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Review of Literature of Women with Co-occurring Disorders through the Feminist and Black Feminist Perspective

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Abstract

A review of literature through a lens of Feminism and Black Feminism of women, addiction, mental illness and trauma was conducted for a different clinical perspective and consideration for treatment provisions provided to women with co-occurring disorders. Studies presented have shown an increased realization that women require treatment that meets their specific needs and the use of a Feminist and Black feminist lens can alter clinician's viewpoints to meet those specific needs of women in treatment.

Keywords: Feminism; Women; Addiction; Trauma; Mental illness; Black feminism; Treatment

Introduction

Women with mental illness, trauma and substance abuse disorders, otherwise known as co-occurring disorders, and their gender specific needs are often overlooked. This has made it difficult to address the specific treatment needs of women with severe mental illness, trauma and substance abuse history in treatment. A woman's pathway to substance use is unique and methods of treatment should reflect those special needs.

Many facilities provide traditional substance abuse treatment models mainly designed for men. The course of addiction tends to transpire much more swiftly for women, often using multiple substances and diagnosed with a mental illness in addition to the substance use disorder [1]. Treatment centres recognized a steady increase in admissions of women; therefore, gender must be highly considered as women tend to enter treatment more vulnerable than men. Additionally, women diagnosed with co-occurring disorders are more likely to suffer from a traumatic event such as physical, emotional and/or sexual abuse. Women with co-occurring disorders have more difficulty receiving proper treatment and managing both disorders [2].

Feminism and Addiction

It is beneficial for this study to briefly review America's history of women and substance abuse and women's role in society in order to grasp some understanding of society's response to offer treatment for women with substance abuse disorders [3].

Kandall revealed the dilemma created by the unrestrained illicit use of addicting drugs that occurred 150 years ago [4]. During the 1800s many physicians prescribed unlimited medications to any and every pain and ache for women. Primarily, physicians prescribed various forms of opium, cocaine, chloroform and cannabis. Cocaine was not only used for medicinal purpose; it was also used recreationally within all social classes of women.

Special institutions and special professionals were created to provide care for intoxicated individuals in the latter 18th century and into the 19th century in an attempt to sober up or cure drinkers with a problem. The first institution developed for inebriate women began in 1841. During this time many women suffering from alcohol problems were put in the insane asylum or admitted to the inebriate asylums in spite of the shame and stigma. Most asylums offered secret entrances to avoid the woman's presence being known [3]

Due to the insignificant success rate of the inebriate asylums, they were replaced by insane asylums [3]. Treatment options remained limited from 1940 to 1970 until the women's movement emerged [5]. It was this socio political movement that defined women as being different and having different recovery needs than men.

Drug use was first criminalized by the 1914 Harrison Act which forced women addicted to drugs to support their habits any way they were able. Many of these women became marginalized within society and were forced into prostitution and crime to support their habits. The emergence of the Comprehensive Crime Control Act of 1984, Anti-Drug Abuse Amendment of 1986 and the Anti-Drug Abuse Amendment of 1988 further criminalized and pushed women into the margins of society, creating stereotypes and anger towards women suffering from addiction [4,5].

The 1990s brought about more pre-trial treatment and psycho-educational treatment programs for drug users and drunk drivers. It was during this time period that supplementary counseling services such as physical and sexual abuse, parenting skills, mental illness, and independent living skills were offered in addition to drug treatment [6].

Bepko stated addiction often brings about such complex and extreme treatment problems that gender is often overlooked [7]. Kandall proclaimed there is an urgent need to aid women struggling with addiction [4]. The vastness of women using drugs has always been greater than what has been admitted in America.

Straussner and Attia gave a report from the National Center on Addiction and Substance Abuse of the millions of women addicted to drugs and alcohol [2]. In the United States 3.1 million women used illicit drugs on a regular basis, 3.5 million wrongly used prescription

drugs and 4.5 million women were alcoholics or abused alcohol. Stevens, Andrade, and Bridget provided the most recent data which indicated approximately 6.5 million women met the criteria for substance abuse or dependence [8]. Brady and Ashley noted gender as being extremely important for treatment services for women substance abusers because of the background, patterns and personal histories that differ from men [2]. Stevens, Andrade, and Bridget 8 stated their differences in the reasons women need and receive substance abuse treatment, as well as differences in outcomes in treatment and retention in treatment.

