Bridging the Gap in Women's Substance Use Services: A Trauma-informed, Gender-Responsive, and Anti-Oppressive Approach

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Abstract

Over the last decade, there has been an increase in trauma-informed substance use services, but a gap still exists between theory and practice. The majority of substance use services lack a gender-responsive and anti-oppressive approach, that specifically addresses the intersectional violence, oppressive barriers, and diverse experiences of women and femmes. Historically, traditional substance use services and 12-step programs were created for the needs of men, leaving out the experiences and realities of women. Women hoping to receive support and a safe space to heal in such programs often experience patriarchal barriers, retraumatization, misdiagnosis, and stigma. These treatment models often tell women how to heal instead of giving them agency over their own path to recovery. This capstone explores the question: How does bringing a gender-responsive, anti-oppressive lens to integrative trauma-informed substance use services promote positive therapeutic outcomes for diverse women in recovery? It will review the current literature on the connections between trauma, gender-based violence, substance use, and mental health to better understand the needs of women in recovery. It will examine traditional and conventional substance use treatment models and propose a 16-week integrative trauma-informed recovery program drawing from feminist, narrative, person-centered, and somatic therapies to provide a holistic, gender-responsive, and anti-oppressive approach to women's substance use challenges.

Keywords: women, substance use services, trauma-informed, gender-responsive, addiction treatment

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Bridging the Gap in Women's Substance Use Services: A Trauma-informed, Gender-Responsive, and Anti-Oppressive Approach

Chapter 1

Substance abuse and addiction have profound and devastating effects on millions of people across Canada and around the world. In Canada, addiction has been called an epidemic and a public health crisis as the number of substance-related deaths, overdoses, and suicides have reached record highs (Centre for Addiction and Mental Health; Public Health Agency of Canada, 2019). The individual, familial, and societal impacts of substance use and addiction are far reaching, resulting in human loss, suffering, grief, stigma, disconnection, separation of families, marginalization, oppression, incarceration, and gender-based violence (Greaves & Poole, 2012). Additionally, it is common for people accessing substance use services to report prior experiences of trauma and violence (Greaves et al., 2012; 2015).

Studies show that 60%-75% of women who enter into treatment for substance abuse have experienced sexual violence, physical abuse, partner violence, or other forms of oppression and gender-based violence during their lifetimes (El-Bassel, Gilbert, Schilling, & Wada, 2000). Gender-based violence is defined as "any act or threat of violence or harassment, directed at an individual based on their gender that results in, or is likely to result in, physical, sexual or psychological harm or suffering" (United Nations High Commissioner for Refugees [UNHCR], 2021). It is rooted in gender inequality, the abuse of power, and harmful sociocultural norms (UNHCR, 2021). Gender-based violence is often used interchangeably with violence against women, because it disproportionately affects women and girls around the world (UNHCR, 2021). In Canada approximately one in three women have experienced violence in their adult lives and one in 10 women experience violence on any given day (Canadian Women's

Foundation, 2021). Over 6,000 women and children sleep in shelters on any given night because it is not safe at home and approximately every six days a woman is killed by her intimate partner in Canada (Canadian Women's Foundation, 2021). Additionally, Indigenous women are killed at six times the rate as non-Indigenous women and trans women are disproportionately targeted for harmful acts of violence, harassment, and assault (Taylor, 2021; Canadian Women's Foundation, 2021).

The impacts of trauma and gender-based violence on women are all-encompassing. The violence women experience just for being women in today's patriarchal, or male-dominated, society has life-altering impacts (Covington, 2008; 2002; Marcellus, 2014). Some of the physical, mental, emotional, spiritual, and relational impacts of gender-based violence include, but are not limited to: disturbances in emotional regulation, impulse control, self-esteem, cognition, and the ability to form secure and trusting relationships with self and others (Greaves & Poole, 2012; Haskell; 2012). Additionally, women's experiences of violence vary based on their race, sex, gender identity, class, sexual orientation, culture, religion, ability, age, and other forms of diversity (Crenshaw, 1989; Greaves & Poole, 2012). All of these factors can interact/intersect to increase vulnerabilities related to trauma and violence. However, these factors also intersect to increase resiliency in the face of trauma (Crenshaw, 1989; Greaves & Poole, 2012).

Trauma is a key element in understanding addiction (Greaves & Poole, 2012; Greaves et al., 2015). Experiences of violence and trauma not only impact women's mental, physical, and emotional health, but it can also increase their likelihood of using substances (Covington, 2008; Canadian Women's Foundation, 2011). Women may use or abuse substances to cope with or reduce the adverse effects of trauma (Covington et al., 2008; Carpenter & Hasin, 1999). For

many women, substances offer a means of coping with trauma, such as childhood abuse, sexual abuse, intimate partner violence, and for Indigenous, Black, and women of colour, the intergenerational effects of colonization and racism (Niccols et al., 2010). Substances may provide temporary relief from some of the adverse effects of trauma; however, if the trauma is left unaddressed over time, many women face the challenge of developing substance-use dependencies and addiction (Hien et al., 2009). The links between trauma, violence, and addiction are important to all disciplines interested in women's addiction treatment, prevention, and harm reduction (Greaves et al., 2015).

The strong link between women's experiences of trauma and their patterns of addiction, suggests the increasing need for trauma-informed services for women seeking addiction treatment; services that hold an integrative trauma-informed lens in order to provide diverse women with a safe and supportive space to heal; and provide a space free of stigma, pathologizing beliefs, and harmful practices. However, there is a gap between the ideal and existing practices. The unfortunate and disturbing reality is that women seeking substance use treatment often experience oppressive barriers, first in their attempts to access services, and then from within the services where they seek support.

Many traditional addiction and recovery services lack an understanding of the diverse realities of women's lives and the strong links between violence against women, trauma, substance use, and other mental health diagnoses (Greaves & Poole, 2012; Covington; 2007). The services fail to work from a truly trauma-informed approach—one that is both gender-responsive and anti-oppressive in its framework —to address the systemic barriers and intersectional violence that are contributing to women's emotional pain and substance use. The current programs' lack of knowledge on the effects of trauma, the connection of trauma to

substance use and mental illness, and the diverse needs of women, often lead to misdiagnosis, extended suffering, and re-traumatization (Centre of Excellence for Women's Health, 2009). Furthermore, once women are in treatment and on the path to recovery and sobriety, failure to attend to and address their trauma can often lead to relapse (Covington et al., 2008; De Bellis, M.D.; 2002). Recovery from addiction is most successful when it is addressing not just the problematic substance-using behaviors, but the underlying issues and past trauma (Cunha, 2015). Clearly, there is still a great deal of work that must be done to better support the diverse needs of women with trauma, substance use, and mental health challenges. Substance use services need to develop treatment programs that integrate and reflect a holistic, gender-responsive and anti-oppressive approach for women.

In this chapter, I will discuss the background to this problem. I will explore the intersections between violence against women, trauma, substance use, and mental health. I will highlight how trauma and addiction are a public health concern for women and will discuss the barriers to treatment. This section will also review the different theories of addiction and outline the holistic and trauma-informed model of addiction that I will propose in this capstone, drawing on Covington (2002;2008) and Greaves and Poole's (2012;2015) influential work in women's substance use research and treatment. Lastly, I will speak to the significance of this capstone and its therapeutic implications.

In the next chapter, I will highlight the literature on the complexity of trauma and its impacts on women's mental, physical, spiritual, and relational health. I will review traditional treatment models and addictions services, primarily the most common model, 12-step mutual help programs, but also briefly include residential, inpatient, and outpatient models, to discuss strengths and limitations. I will highlight several current integrative trauma-informed and

gender-responsive addiction treatment and recovery services for women to review therapeutic outcomes and impacts on women.

In chapter three, I will propose a 16-week integrative trauma-informed recovery program for women. The program will draw on feminist therapy, person-centered therapy, narrative therapy, and somatic therapy to provide a gender-responsive and anti-oppressive framework to specifically address the systemic barriers and intersectional needs of diverse women. Together, these frameworks aim to facilitate the creation of a holistic, woman-centered, and resilience-based recovery space for women to engage in a meaningful healing process.

Purpose and Positioning

As a cisgender heterosexual white woman and settler, I want to name the social locations of privilege that I occupy and acknowledge that this capstone will have blind spots and limitations. I also want to name the personal importance and connection that this topic has to me. Addiction and substance use has impacted multiple generations of parents, grandparents, and ancestors on both sides of my family. I have learned firsthand about some of the challenges my mother and grandmother have experienced as women on their recovery journeys. Additionally, I had the privilege of doing my clinical internship in substance use and concurrent mental health services. I worked with many women who bravely shared stories of resilience in the face of violence, oppression, and misogyny in the very spaces where they were hoping to get support. This has fueled my desire to shine light on the harm being done and hopefully encourage more awareness, discussion, systemic change, and action.

