and safety.

Gwen is an African American female who identifies as spiritual and completed 7-9 years of school. She is unemployed and has an annual income of below \$12,000. She has been a victim of verbal abuse, physical abuse, and has been diagnosed with Bipolar Disorder. Her primary substance of use is crack cocaine. Her current legal issues include waiting for a court hearing date and mandatory urine screens. She reported that she has wanted to cut back on her substance use and has used various methods to try to stop including self-motivation, attending support meetings, assistance from friends and family, attending substance abuse treatment programs,

prayer/faith, reading self-help books, and “wanted it bad enough,” which have allowed her to maintain a lifestyle change for 4 years. The participant has attended more than three substance abuse treatment programs, has completed one program, and has been sober 1-3 months. She reported that her addiction has created problems for her, her family, finances, housing, physical health, friendships, and safety.

Holly is a 39 year-old African American and Caucasian female who identifies as spiritual and completed one or more years of college, without obtaining a degree. She is unemployed and has an annual income of less than \$12,000. She has a history of verbal abuse and has been a victim or witnessed trauma in the past. The participant reported that she has been diagnosed with severe depression, PTSD, and alcohol dependency. She has three daughters ages 5, 6, and 20 years old who currently reside with their father while the participant completes treatment. Her primary substance use includes marijuana and alcohol. She reported that she has wanted to stop her substance abuse and has previously attempted through attending support meetings, participating in substance abuse treatment programs as well as prayer and faith which have enabled her to change her lifestyle for over 6 months. The participant is currently attending her first treatment program and has been sober for 6-12 months. She indicated that her addiction has been problematic for her, her family, education, housing, work, and children.

Iris is a 44 year-old African American, Christian female who completed 10 or more years of school, without obtaining a diploma. She is employed part-time and has an annual income of less than \$12,000. She has a history of Intimate Partner Violence, verbal abuse, physical abuse, has been a victim or witnessed trauma, and has been diagnosed with PTSD. She has six daughters and two sons. She reported that her children had been removed from her custody, but she regained custody and they now reside with family members. The participant’s primary

substance use included crack cocaine and alcohol. She reported that she has wanted to stop her substance use and has attempted to do so through self-motivation, support group meetings, and prayer/faith. She has attended substance abuse treatment once and has been sober 3-6 months. The participant reported that her addiction has negatively impacted several aspects of her life including her family, housing, work, physical health, friendships, mental health, safety, her children and their health.

Jewel is an African American and Native American female who identifies as Christian and completed 10 or more years of school without obtaining a diploma. She is unemployed and has an annual income of less than \$12,000. The participant has a history of verbal abuse, physical abuse, and is a victim or witnessed trauma in her past. She has 6 children who have been removed from her custody and are adopted by other families. Her primary substance of use is marijuana; she is on probation and is mandated to treatment by her probation officer. The participant reported that she has wanted to cease her substance use and has attempted through attending a substance abuse treatment program by which she was able to change her lifestyle for 1-2 years. She has attempted treatment programs more than three times, has completed 2-3 programs, and has been sober 1-3 months. Her substance addiction has negatively impacted her, her family, education, mental health, and children.

Kenya is a 46 year-old African American, Christian female with a high school diploma. She is unemployed and has an annual income below \$12,000. She reports being a victim of physical abuse, has been victimized or witnessed trauma in her past, and has been diagnosed with Schizophrenia, paranoid type and PTSD. The participant has two sons ages 18 and 23 years old. Her primary substance use included marijuana, alcohol, and crack cocaine. She reported that she is facing legal pressures including traffic violation debts and is required to attend substance

abuse treatment by Veteran's Affairs and the Matrix Program. The participant expressed that she has wanted to stop her substance use and has tried by attending a substance treatment program, which allowed her to maintain a lifestyle change for 4-6 months. She has participated in more than three treatment programs, completed one program, and has been sober for 6-12 months. She reported that her addiction has impacted her, her family, finances, work, physical health, mental health, and safety.

Lisa is a 49 year-old African American, Christian female who attended one year of college, business, or trade school. She is unemployed and has an annual income of less than \$12,000. She has a history of verbal abuse, physical abuse, and has been a victim or witnessed trauma. The participant disclosed that she has been diagnosed with Major Depressive Disorder, Anxiety Disorder, PTSD, and Bipolar Disorder with psychotic features. She has three children including two sons ages 16 and 21 years old and a 24 year-old daughter who reside with other family members. Her primary substance use included alcohol, crack cocaine, and marijuana. Her current legal problems include SSI and she is self-referred to treatment. The participant endorsed wanting to stop her use and has attempted through support group meetings, assistance from friends and family, attending substance abuse treatment programs, prayer/faith, and church, all of which had allowed her to maintain a change in lifestyle for over 2 years. She has participated in 2-3 substance abuse treatment programs without completion, and has been sober 1-3 months. The participant's addictive lifestyle has negatively impacted her, her family, finances, work, friendships, mental health, and her children.

Marlise is a 49 year-old African American, Christian female who has a two-year college degree. She is unemployed due to disability and has an annual income of less than \$12,000. She has been a victim of Intimate Primary Violence, verbal abuse, physical abuse, has been a victim

or witnessed trauma in her past, and has been diagnosed with chronic depression, and Schizophrenia, paranoid type. She has a 21 year-old child who was removed from her custody in the past. The participant's primary substance use includes crack cocaine, alcohol, and marijuana. She reported that her current legal issues include surrendering to jail and she self-referred to treatment. She indicated that she has wanted to stop her substance use and has attempted to do so through self-motivation, substance abuse treatment programs, prayer/faith, and jail, which allowed her to change her behavior for 4-6 months. She has participated in more than three treatment programs, completed one program, and has been sober for 6-12 months. She reported that her substance abuse has been problematic for her, her family, finances, education, housing, work, physical health, friendships, mental health, safety, her children and their education, health, and safety.

The focus groups prompted active discussion among the female participants as they shared similar and divergent experiences regarding their upbringing, digression into substance abuse, history of incarceration, and entry into treatment. The women candidly disclosed personal aspects of their history that were still raw as evidenced by the amount of emotion elicited by their stories of survival. Throughout the discussions, the group members gave testament to the significant traumatic experiences they endured and witnessed, which contributed to their substance abuse and seeming moral injury. Common themes emerged from the discussions including child abuse, emotional neglect, early traumatic exposure, maladaptive family patterns, family history of substance abuse, lower socioeconomic status, peer pressure, and the use substances as a coping mechanism. Issues including isolation, morally compromising behavior, and shame were also prevalent throughout the group discussions. However, despite the adverse experiences they survived, the women demonstrated compassion and empathy for one another

while positive factors of resilience were an underlying theme in their dialogue including peer support and spirituality.

Data Analysis

Each focus group was audio-recorded and transcribed by the researcher. The initial themes that were most prominent following the groups included process elements of the groups. The positivity of the women and their resilience was clearly evident throughout the group process, in addition to the vivid, tragic stories the women were able to share about their emotional journeys in an effort to have their voices be heard. The software Atlas.ti was used to identify word frequency and allowed the researcher to code the concepts discussed into larger concepts. The content related themes were those extracted from the text that were not immediately evident, but upon review were common threads throughout the narratives of women in their addiction.

Research Questions and Emergent Themes

The overarching feeling when leaving both groups was one of humility and profound gratitude. The women had not only been willing to share their personal accounts of their addiction, but consistently made each and every participant feel acknowledged and validated. They exemplified the fortitude and resilience of women as well as the powerful restorative properties of the group process.

Positive Factors

Throughout the groups the women were able to share their experiences and relate to one another based on similarities in their stories and situations they had endured in their addiction. Although many of the accounts were traumatic and heart wrenching, the women were able to

find a common voice and conveyed the empathy and compassion they felt for one another through positive words and actions of support and comfort.

Peer support. The support of others who have survived similar experiences provides a sense of belonging and understanding. Throughout the focus group, various members verbally agreed with others and provided validation and encouragement to each other, promoting a safe environment for women to share openly without fear of reprisal or judgment. Evie is currently in her first treatment episode and described the benefits of being in a program and feeling the support of the other women around her.

So me being in this program it's really good because I've got people who, you know what I'm saying, who care about me, who are my friends. And all this is kind of like new to me, it's scary, but I'm willing to try to change my life, cause I want to do something different, this is not what I wanted in my life, I didn't say when I grew up when I was a little girl, I didn't say that I wanted to be a drug addict. I wanted to be a doctor or psychiatrist. Whichever one didn't prescribe medicine [laughter] that's the one I wanted to be. (Evie, personal communication, August 22, 2014)

In response to another group member who had shared an emotional account of her past, Iris offered words of encouragement and guidance.

So, don't let your past be your future and don't be scared because you got to crawl before you walk. You gotta surrender. When you surrender, you can find out who you are. You got to let Him and stop fighting. He'll give it to you, believe me he will. (Iris, personal communication, August 25, 2014)

Holly provided uplifting words and lauded one of the participants for opening herself up to the group of women and letting her voice be heard. She acknowledged the difficulty women have

with trust, which limits their personal growth and prevents them from recognizing the similarities in their struggle.

You're making the right steps right now with um, opening up, you know, because we're all different women of all different walks of life. And um I'm learning a lot from everybody, you know. I think all of us can learn something from each other. We're so used to giving to men. We'll do anything for a man, you know, but it's so hard to trust women. And-and making the first step, and I say that personally, for myself, I'm the only girl I have 3 brothers, you know, that was hard, but it's like you know, um, just women getting together and learning to know that we have a lot similarities, you know. Instead of fighting each other, you know working together is actually the beginning, you know, and right now like I commend you for opening up and still, like you said, you are a soldier. You are the meaning of a soldier you know, all of us in here are. (Holly, personal communication, August 25, 2014)

In response to past abuse at the hands of others, Kenya emphasized to another participant that she was not responsible for the way others treated her and encouraged her to continue to heal from her past in order to move forward.

I just want to say, you know, you are not responsible for what someone else did to you, that was their issues. Like she said, what you have to do, you have heal yourself and you know who you are, you just have to allow that to manifest, you know what I'm saying. Keep working on yourself, try to live a quality life, make the right decisions, the right choices, you know, apply yourself, it will work. Just have some patience and some understanding. Read some self-help books, go to groups, or whatever. (Kenya, personal communication, August 25, 2014)

When reflecting on the process group, Gwen shared how her view of women has changed since she has been in the program and she recognizes how much she can relate to and learn from fellow women and their shared experiences.

I got something out of it. What I got out of it was that uh you know women do recover and I got out of it you know cause I-I'm not used to women, all my friends are male. So, so since I've been coming to the nine o'clock groups I've been learning how to interact with women, and I think that, whether I want to admit it or not, which I'm going to admit it, is helping me. You know what I mean, but I really look forward to seeing her [Iris] face. I don't know why. Yeah her and [Holly], certain people, and I be like, yeah, you know. You know what I mean, but it helps, like she helped me today so you don't need to know them. (Gwen, personal communication, August 25, 2014)

Spirituality. Spirituality and faith was an undercurrent in the stories of several group members and came in the form of an "Amen" in agreement to discussion of the role of religion in one's life and recovery. Many of the women commented on the role church and religious teachings had on their view of morals and values as well as the strength that they have gained from returning to the Bible or services where they have found comfort. Cynthia alluded to her faith and the role she believes her Higher Power has in her life and her ability to change.

So I thank God that He did, for a long time I said, I don't got no problems, you all send me to a program for weed, that's not like a drug, it's a plant, it grows, you know. But at the same time I did have a problem because I was trying to block out what I went through and I was trying to block out things I've done but at the same time I thank God that God put me here and I know I'm here for a reason because this place helps me to find me and to deal with those problems I was blocking out and it feels good, it feels real good as I've

been here for way, it feel like my shoulder's not heavy no more. And it took all them years for me to come here in order for me to feel that feeling and it feels real good, it feels good. And I'm glad that I'm here and I'm glad that I'm able to face it and deal with it, you know. Like not stuff it in, bury it, I'm able to deal with it now and I'm not afraid to deal with it because like I told you I like change and I do believe that one day this too shall pass, you know. (Cynthia, personal communication, August 22, 2014)

Cynthia discussed the role of church and religion in her early development and the importance it had in several generations of her family.

I had-I still-I had praying grandmothers and grandfathers. My great-grandparents they went to church all the way until they had Alzheimer's disease, still sitting in church and would ask you if I was sitting next to them, "Baby now who's daughter you say you was again?" You know, I was brought up in church, I was brought up as Christian. (Cynthia, personal communication, August 22, 2014)

Kenya credits God for her parents and their ability to be supportive and upstanding individuals who have proved to be positive role models for her and her children.

It's by the grace of God that I had parents who were responsible, who had a good life and they raised foster children and bring children into their home and people, you know what I'm saying, and help others, that my children would have been in the system. And it's by the grace of God that I have parents that didn't talk bad about me to my children, who, that I was their mother, and my sons, even though we may have issues and our relationship isn't what it's supposed to be, they love me and they respect me. (Kenya, personal communication, August 25, 2014)

Faith and God were identified as a significant part of Iris' daily life and survival as she described herself as being on a spiritual journey and discusses how her daily reading of the Bible provides her inner fortitude to make it through one more day with grace and patience.

I'm gonna tell you how I deal with stuff, it took, it took me a *looong* time and I'm just, I just turned 44. Don't get me wrong, I have bad days, but I have to, I give mine to God. I read Proverbs everyday from the every day to day... Can't no meeting, can't no nothing stop me but that Man upstairs and whatever I do I have to go to Him. I go to meetings because it keeps my sanity, you know what I'm saying. Talking to somebody else just like me. So maybe you need to take some, you find somebody like you, you need to talk I'll talk. I listen because we're supposed to listen. I'm on a spiritual journey right now.

(Iris, personal communication, August 25, 2014)

Resilience. One of the most remarkable outcomes from the focus groups was the resilience and strength demonstrated by the women. The challenges and seemingly insurmountable obstacles they faced were humbling to hear as they have not only survived, but exhibited tremendous character that allowed them to fight the colossal opponent of addiction in a battle for their lives. Their resilience and courage was awe inspiring to all those in the room as every woman was provided the opportunity to recognize and celebrate the strength of women. Upon arrival to the program, I overheard Farrah providing an excited account of her day where she attended an appointment with Cynthia and ran into a group of people she knew from the streets. She was literally jumping in excitement, with her friend equally excited and talking over her by her side as they described the confidence and strength she demonstrated by not taking advantage of a situation that would have proven so tempting in the past. During the focus group,

Farrah had the opportunity to express the pride she had in herself for accomplishments she views as tremendous feats such as not getting high when she runs into old acquaintances.

I'm so proud of myself today, you heard me in there, I'm so proud of myself today because I actually went to my old stomping grounds and I didn't get high and I ran into so many people I knew and I didn't get high. (Farrah, personal communication, August 22, 2014)

Cynthia has a long history of foster care, substance use, and incarceration, but spoke of her acceptance and appreciation for change and her readiness to be a better person with confidence and eager anticipation of the unknown.