Collins discussed the use of the disease model to understand the addiction phenomenon, but this seemed to overtly simplify addiction problems manifested within women [6]. This model left out significant social facets such as race, sex, class, and age in precipitating factors leading to and perpetuating the addiction.

Covington, Burke, Keaton, and Norcott identified a difference in pathways to drug use and abuse for men and women [9]. Because of different societal gender roles and expectations for women, there is a more significant impact on employment, child custody and housing to name a few.

Clark, Samnaliev, and McGovern said that 50 to 100% of individuals receiving Medicaid benefits are more likely to be diagnosed with psychiatric or substance abuse disorders than the general population [10]. Mandell and Werner reported most women with substance use disorders are involved in several public service systems, such as the criminal justice system, child welfare, Medicare or Medicaid [11].

Although awareness was noted regarding the challenges that exist for women with principal child rearing responsibilities to engage in treatment, many services are not designed to meet specific needs such as child care. The complexities often compound the effects of alcohol and drug use for women [12]. Brady and Ashley reported inpatient hospital facilities were less likely to offer special addiction programs for women and pregnant women, but they were more likely to offer prenatal care [2].

Black Feminism and Addiction

Mainstream treatment for addiction has generally left out the unique needs of women and Black women specifically [13]. Even though Black women share a history of sexism and racism in America, it is important to remember they are not monolithic; they have different ethnic and racial backgrounds [8,13].

Gray and Littlefield stated that the cultural and ethnic foundation of an individual creates the lens for them to view the world and their life experiences [13]. Rhodes and Johnson declared African American women as being most likely to receive insufficient therapy and to be punished for the behaviour associated with substance use [14].

There is a limited amount of literature that measures substance abuse, race and ethnicity along with subgroups of Black women. This makes it challenging to truly know the prevalence of substance use and to understand the cultural characteristics of addiction over the life span of Black women [13,15]. Traditional models of addiction have failed to recognize the disparate allocation of resources for Black women. These models fell short of distinguishing the environmental factors which shape the minority female addict [14].

The insufficient awareness of sexism and racism greatly denies the position of Black women and compromises the treatment experience [14]. Development of Afro-centric lenses to view the world could be beneficial for Black women in treatment. Afro-centric lens is defined as exploring ethnic identities and cultural rituals in order to enhance recovery. Developing a strong African American identity could augment self-esteem and reduce drug use [6].

Understanding the complexities of the addiction phenomenon of Black women requires accounting for the personal characteristics of the individual addicted woman. Also, it is important to take into account the socio-political facets that create the circumstances in which she defines herself and her lived experiences [13]. There is a need to understand the varying backgrounds of women who abuse substances by ethnicity and race. This could make a significant difference in how these women view themselves and may help in recovery [6,8].

Gray and Little discussed a study that enrolled Black women and their children into comprehensive culture and gender specific long term residential treatment [13]. The findings were significant in that 88% of the women maintained sobriety while in treatment and when discharged. Due to the sizeable number of reports of physical and sexual abuse of Black women addicted to alcohol and drugs, trauma recovery should be centre stage in programs in order to be effective and promote recovery. It is essential to comprehend the overlapping of various factors that cause and perpetuate female addiction. Also, it is critical for developing effective treatment interventions [14].

Feminist and Black Feminist Perspectives on Mental Illness and Women

Linhorst, Hamilton, Young, and Eckert stated that there is a long history of individuals with mental illness lacking empowerment [16]. Ritsher, Coursey, and Farrell reported that an understanding of social based gender differences as well as biological differences are required in order to gain an awareness of the needs and experiences of women with severe mental illness [17].

Ballou et al. recommended recognizing actual lived experiences as an efficient way of creating information, instead of forcing societal structures on that lived experience [18]. By recognizing the actual lived experience, it urges vigilant attention to actual lived experience instead of forcing structure on the lived experience. Once this occurs there is opportunity for contextual and cross cultural appreciation. Avery stated feminists have often ignored the needs of women with severe mental illness, but at the same time feminists have redefined mental illness as a type of oppression within society for women [19].

Nabors and Pettee defined the theoretical orientation of feminist therapy as deconstructing the pathology of women's symptoms [20]. This framework permits therapists to view women's problems appropriately. Ballou et al. emphasized the need for more research on the differences between gender, schizophrenia and chronic mental illness across ethnic groups to keep up with the research conducted on depression [18].