I want to acknowledge that when I use the word women in the capstone, I am referring to anyone who identifies as a woman, including trans, two spirit, intersex, genderqueer, and non-binary people who are significantly femme-identified (Ricketts, 2021; ATIRA, 2019). I also

want to acknowledge that in this description I may be missing some people and hope that this capstone can apply to anyone of any gender identity who experiences misogyny, gender-based violence, and oppression in accessing mental health and substance use services. While not all diverse women's experiences can be represented in this research, this capstone aims to include the voices of women who have been impacted by these issues directly, especially those most marginalized, to ensure their voices are heard. Additionally, it is important to note that not all substance use is harmful or problematic. For many, substances offer a range of useful outcomes, and for many their relationship to substances adapt and change over their lifetime. This capstone hopes to shine light on the stigma women experience in both accessing and receiving treatment for substance use that they have self-identified as a challenge in their individual journeys. Furthermore, in my review of traditional addiction services, including 12-step programs, it is important to note that these programs have made and continue to make positive impacts on many people and women's lives. This capstone aims to identify the gaps in treatment so that we can better support women with substance use challenges, while also acknowledging that every treatment model has strengths and limitations and there is no one-size-fits-all approach to recovery.

The purpose of this study is to explore the impact that integrative and holistic trauma-informed recovery programs have on therapeutic outcomes for women with substance use and mental health challenges. The questions guiding this research are: *What impact do integrative trauma-informed substances use services, that hold a gender-responsive and anti-oppressive lens, have on promoting positive therapeutic outcomes for diverse women in recovery? How can taking a holistic and trauma-informed approach to addiction support women's physical, mental, emotional, and spiritual health? How can applying an anti-oppressive and gender-responsive*

lens to substance use services help bridge the gap between trauma-informed theory and clinical practice?

Background

Until recently, in-depth knowledge about women, substance use, and addiction was missing. There has been significant research done on men and addiction, but historically women have been left out of the picture (Covington, 2002; 2008; Marcellus; 2014; Najavits, 2002). As a result, many of the addiction and recovery services that women encounter in the public and private sectors today were not designed for women (Marcellus; 2014; Covington, 2002; 2008; Najavits, 2002). The treatment programs were originally created by men for the needs of addicted men, and then women were inserted into the treatment model with very little thought or care for potential differences in treatment needs (Covington, 2002; 2008). For example, Alcoholics Anonymous (AA) was first developed in the 1930s by two white men and it was based on the premise that addiction was a progressive, permanent disease primarily affecting men (Covington, 2002; 2008; Marcellus; 2014; Najavits, 2002). Women were added into the program shortly after, but women's biopsychosocial needs, and their lived experiences of gender-based violence and trauma, were not acknowledged (Covington, 2002; 2008; Greaves & Poole, 2012; Marcellus, 2014).

The barriers, needs, and impacts of substance use for women are diverse and often different from men. Evidence suggests that women who have substance use disorders are more likely than men to face multiple barriers affecting access and entry to substance abuse treatment (Tuchman; 2010). In comparison to men, women who abuse substances have fewer resources, experience more severe substance problems at the beginning of treatment, and have higher rates of trauma (United Nations Office on Drugs and Crime, 2004). Women with substance use

dependencies are more likely to have concurrent mental health challenges including depression, anxiety, eating disorders, and post-traumatic stress disorder (Covington, 2002; 2008; Najavits, 2002). Women tend to use substances at lower rates than men, but the physical and mental health impacts of women's use are substantial, and in some cases greater than those from men (Statistics Canada, 2002). With exposure to smaller amounts of alcohol over a shorter period of time, women are susceptible to conditions such as osteoporosis, brain impairment, gastric ulcers, and breast cancer (National Institute on Alcohol Abuse and Alcoholism, 2002). Women also tend to have lower self-esteem due to the societal stigma around their substance use and the oppressive barriers they face in trying to access and receive treatment (Najavits, 2002).

Although there has been an influx of substance use research, theory, discussion, and debate over the last several decades, many traditional substance use services continue to employ concepts of wellness and healing originally rooted in theories from Western psychology and medicine; these generally focus solely on mind and behaviour, and treat the mind and body as separate entities (Letendre, 2002, Linklater 2014; Haines, 2019). Some of these traditional theories of addiction include the moral model, the disease model, the medical model, the sociocultural model, and the social learning model. These varying theories look at things like genetics, environmental factors, sociocultural factors, behavioral factors, individual factors, character defects, and more (Faguet, 2008). The majority of these theories are very pathologizing in their approach, place blame on the individual for their addiction, and take an abstinence-based approach to healing that is focused solely on sobriety as the only objective (Covington, 2008; Haskell; 2012; Greaves & Poole; 2012).

In recent decades, more progressive models and approaches to addiction have emerged in light of new research into the neurophysiology of trauma and the lifelong impact of

environmental influences. For example, Bruce Alexander's theory of dislocation (2010), views addiction as a response to human dislocation and disconnection. Instead of pathologizing the individual, Alexander looks at social, political and economic barriers causing displacement, marginalization, and oppression (Alexander, 2010). Additionally, Gabor Maté's influential work views addiction as a symptom and response to childhood trauma (2008) and looks at some of the biopsychosocial factors that are at the root of addiction. In Maté's view, addiction is a response to internal pain and can be seen as self-medication for the effects of trauma (Maté, 2008). Additionally, harm reduction models have been more widely adopted in substance use services aiming to minimize barriers. A harm reduction model is "a client-centered approach that seeks to reduce the health and social harms associated with addiction and substance use, without necessarily requiring people to stop or abstain from using substances" (Canadian Mental Health Association, 2021, p. 1). It gives people who use substances a choice of how they will minimize harms through non-judgmental and non-coercive strategies in order to enhance skills and knowledge to live safer and healthier lives (Canadian Mental Health Association, 2021).

This capstone will propose that a holistic trauma-informed approach to addiction, one that holds a gender-responsive and anti-oppressive lens, is ideal for the treatment needs of women. A holistic model allows clinicians to treat addiction, while also addressing the complexity of issues that women bring to treatment. It looks at genetic predisposition, health factors, structural and social barriers, including oppression, shame, isolation, a history of abuse or trauma, or any combination of these (Covington, 2002, 2008). It takes a whole-person approach and addresses substance use, mental illness, chronic health conditions, triggers, histories of trauma, and sociocultural and systemic barriers (BC Mental Health and Substance Use Services, 2021). A holistic perspective aims to understand every aspect of the women's self

equally—the spiritual, emotional, mental, and physical— as well as the environmental and sociopolitical aspects of her life, in order to better understand addiction (Covington, 2008; Greaves & Poole, 2012).

In contrast, traditional 12-step, abstinence-based recovery programs, such as Alcoholics Anonymous or Narcotics Anonymous, and many existing residential programs have always focused primarily on the addiction itself and not an integration of issues like trauma, sociocultural factors, or co-related mental health challenges. This remains mostly the case today. Many current treatment models still primarily use a Western medical model, which focuses on illness, rather than a holistic model, which focuses on wellness (Linklater, 2014). While some programs have adapted and evolved somewhat to take a more holistic approach to the disease model and to include physical, psychological, emotional, spiritual aspects (Northrup, 1994; Covington, 2002), for the most part they are still rooted in Western psychology and patriarchal attitudes. They lack a trauma-informed approach—one that recognizes the influence of trauma, oppression, and gender-based violence—and often fail to acknowledge the sociocultural barriers clients face and the oppressive systemic structures at play (Covington, 2002; 2008). Current research suggests women would be better served by an integrative model, one that considers the impact of trauma, addresses intersecting levels of marginalization based on women's varying social locations, and uses a framework that addresses power imbalances and structural barriers created by patriarchy, white supremacy, colonialism, and capitalism.

Addiction is rarely, if ever, a single-dimension issue for women (Covington, 2008; 2002). As Audre Lorde says, "we do not live single-issue lives" (1984) and that complexity will inevitably interact with all aspects of women's addiction and mental health treatment. Individual social factors including—but not limited to—race, sex, gender identity, culture, sexual

orientation, age, spirituality, ability/disability, and class intersect to shape the experiences of individuals; that identity is multidimensional (Crenshaw, 1989). Addiction is always a part of a larger portrait that includes a woman's individual history and the social, economic, and cultural factors that create the context of her life (Covington, 2008, 2001). Covington (2008) explains that, "in thinking about treatment for addicted women, it is essential to start from the premise that theory and practice should be based on a multidimensional and integrative perspective" (p.1). She cites Abbott and Kerr (1995), who suggests that, if treatment is to be effective, it must take the full context of women's lives into account. Treatment must acknowledge the diverse and intersecting experiences and impact of living as a woman in a male-dominated society, and therefore, gender must be a part of the clinical approach. Covington (2001) calls such services *gender-responsive,* meaning they consider the sociocultural experience and perspective of gender to better understand and serve their clients. For services to be gender-responsive for women, they should create an environment—through site selection, staff selection, program development, content, and implementation of services —that reflects a deep understanding of the diverse realities of women lives, and that addresses and responds to their challenges and strengths (Covington, 2008; 2001). By providing gender-specific care and considering the sociopolitical circumstances of women's lives, theorists, researchers, clinicians, and service providers can learn to develop and use strategies for change that promote both personal and political empowerment (Greaves & Poole, 2012).