I'm giving myself a chance, another chance to change, you know. And I like change and I believe in change. I'm not afraid of change. Some people are afraid of change, but I'm one of them that's not. I think I'm like that because of what I've been through in my life growing up. You know, bounced around, and I've seen a lot, so I think that's why I like change. I wouldn't change it for nothing else in the world because it made a strong, strong person. (Cynthia, personal communication, August 22, 2014)

She discussed her goals and dreams for the future, which include giving back to young individuals in need, who are enduring similar experiences to her own.

And you know my goals and my dreams, a lot of them I can't do, but it's some that I could do and that's one thing I wanna do is I want to give back one day. I want to go to the juvenile halls and I want to speak and I want to do it for free. I don't want no one to pay me for that. I want to go and I want to let them know my testimony and the things that I went through and let them know that change is possible and God is real and no matter what you went through, because there's a lot of people that's in the juvenile

system just like me. That grew up in the system, I want to go talk to kids like that, I love kids, but I don't have no kids. So, that's my whole motto. That's why I feel like giving this program a chance because when I first got here, they'll tell you, I was like "I'm not supposed to be here. I'm leaving." Everyday I was leaving. (Cynthia, personal communication, August 22, 2014)

Kenya expressed how she has to move forward despite the past and make the most of her life by learning to love herself.

Today I understand that and it's too late, the past's the past, but I still have to move forward so I'm trying to learn how to move forward. I'm learning how to forgive myself, love myself again, not just on the outside because I damaged and scarred myself on the inside... So I'm thinking I have hope today. I can still go to school, I can be a grandmother, I can still be a mother to my children, I can still be a mother, a sister, a brother, a daughter, anything that I want to be in life and that encourages me on a daily basis. (Kenya, personal communication, August 25, 2014)

After reflecting on the group experience, Kenya acknowledged the damage the past has done and the work that still lies before her however, she now has the confidence to praise herself for the strides she has made to live the life she dreams of for herself and her family.

I was going to say that you know what I got out of the group is that I'm making progress and I still have some emotional scars, you know when I still talk about the things that I've experienced and at times it still hurts I can tell in my voice. But I'm thankful that I am making progress and I'm not going to give up, you know. I think all of us should allow ourselves the opportunity to um to heal and just move forward. (Kenya, personal communication, August 25, 2014)

Family assistance. Many of the group members discussed the difficulty they have returning home due to the lack of trust and inability for their family to relate to their experiences or recognize how their own choices have impacted the lives of the women and their behaviors. Participants shared how they would appreciate family members to just be there for them and avoid talking down on them. Antonia offered, “while you’re in your recovery don’t feed into the past addiction like don’t bring it up with up, what you used to do... just go with the flow and don’t keep making me swim upstream to get to you, you know.” The impact of the environment and the behavior of family and friends around a recovering addict was also addressed by Cynthia who stated, “some people think alcohol and marijuana they’re not an addiction, so don’t smoke no weed around me because that weed may trigger me to go smoke something else.” Farrah expressed how she appreciates the way in which her parents respond to her when she is in recovery and shared that they ask questions in a manner that allows them to get to know her and her life more than as ammunition to use against her.

I really have good parents, um. They’re already supportive of me, but my dad is, he’s a very curious person because he didn’t lead this type of lifestyle, really. Um, he changed his life around. He’s seen all the things that I’ve seen out there on the streets so he’s, I can talk to him about everything and anything. I can talk to him about whatever, I’m real comfortable with him. And he asks me questions about different things that I’ve seen and he don’t look down on me. He just asks me questions for his knowledge, he don’t never look at me and sometimes he might look at me like “Wow”, and it helps me to know that he’s not looking down on me, he just, I can just talk to him about anything. It’s cool. And my mother too, it’s cool. (Farrah, personal communication, August 22, 2014)

Mental health assistance. Psychological issues and emotional damage are frequently identified as co-occurring problems for individuals with a history of trauma and substance abuse. The emotional ramifications of years of abuse and victimization are profound and negatively impact various aspects of one's life including relationships, ability to work, trust, functional ability, and judgment. In response to mental health and ways in which services or clinicians could assist women in recovery and coping with issues surrounding moral injury, Antonia discussed the importance of really listening to the individual and not making a brief assessment based on one's physical appearance without understanding some of the underlying issues that make daily tasks so burdensome.

But people will only get the help they need if they stop looking past um, me spelling words or me saying doop-di-doop with a child, or me saying oh or putting down a nice purse, look at me and think about this and then jump to this? Or why did she say that, you know, like really listen to what I'm talking about, you know, because I think I do, but I don't want help to get SSI or get meds, maybe I just want some closure, you feel me? Or if they do say, you need some meds? Alright I may see what's up, you know what I'm saying? Or if meds are cool. (Antonia, personal communication, August 22, 2014)

In the same vein Cynthia commented on the necessity of taking the time to learn more about an individual and the taking into account how their past has impacted them before passing judgment.

I think that mental health can help me more uh far as what [Antonia] was saying, it's true, like some people be like "oh if you go to your therapist looking like that, they're going to think you don't have a mental problem." Well, why not? Because... of the way I dress, because I'm me? Especially hitting on what she said, I agree with what she said and as far

as everything else, they great, they great. They help me out and them my best friends. As long as I keep a therapist in my life, I think that I'm going to be alright. But without a therapist I'm going to go crazy. I'm gonna start seeing people and hearing stuff and I thank God for therapists. (Cynthia, personal communication, August 22, 2014)

Contributing Family Issues

While moral injury has been applied to the challenges faced by veterans as they return from combat, the concept also resonated with women in both focus groups who were able to relate their experiences in their addiction to the perceived moral transgressions that they are faced with in recovery. The role of family and early childhood experiences were a common factor among many of the participants as they described their introduction to substances and illicit behavior that perpetuates the cycle of addiction, trauma, and shame. At the commencement of the group discussion each group member was provided a laminated definition for moral injury and were asked how they felt the concept related to their personal experience, if at all. The women asserted their agreement that the concept related to their stories and proceeded to share the particular incidents from their past that they deemed applicable to the concept of moral injury and how it attempts to explain the challenges faced in their addiction.

Whereas moral injury has been applied to veterans as more of a result of ethical transgressions engaged in during combat, for the women in the study, moral injury appears to be more of a process than an outcome. As the women described the circumstances that led to their addiction, they included various moral transgressions, typically originating in childhood, that were both violations of their values by others or behaviors they personally engaged in or witnessed that went against their morals and values. The women described how through their life experiences and in their addiction, there is a deepening of the trauma and moral injury as they are

exposed to further trauma, engaging in higher risk behavior, and subsequently deepening the moral injury. Due to the complex nature of their experiences, moral injury for this particular population seems to start as a scratch or abrasion that can be deepened by subsequent violations of critical values, until it becomes a disfiguring wound. The themes that emerged from the discussion reflect the ways in which the women experienced moral injury while in their addiction.

Child abuse and neglect. The experience of child abuse, neglect, maladaptive patterns of behavior including substance abuse, and exposure to trauma at an early age were some of the most poignant stories shared and appreciated among the group of women. These experiences seem to contribute to poor emotional regulation and low self-esteem as the children develop into women who doubt their worth and turn to substances to dull the emotional and physical pain of their lives. Evie observed significant domestic violence between her parents at a young age and described some of the most impactful experiences within her household between two parents who actively used substances and exposed the participant to violence and impulsive behavior at a young age.

My mom and dad were both drug addicts. My mom she got... she's half Indian and when she gets drunk she acts stupid. Bust out the windows, break her ankle for no reason, just whatever. But my dad he was paralyzed from the waist down, but my mom she was really crazy because my dad's already paralyzed from the waist down, she gets a 2x4, breaks his ribs, then I see my dad shoot my mom in the stomach, you know. Um, so yeah I did come from an abusive family, you know. And I think, I'm not for sure, but I think that I was born on drugs, because my mom and my dad used drugs. But they're both clean, well my mom is dead, well my dad is dead, but my mom is in the pen, for forever, for the rest

of her life in Chicago, but um, so yeah, I can relate to this. (Evie, personal communication, August 22, 2014)

Several women also shared how neglect by their primary caregivers and family members continue to have resounding ramifications in their adult lives as evidenced by the emotion demonstrated. Cynthia described the challenges she continues to face as a result of being neglected by her mother and subsequent damaging experiences she encountered in foster care.

My mom was not there so like I was lied to all my life. She'd come, it's like she would come and go and be like, "I'm gonna be back," and I wouldn't see her for a loonnngg time. That's why I hated liars. I don't like to be lied to. I just got issues because of that lady, but I love her dearly to this day. (Cynthia, personal communication, August 22, 2014)

Antonia shared the dynamics between her and her mother, who worked the swing shift and was not home in the evenings, "my mom she bought me a lot of things, but she didn't touch me a lot, you know," which she indicated may have contributed to her experimentation with alcohol and club drugs at an early age. Jewel described a significant history of neglect, emotional, and physical abuse as a child. Her decreased sense of self and disparagement by her mother diminished her competence for emotional regulation and resulted in substance use as a maladaptive coping skill for managing her negative emotions and experiences.

I was always... my mom... my mom would tell me, "Oh I didn't want you here and I don't want to be bothered with no girls; I got boys." So my dad would come get me, bring me back home, he'd tell her, "You know you can't just drop my daughter off and leave her and keep the boys, so." But at the time, I feel at the time, my mom was using

me, you know [crying]. She didn't want me there. (Jewel, personal communication, August 25, 2014)

Sexual abuse and molestation were also implicated as traumatic situations for several participants that has reverberated through their lives and contributed to their inability to effectively navigate subsequent experiences in a healthy and adaptive manner. The shame and isolation of sexual abuse and molestation were detailed in their accounts. Iris was sexually assaulted by her mother's boyfriend as an adolescent and subsequently had a child as a result. She describes the belittling relationship she had with her mother who engaged in verbal and emotional abuse as a result of the assault, shaming her daughter and forcing her into a spiral of isolation and shame where numbing the pain was the only way for her to survive.

Well, I was molested... so and I have a daughter that's 25 now by my mama's old man and my mama loved that old man more than she loved me. And to this *DAY* she still love that man more than she love me. She will not admit that he raped me, but she still wanna be with that man... and she said I'm the reason why her man left her and my mama hates me for that and I know she do. And she never told me she love me and I'm 44, but one time. She never hugged me, I'm bitch, I'm hoe, my children bitches, hoes, but she, the daughter that I had out of the process, she stays with her. And she talk bad about me to my kids, but my kids love their mother enough to let her know as they got old enough and wonder why they don't respect her and they cuss in front of her and do what they want because you disrespect their parents. So my children don't like that, but I try to tell them the other way because I just got a relationship with my mama cause when my mama said bitch, I said bitch. If she said hoe I said hoe. And I told her I spit on her and she back, you know what I'm saying. And I mean it was that bad, so I think, it was bad, real

bad. I mean, I'm ashamed of some of the stuff I said to my mama cause regardless, whether I know it or not, she need help too. Her dad abused her, not molestation, but they used to lock her in the door with padlocks. I had to find out what's wrong with her to make her treat me the way she treated me. So she didn't know what love was cause she wasn't taught that. (Iris, personal communication, August 25, 2014)

Jewel disclosed being raped at the age of 16 years old and having a child as a result of the offense. She not only had to cope with the sexual assault at a young age, but also provides an account of the emotional impact of her mother seeming to choose her baby over her own daughter. Even as an adult the repercussions of her childhood suffering was evident as the participant was visibly emotional during the group as she described the pain and torment she still feels as a result of being rejected by her mother and never feeling as though she was good enough.

You know, as I got older I got raped, whatever, and I ended up having my daughter at 16 and uh that was, my mother wanted um, I guess she wanted, she had gotten to that age so she wanted another daughter, but she didn't want me, I wasn't good enough. So I have my daughter, she took my daughter from me. I told my daughter I wanted to see her whatever, whatever, you know that was her daughter, not mine. I had her for her she told me. Growing up she told me she hated me, told my daughter that's like me that I wasn't shit. (Jewel, personal communication, August 25, 2014)

Early trauma exposure resulting from maladaptive family patterns. The impact of childhood trauma has been proven to have a significant impact on the lives of those involved and their subsequent relationships (Finkelstein et al., 2005; Kinsler & Saxman, 2007). Several of the group members shared traumatic experiences to which they were exposed at an early age that left

a lasting impression on what they deemed normal and acceptable throughout their development.

Evie discussed the physical abuse she witnessed between her parents at an early age, which had a profound effect on her adult relationships.

I seen my dad be physical with my mom and my mom be physical and then the mental abuse that I've been through, you know. It still hurts, you know, and for a long time as I was coming up, I blocked it out, you know so. Right now it just surfaced back up you know. And all the stuff, I had to go see a psychiatrist because I seen [sic] my dad shoot my mom in the stomach and for a long time, I just. I don't know, my body just blocked it out because I said that I used to say that it was a dream, you know. But you know I didn't want to face that it was real, but I know that it was real. So sometimes I feel like a little girl, I'm still a little girl, you know, and I'm still trapped inside. You know, so I know that's why I do drugs, you know because I have a lot of resentment toward my mom and my dad but I also know that they were in their drug addiction when they did the things they did. They wasn't [sic] in their right frame of mind. It took for me to get grown to understand that and I love my mom and my dad with all my heart because they're my mom and my dad, you know. (Evie, personal communication, August 22, 2014)

Holly described a happy childhood that was significantly altered by the disappearance of her father and the lack of communication within the family regarding the situation. Despite the values and pride instilled in her by her parents at a young age, the absence of her father during her adolescence and her inability to express the pain she felt prevented her from addressing the loss and instead was visibly evident as she discussed the agony that is still fresh and real for her over two decades later.

You know I was raised with my mother and father and um my-my mom uh, my mom is white, my father's black. My mom's a proud white woman and my father's a proud black man, so you know, they raised us to be proud of ourselves and they instilled a lot like, they were very involved, hands on, you know my father and everything. But uh my father was also um, he the type he was involved in everything, he was the coach on the field, we grew up on the baseball field, but he worked graveyard, so it was like I grew up like everybody sat at the dinner table to eat and everything. But he disappeared when I turned 16 so you go from uh, having all of...everything right there to him just disappearing and you not knowing, you know, you don't know what happened. We weren't allowed to talk about it. So, you know, in the beginning like the first couple of months it was like, we kind of felt like we had freedom, because we were like "oh dang." [teary eyed] but then it was like, wait a minute, where's my dad? You know? And I'm the only girl so I was like, it's hard, so it was like, you have to, I don't know, at some point like I wasn't raised like to do drugs. I did the DARE and all of that stuff and I-I didn't I grew up thinking seriously I was going to be, I was definitely going to college I was gonna [sic] fulfill all of that, but something happened when my father left I kind a, I guess at some point, and I'm not realizing it until now. I didn't realize it growing up, that that played an impact because we weren't allowed to talk about it. (Holly, personal communication, August 25, 2014)

The maladaptive patterns of behaviors within the family system were evident as the participants discussed their upbringing. Cycles of addiction, abuse, domestic violence, and degradation were a theme heard throughout the sessions as the women shared their stories of how their fate and that of their children has been considerably impacted at an early age by the

actions of others. Evie described the maladaptive patterns of her parents and how they affected her and her role as a mother.