Avery stated two ways in which sexism influences the concerns of women with mental illness. The effect oppression has on women potentially intensifies the level of mental illness and gender bias, which leads to more women with the diagnosis of mental illness [19].

Carter and Parks stated most research on gender has been unsuccessful in exploring the effects of race on various criterions [21]. Nadeem, Lange, and Miranda reported deprived young ethnic women are over represented and have the most risk for multiple psychiatric

disorders. In addition, they are less likely to receive the needed mental health treatments [22]. The National Survey of Black Americans reported most African Americans did not seek mental health services as a response to emotional distress [23,24].

Individuals diagnosed with severe mental illness often need help with basic life necessities [25]. Wilson reported that 43% of African Americans and African Caribbean's responding to a survey were diagnosed with a major mental illness such as schizophrenia [26]. Eighty-five per cent received their treatment in a psychiatric hospital setting.

Groh concluded the United States had reached a defining moment with poor and low income individuals receiving mental health services as funding continued to dissipate on a yearly basis [27]. Diala et al. said that bias from providers offering treatment and diagnoses of mental disorders tend to affect African Americans seeking care [28]. Suite, La Bril, Primm, and Harrison-Ross claimed there is a need for providers to take a history sensitive approach when providing treatment to people of colour [29]. The U.S. Surgeon General's report stated that significant barriers for mental health treatment for people of colour are stigma and mistrust.

Suite et al. discussed records of acts of violence against women of colour in the medical establishment [29]. Specifically, routine sterilization of women of colour was a common practice within the medical field and exacerbated the mistrust. Neighbours et al. stated that several studies found significant differences between people of colour from varying ethnic and racial groups to be just as different as their white counterparts [23].

Waite and Killian made clear that cultural identity will considerably alter women's experience of depression [30]. Depression was reported as the leading cause of mental illness among women. Underserved women are substantially more likely to be diagnosed with depression. The authors also stated the need for understanding the multifaceted circumstantial factors that may have some effect on the outcomes of mental health treatment.

Collins stated women of colour with severe mental illness experience stigma in reference to their illness along with racial discrimination, poverty, immigration status or ethnicity [31]. The author used the intersectional approach to view the complex systems of oppression such as mental illness, race and gender. Inter sectionality was defined by understanding the interlocking of systems of oppression which views all the dimensions of the woman that make her unique.

There is a need to address the racial inequality of treatment offered for psychological disorders, and it is vital to create a way to explicitly understand the experiences of women struggling with the oppressive nature of society. The framework of inter sectionality allows for an explicit viewpoint of ethnicity, mental illness and gender identity and how they all interact when exploring the psychopathology of the woman [32].

Mollow reviewed Meri Nana-Ama Danquah's Willow Weep for Me [33]. In the book Danquah discussed using inter-sectionality as a way to explore the various aspects of the medical model of mental illness. The lack of access to proper healthcare and improper forcing of healthcare is one of the most oppressive factors of mental illness and politics. Treatment for mental illness remains complex and opposed within the political sector.

Sparks stated people of colour face imbalanced and significant rates of mental and physical illness and untimely death rates [34]. Mental illness and mental health dwell within the socio political, socio-cultural and economic framework. This contributes to and influences the creation of labels for mental illness, treatment approaches, prevention and the types of labels given when people are diagnosed.

Society classifies an individual by his or her race, gender and class; however, a person's life experience and social environment have a tremendous impact on his or her identity. The influences of race, gender and class are varied based on having privilege or not. More attention should be given to the intersections of class, race, gender and mental disorders [34]. Mollow stated having a diagnosis of a mental illness increased the potential for being placed in the institution unwillingly, treatment with unsafe medications or societal stigmatization [33].

Feminism and Trauma

Brison said that a person feeling totally powerless in the midst of something that is seemingly life-threatening constitutes a traumatic event [35]. Courtois and Ford stated there are several definitions of trauma [36]. The author's further state once psychological trauma takes place, the individual will more than likely neutrally experience traumatic events but afterwards will subjectively anticipate an experience of trauma.

Herman discussed the historical points of view of hysteria and combat neurosis [37]. Just thirty years ago the realization and connection of identical post-traumatic stress syndromes were made between combat veterans, rape survivors, and victims of incest and domestic violence. The reality is trauma is trauma no matter who experiences it and no matter the origin of the trauma.