In a comprehensive report, the Canadian Women's Foundation found that the impact of gender-based violence is critical to understanding women's substance use patterns (2011). One study found that women's experiences of violence may precede their substance use and/or mental health issues (Gatz et al., 2005). Additionally, approximately two-thirds of women

accessing anti-violence services report that they began their problematic substance use following experiences of gender-based violence in their relationships (Parkes et al., 2007). Some researchers have argued that consistent correlations between violence against women and mental health and substance use issues suggest a causal relationship (Golding, 1999). At the same time, there is evidence that substance use and/or mental health concerns can create a vulnerability to violence and the pre-existence of these conditions may exacerbate the effects of the abuse (Gatz et al., 2005). The association between these three issues is therefore both complex and multidirectional (Gatz et al., 2005). The 2011 report's findings demonstrate why taking an integrative and holistic approach to addiction is important. In order to support women in their treatment and recovery, service providers need to acknowledge and hold all of these complexities and interconnections at once.

Women encounter significant systemic, structural, social, cultural and personal barriers in both accessing and receiving effective substance use treatment (United Nations, 2004). There are still very few programs that are accessible, affordable, and appropriate for women, especially mothers, pregnant women, Black, Indigenous, and women of colour, LGTBQ+ women, women with disabilities, sex workers, women offenders, and women with co-occurring mental health or trauma issues (Parkes et al., 2007). Additionally, when accessing substance use treatment or acknowledging their substance abuse, women face the potential threat and trauma of having their children removed and frequently the further threat from a partner/family to report them to child welfare authorities (Covington, 2008; Greaves & Poole, 2012; Najavits; 2002). Women often experience stigma attached to violence and substance use in relation to being a pregnant or parenting woman, which can prevent many women and mothers from seeking the help they need (Covington, 2008; Parkes et al., 2007). Overall, research shows many women have limited

access to mental health and substance use services and have to contend with the barriers of shortages of services, qualified service providers, lack of appropriate services for their needs, location or budget, lack of childcare, and long waiting lists for more appropriate/community-based services (Covington, 2007). Additionally, many women report being turned away from mental health and addiction services, for having more than one presenting issue (Centre of Excellence for Women's Health [CEWH], 2009; Poole & Pearce, 2005). Given the myriad of barriers, many researchers and service providers have urgently called for the development of integrative woman-specific prevention, harm reduction, and trauma-informed treatment approaches (Greaves & Poole, 2012, Parkes et al., 2007).

Significance and Chapter Summary

Despite the increasing need, effective and accessible treatment options remain elusive for diverse women struggling with trauma, substance use, and mental health challenges; leaving a significant treatment gap (Covington, 2008; 2002; CEWH, 2009; Greaves & Poole, 2012). Furthermore, most addiction and substance use services focus on a single-dimension outcome, which is helping clients achieve sobriety, regularly ignoring the impact of trauma and violence on women's everyday functioning and mental health. These conventional and traditional recovery programs and services have been largely unsuccessful in supporting women to overcome their substance use dependencies and heal (Covington, 2007; Greaves & Poole, 2012). Many women access services intending and hoping to get support, heal, and overcome their substance use challenges; instead, they often experience rigid, abstinence-based recovery frameworks originally created for men. Many of these traditional services lack a trauma-informed approach. Other services claim to work from that model, but there is a gap in theory and practice (Elliot et al., 2005). They are still missing a trauma-informed approach that holds

both a gender-responsive and anti-oppressive lens that understands the impact of trauma, the structural barriers, and the diverse realities of women's needs and experiences. The stigma and marginalization women experience in such spaces prevents and discourages them from seeking the support and care that they need.

This lack of effective addiction and recovery services for women results in significant costs for individuals, families, communities, service systems, and for governments (CEWH, 2009), increasing the urgency of the problem. Substance abuse costs Canada over $38 billion a year, which is an estimated $1,258 for every person in Canada (Canadian Institute for Substance Use Research; Canadian Centre on Substance Use and Addiction, 2017). The estimated annual cost to the Canadian health care system for medically treating women who have experienced violence ranges from $408 million to $1.5 billion (Cohen & Maclean, 2004). This capstone will address the gap in trauma-informed substance use services for women and the impact it is having on society. It will review ways in which substance use services can better meet the needs of women suffering from violence and marginalization through gender-responsive and anti-oppressive care.

Definition of Terms

Addiction: Used to describe a chronic condition with biological, psychological, social and environmental factors influencing its development and maintenance. It is often marked by cravings to use substance(s), loss of control of amount or frequency of substance use, and a compulsion to use despite consequences. It can often lead to physical and/or psychological dependence on the substance(s) (CAMH, 2021).

Anti-oppressive framework: A treatment framework that requires the practitioner to critically examine the power imbalance inherent in an organizational structure, with regards to the larger sociocultural and political context, in order to develop strategies for creating an egalitarian environment free from oppression, racism, homophobia, transphobia and other forms of discrimination (Strier, 2007).

BIPOC: Black, Indigenous, and People of Colour. This term is used to acknowledge that not all people of color face equal levels of injustice. BIPOC is significant in recognizing that Black and Indigenous people are more severely impacted by systemic racial injustices (Merriam-Webster, 2021).

Femme: A queer identity for a person who is feminine-associated or whose gender expression is considered, but not limited, to be feminine (Bashan, 2020).

Gender-based violence: Any act or threat of violence or harassment, directed at an individual based on their gender, that results in, or is likely to result in, physical, sexual or psychological harm or suffering. (United Nations High Commissioner for Refugees [UNHCR], 2021).

Gender-Responsive Services: Services that include the sociocultural experience and perspective of gender to better understand and serve their clients (Covington, 2008; 2001).

Harm-Reduction: Refers to policies, programs and practices that aim to reduce the harmful health, social, and economic consequences of substance/drug use without necessarily reducing the amount of drugs or substances the person uses (Fraser Health Authority, 2020).

Heteropatriarchy: A socio-political system where, primarily, cisgender males and heterosexuals have authority over cisgender females and over other sexual orientations and gender identities. It is a term that emphasizes that the discrimination of women and LGBTQ+ people has the same sexist social principle (Valdes, 1996).

Holistic: A whole-person approach that aims to understand every aspect of an individual equally—the spiritual, emotional, mental, and physical—as well as the environmental and sociopolitical aspects, in order to better understand the intersections between mental health, physical health, substance use, and trauma (BC Mental Health and Substance Use Services, 2021; Covington; 2002; Greaves & Poole, 2012).

Retraumatization: The psychological and/or physiological experience of being triggered or bringing up a trauma response, which may include fight, flight, or freeze responses (Greaves & Poole, 2012).

Substance abuse: Excessive use of a substance or substances in a way that is detrimental to self, others, or both (CAMH, 2021).

Substance Use Disorder (SUD): The medical term for addiction used in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. A complex condition in which there is uncontrolled use of a substance despite harmful consequences. People with an SUD have an intense focus on using a certain substance(s) such as alcohol, tobacco, or illicit drugs, to the point where the person's ability to function in day-to-day life becomes impaired. SUDs vary in intensity from mild, moderate, or severe (American Psychiatric Association, 2013).

Trauma: The emotional, physical, or behavioural response to a harmful or life-threatening event, or series of events, with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). Trauma is not limited to witnessing or suffering violence; it also includes stigmatization, marginalization, or oppression because of gender, race, class, sexual orientation, age, spirituality, and ability (Covington, 2008).

Trauma-informed services: Trauma-informed services are those in which service delivery is influenced by an understanding of the impact of interpersonal violence and victimization on an individual's life and development (Elliot et al., 2005). Trauma-informed services take into account the knowledge and impact of trauma on client's physical, psychological, and emotional health, and integrate this knowledge into all aspects and levels of service delivery (CEWH, 2009; Harris & Fallot, 2001).

Women: Refers to anyone who lives and identifies as a woman, including trans, two spirit, intersex, genderqueer, and non-binary folks who are significantly femme-identified, and those of any gender identity who face misogyny (Ricketts, 2021; ATIRA, 2019).