I would never, I would never want to put my kids through what I went through, you know? But then again I feel like it's an ongoing cycle as far as my kids because my mom was never there you know in my life and I'm not there in my kid's life. Well my mom couldn't boil a pot of water, but I can boil a pot of water [laughter]. Cause my dad raised me, my dad raised me from the waist down, I mean he's paralyzed from the waist down, but if it wasn't for my dad I wouldn't be the strong black woman that I am today, you know what I'm saying? Because my mom she wasn't there at all, my mom she was on drugs, she kept a job, she was on drugs, she was a prostitute, um, just whatever she chose to do, you know. But you know, it hurts, but you know I did drugs, because I was trying to mask all that up or cover it up, but it, me being in this program has helped me to come to touch with my feelings you know [crying, then laughter]. But that's all I'm gonna [sic] say. (Evie, personal communication, August 22, 2014)

Iris described the problems in her childhood home including the absence of a father, domestic violence, lack of parenting from her mother, and a familial pattern of substance abuse.

I didn't have the parents and the house and all of that. My mama interest was how I'm gonna [sic] keep my man and my daddy got killed by my step-mama so I never knew my father as a father. I knew a trick, that's how my daddy was, my daddy died when I was a baby so I can't even tell you what he looked like. They tell me stories about him so I guess I got his attitude. I just lost two aunties, all of them was [sic] alcoholics and crack heads, I guess that where I get it from... Everything that happened to my mama happened to me. So, you know, she-she was a, I was an alcoholic since I was a baby. She sold

alcohol and I drunk alcohol so when she say go get me a beer out of the fridge I pour me one and take them two so I've been drinking since I was a little baby, so you know it's just normal. To me it was normal, hey. But then when I get drunk everybody want to talk. Why talk, y'all the ones who start me drinking so why complain now? (Iris, personal communication, August 25, 2014)

Holly discusses the cycle of abuse and addiction and her perception of how it applies to African American women and the acceptance of this destructive image in the community.

I do think that um, with African American women, being that this group is based on that, um I would say that it does kind of, because, you know history repeats itself, you know. What you're taught is what you pass onto your child because that's what you know. As well as your child passes it on and passes it on. Now where it stops at, you know there, abuse has been going on for-for many years, you know, for generations, but primarily was very known within the black women, you know so it-it depends on what, you know, what history where it stopped. Some it hasn't and-and yeah [looking at Iris]. (Holly, personal communication, August 25, 2014)

In agreement with the discussion at hand, Iris describes how she is trying to break the cycle in her own family system and reflects on how the contemptuous remarks between she and her mother, as well as what she permitted to occur in relationships, influenced the manner in which she related to her own children, which she has come to recognize as toxic and is making a concerted effort to amend.

I'm going to piggy back on what you said with the, it is up to where you stop it. It stops with me, that's why I'm here. That's all I was saying. I'm breaking the cycle because somebody's got to do it. My mama couldn't do it, Imma [sic] do it for my children

because I don't want my children to go through what I'm going through, you know what I'm saying. Thinking mens [sic], it's ok for men to call you bitches and hoes and slap around on you, don't do nothing for you and it's ok for me to call you bitches. I stopped calling, I used to call my children bitches and hoes you know, that's what I heard. (Iris, personal communication, August 25, 2014)

Family history of substance abuse. A family history of substance abuse and involvement in criminal activity proved as a blueprint for several of the women currently in recovery and continuing to struggle with their own addictions in adulthood. The substance use modeled for these women during early development demonstrated how drugs and alcohol could be used as a coping mechanism for managing negative emotions as well as in some cases, providing an unrealistic example of fleeting wealth and prestige associated with the sale and distribution of substances. Several participants described how their parents used and sold drugs and Benilda shared "I was born as a drug baby and my uh my mom she was in a crack house with us and she was doing drugs and the DCFS and my grandmother came and got us." Cynthia also shared, "I was a drug baby so I've been through a whole lot." Donna described that at a young age she saw family members involved in gang activity and was influenced by the money and affluence that their lifestyle afforded them. Although she discussed the lengths to which her mother tried to correct these behaviors in her children, the participant failed to be dissuaded and engaged in prostitution that left her vulnerable to the toxic environment of drug and gang activity.

My mom was the man at it, you know what I'm saying, and they changed, they're always having jobs, they have jobs, careers and stuff, but they still chose to still live the fast life too and then they quit. My mom got tired of it because she got tired of my daddy getting

caught up and going to jail and having to wait for all of them years for him to get out and help him get back on his feet. So I'm like, I'm leaving this alone because I don't want my kids to grow up trying to repeat my footsteps thinking they the man, you know what I'm saying, because that's how it rolls. You know you see somebody doing something illegal like that and then you seeing all this money and you seen all these clothes and these nice cars and stuff and you grow up. (Donna, personal communication, August 22, 2014)

Gwen described how her parent's parties and casual use of alcohol and pills led to her experimentation with substances at a young age due to accessibility and curiosity. She also alludes to the fact that due to her parent's work, she was raised primarily by her grandmother and later in the session relates to the experiences of Jewel in her feeling unwanted by her mother, and the lasting consequences of these relationships in their lives.

I remember when me-my mother used to throw parties like, "Thank God it's Friday," cause she like your parents [looking at Marlise] they worked all the time, provide for us, you know. I used to miss my mom, my grandmother raised me a lot. My mom and dad was in the home, but my grandmother was more there because my mom and dad both worked. You know, full time jobs, so um, anyway, she would you know, on Fridays they would you know, and uh, I don't know of my family doing any hard core drugs, but at the course of me getting older I found out they used to pop a little pill here or do the weed thing, but they grew out of it, it was like a phase, which I think is probably happening to me, I hope. But um, to make a long story short, we used to have to clean up (Gwen, personal communication, August 25, 2014)

Holly & Marlise: oh yeah, all those empty cups [laughing in agreement]

Gwen: and they be having all them glasses and cups of alcohol, we not talking wine, we talking, uh-uh

Marlise: Jack Daniels

Gwen: Hennessey, Jack Daniels, uh, Johnny something

Jewel & Marlise: Johnny Walker

Gwen: yeah all kinds, and boy we'd go up in there, all of us. And at that time, I don't know if it's true or not, but you know, I was going through stuff in the house, but when I- when I decided to pick it up or we decided to taste the stuff I know for a fact for me, I wasn't doing it to hide nothing or feel better. I just wanted to see what it is that they-that they uh, "What is this in this cup? Let me taste some of this." You know, then I found out it would get you loaded so "who want to help clean up? Me!", you know, so, yeah.

(Gwen, personal communication, August 25, 2014)

Kenya described a more idyllic family portrait initially in the group discussion and attributed her addiction and maladaptive behavior more to her military duty than her upbringing. However, through the course of the group she described her parents as less affectionate, although she stated she recognized they loved her.

They weren't the type, like you say, to hug us all the time, but their actions and on certain occasions and on special events I knew my mother loved me and she would tell us on birthdays or whatever, but um my step-father was more the disciplinary one, you know what I mean, because he worked from sun up to sun down and whatever, if one got in trouble, we all got in trouble. (Kenya, personal communication, August 25, 2014)

She went on to talk about her brothers and how their role in the community drug trade made her access to marijuana easier and her mother's seeming naïveté about substance use prompted her use in the home to be tolerated as a means of paternal oversight.

My brothers were small town big time dope dealers. My parents didn't know that, but that's what they did for themselves so I was like shit, I want to smoke a joint, that would be my first joint. I flipped out and after I flipped out I went home and I told my mother, she took me to the church, had the preacher pray for me and shit. I don't know why I told her, but it scared the shit out of me, you know. And she was like if you're gonna do something like that, I would rather for you to do it at home, even though she doesn't condone drugs and if something would have happened to me, she wouldn't have known what was going on because even today she's supporting me, but my mother is clueless about-about how drugs affect you, but she's, you know, we've had too many people, so many young adults die behind drugs and alcohol, you know. (Kenya, personal communication, August 25, 2014)

Socioeconomic status. Socioeconomic status has been linked to higher rates of substance abuse, violence in the home, and exposure to trauma. During the description of their upbringing, participants alluded to financial constraints that may have been a factor in terms of what they were vulnerable to at a young age. Antonia stated that her mother worked the night shift, which is when she “started coming out of my little shell.”

My mother used to have to go to work at 11:00. At night. Ok, so she started going to work at 11:00 she wasn't coming home 'til like 7, and I should already be on the way to school, you know, when she was getting off at 7. (Antonia, personal communication, August 22, 2014)

Donna described how her mother's work required her to leave her children with her sisters.

She stepped out because she always wanted to be a working mom and leave us with her sisters and stuff and you know my mom, she's cool, she lets me do anything I want I don't care what, I'll get my own place, you all can do what you all want to do as long as you do it around me because I don't want to get a phone call saying my daughter's doing this, doing this. (Donna, personal communication, August 22, 2014)

Parentification of children in the family often results from parents needing to spend time outside of the home for various reasons, including due to vocational requirements such as managing multiple jobs in an effort to provide for the family. Marlise explained that her parents worked multiple jobs and relied on the children to care for one another in their absence.

But you know my parents, they were never the type to hug you, and kiss you, and stuff like that. "Go on to bed." They was [sic] too busy working trying to give us everything. They didn't have time for that. Mama was working two jobs, Daddy was working his ass off, you know, everybody was working to make ends meet so they didn't have time for that. My oldest sister, it was five of us at the time, so me and my little brother we was two years apart and I had an older sister and an older brother that were like one was five years older than me, the other was seven years older than me, so my mother gave each of them, "this is your chil' and this is your chil'." So my oldest brother had me and my older sister had my little brother. Then I had a sister who was just left there. And she's the only one who really did her thing, you know. (Marlise, personal communication, August 25, 2014)

Despite her family's financial struggles, the participant described doing well in school and having a supportive family environment.

I was an honor roll student, lived in a family where we was doing very well. We didn't have to want for anything, wore the best of clothes, uh when you graduated from high school you went to the car lot and picked out any car you wanted. I had a brand new car at the age of 18, you know. I got a full scholarship to UC Santa Barbara, but I didn't go because I was so used to being around my family. (Marlise, personal communication, August 25, 2014)

Kenya also described having a comfortable life where she was raised by her mother and step-father who were hard workers and provided for their family.

My real father and my mother divorced when I was five. She had previously been married before she met my father. She had three sons and then she had myself and my brother. She met my step-father when I was 5 years old so my mother's 3rd marriage was her longest marriage, up to 40 years until my father died, which I consider my step-father my father because he came into my life at the age of 5. My real father, I really didn't know him because by the time he was gone, my step-father was in the picture and you know, my parents all they did was work, be responsible, and like everyone else I was sheltered and never had to have a need for anything and got some of the things we wanted. (Kenya, personal communication, August 25, 2014)

Values. Values and morals are typically constructs established in childhood by parents and elders in the family that continue to structure the way in which individuals conduct themselves and treat others. In terms of moral injury, it has been posed that going against those indoctrinated values can result in significant shame that can be paralyzing as an individual gets lost in a cycle of maladaptive coping to temporarily quell negative emotions (Litz et al., 2009). Farrah described her difficulty navigating between the values that her parents taught her and her

recognition of how her actions in her addiction are the antithesis of the principles instilled in her at an early age.

Me and my father were very close coming up and he didn't teach me that it was ok to get beat up by a man, he didn't teach me it was ok to get beat up so when I allowed myself to stay in a relationship like that or keep going into relationships like that, it was going against my values, so to this day it really bothers me because that's not how he raised me, that's not what he taught me, how a man is supposed to treat you. And coming from your father it means a lot because he stayed there and he raised me and he's raising my children now. And it's just not ok and I went against all my values to stay in that kind of relationship so I kind of blame myself for ALL the things that have happened to me because he told me, he taught me better. (Farrah, personal communication, August 22, 2014)

Although Evies' father instilled values in her as a child, she explained how his actions made more of an impact on her behavior.

I mean my dad pretty much did tell me that it's not ok for a man to put his hands on you, but at the same time I watched him put his hands on my mom or his girlfriends when I was coming up so as far as my values go, as me coming up on my own, I'm saying ok, that's not something I want in my life. (Evie, personal communication, August 22, 2014)

Farrah described her childhood as sheltered and described how her perceived lack of freedom prompted her to go against the direction that her family tried to steer her.

I come from a family that didn't do nothing. They don't even smoke cigarettes. So, and if they do drink it's on occasion and if they're social outing and they the type and they the type that you take them one drink a-a-and that's it. So, how I ended up like this I don't

know. I was raised in all kind of-I think too many morals and standards at, there was too many standards. Sheltered. I wanted to do everything that they told me not to do.

Everything that they told me not to do and everything that I've done, they've done told me the opposite. No cigarettes, no alcohol, no uh, they even told me I was marrying an alcoholic and I didn't think he was an alcoholic so I married him anyway but come to find out he was, he is and alcoholic [laughter]. (Farrah, personal communication, August 22, 2014)

Kenya explained that she was brought up with values and was aware of right and wrong.

We were taught to be responsible and-and-and we were intelligent enough to understand what was right and what was wrong. You know my mother she's always been honest with us. My parents didn't drink or do drugs. Um, they smoked the hell out of fucking cigarettes, excuse my language, but um when I uh, when I was uh 18 and I went to the service, you know, I started drinking. Before then I started smoking a little marijuana and stuff, and I knew it was wrong. And I just-I didn't do anything because I wanted to escape anything because I wasn't raised to be emotionally abused or verbally abused, my parents never called us out of our name, never talked bad about our fathers because they weren't there. You know, my parents really loved us. (Kenya, personal communication, August 25, 2014)

Family reunification. Reunification with family members has been discussed as a potential source of contention and stress due to the potential for shaming and blame directed at the individual who has engaged in negative behaviors during their addiction. Some of the group members addressed how family reunification has been difficult in the past due to a lack of support or understanding of addiction as well as arrogance from family members who previously

struggled with addiction and have been able to maintain sobriety. Cynthia described her difficulty returning home to her family due to their lack of trust in her based on her previous actions.