Courtois and Ford described two types of trauma [36]. Type I trauma is defined as a single incident. Type II trauma, also known as complex trauma, is defined as a recurring of incidents. Complex trauma is more common and affects between one in seven to ten children. Typically an individual's trust is betrayed by a primary caregiver or relationship during a vulnerable developmental period.

Herman said that the basis of human relationships is called into question once a traumatic event happens [37]. Brison stated when a traumatic event originates from another human being deliberately, it shatters the basic beliefs about the world and safety in the world [35]. Also, the individual who is traumatized loses a sense of self and connection with self [38]. The difficulties of women who have been traumatized are often exacerbated due to the constricted tolerance of those with whom they have close relationships. In addition, there is minimal approval allowed by society for women to disengage or communicate their feelings. The principal experiences of psychological trauma are disempowerment and disconnection from others [37].

Frueh et al. found that 51 to 98% of individuals with severe mental illness in the public mental health clinics shown to have had high occurrences of traumatic victimization, and approximately 43% had post-traumatic stress disorder [39]. They also found these individuals are vulnerable to vicarious traumatization within the psychiatric settings. The mental health systems are saturated with survivors of recurring and prolonged childhood abuse [37].

Increasingly a history of trauma has been recognized as a major concern of women with co-occurring disorders. Savage, Quiros, Dodd, and Bonavota conducted a study to determine the prevalence of

interpersonal trauma and abuse ensued by women with co-occurring disorders [40]. The authors found that 85% of the women had been physically abused, and almost 70% had suffered violent penetrative sex; furthermore, 43.4% of women stated they had experienced violent penetrative sex as an adult, and 20% reported they had experienced this before age eleven. The authors also discovered the earliest onset of interpersonal trauma and abuse occurred as early as the preschool and elementary years.

Gallop, McCay, Guha, and Khan revealed women are more likely than men to be hospitalized for disorders such as borderline personality and dissociative disorders, which typically are a result of prolonged childhood trauma [41]. The authors report these are potential risks for re-traumatization or re-victimization by interventions used to manage behaviors during hospitalization for survivors of abuse.

All aspects of a woman's well-being are affected and strongly impacted by trauma [42]. Due to the increased awareness of the relationship between substance abuse, mental illness and trauma, the federal government agency, Substance Abuse and Mental Health Services Administration (SAMSHSA), initiated a national evaluation of the effectiveness of a comprehensive program for women with histories of trauma, mental health, and substance abuse disorders. [12,42] This study was the first effort from the federal government to undertake the shortfall of services provided for women with co-occurring disorders and trauma [43].

Collins stated women have reported that they frequently use drugs to numb the pain that is a direct result of trauma, self-hatred, anger and neglect [6]. These traumas also include sexual and physical abuse from interpersonal relationships. Self-medicating the effects of trauma is common and interrupts the ability to sort out the experiences of the trauma and symptoms of post-traumatic stress disorder (PTSD) [2].

Covington reported suffering violence is not the only way of experiencing trauma, but it is inclusive of witnessing a violent incident [44]. Trauma is defined as a response to an event as well as an event in itself. The author also described the relationship between substance abuse and trauma as a means of sustaining a connection to a non-healthy relationship. The use of the substance tends to offer a numbing effect to a violent relationship. Clark et al. reported that women who have been abused display difficulty trusting others [45]. It is essential for a strong therapeutic alliance to be developed as part of the recovery.

Inadequate attention to the effects of trauma, mental health symptoms and substance abuse could cause misdiagnosis and misguided foci in treatment. It is not often that treatment services are designed specifically for women, and this leads to inaccessibility and ineffectiveness [46]. Due to the difficulty in sustaining close relationships, women surviving traumatic events tend to be susceptible to re-victimization by caregivers. They often become involved in repetitive harmful interactions. The mental health system often inadvertently re-creates the actions of the abusive family and re-traumatizes the victim [37]

Women are known to drink more frequently to reduce symptoms when they are experiencing negative effects from their trauma. These women are also much more vulnerable to the possibility of re-traumatization and engage in self-destructive behaviour [9].

DiNitto and Crisp reported women diagnosed with severe mental illness such as schizophrenia and substance abuse disorders are more vulnerable and at risk of physical and sexual abuse as a result of cognitive and social skills deficits [47]. The level of burden experienced by women, along with multiple barriers and vulnerability, often impede the treatment and recovery process; this often causes relapse and early departures from treatment. [48,49].