Chapter 2

This chapter looks into the literature surrounding trauma, women, and substance use, including treatment programs and interventions used to support women in recovery. The literature review will look at three things: first, the complexity of trauma, its interaction with substance use, and the impacts on women's mental, physical, spiritual, and relational health; second, the effectiveness of treating women in traditional recovery spaces; and finally, how trauma-informed, anti-oppressive and gender-responsive treatment programs impact the outcomes for women with substance use issues. It will also provide an overview of feminist therapy, person-centered therapy, narrative therapy, and somatic therapy and outline how they align with the principles of trauma-informed, gender-responsive, and anti-oppressive frameworks to address the intersectional needs of diverse women and provide a holistic approach to substance use treatment.

The Complexity of Trauma

Trauma has been defined in many different ways. The American Psychological Association defines trauma as: "an emotional response to a disturbing event like an accident, death, serious injury, sexual violence or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea" (2020). Similarly, SAMHSA (2017) describes it as "the emotional, physical, or behavioural response to a harmful or life-threatening event, series of events, or set of circumstances experienced by an individual, with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being". Trauma can be both an event and a response to an event (Covington, 2008). SAMHSA (2012) recommends framing it with three E's—taking into

account the event itself, the experience of the individual, and the effect on the individual to capture the diversity of its variations. Trauma events can include a wide range of life-threatening experiences, including physical and sexual abuse, neglect, partner violence, accidents, natural disasters, incarceration, war, terrorism, familial loss, severe bullying, and exposure to domestic and community violence (Gerson & Rappaport, 2013).

There are many forms of trauma—simple, complex, developmental, collective, intergenerational—and many variations in how trauma is experienced by each individual (Marcellus, 2014). Trauma can undermine or damage people's sense of safety, self, and self-efficacy, as well as the ability to regulate emotions and navigate relationships; people who have experienced trauma often feel terror, shame, helplessness, and powerlessness (Greaves & Poole, 2012). Biere and Scott (2015) discuss how trauma responses can be more complicated, frequent, or intense based on the trauma survivor's individual factors, characteristics of the stressor, and how those around the trauma survivor respond. They refer to gender, race, class, and sexual orientation, as survivor variables, or aspects of the survivor that were in place before the relevant trauma and that can increase the likelihood of sustained posttraumatic difficulties. Other variables may arise from early childhood trauma or maltreatment causing psychological disturbance and problematic coping (Biere & Scott, 2015; Briere, 2014). Trauma can be accumulated and compounded by ongoing harmful experiences including gender-violence, abuse, oppression, and marginalization.

The Injustice of Trauma: Violence, Oppression, and Marginalization

Trauma is not limited to witnessing or suffering violence, neglect, or abuse. It includes stigmatization, marginalization, or oppression because of gender, sex, race, class, sexual orientation, age, ethnicity, culture, spirituality, ability/disability, and other forms of diversity

(Greaves & Poole, 2012; Covington, 2008). In Vikki Reynold's work, "In an Ethical Stance for Justice-Doing in Community Work and Therapy," she discusses how critically engaging with language is important (2012). She describes the harm of normalizing language such a trauma and suicide into a mental health issue. She says that by doing so, medicalization covers up oppression and violence in the context of social justice and human suffering (Reynolds, 2012). She states that, through the medicalization of mental health, "we now have symptoms and medication, when what we require is justice" (2012, p. 27). Reynolds' lens helps to illuminate some of the important pieces often missing in treating clients with trauma, particularly women and those most marginalized, and helps explain why a gap still exists in trauma-informed care.

Haines (2019) states that most of the root causes of trauma stem from what she refers to as "power-over social conditions." Haines (2019) writes that in societal structures based on hierarchy "power-over systems dictate that some peoples, nations, ethnicities, genders, and lives are more worthy of safety, belonging, dignity, and resources than others" (p. 13). Power-over conditions can be found at individual, interpersonal, social, and institutional levels where they dehumanize, undermine, and oppress whole groups of people, manifesting in the form of racism, sexism, ableism, classism, heterosexism, homophobia, transphobia, xenophobia, fatphobia, among others (Caldwell & Leighton, 2018). Such oppression depends upon violence, threats of violence, coercion, and a steady stream of misinformation to work (Haines, 2019). These oppressive behaviors can be overt and physical, such as sexual or physical abuse, or subtle and insidious, as when a person is subjected to acts of social exclusion, dismissal, diminishment, and disempowerment (Greaves & Poole, 2012).

Social, economic, and political systems such as patriarchy, colonialism, white supremacy, and capitalism can also contribute to women's diverse experiences of violence, trauma, and

oppression (Ricketts, 2021; Haines, 2019). In her book, *Decolonizing Trauma Work*, Renee Linklater (2014) explores the traumatic impact of colonization on Indigenous people as well as other marginalized populations. Linklater writes: "Since colonization began, trauma has created a climate of systematic oppression, violence, and abuse" (p. 10). Additionally, she describes how slavery, segregation, and racism have caused disconnection and dehumanization. She asserts that these forces have been disconnecting Indigenous and other marginalized populations from family, land, and culture. She discusses how colonial violence continues to be perpetuated in many forms and is enforced by the government through legislation and institutions, through the education system, health care system, legal system, and others. This causes multigenerational trauma to be passed down within marginalized communities, with many social consequences, especially for women. Women living with trauma often engage in pervasive use of alcohol and drugs, which puts them at heightened risk of economic and social problems, such as lack of affordable housing, homelessness, involvement with the justice system, acts of violence, suicides, accidental deaths, family separation, and increased involvement with the child welfare system (Linklater, 2014; Niccols et al., 2010). Additionally, when seeking help, women often encounter more alienation, pathology, and traumatization (Linklater, 2014; Greaves & Poole, 2012, Covington, 2008).

The Risks and Criminalization of Substance Use

Research shows that women who use substances and have challenging life circumstances may have an increased risk of sexual exploitation and violence. One study found that more than 50% of women entering substance use treatment in the United States have reported trading sex for money or drugs (Burnette et al., 2008). Many times, women are trading sex for money, housing, drugs, and/or other necessities, which can significantly increase the risk of sexual

exploitation and trafficking (Gerassi, 2018; Sloss & Harper, 2010). Sexually trafficked women and those involved in commercial sex work experience extensive rates of trauma and are at high risk of adverse substance use disorders and mental health disorders (Gerassi, 2018; Burnette et al., 2008). Women have also utilized drugs as coping mechanisms to survive multiple forms of violence in the sex industry (Gerassi, 2018; Syvertsen, 2013). Additionally, women impacted by sex work and sexual exploitation are often arrested or convicted for their own substance use related to crime or held responsible for crimes committed to benefit a trafficker or pimp (Gerassi, 2018).

Both trauma and substance use increase the likelihood of interaction with the criminal justice system (Tuchman, 2010; Covington, 2008). Women incarcerated for drug and substance-related offenses represent one of the fastest growing populations in jails and prisons (Tuchman, 2010). Between 1980 and 2019, the number of incarcerated women in the United States increased by more than 700%, rising from a total of 26,378 in 1980 to 222,455 in 2019 (Bureau of Justice Statistics, 2020). Women in state prisons are more likely than men to be incarcerated for a drug or substance-related offense (Tuchman, 2010). Twenty-six percent of women in prison have been convicted of a drug or substance-related offense, compared to 13% of men in prison (Tuchman, 2010). Additionally, BIPOC women experience higher incarceration rates than white women. Black women are more than three times as likely as their white peers to be incarcerated, and Indigenous women are more than four times as likely (Bureau of Justice Statistics, 2020).

The Gendered Impact of Trauma

Although the effects of trauma are a devastating phenomenon for all people and genders, research shows that women face specific issues and vulnerabilities that are different from those of men (Covington, 2002; 2008; Greaves & Poole, 2013). Greaves & Poole (2012) emphasize

the importance of recognizing the gendered pattern and ongoing nature of the intersections and connection between violence, trauma, and substance use; the impact can be lifelong. A study involving six women's addiction treatment centres from across the United States, found that 90% of the women interviewed reported childhood or adult abuse histories in relation to their problematic substance use (Brown, 2009). Between 66% and 90% of the women who enter substance use treatment services have histories of either sexual or physical abuse, or both. (Covington 2008; Hien et al. 2005; Najavits, 2002). Women with a history of early childhood trauma, may also engage in more risk-taking behaviors, such as substance abuse, multiple sex partners, criminal involvement, and are at a greater risk for sexual assaults and relationship violence (Lipschitz et al., 2007).