It's hard, it's hard because it's like they don't really trust me no more they don't trust my word. So it's like I've got a lot of proving to do. Not even for them, for myself first. It ain't even about them, it's about me. And then what's about God, then me, and then them. That's how I put it. But, It's real hard you know, and then when I go around they be looking, they be hoping I don't do nothing, I don't snap on nobody or I don't, cause I'm a violent person. So, it's real hard when I be around my family. But they love me and they always take me in, they always take me in, every time. (Cynthia, personal communication, August 22, 2014)

Donna explained her family's reaction when she would return home while in her addiction and how their reactions influenced the negativity she felt about herself and her actions.

cause my sister and them they looking at prostitution, they used to look down on me like, "You nasty, like ew, how can you just be out there like just letting anybody on top of you or just being in all these men's faces, in their cars, you know giving yourself away like that? Like you don't cherish yourself? You don't think you're worth more than that? Like you don't even gotta [sic] do that, like mom never raised us like that, we're not doing it so why you doing it?" "Like you know you better than that [Donna], stop playing stupid, stop trying to be dumb, you know what you doing, you know what's about this school and this education." She said, "You ain't gonna [sic] get nowhere like that, but end up in jail like Daddy and them did." (Donna, personal communication, August 22, 2014)

Iris explained how she has had to make tough decisions regarding her relationship with her children and the extent to which she will allow them to have power over her as they have difficulty moving on from the past. She discussed how she uses her faith to help her navigate the strained relationships she has with them as she recognizes that their inability to forgive the mistakes she has made in the past is detrimental to her own recovery.

But like I said, this weekend I gave my children to God because my children are still, they still live in the past sometime, which my older daughter keep it moving and I'm glad she's like that, I just got the other oldest one to keep it moving too because used to be they throw it in my face what I have done. I asked for your forgiveness and I'm only gonna [sic] ask you this last time. If you don't forgive me that's your business cause I'm gonna [sic] move on. So I gave my children to God. (Iris, personal communication, August 25, 2014)

Women and Substance Abuse

Peer pressure. Adolescence can be a challenging time for anyone and is typically identified as a period of experimentation and self-exploration as individuals begin to exert more independence. Peer pressure was identified in several stories as a common precursor to substance use in an effort to fit in or gain acceptance from peers. Donna described her early substance use and hanging out with the wrong crowd as a way to be accepted.

We thought it was cool we thought it was fun, like that's the thing to do and we knew it wasn't the thing to do, but we just tried to fit in to let them see how we get down so they could fit in with us so you know to try to change somebody, but my mom said you can't change nobody. You know, she said, people will be who they are. (Donna, personal communication, August 22, 2014)

Even as an adult, Donna referred to her environment and those she surrounds herself with as a challenge in her recovery.

I'm trying to change. I've always tried to change, but something just keeps holding me back you know, and I know what it is. It's the people that I'm around. You know, and I know it's not me. So I need to focus on myself and move forward and stop looking back at everybody else. (Donna, personal communication, August 22, 2014)

Gwen described how her substance use began as a means of fitting in with her peer group and eventually manifested into a way of coping.

I was a graduate of DARE, the Drug Abuse Resistance Education, so when uh I started doing drugs at 13, uh I knew I was doing wrong, but like I did it to uh, at the time it wasn't for escape, it wasn't for you know, the high feelings, it was to fit in, you know, uh, because everybody else was doing it, it looked like they was having fun so you know I wanted to have fun and do it too. And so just like that [snaps fingers], you know, but I know from the way I was raised, and like I said the DARE program, I know about drugs and that was not you know a good thing to do. (Gwen, personal communication, August 25, 2014)

Trying to fit in during adolescence also related to Marlise who discussed her introduction to marijuana and subsequently to alcohol as a way to conform and gain approval from her peers.

I can remember when I first got high it was on some weed when I smoked that weed it was only because my cousin was smoking it and she was like "hit the weed, hit the weed." And I was like "girl, nah-uh, we gonna get in trouble." I'm 17, we gonna get in trouble. So I hit it, but I was scared to go home after hitting it one time because I knew in myself, that was not me. I wasn't raised like that and you know that's disrespecting

yourself and your family. So I never did it again after that. But I can remember when I had my first drink it was just because I wanted to be fitting in, you know, I was at a club and a guy asked me, “you want a drink?” I didn’t know what to say. I said, “yeah, you pick it for me.” He said, “Long Island Iced Tea.” And I’m drinking it like it’s Cool-Aid. (Marlise, personal communication, August 25, 2014)

Jewel began smoking with her aunt when they were adolescents and expressed how her longing to be near someone who was nice to her led to her use at a young age.

My aunt was smoking weed and she decided, I was 14 years old, she brought it on me so I started smoking with her, hanging out with her for the summer. And I wanted to be with her because she would take me to fun places, do things, to the malls every day, I just wanted to be with her, so I was just like let me get high. Let me smoke this weed with you so I could follow you, so I could just be with you, you know. (Jewel, personal communication, August 25, 2014)

Substance use as a coping mechanism. Substance use as a means of numbing emotional and physical pain has been established as a frequently utilized, yet maladaptive coping skill. Several of the women interviewed identified their substance use and subsequent addiction as being a consequence of previous trauma and negative situations that they were trying to negate by means of temporary escape. Unfortunately, the cycle of substance use often leaves an individual vulnerable and even more susceptible to additional traumatic experiences and associated negative emotions. Farrah described using substances to cope in an abusive relationship.

When I married, I married an abusing husband so, and ever since then being married to this man and him abusing me for seven years, I turned to alcohol first. And I’ve done

some prescription meds, crack, and I keep going back to it. (Farrah, personal communication, August 22, 2014)

Cynthia described how she turned to substances to numb the pain resulting from the absence of her mother

My mom was on drugs all my life so I guess that's where my addiction comes from. Since she wasn't there it's like I wanted to numb myself like and then when she did come back around I didn't get from her what I thought that, I didn't get from her the reaction I thought I was going to get. It was more like her talking down on us once she got her life together. (Cynthia, personal communication, August 22, 2014)

Benilda attempted to escape low self-esteem, the devastation of an abusive boyfriend and the loss of her mother through substance use. She later lost custody of her children further perpetuating the succession of shame and abuse.

My mom was out there doing drugs and when, when I met my baby daddy he used to beat me and like threaten me and say that I was worthless, I was no good, that no one would ever want me. And for me, to take the pain away, I would use drugs. Then as I said, a few years later my mom passed and I found her dead in the bathroom and I turned to drugs. My kids got taken away, I turned to drugs. To numb the pain. (Benilda, personal communication, August 22, 2014)

Cynthia grew up in foster care and the juvenile system. She described how she smoked marijuana to cope with her childhood and block out the memories that she could not escape.

What I was doing was I was taking my past and what I went through as a child and I let it mess my life up, like as far as trying to block it out. That's why I was smoking weed a lot because it would take me on another cloud. I would forget about everything and guess

what, it defeats the purpose because when your high go down, your problems still there.

(Cynthia, personal communication, August 22, 2014)

A long history of sexual abuse by men and emotional abuse by her mother prompted Iris to use crack cocaine to “depress the issue” of her molestation and abuse alcohol to complete such basic tasks as interact with people stating, “That’s the only way I could cope with people because if I didn’t drink you had a bad day.” Gwen commented on how staying high from substances allows an individual to never have to feel, which can be a significant reward when one’s past illicit unbearable emotions. She discussed the progress she has made through her participation in group as she continues to share more about her past and how she uses substances to stop feeling.

But I shared something in my class today and uh it-it uh, it like uh I see what she mean about how like she was saying in the end that as we gradually go on, you know, the drug use became like a coping, a coping. It wasn’t like that in the beginning, but it became, well for me, I’m going to keep it on me, a coping mechanism because when I’m high I don’t give a damn what’s going on, who’s saying what because I’m high. And so then when I come down, I say here it come again, so it just made my, it just made me do more and more and more and more and more because now I gotta [sic] stay high. You stay high and you don’t never [sic] come down, you know, so you ain’t never got to feel it. (Gwen, personal communication, August 25, 2014)

Social isolation. Trauma, substance use, morally compromising behaviors, and shame all contribute to a sense of isolation. The compounding factors place an individual in situations where they feel as though others do not understand, as well as resulting in issues with trust and confidence. Isolation is a product of many of the women’s experiences however, it is also a contributing factor to in self-harm including substance abuse, impulsive behaviors, and

dysfunctional relationships. Evie expressed, in an almost child-like manner, her feeling of being alone and the despair she endures by not having her parents in her life.

And in my mind, like I said my dad was there, but my dad ain't there, but in my mind I say that he's dead, you know what I'm saying, because I don't know, he's not there for me, he's not here for me and I don't know where he's at. [sobbing] And I'm grown and I feel like if I really want to see my dad I should be able to find my dad, but cause I'm in my drug addiction, I'm too busy getting high. And I don't have no brothers or sisters so I've been through this all by myself. (Evie, personal communication, August 22, 2014)

Gwen became emotional as she described her need to rely on her counselor for encouragement when she struggles with her addiction because at this time her support system lies solely within the program.

And so uh, so right now I'm where she at I guess the process she been going through and [crying] I went to go talk to [her counselor] because I needed to hear somebody else say I could do this. I needed to hear somebody say I could make it because I'm scared, because I'm so happy right now, even though I'm sad at the same time, but um I don't want to fall, but I'm used to falling. So in my mind it say, I be saying, "Whoo today a good day today" then another time I be saying, I wonder how long this gonna [sic] last, you know. (Gwen, personal communication, August 25, 2014)

Morally compromising behavior. Engaging in morally compromising behavior such as theft, prostitution, and the sale and distribution of substances are some of the behaviors that typically lead to female incarceration as a result of substance abuse. These behaviors have also been found to result in feelings of shame once the individuals are in recovery and begin taking account of their actions and the impact their choices have had on their lives as well as their

family and children. Evie describes sexual behavior she engaged in while in her addiction in an effort to gain access to substances.

I've done sexual things for drugs, you know, that I wouldn't have done normally, you know. Um, in weird places, you know, I don't want to get in all the details of that, but yeah, I've done some things. I've hurt people, you know what I'm saying, behind drugs.
(Evie, personal communication, August 22, 2014)

Cynthia did not consider her marijuana use as problematic and was against treatment when she was first mandated to the program by her parole officer. However, through her work in groups and individual therapy she has recognized her substance use as an addiction and described her participation in violent criminal behavior that hurt unknowing victims. She also commented on how her behavior has resulted in punishment for her through incarceration, but also for her family through empty promises and her absence.

By me being in jail because I'm not the victim, they the victim, like every time I go to jail I'm hurting them so, by me being absent from the family, put it like that. And every time, like, putting them down like, "Oh when I get out I'm like I'm not going back" and I keep going back. So I'm hurting them. As far as like the drug addiction, yeah I've robbed, I've never stolen nothing from nobody, but I've robbed, I've pistol whipped people just to get some marijuana or a lot of marijuana, not just no sack, but yeah I've hurt a few people and I regret it that's why I'm giving myself a chance, another chance to change, you know. (Cynthia, personal communication, August 22, 2014)

The impulsivity and treacherous nature of the environment was addressed by Farrah as she describes the lack of control she has in her addiction in terms of what she may witness, how she may be forced to respond, or what may be done to her in various situations.

I never know when I'm gonna [sic] do something stupid. I never know who I'm gonna [sic] come across and who and what I'm going to do. I might get beat up, I might have to do a favor I don't want to do, a sexual favor I don't want to do. I don't know who I might rob or uh, who I might try to take hostage because they got something I might want. I don't know what I might do. And that's normal to me. Even though I know it's not. But it's normal to me. (Farrah, personal communication, August 22, 2014)

Kenya described her journey through addiction, which had lasting ramifications on her relationships with her family and the lives of her children due to choices. Despite being in treatment, she still struggles with making safe decisions for herself as the lure of short-term gratification through fast monetary gain still presents as a formidable temptation.

And I had children, I left my children thinking I was going to start a new life here, but it didn't happen like that. I ended up on drugs, my mother really didn't want to talk to me cause, and I couldn't talk to my children because it would upset them, but they were very disappointed in me so it took me a lot, I mean I went through a lot here in 20 years and just now I'm really getting myself back to who I know that I am and how I know I was raised and my morals and values. (Kenya, personal communication, August 25, 2014)

Several women in the group disclosed a history of heightened promiscuity and prostitution while in their addiction. Prostitution has been identified as a common factor in the lives of women in their addiction as it provides a means to access substances, which provide an escape from the violations and indiscretions involved in the behaviors. Kenya had a long history of prostitution and discussed how being in certain areas of the city can be a trigger for her due to the men in the area who knew her in her addiction and still respond to her in that manner. She

also discusses the stigma that her lifestyle reflects on her family and how it goes against how she was raised.

I came here in 1996 and that's when my uh addiction really set off, you know. Being downtown and everything, 'cause shit, it is what it is, you know. People doing everything, you know and I started hoeing and I felt like I was suppressed to homelessness. I couldn't get a place to live and I mean and stuff like that really started bothering me because I never thought, you know, a hoe in the family is like damn, she's one of those, you know. You be thinking damn, you know, you have, you be looking at them like they're dirty people or something you know... You know I might still turn a trick every now and then, but it ain't like it's every day and ten damn men a night just to come up with four or five hundred dollars, you know what I'm saying, and then gotta go take a shower and wash the dirt off just to keep from sleeping on the streets. You know, and that's one thing. I wasn't raised in the streets and I wasn't fucking sleeping in the streets so I did everything I can to keep a hotel, keep clothes on my back, I might, like people say I was dressed up on the inside, but I was going through some on the outside, but I was going through a lot of shit, you know. (Kenya, personal communication, August 25, 2014)

Farrah provided one of the most graphic accounts of bearing witness to a traumatic experience when she was in her addiction and living in the precarious environment of downtown Los Angeles.

What disturbed me most is I'm a female and I was hanging around with a bunch of people that get high and uh and that sold dope and it was a girl and she owed the dope man some money and um, this is downtown, we was in the tent. And I-I-I, uh we were in

the tent in one of these back alleys and it's late at night so can't nobody hear, but I'm watching them tie this girl up and I'm the only female out there. And I'm watching them tie her up and uh, cause she don't want to pay the money back or whatever she did, she owed quite a bit she didn't want to pay back and I'm watching her uh cause she was smoked up a lot of sacks and stuff she just did too much and I'm watch them tie her up and rape her and beat her and I'm just glad it wasn't me, but I couldn't call the police or something. And I feel bad because it could have been me. Because I don't know if she was really owing them money or if they was just doing this stuff to be mean to her, I can't say what the reason why, but I'm watching them tie her up with stockings and just rape her and beat her and making her suck their dicks or penises or whatever, and whatnot, something thing like that, or whatever, whatnot, and I'm just watching this because I'm a female and I'm the only female out there and it could have been me. What if one day they decide to do this to me in one of these back alleys? And I'm watching them do this and they're telling me to shut up and so I shut up. They let her go after they was through with her, but it's just the point that it went against everything that I know. And most of all because I am a female watching them do this to another female really hurted [sic] me. And I've experienced similar things, but I wasn't tied up and stuff like she was. I'm not going to be still long enough for you to tie me up, I'm fin to act a fool. She was just quietly going along with this, so I figured, she ain't saying nothing, she ain't screaming so I ain't fin to scream neither. But really I'm looking at this and I'm saying I want to scream. (Farrah, personal communication, August 22, 2014)

The cycle of addiction, and the resulting criminal behavior that typically ensues, leaves individuals vulnerable to dangerous situations in the street, but also in prison where politics and

violence are accepted aspects of the daily milieu. Cynthia described traumatic experiences she witnessed in prison that still continue to haunt her and contribute to her posttraumatic stress.