Commonly trauma is a trigger for relapse and mental health symptoms. In addition, psychological development and a woman's ability to connect are profoundly hampered. This in turn impacts the way in which a woman who has experienced trauma interacts in the therapeutic environment [9]. Using trauma as the framework of treatment can enhance the treatment environment and fortify the interventions for recovery [48,49].

According to Brown, Rechberger, and Bjelajac, gender specific treatment and trauma informed care are two specific criteria needed in developing a program for women with co-occurring disorders [50]. In order to expand the results of treatment for complex trauma, there is a need to integrate interventions specifically targeted in this area [51].

Gatz et al. found supportive evidence that integrated trauma informed treatment programs can have success for treating women with co-occurring disorders and histories of trauma by increasing their coping skills [49]. This study also called for the need to assess for trauma at the point of entry into a treatment program.

The goal of the Cohen and Hien study was to determine the effectiveness of cognitive behavioural therapy in a sample of urban women with substance abuse disorder and trauma [51]. The results indicated a decrease in some symptom clusters in a short period, but more complex issues of trauma may be less amenable to this treatment.

Holdcraft and Comtois stated there is a need for women with co-occurring disorders to be provided with treatment that is inclusive of empowerment [52]. The treatment should build hope and confidence through the use of training skills development, community support, and education and motivation enhancement. Women only programs could provide a greater effect for those suffering from mental illness.

The Morrissey et al. study reported the interventions used over twelve months improved symptoms of trauma in conjunction with the comparison group [53]. The interventions consisted of a comprehensive selection of services. The staff providing the services were all trauma informed. All services integrated treatment of mental health, trauma and substance related issues, and the consumers of the service were involved and served in an advisory role.

Gray and Littlefield expressed the significance of trauma in the lives of Black women. Reports showed sixty one per cent of Black women who used crack cocaine had been sexually abused at some point in their lifetimes [13].

Black Feminism and Trauma

Hooks stated sexual exploitation of Black women at the time of slavery caused the devaluation of black womanhood, which did not change for one hundred years [54]. Survivors of rape in the patriarchal society lost their significance and importance due to the humiliation they had to endure.

McNair and Neville revealed that minimal literature exists that examines the experiences of African American women survivors of sexual assault [55]. The authors explored the experiences of African American women survivors' experiences within the intersections of race and class.

Cusak, Morrissey, and Ellis said that the outcomes of diversity in trauma implies that people with a history of trauma, mental illness and substance abuse disorders should not receive the same interventions to help them cope with their experiences [56]. White, Strube, and Fisher stated the Black feminist perspective put emphasis on the oppressive systems of race and sexism on social and human domination [57]. It expanded this viewpoint to explore the intersections and the effects that diminish attitudes towards rape.

McNair and Neville informed readers of the qualitative difference in the socio-historical background of African American women compared to non-minority women [55]. Slavery used sexual exploitation and rape to control African women by stigmatizing them as temptresses. It was believed that the African slave could not be sexually exploited and that she actually welcomed the sexual advances.

Crenshaw stated the black feminist point of view offered a political and intellectual response to the black woman living in the intersections of race and sexual subordination [58]. The aim was to bring together what otherwise would be varying aspects and alienated awareness, and to address the political marginalization of wanting to view race or gender in isolation instead of viewing them together.

The political goals of black feminism are to build and give power to a political responsiveness that is actively opposed to racism and misogyny concurrently. Violence that occurs against women of colour should be understood as a crucial issue in the anti-violence or the anti-racist dialogue [58].

Stephens and Phillips argued that African American women have a shared set of experiences unique to their racial and gender background which shape their view of their sexuality. Furthermore, mass media, peers and family units all act as primary informants of the socialization of sexuality for African American women [59]. The information received by these various sources is experienced differently by these women than by non-minority women.

Crenshaw said that the disregard for women of colour being victimized by violence and rape may be attributed to the difference in culture; this highlights the propensity for the public to not take the intra-racial violence seriously [58]. Brison said that the intersections of the various taboos of rape, such as talking openly about violence, sex and trauma, brings conversation to a stalemate and immobilizes the prospective supporter [35]. There is no way to ease the discomfort, and the vocabulary needed to express concern is lacking.