Posttraumatic Stress Disorder and Dual Diagnoses

Compared to men, women who have experienced a traumatic event have a greater risk of developing more serious health consequences and anxiety disorders, including Posttraumatic Stress Disorder (PTSD) (Greaves & Poole, 2013; Danielson et al. 2009). PTSD is characterized by the re-experiencing and avoidance of the trauma and increased nervous system arousal, with longstanding symptoms causing significant distress and impairment (American Psychiatric Association, 2020). Women are twice as likely as men to develop PTSD after a traumatic event and the chronicity of symptoms for women persist up to four times longer than men (Norris et al., 2002; CEWH, 2009). Rates of PTSD among female substance abusers range from 14% to 60% (Brady et al., 2001, Hien et al., 2005). The majority of women who are dually diagnosed with both PTSD and substance use disorders are not only victims of childhood abuse, but are also more vulnerable to repeated interpersonal trauma throughout their lives (Hien et al., 2005). These women tend to present to treatment with high rates of concurrent disorders, including

anxiety and depression, as well as with interpersonal, behavioural, and affect regulation deficits that significantly complicate treatment and prognosis (Hien et al., 2005; Logan, et al., 2002; CEWH, 2009.)

Historically, the challenges faced by women with dual diagnosis have been compounded by the lack of treatment services designed to address both issues simultaneously. To date, and despite advocacy and awareness-raising by women's health researchers, there has been insufficient research synthesizing the complex intersections among substance use, trauma, gender-based violence, mental health concerns, and the range of social determinants of health for girls and women (Greaves & Poole, 2013, 2012; Covington et al. 2008; Humphreys et al., 2005; Herman, 1992).

Severity of Substance Abuse

In comparison to men, women also experience different forms of trauma and may develop a greater severity of substance abuse and dependence in response to the trauma (Greaves & Poole, 2013; Danielson et al. 2009). Additionally, research shows that women who experience violence, abuse, and trauma earlier in life are more likely to abuse substances and develop substance use dependencies (Covington, 2008; Greave & Poole, 2013). Women who experience forms of abuse as children are significantly more likely to have used illicit substances than non-abused children (National Institute on Drug Abuse, 1998), and women who are abused as children have an earlier onset of substance dependence (Hien et al., 2000).

Impacts on Women's Physical and Mental Health

Trauma can have a profound effect on development, with a lifelong impact on both physical and mental health. Depending on contextual factors such as developmental stage, social supports, and resources, trauma can impact an individual's functioning and physical, social,

emotional, and spiritual well-being (Marcellus, 2014). The affected domains of functioning include adaptive and interpersonal functioning, emotional regulation, cognition and memory, and neuroendocrine function (Gerson & Rappaport, 2013). Additionally, trauma can impact impulse control and self-esteem (Bartlett, Smith, & Bringewatt, 2017). Most people who experience significant trauma display disturbances of mood, arousal, sleep, and behaviour (Haskell, 2003; Gerson & Rappaport, 2013). Also, trauma causes central nervous system changes, cardiovascular problems, gastrointestinal and genito-urinary, and reproductive problems (Haskell, 2003; CEWH, 2009).

Survivors of trauma, gender-based violence, and abuse often live in environments where they constantly face the threat of danger. Living in a state of constant fear results in a state of constant alertness, hypervigilance, or hyperarousal which is extremely taxing on the nervous system (Haskell, 2007). Women who live in conditions of constant danger eventually experience a breakdown in the amygdala's ability to discriminate threat cues (Haskell, 2007). Past and present danger becomes confused, and they begin to have persistent, reoccurring, and overly defensive reactions, even to harmless stimuli (Haskell, 2007). Survivors are not remembering their traumatic experiences: they are re-experiencing them (Van de Kolk, 1994; Haskell, 2007).

Living in that hypervigilant state has enormous consequences on day-to-day functioning. Survivors of long-term trauma are focused on short-term survival and are not able to consider the long-term consequences of their coping strategies (Haskell, 2007). They will do whatever they can to keep themselves out of pain and learn to disconnect from their bodies in order to avoid feeling the overwhelming pain and stress (Haskell, 2007). The accumulation of years of prolonged stress, abuse, and violence and the extreme adaptations developed to manage these

chronic states result in greater morbidity, and higher mortality from various tragic causes (Vaccaro & Lavick, 2008).

Attempts to cope with the emotional pain, to reduce tension, and to downgrade high levels of arousal may include self-harming behaviours—for example, cutting, suicidality, eating disorders and addictive behaviours, including substance abuse and dependence (Haskell, 2007). Addictive behaviours can be tailored to induce either numbing or increased arousal or a combination of both depending on the adaptive state of the trauma survivors' nervous system (Fisher, 2003).

Relational Impacts

Trauma impacts the way women relate to their external environment including peers, family members, intimate partners, service providers, and how safe they feel in different spaces (Covington et al., 2008). It can impact their ability to form secure attachments in peer, guardian, and romantic relationships (Bartlett, Smith, & Bringewatt, 2017). John Bowlby developed attachment theory in 1970 to explain how the connection between a child and caregiver during early years can have significant impacts on a child's development throughout their life (Bowlby, 1988). When caregivers are mis-attuned, neglectful, abusive, or distant, this can cause a child distress and lead them to develop insecure attachment (Bowlby, 1988). Hazen & Shaver (1987) later applied attachment theory to explain people's ability to form and maintain connections and romantic relationships in adulthood. Attachment not only influences the way women cope with stress and regulates their emotions, but it impacts their ability to feel safe and trust others. Insecure attachment can lead to long-standing anxiety, stress, feelings of rejection, and abandonment, and continual dissatisfaction with and distrust of close, intimate relationships (Laskell, 2007).

A childhood history of neglectful, untrusting, and abusive relationships with caregivers can increase an adult woman's likelihood to enter and encounter harmful and violent relationships. Among women in substance treatment, between 25% and 57% of women have experienced intimate partner violence (Tuchman, 2010). In the United States, the National Violence Against Women Survey estimated one out of five women to be physically assaulted in their lifetime, and one in 13 to be raped by an intimate partner (Russo & Pirrlot, 2006). Intimate partner violence is the most common source of injury to women between the ages of 15 and 44, more frequent than muggings, auto accidents, and cancer deaths combined (Dwyer et al., 1995). Physical assault in intimate relationships against both married and unmarried women has been a widespread problem, crossing racial, sexual orientation, age, and socioeconomic lines (Koss, 1988; Stark & Flitcraft, 1988).

In addition, trauma also impacts a woman's relationship with herself and her internal environment. Haskell (2007) notes that women who have been neglected and traumatized often struggle to develop a strong internal sense of self and self-agency. They have a tendency to withdraw defensively from both the mental and emotional world, and this self-protective retreat impairs their ability to be self-reflective. They may become unable to name and identify their internal states and emotions (Siegel, 1999). Survivors of trauma tend to dissociate from both their inner and outer worlds, without knowing what they are feeling and lack basic knowledge of their emotional states (Siegel, 1999). In response to trauma or the perceived threat of danger, women may develop adaptive survival strategies including fight, flight, or freeze responses (Haskell, 2007). These responses impact the way an individual is able to cope with stress and regulate their nervous system.

Spiritual Impacts

Besides this disconnect with others and self, trauma also creates a disconnect with spirit. The isolating effect of trauma, violence, and oppression discussed in the section above can cause individuals to feel that their life has little meaning and purpose. They can lose faith in self and humanity, leaving them feeling disconnected from the world around them (Manitoba Trauma Information and Education Centre, 2013). Haines (2019) defines spirituality as, "the connection to energy larger than humans—harmonizing forces, land, environment, earth, and universe" (p. 9). Gabor Maté (2011) says: "The essence of trauma is disconnection from ourselves. It is the separation of our mind from our emotions." Maté (2008) describes addiction "in its many ineffectual forms, as an attempt to fill in the spiritual black hole, the void at the center, where we have lost touch with our souls, our spirit—with those sources of meaning and value that are not contingent or fleeting" (p. 33).

Trauma and Grief

Many people who experience trauma also experience grief. Rogers (2011) describes grief as the sorrow that comes with loss—the loss of someone, something, or feelings of loss in difficult times of change, transition, or uncertainty. This author explains that it is important to differentiate grief from being solely related to death, and think of it more in terms of loss: "We only die once in the lifetime, but we will suffer many losses along the way" (p.18). Rogers (2011) and Herman (1992) discuss how women, who have survived victimization, violence, and other forms of oppression often experience profound grief afterwards. They may grieve the loss of trust, innocence, power, control, and safety. Grief can be complex and everyone processes it and copes with it in different ways.