I experienced seeing some trauma when I was in prison, I um, I've been in prison three times. My second prison term I did 5 years and um I experienced, it was like a lover's quarrel, like I experienced seeing somebody getting a broomstick stuck up in them. I experienced seeing somebody being smashed in the face with a mirror, hog tied, just sticking all types of stuff in them. And the girl was screaming, it was one of my roommates, the girl was screaming and all that stuff, and said "no, stop," and I tried to help her but I really couldn't help her because I wanted to go home and these was lifers, you know, but at the same time, I'm for the underdog no matter what, sports, whatever, I'm for the underdog, so I tried to help her, but I couldn't help her, but to this day I'm on meds because of that too because of the trauma. Like I can still hear her scream, I can still hear the door slam "BOOM!," like an echo, echo, echo, echo. I can still see it, like I get paranoid, I, you know, and then that brought back, that started unburying stuff that happened to me. (Cynthia, personal communication, August 22, 2014)

Shame. The tendency to internalize one's negative actions and viewing oneself as a bad person due to behavior results in a shame response that can create an immeasurable burden that prevents growth and recovery. Cynthia described how her mother treated her and her siblings once she was in her recovery and how this created strain in the relationship and made it difficult to return home. She stated, "It was more like her talking down on us once she got her life together. And she would call us dope heads when she would be mad at us and stuff like that."

Intimate partner violence can also be shaming when an individual assumes blame for the situation and the actions of their partner. The secrecy around the behavior and the devaluation of

the perpetrator debilitates the victim creating an isolating environment. Farrah described how her experience with domestic violence resulted in shame as she was not raised in to accept such treatment. She began to assume responsibility for the actions of the men in her life and internalized the actions as a reflection of her being a bad person.

And it's just not ok and I went against all my values to stay in that kind of relationship so I kind of blame myself for ALL the things that have happened to me because he told me, he taught me better... I thought it was something in my personality that was making these men put their hands on me. I thought it was something about me, maybe it's my mouth. Maybe it's something I'm doing that makes them hit me, but even my father stopped spanking me after a certain age so it couldn't just have all been me. (Farrah, personal communication, August 22, 2014)

Kenya and others discussed the double standard that exists for men and women regarding substance use and other behaviors. She describes the shame and negative impact it has on a woman's reputation that is difficult to live down.

Drugs is not [sic] fucking discriminating against nobody. You would be surprised, but when society said hey, you 18 and you can start drinking, I started popping beers and wine coolers. And my mother is the type of person, women cannot do what men do. My brothers and them could do anything under the sun and still come up clean, but a woman she would never live it down. People remember the things you do wrong instead of identifying with the things you do good. You could never live it down. (Kenya, personal communication, August 25, 2014)

Chapter 4: Discussion

Qualitative interviews focused on women with a history of addiction provide an intimate portrayal of their life experiences and suggest that trauma and poor social support are key elements in how these women are able to manage multiple stressors related to past and current situations. This qualitative study explored the intricacies associated with African American women in their addiction, to determine the presence of similar themes with other groups for whom the concept of moral injury has been applied. Based on the results, it appears that moral injury can be attributed to these women's experiences and their negative view of themselves, in relation to the behaviors they engaged in during their addiction. These findings suggest a need for more standardized scales and assessments that take into account social contexts and meaning of life events and experiences, to facilitate the development of ethnographic approaches that may improve treatment interventions and assess the level of traumatic stressors and shame present in substance using populations.

Feminist therapist Maria Root (1992) introduced the concept of *insidious trauma* which is associated with the devaluing of an individual based on her intrinsic characteristics being different from those valued by those in power (Muzak, 2009). Women from diverse ethnocultural backgrounds are significantly more vulnerable to oppression related to race, ethnicity, and gender which affects role perception and one's sense of identity (Israeli & Santor, 2000). African American women are more likely to be punished for behaviors associated with substance abuse and less likely to receive adequate treatment and access to resources, due to the failure of addiction models to recognize the environmental context of addiction in which sexism and racism are undervalued as integral components of addiction and criminal behavior (Rhodes & Johnson, 1997; Taha-Cisse, 1991). The traditional medical model of addiction fails to account

for influences on substance abuse such as family, socioeconomic status, education, financial issues, social skills, victimization and relationships, which impact the lives of women. Based on conventional views of trauma and coping, African American women's dual association – being Black and female - and an inability to adequately manage adversity in the face of additional traumatic experiences are compounded, resulting in greater severity of symptoms that has multigenerational influence.

African American women's membership in two low status groups, based on race and gender, makes them exceptionally vulnerable to various experiences of prejudice, oppression, discrimination, and inequality. In a similar regard, those who occupy multiple high-status positions, such as European American men are more likely to benefit from various social advantages. Individuals who identify with multiple oppressed groups are more likely to perceive prejudice in domains in which they have a strong group consciousness resulting in psychological stress, health problems, and decreased self-esteem (King, 2003). Similarly, they may be at increased risk for negative outcomes associated with the stress of discrimination as well as a higher incidence of prejudicial experiences than those who identify with a single oppressed group (King, 2005). The level of distress resulting from a triggering event is related to the perception of the event and the assigned meaning given by the individual. In this regard, a history of discrimination and maltreatment may result in lower stress tolerance and increased susceptibility to emotional dysregulation.

Collective consciousness is the concept of unifying beliefs, values, and moral standards that create a sense of community and understanding. In regard to African American women, collective consciousness can function as a schema that influences the perception of the meaning applied to a negative intergroup situation. As central stressors have been found to relate to

personal beliefs and cognitions which influence the ability to cope with stress, it is suggested that those high in ethnic and womanist consciousness may experience increased stress due to increased awareness of discrimination and inequality based on power and status differences (King, 2003). Racism and sexism continue to be impediments to success, as membership in minority groups are associated with institutional discrimination and discriminatory interpersonal experience. In a study of African American college students' perception of discrimination, the women were found to react less strongly to gender prejudice alone, than to ethnically motivated prejudice or that related to both race and gender. The impact of such discrimination has been related to decreased social esteem and increased discomfort in social situations, which may impact one's social network and availability of emotional resources to manage stress (King, 2003).

The collective consciousness of ethnic minorities has the potential to significantly influence an individual's schema regarding safety in the world and negatively impact their ability to manage stress and positively reframe a negative event if an internalized gender and cultural identity has not previously been established. This in turn lends to the theory that African American women may have an increased sensitivity to traumatic experiences due to compounding influences of race, gender, and socioeconomic stressors, which result in an increased risk for heightened distress following traumatic incidents.

Emergent Themes for Women with a History of Addiction

Family of origin and maladaptive patterns of behavior. Homes of substance abusing parents are often found to be more prone to disruption and turmoil, increasing risk factors for children and restricting their ability to learn healthy coping skills for managing challenges and stressful events in the future (Connors et al., 2004; Gance-Cleveland, Mays, & Steffen, 2008).

The family environment and the behaviors of caregivers are important factors in child development. Phillips, Burns, Wagner, Kramer, and Robbins (2002) found that in a study of adolescents, those who had parents with a history of incarceration experienced a substantial number of risk factors over their lifetimes including poverty, parental mental illness, child abuse, neglect, and residential instability. In addition, these individuals were more likely to be exposed to specific stressful life events and trauma, and have been found to have repeated exposure to multiple types of trauma and adversity as well as serious consequences including arrest and incarceration (Johnson & Gabel, 1995). A study by Gance-Cleveland, Mays, & Steffen (2008) found that the perceived severity of substance abuse in the family has a positive correlation with negative responses in adolescent development, which present as physical symptoms and negative mood. Substance abuse in the family increases the probability of poor family functioning, and detrimental effects on the parenting role and the behavior of the children in response to unmet needs (Friend, 2012). As a result, unhealthy family situations seemed to contribute to unfortunate outcomes for the children including mental health problems, poverty, unsatisfactory performance in school, abuse, neglect, delinquent conduct, and eventual continuation of the damaging behavior of substance abuse, perpetuating the cycle throughout multiple generations within the family (Wolock & Magura, 1996).

Several of the women who participated in the study disclosed a family history of substance abuse and maladaptive behavior including aggression, distribution of illicit substances, and incarceration. Parental abandonment or neglect were also reported as concomitant factors that negatively impacted healthy emotional development of the women. Thus, as described by the women interviewed, their early childhood environments had a significant influence on their internalization of maladaptive coping skills and frequently left them vulnerable to predators and

emotional wounds. It appears that their exposure to behaviors that go against societal norms at an early age had an influence on their behavior as they matured, providing limited options for what they considered possible for the future. Parental substance abuse in particular seemed to have had a deleterious negative influence on them due to the myriad of concomitant factors associated with the behavior.

Early childhood trauma exposure and abuse as precipitating factors for complex trauma and emotional dysregulation. The culmination of historical adversity including intergenerational trauma along with the contemporary trauma of oppression, poverty, and racism are significant components of sexual assault on ethnic minority women resulting in higher rates of psychological symptoms including PTSD, depression, substance abuse and decreased self-esteem (Bryant-Davis, Chung, & Tillman, 2009). Exposure to traumatic and violent situations at an early stage in development has been found to have a resounding impact on one's ability to engage in a healthy manner. Statistics of individuals treated in the prison system indicate a pattern has emerged of incarcerating individuals who cope with their prior abuse through depression, anger and delinquent acts of violence, and substance abuse (Kinsler & Saxman, 2007).

There is a significant association between domestic violence in the home and exposure of children to adverse experiences due to increased vulnerability and environmental factors. Due to lack of resources and maladaptive patterns of behavior in the home, a dysfunctional cycle often becomes established within the family system that acts as a recurring theme throughout several generations (Finkelstein et al., 2005). State prisoners who had mental health problems were found to report a history of physical and sexual abuse over twice the amount of other inmates (James & Glaze, 2006; Kinsler & Saxman, 2007). Fifty-two percent of prisoners with mental

health problems grew up in families where one or both parents had a history of incarceration and report double the rate of parental alcohol or substance abuse as compared to those without mental health diagnoses (Kinsler & Saxman, 2007).

A significant theme prevailed among several of the stories portrayed in the focus groups, which included exposure to traumatic experiences including abuse and violence in the home. Similar to previous research, 85% of the participants interviewed (see Table 3) had a mental health diagnosis for which they have received treatment in addition to their history of abuse and trauma (Bjorkenstam et al., 2013; Bryant-Davis et al., 2009; Dore, Doris, & Wright, 1995; Friestad, Ase-Bente, & Kjelsberg, 2012). Many of the women described an early sense of betrayal and abandonment by their caregivers as their abuse was not believed by those in whom they trusted for protection. As a result of this lack of validation, the women had a tendency to seek acceptance from others, which often led to peer pressure to partake in negative behaviors such as substance use. Emotional neglect also occurred as a recurring topic throughout the groups. Individuals indicated a lack of support or parental participation in their lives during childhood, leaving them vulnerable to peer pressure and detrimental situations where they could be easily influenced.

Substance abuse as a coping mechanism for morally compromising behavior, shame, and social isolation. Substances allow a temporary escape from reality, provide relaxation, energy, improvement in mood, and ease social interactions. Women have implicated substance use as an attempt to preserve unhealthy relationships, cope with stress or abuse associated with the relationship, or identified using as a common activity that they shared with their partner (Koehn, 2009). In order to continue their use, the necessity to commit crimes becomes more pertinent. The exponential growth of the prison population over the last decade

has indicated women as the fastest growing group of those newly incarcerated, markedly due to the high incidence of substance use and the subsequent criminal behaviors as a means of supporting the addiction (Beck & Karberg, 2001). In addition, this population of women in prison has been found to have a higher incidence of childhood adversity than the general population (Browne, Miller, & Maguin, 1999; Friestad et al., 2012). Psychological trauma survivors often attempt to cope with their traumatic experiences in ways that re-enact portions of their traumatic experiences through placing themselves in dangerous environments or choosing partners who mistreat them in similar ways to their previously demeaning and abusive relationships. This pattern of behavior results in unbearable emotional and at times physical pain leaving the woman in the predicament of needing to numb the pain with substances and re-offend to support her habit (Kinsler & Saxman, 2007). Women incarcerated with a history of substance abuse typically are charged with non-violent offences including robbery and prostitution in order to maintain their habit. As these women make the transition from abused or neglected child to abused and addicted women, their existence becomes more isolated and they lose connection with their families.

Isolation is a major source of suffering due to the social disconnection and resulting self-blaming and shame, leaving an individual with the perception that they are unworthy of happiness or the help of others (Jordan, 2000; Koehn, 2009). Many of the women interviewed discussed the challenge of family reunification where they are constantly reminded of how they have disappointed their family, and especially their children through years of disengagement. The shame and guilt of women present a barrier to recovering from the past as these emotions tend to influence their interpersonal relationships, by the women not feeling they have the right

to express their needs, due to their history of illicit substance use, or the sense of shame becomes overwhelming when their past is addressed by family members (Koehn, 2009).

All of the women who participated in the study had a history of incarceration and were mandated to treatment as a result of their legal involvement. Throughout the discussion, the women expressed how they used substances as a means of coping with the negative emotions that resulted from trauma in their lives. Even when their initiation into substance use was a result of mere peer pressure or adolescent experimentation, they described how one behavior soon led to another until they had lost control of the situation. In these cases, they began to use substances as a means of numbing their emotional and physical pain. The emotional and physical abuse endured by the women often began in childhood, but more frequently occurred through adulthood as their substance abuse became more problematic and they entered domineering relationships or found themselves involved in precarious arrangements where their character and physical beings were defiled and degraded as a seeming right of passage. Thus began the perilous cycle of substance abuse where use of a substance often resulted in decreased awareness and increased frequency of being in potentially dangerous situations. As the women fell further into their addiction, social isolation was a commonly discussed due to changes in environment and social circle, and behaviors both witnessed and perpetrated result in shame and emotional dysregulation.

Spirituality and peer support as factors for building resilience. Women's relationships have been found to be critical factors in the initiation of substance use, development of maladaptive patterns of behavior, and mitigating factors in their recovery therefore, an individual's relationships are a significant component that need to be addressed to provide comprehensive treatment (Koehn, 2009). Social support and spirituality have also been

found as effective coping skills for ethnic minorities as they provide a safe environment for acceptance and empowerment in order to decrease the stigma and shame from their history and criminal behaviors. Among the African American community, spirituality has been found to be a useful coping skill to help mediate issues of depression with domestic violence and stress (Bryant-Davis et al., 2009; Mitchell et al., 2006). Individually, the women in the groups proved to have a substantial amount of resilience in their willingness to pursue recovery and address the problems in their past, which have had such a devastating impact on their lives. Regardless of age or brutality of experience, the women overwhelmingly expressed a sense of optimism about their future. Spirituality was implied and addressed directly in both focus groups as 85% of the participants identified as Christian, and 15% as Spiritual, but not religious. The women spoke openly about how their faith in a Higher Power has provided additional strength during their recovery and has allowed them the opportunity to forgive themselves and their previous actions in an effort to make progress and live life according to their personal values and beliefs.