Conclusion

Studies have shown an increased realization that women in the clinical care settings require treatment that meets their specific needs. More specifically, treatment should be focused on women's emotional development, trauma, recovery, and parenting skills [60].

Williams noted that knowledge that is subjective and grounded in experience is valued [61]. The personal experience of a woman has the ability to address more than her own encounter because it is reflective of the greater social, historical, political and cultural context within its phenomenon. The interrelationships within the systems of oppression make the task of self-deconstruction and finding the fundamental self becomes an overwhelming task.

The lived experience of women signifies multifaceted networks of relationships, contacts and obstacles that are all interconnected [48]. Having knowledge of the pervasiveness of interpersonal abuse in the lives of women with co-occurring disorders lend itself to the task of incorporating a holistic assessment and to have a fine distinctive individualized understanding of their needs [39]. Approaching addiction, trauma and mental illness from the black feminist perspective creates a shift from looking for internal deficits and moves towards looking for various environmental and cultural interconnections [6]. The key is to create the most effective services that acknowledge and understand the lived experience of the woman in a patriarchal society [62].

References

1. Centre for Substance Abuse Treatment (2005) Substance Abuse Treatment For Persons With Co-Occurring Disorders: A Treatment Improvement Protocol TIP 42. Rockville, MD: Substance Abuse and Mental Health Services Administration.
2. Brady TM, Ashley OS (2005) Women in substance abuse treatment: Results from the Alcohol and Drug Services Study (ADSS) Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.
3. Straussner SLA, Attia PR (2002) Women's Addiction and Treatment through A Historical Lens. The Handbook of Addiction Treatment For Women. San Francisco, CA: Jossey-Bass A Wiley Company.
4. Kandall SR (2010) Women and drug addiction: Ahistorical perspective. J Addict Dis 29: 117-126.
5. Brown S (2002) Women and Addiction: Expanding Theoretical Points of View. In S.L.A. Straussner and S. Brown S. The Handbook of Addiction Treatment for Women (pp. 26-51). San Francisco, CA: Jossey-Bass A Wiley Company.
6. Collins LH (2002) Alcohol and Drug Addiction in Women: Phenomenology and Prevention. In M Ballou and LS Brown: Rethinking Mental Health and Disorder: Feminist Perspectives, New York: The Guilford Press.
7. Bepko C (1991) Introduction. In C. Bepko: Feminism and Addiction : Haworth Press.
8. Stevens SJ, Andrade RA, Ruiz BS (2009) Women and substance abuse: gender, age, and cultural considerations. J Ethn Subst Abuse 8: 341-358.
9. Covington SS, Burke C, Keaton S, Norcott C (2008) Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. J Psychoactive Drugs Suppl 5: 387-398.
10. Clark RE, Samnaliev M, McGovern MP (2007) Treatment for co-occurring mental and substance use disorders in five state Medicaid programs. Psychiatr Serv 58: 942-948.
11. Mandell K, Werner D (2008) Guidance to States: Treatment Standards for Women with Substance Abuse Disorders. National Association of State Alcohol and Drug Abuse Directors.
12. Becker MA, Noether CD, Larson MJ, Gatz M, Brown V, et al. (2005) Characteristics Of Women Engaged In Treatment For Trauma And Co Occurring Disorders: Findings From A National Multisite Study. Journal of Community of Psychology 33: 429-443.
13. Gray M, Littlefield MB (2002) Black Women and Addictions. In S.L.A. Straussner S. Brown. The Handbook of Addiction Treatment for Women, San Francisco, CA: Jossey-Bass A Wiley Company.
14. Rhodes R, Johnson A (1997) A Feminist Approach to Treating Alcohol and Drug-Addicted African-American Women. Women and Therapy 20: 23-37.
15. Davis RE (1997) Trauma and addiction experiences of African American women. West J Nurs Res 19: 442-460.
16. Linhorst DM, Hamilton G, Young E, Eckert A (2002) Opportunities and Barriers to Empowering People with Severe Mental Illness through Participation in Treatment Planning. Social Worker 47: 425-434.
17. Ritsher JE, Coursey RD, Farrell EW (1997) A survey on issues in the lives of women with severe mental illness. Psychiatr Serv 48: 1273-1282.