The Coping Hypothesis

Clearly, the effects of trauma can isolate mind, body, and spirit, and prevent women from feeling truly present and safe in their bodies and surrounding environment. The dual process of a dysregulated nervous system response to stress and daily emotional challenges and deficits in core self-capacities, leaves individuals incredibly vulnerable to substance use problems (Haskell, 2007). Substance use may be seen as an attempt to manage emotions, impulses, and bodily experiences in individuals with limited coping strategies (Hien et al., 2005). Hien (2009) outlines the coping, or self-medication, hypothesis: that individuals with complex trauma or PTSD use substances as a way to manage or avoid the distressing symptoms that accompany trauma, such as intrusive memories, hyperarousal, and uncomfortable emotions, like anxiety and depression. The author notes that self-medicating with alcohol or drugs can lessen the effects of hyperarousal and numbing symptoms in individuals with PTSD (Hien et al., 2009). The choice of self-medicating substance depends on an individual and the specific impact trauma has had on their functioning and nervous system. Hyperarousal symptoms may be diminished or masked by depressants such as alcohol, benzodiazepines, barbiturates, cannabis, and opioids, whereas numbing symptoms, or hypoarousal, may be temporarily relieved by stimulant use (Hien et al, 2009). Stimulants include cocaine, amphetamines, caffeine, nicotine, and other drugs that increase activity in the central nervous system.

Health Impacts of Long-Term Substance Abuse and Dependence

Chronic alcohol abuse can cause mood problems and disturbances in sleep, through inadequate nutritional intake of absorption of certain vitamins (Kelly, 2010). It can cause seizures, liver problems, digestive problems, liver damage, heart disease. It can also affect the amount of insulin someone is able to produce and put them at greater risk for diabetes (Kelly,

2019). Additionally, it can impact the brain and nervous system and make it difficult for people to think, speak, remember things, and make clear and sound decisions. Heavy alcohol consumption can cause mental health problems like depression and dementia (Kelly, 2019). For women, alcohol and substance use can pose additional health risks. Substance use can lead to increased risks with women's reproductive health. This includes increased risk of spontaneous abortion, early menopause, difficulty becoming pregnant, and changes to period and ovulation (Blume, 1997). Additionally, if a woman drinks while pregnant, she may pose the risk of her child developing fetal alcohol spectrum disorder, a set of developmental conditions that can hinder a child for life (Najavits, 2002). Additionally, women who inject substances have increased risk of developing HIV/hepatitis (Najavitis, 2002). The effects of trauma and substance use have profound and all-encompassing impacts on women's physical, mental, spiritual, and relational health. These impacts highlight the crucial need for trauma-informed and women-centered treatment options.

Traditional Therapeutic Models and Treatment Programs for Addiction

Health Canada defines substance use treatment as "an organized set of approaches, strategies, and therapeutic models, which assist clients to reduce or eliminate problematic use of alcohol or drugs and support healthy personal and interpersonal functioning" (Currie, 2001, p.8). There are many different approaches to substance use treatment and many specialists in the field highlight that there is "no one size fits all" approach to recovery (Greaves & Poole, 2012; Currie, 2001). This section will review some of the traditional recovery programs and treatment models— primarily 12-step and mutual help programs, which are the most common, but also other programs including in-patient, residential, and out-patient. It will explore diverse women's experiences in these spaces and review strengths, limitations, and barriers.

Twelve-step Programs

Twelve-step programs, such as Alcoholics Anonymous and Narcotics Anonymous, are the most commonly used treatments for alcohol abuse and substance dependence in North America, accounting for 93% of all alcohol treatment programs (public and private) in the United States (Denning et al., 2004). These programs are often referred to as mutual help programs, meaning they are peer-run. About 60% of publicly funded programs in the U.S. report that the 12-step model is their primary approach, with about half holding 12-step meetings on site (Denning et al., 2004). Additionally, courts and Employee Assistance Programs routinely recommend or mandate 12-step participation, often requiring signed attendance slips (Denning et al., 2004).

Twelve-step programs constitute a free and widely accessible source of community support for those who are struggling with substance use and addiction world-wide (Zenmore et al., 2017). AA has an estimated 2.1 million members worldwide, with 1.3 million of them U.S. residents and close to 100,000 members residing in Canada (Steinmetz; 2010). *The Big Book,* a 12-step guide for members, has been translated into 70 different languages and there are meetings hosted on every continent (Alcoholics Anonymous; 2021). Alcoholics Anonymous and its 12-step model has a wide reach and remains one of the most well-known and mainstream recovery programs for addiction today.

AA was first developed in the 1930s by two white, professional men, Bill Wilson and Bob Smith. (Hoppe, 2020). Both members of a fundamentalist Christian fellowship, they believed the root of all personal problems, including alcoholism, was fear and selfishness; and the only solution was to “surrender one’s life over to God’s plan” (Holly, 2019), a message that remains at the core of AA today. They developed the famous structured 12-step program that requires

individuals to admit powerlessness over alcohol, turn their will over to God, take a moral inventory, catalogue their character defects, make amends to those they have wronged, and carry their message to others (AA, 2021; NA, 2021). Two decades later, Jimmy Kinnon adapted this model for use with addictions to other substances aside from alcohol, creating Narcotics Anonymous in 1953.

Women have been involved in AA/NA from the beginning (White, 1998) and today make up one-third of members (Donovan et al., 2013). As far back as 1945, AA literature acknowledged that women faced barriers in the AA recovery community (White, 1998). Some of these barriers included sexist judgements from men that women couldn't be alcoholics and that they didn't belong in AA because they would be a distraction (Covington, 2008; White, 1998). Additionally, women were added into the program with very little thought or consideration as to how their lived experiences and treatment needs may differ from men (Marcellus, 2014; Covington, 2008). While many women acknowledge benefiting from AA's mixed gender meetings, others have reported feeling an uneasiness in male-dominated AA spaces and meetings (Sander, 2010). Additionally, women across the organization agree that acknowledging gender differences in recovery is an important part of the healing process (Sanders, 2010).

Women-only Meetings

In response to women's unease, the first women-only meeting in AA emerged in 1941 in Cleveland, Ohio (Sanders, 2010). A U.S. study with 167 female AA participants found the majority of women felt safer in women-only meetings (Sanders, 2010). They reported feeling more comfortable talking about their experiences as women in a male-dominated society and talking about gender-based violence, including childhood abuse, sexual abuse or harassment, and other forms of assault. They felt able to express their emotions more freely and were more

comfortable disclosing more intimate details about their lives, including issues not directly related to their immediate concern of alcoholism. In this and other studies, women also reported having the space to discuss mental health issues, such as depression and building self-esteem, rather than deflating pride or ego, which are primary concerns for men in AA (Sanders; 2010; Kaskutus, 1992). Women also valued the chance to form close connections with other women struggling with addiction and substance use, in order to stay sober and enhance the quality of their sobriety experience (Sanders, 2010). Given the priorities and needs voiced by women, the lack of women-only spaces in the twelve-step communities remains a huge barrier. The availability of women-only meetings is scarce at best; they are so rare that one female AA participant said she was frequently the only woman in a group of 15 or more men, because there was simply no other option in her area (Cunha, 2015).

Strengths of Twelve-Step Programs

There have been positive long-term outcomes associated with the involvement in 12-Step programs including: decreased exposure to drinking-related activities and a decrease in cues that induce craving; increased social abstinence self-efficacy; establishment of a foundation of rewarding social relationships not associated with a substance; and “a feeling of not being alone” (Donovan et al., 2013; Moo & Moo, 2006). The format of AA meetings involves alcoholics sharing “their experience, strength, and hope” through storytelling, which evokes a sense of “deep identification” with the storyteller, especially for newcomers to the program, and allows for mutual sharing and connection (Sanders, 2010, p. 23). Many report that the program’s 12-step guide provides a useful structure, accountability, and road map to get them started in their recovery journey (Marich, 2020) and greater attendance improves outcomes (Kelly et al., 2009). AA also tends to engender longer term involvement and commitment as participants are

encouraged to not only sustain their abstinence, but also give back in the process (Zemore et al., 2017). Once participants are successful in maintaining their abstinence from substances and have worked their way through the 12-steps, they are encouraged to become a sponsor and mentor and support other members and peers in their recovery journey, which retains them in the program (Zemore et al., 2017).

Limitations

While AA and NA have been associated with positive outcomes, concrete research on the efficacy of the 12-step treatment model is limited. Denning et al. (2004) point out that the majority of the existing research is conducted and reviewed by peers of the program, leaving room for bias and errors. Their findings suggest that AA has a success rate of only 5% to 39%, with definitive numbers hard to come by (Denning et al., 2004). Other peer-reviewed studies put the success rate between 5% and 10%, which means only about one in every 15 people who enter into treatment is able to become and remain sober (Dodes & Dodes; 2015). Additional research has shown that 12-step committed participation is typically associated with greater (not lesser) addiction severity (Denning et al., 2004; Ye & Kaskutas, 2009). Research suggests outcomes improve when the 12-step approach is integrated with other therapeutic services, including individual counselling, than when it is offered alone (Tonigan et al., 2017).