The concept of change was brought up throughout the discussion both as a proponent of fear and apprehension, as well as a goal and necessary component for success. Many of the women were embarking on a path of new experiences, where participating in a program, speaking openly to a group of strangers, looking for employment, attending 12-Step meetings, and maintaining their sobriety were foreign concepts. However, through faith, support of others, encouragement from counselors, staff, and family they have been able to find their true selves and embrace their past for the strength it has provided them. At the end of both groups, the women remarked on the benefit of participating in a group of women who have survived similar trials and tribulations and have found a voice. There remains a sense that they do not frequently feel that their voice is heard in society, by mental health professionals, or their family members,

which indicates the additional work that remains as the number of women in the criminal justice system struggling with addiction continues to rise at an astounding rate. Similar to the specific needs of veteran's returning from combat, the treatment of women returning from their addiction requires specialized treatment to accurately assess and attend to the demands of a distinct population.

Resilience and women's ability to rise in the face of adversity was a resounding theme felt throughout the course of the study. The women interviewed demonstrated an overwhelming sense of support and encouragement for each other across both groups. Whether exhibited through the physical affection of an embrace or verbal recognition and validation, the participants were able to provide a sense of hope despite the oppressive issues discussed.

Conclusion

High rates of recidivism within the substance abuse community, especially in diverse cultural groups, has been identified as a significant health problem due to the resounding implications it has on the individual as well as the extended family system (Friestad et al., 2012). A study of women in treatment for substance abuse found that several of the participants disclosed dysfunctional relationships with their mothers due to abandonment, neglect, and addiction. Ineffectual role models demonstrated a pattern of impulsive decisions with little concern for the impact on others. As a result, these women adopted the priorities of negative role models and associates in whom they felt an attachment, which frequently included the involvement of drug-related activities (Greene et al., 2003). This arrested development during childhood seems to have impacted their ability for advanced decision-making and sense of direction, which contributed to a maladaptive cycle of substance abuse, homelessness, and trauma due to an inability to problem-solve and improve negative life events in a healthy,

productive manner. Similarly, women enrolled in the study described various forms of dysfunctional mother-daughter relationships that have had lasting implications on their sense of self and their adult relationships. Women in the study described involvement in physically and emotionally abusive relationships and promiscuity as a result of low self-esteem and misinterpreting attention as love as well as taking personal responsibility for the maltreatment they endured. Unhealthy early relationships were a common theme through many of the stories leading to substance use and trickling down to the participant's relationships with their own children. In addition, this cycle of maladaptive relationships seemed to have also impacted their relationship with their children and family due to their inability to adequately communicate their feelings and experiences. Several of the women discussed their continued efforts to improve their relationships with their children while trying to improve their sense of self and decrease the shame from the past.

Recognizing the importance of spirituality in a patient's recovery from substance abuse has been found to be a more relevant component in an individual's treatment of addiction and chemical dependency rehabilitation, which has an underlying association with one's morality and value system and the role spirituality has in the development of moral injury. Moral values have been found to have a relationship to spiritual life. For example, Green, Ball, Belcher, and McAlpine (2003) describe moral reasoning as a developmental process based on the teachings of parents, peers, and the community, and incorporating socially accepted laws and principles with one's personal conscience. It can be assumed that disruptions in this developmental process as a result of childhood maltreatment, neglect, or trauma, might negatively impact an individual's moral reasoning and coping, leading to substance use as a more primary means of escape. Reconciliation of behavioral transgressions may be difficult for individuals as adults in treatment

for addiction, as they face the stigma and condemnation by society and family due to their behavior in addition to the discrepancy between their more mature moral values and their addictive behaviors.

Reflection on the stories of those interviewed suggest potential treatment interventions for the future focused on moral reasoning, decision-making skills, problem solving, and aspects of spirituality that may be beneficial to decreasing the rate of recidivism and providing the fundamental skills women need to escape their dysfunctional patterns of behavior. Shame resilience involves reducing the sense of isolation and powerless through processing and improving one's awareness of shame while creating a network that provides empathy and support. Utilizing this treatment has been a useful strategy for recognizing shame and to improving gender responsive treatment for diverse populations of women with substance abuse related issues. Processing shame in a constructive way that prevents self-deprecation can lead to growth and positive change through empowerment (Brown, 2007; Hernandez & Mendoza, 2011). Reaching out for empathy and remaining open to the recognition of the shared private struggles of others has the potential to provide encouragement and empowerment to live life differently (Brown, 2006).

Feminist therapy has been adopted to support a positive model of women's mental health to promote empowerment by acknowledging that sex roles, female socialization, and minority status in a patriarchal society are components of psychological difficulty (Israeli & Santor, 2000). This therapeutic model addresses the vulnerability of women in the larger culture and rejects adjustment to social standards as the primary goals of therapy (Rhodes & Johnson, 1997). Consciousness-raising, as a component of feminist therapy, includes a discussion of individual and shared experiences in a nurturing environment where women express themselves, externalize

blame, and develop a sense of belonging (Israeli & Santor, 2000). The feminist conceptualization of trauma asserts that women's drug addiction is not pathological, but rather an adaptive response to traumatic events and oppression (Muzak, 2009). A womanist approach to therapy includes multifaceted influences on self-identity and agency for African American women such as race, gender, and class to empower women to create their own personal realities by providing cultural knowledge that allows them to interpret their behavior and experiences (Lewis, 2004). This therapeutic approach can perpetuate new stories of resilience and survival in marginalized populations (Williams & Frame, 1999). This more contemporary view of gender development and the influence of adversity has the benefit of providing a motivating and empowering view of trauma by encouraging victims to regain control of their situation, rather than acquiesce to society's view. Furthermore, recognizing that the symptoms and maladaptive coping strategies utilized were protective features of a tragic experience rather than internalizing them as a reflection of their true selves, is another empowering feature of treatment.

A positive correlation has been found between gender self-acceptance and ethnic identity, suggesting that women who are comfortable with their ethnic identity appear to also be comfortable with their femininity. Assessment of gender self-definition and gender self-acceptance in a clinical setting may provide clinicians with a better understanding of their clients' gender-related self-perceptions, experiences, behavior, and how this relates to their view of self, others, and society (Hoffman, 2006). African American women have internalized negative images from society and media, which makes it difficult to develop a positive self-concept and often results in low self-esteem. Positive role models in treatment including female African American therapists, counselors, and staff members may provide women in treatment for substance abuse role models of successful recovery and hope that a different life is possible,

although not necessarily easy (Lewis, 2004). A feminist perspective of treatment promotes consideration of the contexts in which women live, the challenges they face in accessing appropriate treatment, and systematic oppressions related to ethnicity, socioeconomic status, and politics, which they have endured (Marcellus, 2004). Just as ignoring the effects of trauma can have dramatic consequences and pervasiveness of symptoms, ignoring the reality and context of a woman's environment and oppressive societal factors contributing to their experience can also negatively impact trauma treatment as these factors cannot be appropriately assessed without recognizing their interrelated features.

Research substantiates that maternal trauma exposure and its resulting psychological impact have transgenerational repercussions, which can alter the psychological and biological expression of their children (Jovanovic et al., 2011). Further research and specialized treatment for women and the unique stressors and challenges that await them in their recovery could help stop the cycle of abuse and maladaptive coping before generations of a family are devastated by the substance abuse emotionally and physically. Appropriate trauma treatment and assessment of childhood victimization is an essential component for the clinical management of incarcerated women in order to provide comprehensive and meaningful change in their lives as well as the lives of their children. The U.S. Justice Department report in 2006 indicates that 44.8% of Federal prisoners, 56.2% of State prison inmates, and 64.2% of local jail inmates have diagnosable mental health problems. Additionally, three quarters of female inmates in State prisons met criteria for substance dependence or abuse (James & Glaze, 2006; Kinsler & Saxman, 2007). We place trauma survivors in a traumatizing environment with limited resources to appropriately care for their needs. Ethnic minority women, in particular, face seemingly insurmountable obstacles to assistance, including discrimination, financial constraints, social

stigma, language barriers, and lack of trust in agencies due to a history of violating experiences thereby preventing the reporting of abuse and access to victim services (Bryant-Davis et al., 2009).

As clinicians, there is a need to identify families at risk for transmitting the impact of intergenerational trauma to younger generations of the family to help parents effectively cope with their feelings and to restore structure, security, and stability to the family system at an early stage (Kaitz, Levy, Ebstein, Faraone, & Mankuta, 2009).

Traditional treatment does not always address the specific challenges of women with substance use disorders, in particular the shame associated with gender-based expectations. Further research is necessary in improving gender-responsive interventions focused on shame reduction and resilience (Hernandez & Mendoza, 2011). Family interventions for children and women could assist in decreasing the risk factors associated with damaging family patterns as well as improving protective factors such as support and coping skills (Finkelstein et al., 2005). There is a need for early intervention within the family when parental substance abuse is determined to provide comprehensive care to the entire family system, in addition to the parent, to mitigate the negative impact of the abuse that has the potential to derail multiple generations.

Shame has been defined as the distress due to the internalization of a negative act as a reflection of oneself, which results in decreased self-esteem and self-worth (Dearing et al., 2005; Hernandez & Mendoza, 2011; O'Connor et al., 1994). As the women in the study described their accounts of their conduct while in their addiction, the distinction between shame and moral injury became more distinct. Shame can be viewed more as a component of moral injury as a singular experience can result in the feeling of shame for some individuals. However, the results of this study have suggested that moral injury is more of a cycle and a process that can be

deepened with supplemental exposure to traumatic events and moral transgressions. In terms of the women included in this research, it was not one solitary act or one experience that resulted in moral injury, but rather recurring incidents that created a rift within them leading to an internal discrepancy. Moral injury in this context can be depicted as an abrasion that can be worsened by continued maladaptive behaviors, abuse, and traumatic experiences that deepen the emotional injury.

Results from the study lend further support to the relationship between childhood maltreatment, adult trauma, Posttraumatic Stress Disorder, and substance abuse. Incorporating the concept of moral injury into the equation provides a deeper understanding of the devastating impacts morally compromising behavior and shame have on an individual in recovery (see Appendix M). As clinicians, we work with the last generation's victims and survivors of abuse and neglect. The more time spent understanding and talking with this population, the more we realize that they were not given an opportunity to succeed and need compassion and encouragement from others to move forward and have their voice be heard. Providing a safe environment in which women are able to voice their concerns and emotional responses to the guilt and shame they carry, related to their experiences and behaviors, may improve the facilitation of their ability to resolve some of their self-deprecating thoughts of being a failure, as a woman and mother.

The focus groups conducted for this study far exceeded the expectations of the researcher in terms of the richness of the disclosures, the unity of the group dynamic, and the strength and resilience exemplified by each participant. When reflecting on the challenges of the study, the task of conducting the group in a manner that kept on task, as well as provided the freedom and space for the women to express their stories, was the most prominent. Conducting focus groups

as a researcher and therapist creates a double consciousness that can be difficult to negotiate. As a clinician entering a similar group, culturally and organically there would necessarily be an agenda and the discussion would flow therapeutically as the participants offered their stories and gave and received feedback. However, as a researcher trying to elicit information regarding more specific issues, there is a struggle between being respectful toward the women and what they bring to the group as well as attempting to navigate the discussion back to the issue at hand. Regardless of the internal conflict for the researcher, the quality of the discussion elicited by the women and the relationships formed within such a short period of time proved to be an incomparable experience for all those involved. Group therapy is a highly beneficial intervention for African American women due to the communal nature of the culture that promotes interdependence and social interaction as well as the sense of empowerment that can be generated when provided the opportunity to share one's truth in a non-judgmental environment (Stuart & Tuason, 2008; Washington & Moxley, 2003). The responses from the participants as well as the overall feeling in the rooms spoke to the healing properties of the experience and the value of utilizing group process to assist with the healing of African American women attempting to recover from trauma, abuse, shame, addiction, and moral injuries that have seem insurmountable as an individual, but can be liberating and empowering when confronted as a united group.

Future Research

Culturally sensitive treatment interventions incorporating a comforting, validating, compassionate environment communicating empathy and respect could potentially improve the health and well-being for women and their children. Such interventions could emphasize the importance of addressing fundamental issues of guilt and shame related to one's past in an effort

to resolve feelings of inadequacy and low self-worth that further perpetuates the cycle of emotional repression and substance abuse. More research and evaluation of evidence-based interventions for the treatment of minority women for substance abuse is necessary to advance clinical outcomes and reduce recidivism due to shame and a maladaptive cycle of coping.

Further research is needed to identify if women from other culturally diverse groups experience similar feelings of guilt and shame related to their addiction, particularly in regard to the discrepancies between their behavior and value system. Research regarding the role of family dynamics, social support, and faith or religiosity is warranted in investigating their relationship with moral injury and the implications for treatment and recovery for substance abuse. Responses from this study supports the necessity for additional research and resources to address the impact of intergenerational trauma, substance abuse, and the associated mental health issues for minorities marginalized by socioeconomic and educational constraints.

Limitations and Contributions

The assumption of this dissertation is that moral injury is a concept that can be applied to women in recovery for addiction in regard to their behaviors and the trauma experienced while under the influence of substances. A major limitation of the study is the small sample size of participants from which the data will be collected that limits generalization to a larger population. The study will focus on African American women engaged in treatment in Southern California substance abuse programs and recovery programs including Alcoholics Anonymous. As such, the results from the study may not be applicable to members of other cultures or geographic areas, or men. In addition, the study design utilizing focus groups may be overwhelming or uncomfortable for some participants and they may not provide accurate accounts of their experience due to apprehension about being judged by other group members.

Despite the limitations of the study, the proposed research has the potential to examine the application of moral injury to a larger female population, as it has been restricted primarily to the experience of male veterans. Addressing this aspect of morality may provide a stigmatized group of women undergoing treatment for substance abuse with a voice and a sense of validation of their experience by providing a safe environment for women to disclose perceived shameful events while being understood and accepted by another. Improvement of clinical and treatment applications to address previously unrecognized issues inherent in this population is a goal of this research; to provide women in recovery treatment with a different perspective of their experiences and the impact of morality and personal judgment on their cycle of addiction and shame.

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APPENDIX A

Two-Part Introduction and Recruitment Message to Gatekeepers

Part One: To be sent to gatekeepers to introduce research study

My name is Jaimee Hartman and I am a doctoral student in the clinical psychology program at Pepperdine University, Graduate School of Education and Psychology (GSEP). As part of my doctoral program, I am conducting a research study for my doctoral dissertation requirement, which is supervised by Daryl Rowe, Ph.D., Professor of Psychology at Pepperdine University.