18. Ballou M, Matsumoto A, Wagner M (2002) Toward a Feminist Ecological Theory of Human Nature: Theory Building in Response to Real-World Dynamics. In M. Ballou, and L.S. Brown. Rethinking Mental Health and Disorder: Feminist Perspectives, New York: The Guilford Press.
19. Avery L (1998) A Feminist Perspective on Group Work with Severely Mentally Ill Woman. Women and Therapy 21: 1-7.
20. Nabors NA, Pettee MF (2003) Womanist Therapy with African American Women with Disabilities. Women and Therapy 26: 331-341.
21. Carter RT, Parks EE (1996) Womanist Identity and Mental Health. Journal of Counseling and Development 74: 484-489.
22. Nadeem E, Lange JM, Miranda J (2008) Mental health care preferences among low-income and minority women. Arch Womens Ment Health 11: 93-102.
23. Neighbours HW, Caldwell C, Williams DR, Nesse R, Taylor RJ, et al. (2007) Race, Ethnicity, and the Use of Services for Mental Disorders: Results from the National Survey of American Life. Archives of General Psychiatry 64: 485-494.
24. Schnittker J, Freese J, Powell B (2000) Nature, Nurture, Neither, Nor: Black-White Differences in Beliefs about the Causes and Appropriate Treatment of Mental Illness. Social Forces 78: 1101-1130.
25. Snowden LR, Hu TW (1997) Ethnic Differences in Mental Health Services Use Among the Severely Mentally Ill. Journal Of Community Psychology 25: 235-247.
26. Wilson M (2001) Black Women and Mental Health: Working Towards Inclusive Mental Health Services. Feminist Review 68: 34-51.
27. Groh CJ (2007) Poverty, Mental Health, and Women: Implications for Psychiatric Nurses in Primary Care Settings. Journal of the American Psychiatric Nurses Association 13: 267-274.
28. Diala CC, Muntaner C, Walrath C, Nickerson K, LaVeist T, et al. (2001) Racial/Ethinic Differences in Attitudes Toward Seeking Professional Mental Health Services. American Journal of Public Health 91: 805-807.
29. Suite DH, La Bril R, Primm A, Harrison-Ross P (2007) Beyond Misdiagnosis, Misunderstanding and Mistrust: Relevance of the Historical Perspective in the Medical and Mental Health Treatment of People of Colour. Journal of the National Medical Association 99: 879-885.
30. Waite R, Killian P (2007) Exploring Depression among a Cohort of African American Women. Journal of American Psychiatric Nurses Association 13: 161-169.
31. Collins PY, Elkington KS, von Unger H, Sweetland A, Wright ER, et al. (2008) Relationship of stigma to HIV risk among women with mental illness. Am J Orthopsychiatry 78: 498-506.
32. Kohn LP, Hudson KM (2002) Gender, Ethnicity and Depression: Intersectionality and Context in Mental Health Research With African American Women. Perspectives, 174-184.
33. Mollow A (2006) When Black Women Start Going on Prozac: Race, and Mental Illness in Meri Nana-Ama Danquah's Willow Weep for Me. MELUS 31: 67-189.
34. Sparks E (2002) Depression and Schizophrenia in Women: The intersection of Gender, Race/Ethnicity, and Class. In M Ballou and LS Brown, Rethinking Mental Health and Disorder: Feminist Perspectives, New York: The Guilford Press.
35. Brison SJ (2002) Aftermath: Violence and the Remaking of a Self. Princeton: Princeton University Press.
36. Courtois CA, Ford JD (2009) Treating Complex Traumatic Stress Disorders, New York: The Guilford Press.
37. Herman J (1992) Trauma and Recovery: The aftermath of violence from domestic abuse to political terror, New York: Basic Books.
38. Janoff-Bulman R (1992) Shattered Assumptions: Towards a New Psychology of Trauma, New York: The Free Press.
39. Frueh BC, Knapp RG, Cusack KJ, Grubaugh AL, Sauvageot JA, et al. (2005) Patients' reports of traumatic or harmful experiences within the psychiatric setting. Psychiatr Serv 56: 1123-1133.
40. Savage A, Quiros L, Dodd SJ, Bonavota D (2007) Building Trauma Informed Practice: Appreciating the Impact of Trauma in the Lives of Women with Substance Abuse and Mental Health Problems. Journal of Social Work Practice in the Addictions, 7: 91-116.