Typically, 12-step approaches like AA/NA take a rigid moralizing approach to recovery from substance abuse (Denning, Little & Glickman, 2004). Problematic substance use is often seen as a moral failing of the individual and the main mechanism of behavioural change is assumed to be a spiritual awakening (Glaser, 2015; Kelly, 2017). The rigid spiritual, religious, and moralizing roots and components of AA/NA make some participants, including women, feel unwelcomed, uneasy, and skeptical (Marich, 2020). The 12-step philosophy and ideology, such

as spirituality, religiosity, the need to surrender, and the sense of powerlessness, leave some reluctant to engage in the model (Laudet & White, 2005). While the organization welcomes everyone, despite their religious or spiritual beliefs or lack thereof, the fundamental Christian beliefs ingrained in the framework prevents many people who hold different beliefs and values from feeling comfortable in the AA community.

Many participants in the AA community have reported their sponsors taking an incredibly strict and rigid approach to recovery. Sponsors often take a "tough love" approach, and some may not even consider sponsoring someone unless their sponsee takes all of their suggestions and does things their way (Marich, 2020). There is a saying in AA, "the program does not fail you, you fail the program" (Dodes & Dodes, 2015). This demonstrates how little power the sponsee has in their recovery. Marich writes: "sponsors are supposed to be guides and mentors—not professional clinicians, ministers, or dictators" (2020, p. 92). This approach to recovery and the sponsor-sponsee relationship creates an imbalance in the relationship and another potential power-over dynamic, which can be incredibly triggering and unsafe for trauma survivors and women. Support groups like AA or NA provide merely a peer-to-peer network; they are not run by professionals with training in trauma-informed practices nor are they equipped to address many of the complex issues that come along with addiction (Cunha, 2015). AA and NA are also grounded in the disease model, which views addiction as a chronic, progressive illness. It holds the approach that total abstinence from all substances is the only acceptable "cure" to addiction (Denning et al., 2004). They state that "requiring the 'problem' drinker or substance user to give up all mind-altering substances totally, immediately, and forever, leaves many people with intolerable pain, emptiness, or anxiety in a surefire recipe for relapse" (p. 2). This requirement means some AA programs refuse to accept participants on

medication-assisted treatment; this can lead to people on suboxone, methadone, or other pharmaceuticals being turned away or not being allowed to share at meetings (Marich, 2020, p. 90). Sobriety requirements mean that many current treatments do not offer an accessible and realistic treatment option for women struggling with the effects of trauma and substance use. As a result, treatment eludes up to 80% of alcohol and drug users (Denning et al., 2004). In the face of such exclusion, some people on medication-assisted treatment have risen up to create their own meetings and safe spaces (Marich, 2020).

AA/NA's strict abstinence-based approach also fails to accept that relapse is part of the addiction healing process. The program requires clients to restart their sobriety time if they have one slip/relapse, that includes using any other substances— including substances that the client has not necessarily identified as problematic for them—for example, if a client abstaining from alcohol uses cannabis or other substances to help with anxiety (Marich, 2020). Furthermore, the time commitment in 12-step mutual help programs like AA and NA is frequently criticized as a challenge for participants. AA and NA encourage participants to attend daily meetings in their early recovery when danger of relapse is greatest, then maintain 2-3 meetings a week as they progress, all while meeting with their sponsors outside of regular meeting times and working their way through the 12-steps. Treatment studies indicate that most people fail to meet the recommended, minimal threshold of both short-term and long-term attendance (Cloud et al., 2006; Cloud & Kingree; 2008).

AA and NA have also received criticism for not being trauma-informed in its approach. Significant research into trauma and its connection to substance use has been done in the decades since AA and NA were founded, but these groups remain stuck in historical attitudes and patriarchal traditions. Despite clear evidence that a majority of people seeking substance use

treatment have backgrounds of trauma, they have ignored the findings and calls for trauma-informed care. In the 12-steps, sponsors focus primarily on the addiction itself and do not acknowledge other issues, sociocultural factors, or co-related mental health challenges (Marcellus, 2014). Additionally, for anyone who has experienced trauma from power-over situations like gender-based violence, racism, homophobia, transphobia, marginalization, or other forms of oppression, going through the step work, which ask participants to admit powerlessness over their addiction and acknowledge personal wrong-doings, can be incredibly triggering (Whitaker, 2019; Harlow, 2019). The lack of a trauma-informed perspective within AA/NA can lead to blind spots and ineffective care. One study found that addiction treatment participants with higher experiences of trauma needed more ongoing support (known as maintenance) to complete treatment than those with less trauma experiences (Odenwald & Semrau, 2013). Because of this, many therapists, clinicians, and mental health service providers have suggested that AA/NA facilitators and sponsors should receive mandatory trauma-informed care and training (Harlow, 2019). Without such training, taking people through the steps may end up retraumatizing sponsees and leaving them vulnerable to relapse and other potential harm (Harlow, 2019).

Post-modern and Feminist Critiques of Traditional Twelve-Step Programs

Over the last two decades, growing post-modern and feminist critiques claim that AA beliefs and practices are heavily rooted in heteropatriarchy and white supremacy. Whitaker (2019) and Harlow (2019) discuss how AA was originally created by white men to keep their own egos in check and hold them accountable for their privilege. Whitaker (2019) writes: “the message made sense for its original members as it reminded men that they were not God, encouraged them to humble themselves, to admit their weaknesses, and to shut up and listen.”

Whitaker (2019) adds that those messages may have been much needed for the original white male AA members, but are not appropriate for women, queer folks, and people of colour. She states:

> Women do not need to be broken down or told that they are powerless in a male-based society that already enforces this message...it is quite the opposite—women are drinking because they have so little power and because their egos have been crushed under a system that reduces their value to subservience, likability, and silence. (2019, p.2)

Other criticisms from women who have participated in AA and NA are: not wanting to label oneself as an "alcoholic," not wanting to perceive oneself as "powerless," and not wanting to 'admit' to having a disease (Whitaker, 2019; Harlow, 2019).

There have also been complaints of women feeling uncomfortably and sometimes harmfully exposed to a normalized culture of "forced hugging and touching" in AA (Marich, 2020; Cunha; 2015, p.2). A 23-year-old single mother recounted her first experience in an AA meeting: "What I did not expect was to be fresh meat when I walked into AA meetings. Men wanted my number and wanted to date me. I was newly sober, clueless and craving love" (Cunha, 2015). She goes on to explain that she started dating a man in her meeting and soon found out he was sleeping with multiple other women in the meeting, who were her friends. She said that it could have easily led her to relapse (Cunha, 2015). This experience is not unique, many women have reported feeling uncomfortable and receiving unwanted sexual advances by men in their AA groups (Marich, 2020).

For decades, Alcoholics Anonymous and its affiliates have been criticized for lack of diversity and inability to address effectively the needs of marginalized groups, people of colour,

the queer community, and women. These populations have reported not feeling safe in 12-step spaces that are rooted in fundamental Christianity, heteropatriarchy and white supremacy, and feeling like there is a lack of naming and acknowledging of the oppressive barriers they face (Hoppe, 2020). Ariel Britt, the senior director of an addiction treatment nonprofit called SAFE project, speaks to her experience as a black woman navigating predominantly white recovery spaces including AA (Hoppe, 2020). She says: “The trauma stored in my own body of trying to navigate these spaces had become unavoidable. The isolation. The fight. I never really felt comfortable in my own skin” (Hoppe, 2020, p. 4). Britt credits a separate meeting where she didn’t feel marginalized—a meeting with predominantly black folks, for giving her the strength to stay in AA and continue on in her recovery (Hoppe, 2020).

Britt’s experience is not unique: a lot of women of colour have shared similar experiences in recovery spaces (Castillo, 2019). Tessie Castillo, a journalist for drug policy and harm reduction reform writes: “it’s no secret that the recovery movement is largely dominated by white folks, whether in staff or leadership positions, on organizational boards, or among membership. She asks the question, “Why do so few people of color play visible roles within the recovery community, especially given how much the effects of harsh drug policy and substance use have devastated many communities of color?” (2019, p.3). She discusses that one of the reasons is systemic barriers of oppression. She says that it can be harder for women of colour and people of colour to sustain recovery, because there is little room for mistakes in a world that expects you to fail. She says, “we all know the statistics: despite similar rates of drug use, people of color are more likely to be arrested for drug crimes than white people, serve longer sentences for the same crimes, and find it harder to break the cycle once it starts” (Castillo, 2019).