I am hoping you are willing to distribute information about my research project to potential participants for the study. I am seeking approximately 6-10 women, who self-identify as African American, in recovery for substance abuse, who are willing to participate in a two-hour focus group with other women. I am interested in finding out how, if at all, the concept of moral injury relates to African American women in recovery from substance abuse. Moral injury involves the guilt and shame that can result from acting in a way that contradicts a person's established morals and values, due to exposure to a negative environment. In addition, moral injury has been used to describe the lasting impact of failing to prevent or witnessing cruel or violent acts that cause pain to others. This idea has previously been researched with veterans who have been in combat, and the current study is exploring if it might also apply to some of the experiences of African American women in their addiction. Results of this study could contribute to addiction treatment and relapse prevention programs. Please let me know if you are willing to give me permission to make a presentation to women in your agency regarding information about the study and how to participate. Please feel free to contact me at [REDACTED] if you have any questions. Thank you very much for your time.

Sincerely,
Jaimee Hartman, M.A.

Part Two: To be sent to gatekeepers after obtaining permission to recruit

Thank you for your interest in my research. As I previously informed you, I am a doctoral student in clinical psychology and as part of my doctoral program, I am conducting a research study for my doctoral dissertation requirement, which is supervised by Daryl Rowe, Ph.D., Professor of Psychology at Pepperdine University. This study involves the examination of the potential relationship between the concept of moral injury and African American women in recovery from substance abuse. I appreciate the opportunity to recruit participants from your agency and for your willingness to allow me to provide information about my research project to potential participants.

Please feel free to distribute or post the attached "Recruitment Flyer" and "Research Study Brochure" (included in this packet) about my study to your fellow group members or any other women who are eligible to participate and you think may be interested. I would like the opportunity to discuss the study in person as well and will contact you regarding scheduling if possible. Please feel free to contact me at [REDACTED] with any questions. Thank you very much!

Sincerely,
Jaimee Hartman, M.A.

APPENDIX B

Recruitment Flyer

SHARED EXPERIENCES

PARTICIPATE IN RESEARCH AND DISCUSS EXPERIENCES OF
AFRICAN AMERICAN WOMEN IN TREATMENT FOR
SUBSTANCE ABUSE

ALL PARTICIPATION IS VOLUNTARY AND CONFIDENTIAL

- PARTICIPANTS MUST BE AFRICAN AMERICAN WOMEN IN RECOVERY
- PARTICIPANTS MAY ENTER TO WIN A \$50 GIFT CARD

**PLEASE CONTACT JAIMEE HARTMAN AT [REDACTED]
FOR MORE INFORMATION**

APPENDIX C

Research Study Brochure

WHAT IF I HAVE QUESTIONS?

If you are interested in finding out more about the project or have questions, please do not hesitate to contact me. The following is my contact information:

Jaimie Hartman, M.A.
Pepperdine University
Graduate School of Education and Psychology
6100 Center Drive
Los Angeles, CA 90045
[REDACTED]

You may also contact Dr. Rowe who supervises my research project. Below is his contact information.

Daryl Rowe, Ph.D.
Pepperdine University
Graduate School of Education and Psychology
6100 Center Drive
Los Angeles, CA 90045
Daryl.Rowe@pepperdine.edu

HOW DO I LET YOU KNOW IF I WANT TO PARTICIPATE?

If you are interested in participating in this research project, you may contact me in one of two ways:

1. You can attend one of the scheduled group meetings. Please refer to the insert for the dates and times of the meetings at your site.
2. You can call me at (323) 521-9049 to discuss your participation and times of the scheduled focus groups

PARTICIPATION IN THIS RESEARCH PROJECT IS STRICTLY VOLUNTARY

Pepperdine University
Graduate School of Education and Psychology

Moral Injury in African American Women with a History of Substance Abuse: A Preliminary Study

VOLUNTEERS ARE NEEDED TO PARTICIPATE IN A FOCUS GROUP

WHO IS CONDUCTING THE RESEARCH STUDY?

My name is Jaimee Hartman, and I am a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology.

I am working on my dissertation, which is supervised by Daryl Rowe, Ph.D., Professor of Psychology.

WHAT IS THE STUDY?

Moral injury is the conflict within yourself that results from acting in a way, or witnessing something, that goes against your values and morals due to being in a dangerous environment or lifestyle.

This idea has previously been studied with combat veterans. The current study is trying to see if moral injury might also apply to experiences of women in their addiction. By having a group of women discuss the subject of moral injury, we hope to determine if there is a relationship between what has been found in previous research and the experience and behavior of women with a history of addiction.

WHO CAN PARTICIPATE?

To participate in the study, you must be:

- At least 18 years old
- Identify as an African American female
- Able to read English
- Have a history of substance abuse
- Have been sober for at least 30 days
- Not currently experiencing psychotic symptoms that would influence your participation

WHAT IS INVOLVED?

If you decide to participate in the study, it will involve the completion of a brief questionnaire and participation in a focus group with 6-10 other women who have similar experiences.

The questionnaire and focus group will ask questions regarding:

- Background information about you
- Information about your substance abuse, previous experiences, and behaviors
- Information about whether you think moral injury applies to your experiences

The questionnaire, preparation, and closing of the group should take approximately 30 minutes to complete and the focus group will be scheduled for 90 minutes.

Those who participate in the focus group will be entered in a raffle for a \$50 gift card for their participation.

APPENDIX D

Announcement of Study

Announcement of Study

Hello Everyone. My name is Jaimee Hartman and I am a doctoral student in the clinical psychology program at Pepperdine University, Graduate School of Education and Psychology. As part of my doctoral program, I am conducting a research study for my doctoral dissertation requirement, which is supervised by Daryl Rowe, Ph.D., Professor of Psychology at Pepperdine University.

I am here today to ask for volunteers to help with my study. The study will take about two hours of your time. Should you agree to participate, you will be asked to complete a questionnaire, which can be completed orally if necessary, and meet with a group of women to discuss questions regarding your experiences while in your addiction. The group discussion will be audio-taped and participation will allow you to enter a raffle for a \$50 Visa gift card immediately following the discussion.

The purpose of the research is to find out how, if at all, the concept of moral injury relates to African American women in recovery from substance abuse. Moral injury is the conflict within yourself that results from acting in a way or watching something that goes against your values and what you know is right and wrong, due to being in a dangerous environment or lifestyle. This idea has previously been researched with veterans who have been in combat and the current study is interested to see if it might also apply to the experiences of women in their addiction. For instance, some veterans have returned from combat and had problems dealing with the violence they saw or their own behavior such as killing another individual, due to their beliefs that killing is wrong. In a similar way, some women have difficulty accepting the things they did while in their addiction, such as prostitution or stealing from family, due to their actions in their addiction going against their values and morals.

The information I collect from you will be kept confidential. I will remove all information that can identify you. I will use a participant number that will match a “fake name” on the questionnaires you complete. Audio-tapes and notes taken during the discussion will be stored in a locked safe in a secure office in my home of residence. Audio-tapes, notes, and transcripts will be destroyed within five years of the end of the study. Computers used to store and analyze data will be secured with a password and firewall protection. Only myself and my supervisor will have access to the audio-tapes and transcripts.

I want to make sure that you know that participating in this study is strictly voluntary and has no effect on your relationship with *[insert organization or facility]*. If you decide this is something you are interested in doing, please speak with me after this meeting or contact me at [REDACTED]. Two focus groups will be scheduled on *[date, time, and location of focus groups]*. If for any reason you are not identified as a Donna despite your interest, a letter will be mailed to you.

I have also included my contact information on the brochure in the event that you think of questions after I leave. If you know of others, not in attendance, who may be interested in participating in this study, please feel free to share the information with them.

Thank you for taking the time to listen. I hope to hear from you soon and look forward to hearing your thoughts at the focus group. Are there any questions?

APPENDIX E

Recruitment Letter to Participants

[Date]

[Participant's name]

[Participant's address]

Dear [Participant],

Thank you for being interested in participating in my dissertation research. Included with this letter are the following materials:

1. A copy of the form entitled, *Informed Consent for Participation in Research Activities*
2. A flyer with the date, time, and address of the focus group location.
3. A map of the location where the focus group will be held.

Please read over the *Informed Consent for Participation in the Research Activities* form carefully. This form will be provided to you at the beginning of the focus group for your signature. A copy of the consent will be given back to you to keep for your records. If you have any questions about its content, feel free to speak with me.

To participate in the study, you must be 18 years of age or older, identify as an African American female, feel comfortable reading and speaking in the English language, and be in recovery for substance abuse.

The following are the key elements of the Informed Consent form that I feel is important to highlight:

1. Your participation in the study is strictly voluntary.
2. You may discontinue your participation in the focus group at any time or refuse to answer questions you prefer not to answer without any negative consequences.
3. In the focus groups you will be asked questions regarding your background, beliefs, behaviors, substance use, and issues related to your family.
4. Your participation in the study will require approximately two hours of your time.
5. The study poses no more than minimal risk. If for some reason you do not feel comfortable answering any of the questions, you are under no obligation to answer them.
6. Although you will not directly benefit from participating in this study, the findings may help psychologists better understand the relationship between moral injury and substance abuse.
7. The focus groups will be recorded for analysis purposes and will only be reviewed by the researcher and the researcher's supervisor. The original recordings will be locked in a combination safe and the researcher will be the only person who has access. The tape recordings will be destroyed once they have been reviewed (not to exceed five years).
8. To protect your confidentiality, you will be assigned a pseudonym or "fake name" in transcriptions of the focus groups. If the findings are published or presented at professional conferences, the results for the group as a whole will be discussed. If specific quotations are shared due to their importance, the comments will be associated with the "fake name".

9. The findings from this study may be shared with other researchers who are doing similar research. If the data are shared, the data will be released without any personally identifying information, so that you cannot be identified.
10. The information you provide is treated confidentially and will not be released to others, unless such disclosure is required by law. These exceptions are the suspected abuse or neglect of a child; abuse or neglect of an elder or dependent adult; or if a person wishes to inflict serious harm to him/herself, to someone else, or to someone's property that will involve harm to others.

Again, I want to thank you for being interested in participating in my study. Please feel free to contact me at [REDACTED] with any questions.

Sincerely,

Jaimee S. Hartman, M.A.
Doctoral Student
Pepperdine University
Graduate School of Education and Psychology

APPENDIX F

Interest Appreciation Letter to Participants

[Date]

[Participant's name]

[Participant's address]

Dear *[Participant]*,

Thank you for your interest in my research on Moral Injury and for taking the time to review the information provided regarding the study. Unfortunately, I have been able to identify the adequate number of participants for the study and will not be able to schedule you for a focus group. Again, I want to thank you for your time and interest in participation.

Please feel free to contact me at [REDACTED] with any questions. Thank you very much.

Sincerely,

Jaimee Hartman, M.A.

APPENDIX G

Demographic Questionnaire

Demographic Questionnaire

INSTRUCTIONS: The following questions are designed to obtain information about your background. Please read each question carefully and provide your response by writing out the requested information or by placing an "X" in the appropriate space.

1. What is your age? _____ years.

2. What is your ethnicity? (Please check all that apply)

____ African American

____ Asian

____ Caucasian

____ Latino/Latina

____ Native American

____ Pacific Islander

____ Other

3. What is the highest level of education you have completed?

____ less than 7 years of school

____ 7-9 years of school

____ 10 or more years of school, without diploma (part high school)

____ High school graduate (12 years of school)

____ GED

____ Less than one year of college, business, or trade school

____ One or more years of college, without degree (also business or trade school)

____ Two year college degree (Associates Degree)

____ Four year college degree (Bachelor's Degree)

____ Professional degree (Master's Degree)

____ Professional degree (Doctoral Degree)

____ Professional degree (MD, DO)

4. What is your current religious or spiritual affiliation?

____ Christianity

____ Judaism

____ Islam

____ Buddhism

____ Hinduism

____ Spiritual, but not religious

____ Other

____ None

5. What is the range of your annual income?

____ below \$12,000

____ \$12,000-\$18,000

____ \$18,000-\$25,000

____ over \$25,000

6. What is your present occupational status:

- Employed full time
- Employed part time
- Unemployed

7. Have you ever been a victim of Intimate Partner Violence?

- Yes
- No

8. Have you been a victim of emotional/verbal abuse as an adult?

- Yes
- No

9. Have you been a victim of physical abuse as an adult?

- Yes
- No

10. Have you been a victim or witnessed any other trauma not mentioned?

- Yes
- No

11. Have you ever been diagnosed with depression, anxiety, or any other mental disorder (other than a substance-related disorder)?

- Yes
- No

If yes, what has been your previous diagnosis _____

12. Are you currently experiencing any hallucinations or delusions that may make it difficult for you to participate in this study?

- Yes
- No

13. How many, if any, children do you have? (Gender and ages) _____

14. Have any of your children been removed from your custody? _____

If yes, have you regained custody of your children? _____

15. If you have children, how many are currently living:

- with you
- with other family

- with friends
- in DFCS custody or foster care
- adopted by other families

16. Are you currently facing any pressure from the Department of Family and Child Services (DFCS) (check all that apply)?

- reported for child abuse/neglect
- open child abuse/neglect case
- children in foster care (temporary)
- children in foster care (permanent)
- visitation rights
- other: _____

17. Please rank the three substances below that you have used the most (1=primary, 2=secondary, 3=third):

- marijuana
- speed (meth, ice)
- powder cocaine
- prescription drugs (type: _____)
- crack
- club drugs (example: ecstasy, G, K)
- alcohol
- heroin
- PCP/angel dust
- other: _____

18. Are you currently facing any legal pressures (check all that apply)?

- waiting on a hearing date
- waiting on sentencing
- drug court
- probation
- criminal charges
- parole
- mandatory urine screens
- other: _____

19. Who or what agency is requiring that you attend substance abuse treatment?

- DFCS / CPS caseworker
- Probation or parole officer
- other: _____

20. Have you ever wanted to cut back or stop your drug or alcohol use?

- Yes
- No

21. Have you ever tried to cut back or stop your drug or alcohol use?

Yes

No

22. If you have wanted to or you have cut back or stopped, how did you do it?

(check all that apply):

I just did it

I went to support meetings (12-Step, etc)

Friends or family helped me

I went to a substance abuse treatment program

Prayer / faith

reading / self-help books

other: _____

23. How long were you able to maintain that change?

1 week

1-3 weeks

1 month

2-3 months

4-6 months

7-12 months

1-2 years

other: _____

24. How many times have you ever attended a substance abuse treatment program?

never

1 time

2-3 times

more than 3 times

25. Have you ever completed a substance abuse treatment?

never

1 time

2-3 times

more than 3 times

26. How long have you been sober?

1-3 months

3-6 months

6-12 months

over one year

27. Do you feel like your drug or alcohol use has ever created problems for (check all that apply):

you

your family (parents, siblings)

- your finances
- your education
- your housing
- your work
- your physical health
- your friendships
- your mental health
- your safety
- your children
- your children's education
- your children's health
- your children's safety
- I have not experienced any problems
- other: _____

Thank you for your participation!