41. Gallop R, McCay E, Guha M, Khan P (1999) The experience of hospitalization and restraint of women who have a history of childhood sexual abuse. Health Care Women Int 20: 401-416.
42. Huntington N, Moses DJ, Veysey BM (2005) Developing and Implementing A Comprehensive Approach to Serving Women with Co-Occurring Disorders And Histories Of Trauma. Journal of Community Psychology 33: 395-410
43. Giard J, Hennigan K, Huntington N, Vogel W, Rinehart D, et al. (2005) Development and Implementation of A Multisite Evaluation For The Women, Co-Occurring Disorders And Violence Study. Journal of Community Psychology 33: 411-427.
44. Covington SS (2007) Working with Substance Abusing Mothers: A Trauma-Informed, Gender-Responsive Approach. National Abandoned Infants Assistance Resource Center 16: 1-11.
45. Clark C, Young M, Jackson E, Graeber C, Mazelis R, et al. (2008) Consumer Perceptions of Integrated Trauma-Informed Services among Women with Co-Occurring Disorders. Journal of Behavioral Health Services and Research, 35(1), 71-90.
46. Veysey BM, Clark C (2004) Introduction. Alcoholism Treatment Quarterly 22: 1-18.
47. DiNitto DM, Crisp C (2002) Addictions and Women with Major Psychiatric Disorders. In SLA Straussner and S Brown. The Handbook of Addiction Treatment For Women. San Francisco, CA: Jossey-Bass A Wiley Company.
48. Cadiz S, Savage A, Bonavota D, Hollywood J, Butters E, et al. (2004) The Portal Project: A Layered Approach to Integrating Trauma into Alcohol and Other Drug Treatment for women. Alcoholism Treatment Quarterly 22: 121-139.
49. Gatz M, Brown V, Hennigan K, Rechberger E, O'Keefe M, et al. (2007) Effectiveness of an Integrated, Trauma-Informed Approach to Treating Women with Co-Occurring Disorders and Histories of Trauma: The Los Angeles Site Experience. Journal of Community Psychology 35: 863-878.
50. Brown VB, Rechberger E, Bjelajac P (2004) A Model for Changing Alcohol and Other Drug, Mental Health, and Trauma Services Practice: PROTOTYPES Systems Change Center. Alcoholism Treatment Quarterly 22: 81-94.
51. Cohen LR, Hien DA (2006) Treatment outcomes for women with substance abuse and PTSD who have experienced complex trauma. Psychiatr Serv 57: 100-106.
52. Holdcraft LA, Comtois KA (2002) Description Of And Preliminary Data From A Women's Dual Diagnosis Community Mental Health Program. Canadian Journal of Community Mental Health 21: 91-109.
53. Morrissey JP, Jackson EW, Ellis AR, Amaro H, Brown VB, et al. (2005) Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. Psychiatr Serv 56: 1213-1222.
54. Hooks B (1981) Ain't I A Woman: Black women and feminism. Cambridge, MA: South End Press.
55. McNair LD, Neville HA (1996) African American Women Survivors of Sexual Assault: The Intersection of Race and Class, Women and Therapy 18.
56. Cusack KJ, Morrissey JP, Ellis AR (2008) Targeting trauma-related interventions and improving outcomes for women with co-occurring disorders. Adm Policy Ment Health 35: 147-158.
57. White AM, Strube MJ, Fisher S (1998) A Black Feminist Model of Rape Myth Acceptance: Implications for Research and Antirape Advocacy in Black Communities. Psychology of Women Quarterly 22: 157-175.
58. Crenshaw K (1993) Beyond Racism and Misogyny: Black Feminism and 2 Live Crew. In Matsuda M (Ed.) Words that Wound: Critical race theory, assaultive speech, and the First Amendment, Boulder, CO: Westview Press.
59. Stephens DP, Phillips L (2005) Integrating Black feminist thought into conceptual frameworks of African American adolescent women's sexual scripting processes. Sexualities, Evolution and Gender 7: 37-55.

60. Kassebaum PA (2008) Substance Abuse Treatment for Women Offenders: Guide to Promising Practices. Technical Assistance Publication (TAP) Series 23. Rockville, MD. Substance Abuse and mental Health Services Administration.

61. Williams A (2007) Deconstructing This Self: One Black Woman's Exploration of Childhood Sexual Abuse and Process of Personal Reclamation. OCHRE Journal of Women's Spirituality. Advance Online Publication.

62. Covington SS (2008) Women and addiction: a trauma-informed approach. J Psychoactive Drugs l5: 377-385.