APPENDIX H

Informed Consent for Participation in Research Activities

Informed Consent for Participation in Research Activities

The Implications of Moral Injury Among African American Women with a History of Substance Abuse: A Preliminary Study

I. I agree to participate in a research study being conducted by Jaimee Hartman M.A., Doctoral Candidate in Clinical Psychology at Pepperdine University in Los Angeles, California to fulfill dissertation requirements, under the supervision of Daryl Rowe, Ph.D., Professor of Psychology.

II. I understand that participation in this study is completely voluntary and that there will be no negative consequences if I choose not to participate. In addition, I understand I may choose to stop participating in the study at any time, for any reason, and there will be no negative consequences to me.

III. I understand the purpose of the research study is to see how moral injury might also apply to experiences of women in their addiction. I also understand that this study is *only* interested in those persons whose have a history of substance use.

IV. My participation in this study will consist of completing one questionnaire that will ask about the following areas: background information and experiences (e.g., age, occupation, education, adult trauma experiences, alcohol/substance use history) and participating in a two-hour focus group with other women.

V. I understand that participation in this study will be confidential. There are, however, important exceptions to confidentiality that are legally mandated. In some cases, the California courts have held that if there are suspicions of child abuse, elder abuse, neglect, or if I am determined to be a danger to myself or a danger to others, it is the researcher's duty to warn the person and/or the family of the person who is likely to suffer the results of harmful behavior, and report suspicions of child abuse to the proper reporting agency. I will not be asked to share any personally identifying information on any of the research forms or questionnaires. I have been informed that the focus groups will be audiotaped for analysis purposes and will only be reviewed by the researcher and the researcher's supervisor. The recordings will be used for research purposes only. The tape recordings will be destroyed once they have been reviewed and transcribed and will not be kept for more than one year. To protect my privacy, I will be assigned a pseudonym or "fake name" in transcriptions of the focus groups. Any findings from this study that are published in professional journals or shared with other researchers will only involve group data with no personally identifying information included. Security of the data will be maintained by password protecting the data files, as well as by storing the data on a password protected USB drive for 5 years after the study. The USB drive will be stored in a combination safe to which the researcher will be the only person who has access. After 5 years of storing the data files, they will then be destroyed in a secure manner.

VI. My participation in this study will take about 2 hours. I understand that the materials are written in English.

VII. I understand that there is no direct benefit to me for my participation in this research. However, I may feel a sense of satisfaction from contributing to a research study of those who have a history of addiction. Findings from this study will not only potentially contribute to the scientific literature in this area, but also possibly assist to improve the understanding of the

relationship between moral injury and substance abuse. This information may help improve treatment interventions and gender based treatment within the community.

VIII. I understand that participation in this study involves no more than minimal risk. Such risk is similar to what is encountered in daily life or during the completion of routine psychological questionnaires. It is possible that I may experience some emotional discomfort in responding to certain questions about my experiences in my addiction. I understand that I am free to not answer any questions that I do not want to answer. I also understand that I may contact Jaimee Hartman, M.A. at [REDACTED] or the dissertation chair, Daryl Rowe, Ph.D. at Daryl.Rowe@pepperdine.edu should I have any concerns that I wish to discuss further. Mental health and sobriety support resources will be provided following the questionnaire, whether or not it is completed, to assist with any distress that may arise.

IX. If I have any questions regarding participation in this research project, I understand that I may also contact Thema Bryant-Davis, Ph.D., Chairperson of the Graduate and Professional Schools Institutional Review Board (GPS IRB), at Pepperdine University Graduate School of Education & Psychology, 6100 Center Drive, 5th Floor, Los Angeles, CA 90045, or by telephone at [REDACTED], or at tbryant@pepperdine.edu.

X. I understand the information regarding participation in this research project. All of my questions have been answered to my satisfaction. I have read this informed consent document and I have understood it. I understand that I am free to print this Informed Consent document if I want to keep a copy. I am 18 years or older and hereby consent to participate in the research described above.

Name of Participant (please print): _____

Participant's Signature

Date

I have explained and defined in detail the research procedure in which the subject has consented to participate. Having explained this and answered any questions, I am cosigning this form and accepting this person's consent.

Name of Principal Investigator (please print): _____

Principal Investigator

Date

APPENDIX I

Mental Health and Recovery Resources

Mental Health and Recovery Resources

Be Sober Hotline

1-800-BE-SOBER (1-800-237-6237)

Didi Hirsch

4760 S. Sepulveda Blvd.

Culver City, CA 90230

1-310-390-6612

Didi Hirsch Community Mental Health Suicide Prevention Center

1-877-7CRISIS (877-727-4747)

International World-Wide Suicide & Crisis Hotlines

<http://www.suicidehotlines.com/international.html>

Los Angeles County Department of Mental Health Hotline

1-800-854-7771

Pepperdine University Psychological and Educational Clinic

6100 Center Drive, Suite 559

Los Angeles, CA 90045

1-310-568-5752

National Drug & Alcohol Treatment Hotline

1-800-662-HELP (1-800-662-4357)

National Suicide Prevention Lifeline

1-800-273-TALK (1-800-273-8255)

APPENDIX J

Introduction to Focus Group

Introduction to the Focus Group

Hello everyone. Once again I would like to thank each of you for joining me today and agreeing to engage in a discussion about topics relevant to women and recovery. Before we begin I would like to take this opportunity to introduce myself. As, you know, my name is Jaimee Hartman and I am conducting this study as part of my doctoral program in psychology at Pepperdine University. Personally, this topic resonates with me as I come from a long line of African American women who have had a significant influence on my life. My mother, grandmother, aunts, and great-aunts raised me with certain values and morals consistent with our culture and traditional beliefs of faith and strength.

When I started my graduate work I had the good fortune of being assigned to work at a residential program for women who had been incarcerated for substance abuse related crimes and I have continued my work with this population since. I am overcome by the resilience, strength, and courage that women such as you demonstrate on a daily basis. Your stories have motivated me to remain focused on trying to assist other women in any way I can and I hope that the discussions that follow will help to give you a voice and help you all to recognize through your shared experiences that you are not alone.

I would like to start the group discussion with a song from “Sweet Honey in the Rock”, which you may be familiar with entitled, *Sometimes I Feel Like a Motherless Child*.

[The song will be played]

APPENDIX K

Focus Group Questions

Focus Group Questions

Provide laminated sheets with the following definition of Moral Injury:

Moral injury is the conflict within yourself that results from acting in a way or watching something that goes against your values and what you know is right and wrong, due to being in a dangerous environment or lifestyle.

For instance, a veteran recently returned from combat and was having problems getting along with friends and family, was isolating in his room, and began drinking heavily. His family referred him to therapy where he discussed how while in Afghanistan he witnessed a lot of violent and cruel acts against others due to being in a war zone and needing to survive. However, now that he has returned, he shared that he feels ashamed because these things went against his values and beliefs and he was unable to put a stop to what was saw being done.

This reaction to previous actions can also be heard in the stories of women in recovery. I recently treated a woman in treatment who would do well and remain sober for a couple months and then kept relapsing, despite her progress. When we began working on this cycle, she discussed how once she began getting back with her family, she was so ashamed of what she had done in her addiction as well as how it impacted her family, that she used drugs to help decrease the emotions. While in her addiction, she had sold herself to get drugs, stolen from her grandmother to get money for drugs, and had neglected her children to the point that they were taken into foster care. These choices were made while influenced by her addiction as well as a toxic environment. However, in her recovery, she had difficulty accepting her actions as negative behaviors and instead believed that this made her a bad person for which she was ashamed because it went against how she was raised and her view of herself as a mother.

1. What do you think of the term moral injury as just defined for you?
2. How does it apply to the experiences you have had while in recovery?
3. Using the definition of moral injury provided, what types of events that you have experienced or witnessed in your addiction that might contribute to moral injury?
4. Could you describe the experience for me? What was the situation and how does it relate to moral injury?
 - a. How did that make you feel?
 - b. What did you do?
 - c. What did you think?
 - d. What about that experience is most memorable?
5. What impact do you think your history of trauma has had on your experience of moral injury?

6. How do you think moral injury applies to you specifically as an African American woman? Would it be different if you were a white, Asian or Latino female?
7. How could one's family or support system help an individual with moral injury?
8. When you were growing up, how supportive do you feel your family was?
9. When you were growing up, how important were morals and values?
10. When you were growing up, how important were religious or spiritual beliefs in your daily life?
11. In your addiction did you engage in behaviors that went against your moral beliefs?
12. In your addiction did you witness behaviors that went against your moral beliefs?
13. Did you ever regret not doing more to stop or prevent those immoral behaviors from happening?
14. How important are religion or spiritual beliefs in your daily life currently?
15. Do you have any additional thoughts or comments about the term moral injury?
16. What could mental health care providers do to help an individual who is having difficulty coping with the consequences of their behavior while in their addiction?
17. Is there anything else you would like to share?

APPENDIX L

Closing of Focus Group

Closing of the Focus Group

Briefly, before we leave, could you share what you have learned about yourself regarding moral injury or from the discussion? How do you feel you are better after participating in the conversation?

I want to thank you all again for your participation and openness throughout this discussion. Once my research is completed, I would appreciate the opportunity to return and share my findings with you.

In closing, I would like to end the group in a similar manner as how we started by showing you a video of Maya Angelou reciting her poem *Still I Rise* (Mohitbahi, 2007), which speaks of our ability to overcome oppression and rise above obstacles of fear, shame, and pain.

[The video of Maya Angelou reciting the poem *Still I Rise* will be viewed and a copy of the poem distributed to each group member]

Still I Rise

- by Maya Angelou

You may write me down in history
With your bitter, twisted lies,
You may trod me in the very dirt
But still, like dust, I'll rise.

Does my sassiness upset you?
Why are you beset with gloom?
'Cause I walk like I've got oil wells
Pumping in my living room.

Just like moons and like suns,
With the certainty of tides,
Just like hopes springing high,

Still I'll rise.

Did you want to see me broken?
Bowed head and lowered eyes?
Shoulders falling down like teardrops,
Weakened by my soulful cries?

Does my haughtiness offend you?
Don't you take it awful hard
'Cause I laugh like I've got gold mines
Diggin' in my own backyard.

You may shoot me with your words,
You may cut me with your eyes,
You may kill me with your hatefulness,
But still, like air, I'll rise.

Does my sexiness upset you?
Does it come as a surprise
That I dance like I've got diamonds
At the meeting of my thighs?

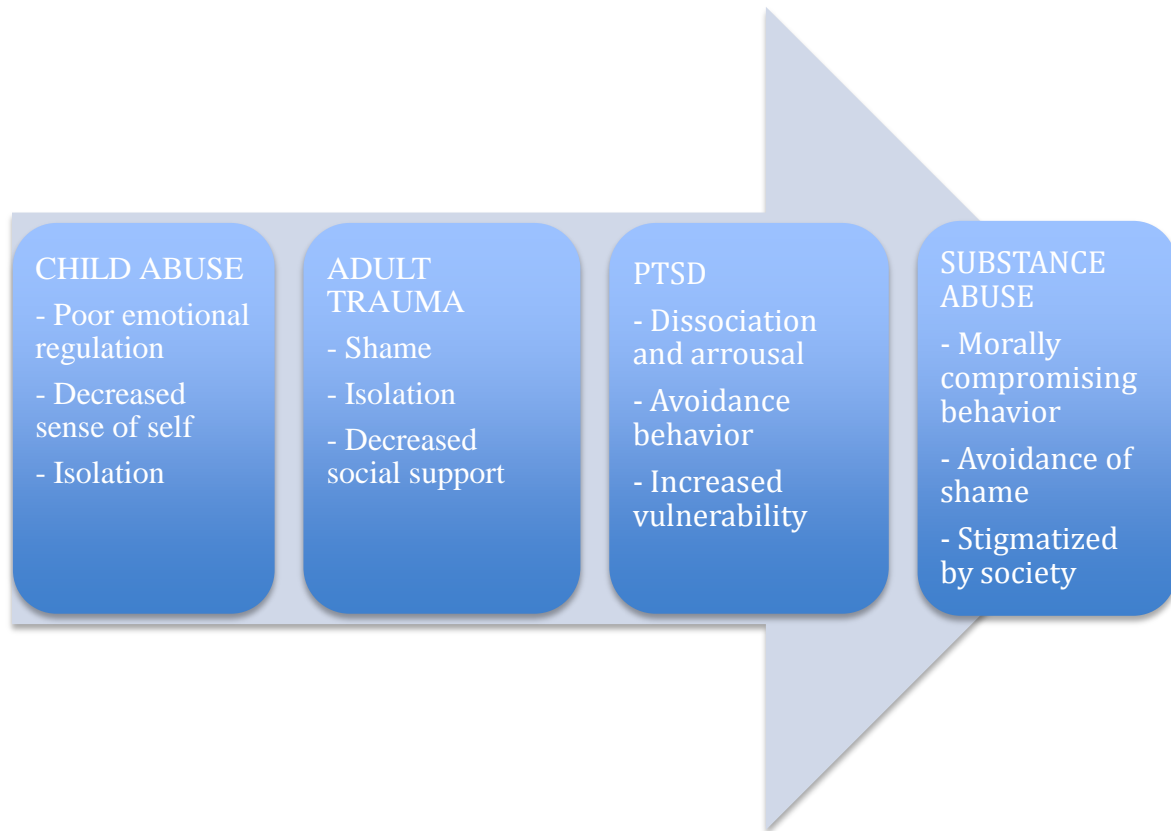
Out of the huts of history's shame
I rise
Up from a past that's rooted in pain
I rise
I'm a black ocean, leaping and wide,
Welling and swelling I bear in the tide.

Leaving behind nights of terror and fear
I rise
Into a daybreak that's wondrously clear
I rise
Bringing the gifts that my ancestors gave,
I am the dream and the hope of the slave.
I rise
I rise
I rise.

APPENDIX M

Moral Injury Process

DEEPENING OF MORAL INJURY



APPENDIX N

IRB Approval Notification

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

June 16, 2014

Jaimee Hartman


Protocol #: P0414D02

Project Title: The Implications of Moral Injury Among African American Females with a History of

Substance Abuse: A Preliminary Study

Dear Ms. Hartman:

Thank you for submitting your application, *The Implications of Moral Injury Among African American Females with a History of Substance Abuse: A Preliminary Study*, for expedited review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your advisor, Dr. Rowe, completed on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 7) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted **Full Approval**. The IRB approval begins today, **June 16, 2014**, and terminates on **June 16, 2015**.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. One copy of the consent form is enclosed with this letter and one copy will be retained for our records. **You can only use copies of the consent that have been stamped with the GPS IRB expiration date to obtain consent from your participants.**

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For *any* proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond [DATE], a **Continuation or Completion of Review Form**

must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to “policy material” at <http://www.pepperdine.edu/irb/graduate/>).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact me. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

6100 Center Drive, Los Angeles, California 90045 310-568-5600

Sincerely,



Thema Bryant-Davis, Ph.D.
Chair, Graduate and Professional Schools IRB
Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Mr. Brett Leach, Compliance Attorney
Dr. Daryl Rowe, Faculty Advisor