Additionally, despite the fact that substance use disorders disproportionately affect large numbers of the LGBTQ+ community, many women and femmes from the queer community have reported that AA and other recovery spaces are largely heteronormative (Feldman, 2017). Both mutual aid meetings and online recovery communities are geared more to cisgender and heterosexual individuals, making these spaces feel exclusive to many in the LGBTQ+ community (Faces & Voices of Recovery, 2020). Brooke Feldman, a queer recovery activist (2017) points out how AA and other recovery communities are not always the most gender-affirming place for LGBTQ+ individuals. Brooke explains that naming programs simply for men and for women discounts the reality of gender identity being far more than a binary of male or female. She highlights the need for more open-minded, inclusive, diverse, gender-affirming, and trauma-informed spaces in AA and the recovery community in general.

Other Common Substance Use Treatment Programs

Other forms of treatment for substance use dependency and addiction include in-patient care, residential treatment, and out-patient/day programs. Rather than relying on mutual and peer support of clients, these programs are distinguished by their use of professionally trained and licensed medical and therapeutic staff to guide the recovery process. In-patient programs are intensive and take place in a hospital-like setting where clients are closely monitored, have 24-hour support, and a highly structured model of care. These programs are particularly useful for clients who may need support detoxing from a substance, with medical and mental health support in place as they experience withdrawal symptoms (Gerassi, 2018; Addiction Centre, 2021). This type of treatment may also be more effective for people with more serious medical or psychiatric diagnoses (Currie, 2001). In-patient treatment is generally short-term, ranging from a few days to a few weeks.

Residential treatment centres, also typically known as “rehab,” often follow inpatient care. The main difference is the setting and intensity of care (Gerassi, 2018; Addiction Centre, 2021). They offer home-like residential settings, where clients can focus on getting sober without the distractions of everyday life. There are staff to assist the patients, but without the 24-hour monitoring of inpatient treatment. Most residential treatment programs have an integrative team of psychologists, counselors, and psychiatrists, as well as structured programs that include individual counselling, group counselling, structured activities to support clients in their recovery (Addiction Centre, 2021). Well-known examples of such programs include the Betty Ford Centre, Aurora Recovery Centre, and the Chopra Addiction and Wellness Centre.

In outpatient treatment, also known as day treatment, participants are responsible for visiting a local treatment center or recovery program a few days a week or part-time, for an average of 10 to 12 hours programming a week (Addiction Centre, 2021). It is much less restrictive than in-patient and residential treatment with more flexibility. It can be a standalone option, or can follow in-patient or residential recovery. Twelve-step programs are an example of outpatient care. Outpatient can be enough for someone with a mild addiction, or it can be part of a long-term treatment program (Addiction Centre, 2021)

Limitations of Inpatient, Residential, and Outpatient Programs

Dodes and Dodes (2014) have outlined a number of drawbacks to these types of programs. One significant barrier is cost. Many inpatient and residential facilities are incredibly expensive, costing some patients up to $1,000—$3,000 a day and some surpassing $90,000 a month. Additionally, some of these treatment models use a similar approach or adaptation of the 12-step models, but with a significantly higher price tag because of the resort-like accommodation and exciting activities including horseback riding, wilderness therapy, yoga,

acupuncture, and fire-side chats. Additionally, once clients leave rehab and go back into the "real world" many experience relapse; it is not uncommon for clients to return and check back into the facility a second or third time. Dodes & Dodes (2014) discuss how these facilities allow readmission with no special considerations or review, as it is a thriving business after all, feeding into the capitalist world of profit. For those who cannot afford the luxury private treatment centres with a high price tag, their options are limited to publicly funded programs, which often have long waitlists, ranging anywhere from two weeks to three months, creating another barrier for women and those struggling with substance use (Pindera, 2020).

Women in these spaces also encounter similar sexual harassment to those attending AA meetings (Cunha, 2015). A 19-year-old woman, one of the only young women in her rehabilitation groups, found herself a main target for sexual advances from men in the program. While she tried to abide by the guideline that clients should have one year of sobriety before they start dating anyone, she ended up pregnant by a man 15 years her senior while in rehab. She reports, "I was too young to be navigating my sobriety around so many troubled people and especially around men" (Cunha, 2015, p. 2).

Traditional Sobriety Requirements as a Gatekeeping Barrier

Sobriety requirements can present women seeking treatment with an additional hurdle. Many traditional addiction centres and recovery programs do not work from a harm-reduction philosophy, but instead from an abstinence-based approach. They have strict policies that clients who are actively using substances may not receive treatment or services. Many such programs require a certain period of sobriety time before admission, anywhere from 14 days to a month (Gerassi, 2018; Denning et al., 2004). Some even require a negative drug test before being granted acceptance into the program (Gerassi; 2018). This can mean women have to access

detoxification services, before even being considered for residential substance use treatment. Gerassi (2018) describes this as a significant barrier, especially for women and those who are femme-identified who are vulnerable and are living on the streets, involved in sex work, or any woman who lives on their own and does not have the resources to access detox services in their area. She says many women avoid trying to detox on their own, unless they have a safe place and care, to avoid going through painful withdrawal symptoms on the streets or at home alone, which leaves them at particular risk of exploitation and harm. For women who are mothers, all these requirements may prove impossible to meet on top of finding childcare. This is why many women maintain their substance use: because the process of getting the treatment and services they need feels so unattainable (Gerassi, 2018). A street mental health outreach worker, who supports women who are homeless and involved in sex work, describes the disheartening process. She says, “It’s really heartbreaking because you have women coming, who are dealing with substance abuse that want to get help and go to treatment, but have to go through so many hoops in order to get to that point” (Gerassi, 2018, p. 203). She notes that coordinating both a detox bed and placement in a treatment program can be incredibly challenging, especially with long and unpredictable wait times. Additionally, the focus on abstinence and sobriety means some programs are not understanding or accepting of relapses and will ask the clients to leave the program if they use substances again (Gerassi, 2018). This pushes many marginalized women back onto the streets and increases their risk of harm (Gerassi, 2018).

Women with concurrent mental health challenges face even more barriers to access more specialized mental health services. Some services are concerned that uncovering trauma issues will put a client’s sobriety as risk, and therefore, the trauma should not be addressed until the individual is “stabilized,” meaning that client has achieved six to 12 months of recovery

(Covington et al., 2008). This leaves dually diagnosed clients, particularly women with extensive and gendered trauma histories, in a disadvantaged position. Despite the significant body of research that shows the relationship between substance abuse disorders and traumatic experiences, women will not be able to access trauma-informed services until they have first conquered the massive hurdle of sustained abstinence (Covington et al., 2008; Brown, Reed, & Kahler, 2003).

This failure to treat trauma simultaneously with addiction is particularly concerning because many substance use services, programs, and treatment modalities retrigger trauma reactions in clients and are experienced as emotionally unsafe and disempowering for survivors of trauma (Elliott et al., 2005, Harris & Fallot, 2001). Many services claim to incorporate principles of trauma-informed treatment or understand the long-term impact of trauma, but inadvertently create an invalidating environment. As a result, they fail to reach many women who are in great need of support and experience higher dropout rates than necessary (Elliott et al., 2005). Moreover, recovery programs and traditional programs have a tendency to work from a *righting reflex* that ignores clients' own agency. The righting reflex is the natural tendency or desire to fix, give advice, make better, or even prevent harm from happening to clients (Greaves & Poole, 2012). Rather than telling clients, or women, what to do and why they should do it, Greaves and Poole (2012) argue that service providers should provide a safe space and collaborative relationship that allows women to set their own pace, identify their own motivations, goals, and possibilities for change. Therapy and recovery should respect clients' autonomy and decisions. Sharing power and collaborative decision-making are key aspects of trauma-informed care.

Potential for Misdiagnosis

When service providers do not bring an understanding of trauma, intersectional violence, and how certain symptoms demonstrate an attempt to cope with trauma, misdiagnosis and inadequate treatment can occur. For example, without applying a trauma lens, some substance use treatment models may expect women to completely abstain from using substances, but fail to provide effective resources or coping skills to women to help them replace that behavior. Women who stop their substance use can experience extreme withdrawals, mood swings, headaches, seizures, depression (Gerassi, 2018). Such women may unnecessarily be given diagnoses such as bipolar disorder, and treated primarily with antidepressant medications, or given a diagnosis of borderline personality disorder (BC Centre of Excellence for Women's Health, 2013). Additionally, behaviours such as aggression, confrontation, or withdrawal—developed in the past to cope with trauma—may be viewed as so problematic that a client may be deemed "unfit" for a treatment program. Ideally, service providers will recognize that women with complex PTSD and substance dependence may sometimes exhibit symptoms that appear to correspond to various mental health diagnoses, but in reality the symptoms represent the complex physical, emotional, cognitive, interpersonal, spiritual, and behavioral effects of trauma (BC Centre of Excellence for Women's Health, 2013).

Social Stigma

Stigma is the main psychosocial issue differentiating the substance abuse of females from that of males (Covington, 2002; 2008; Najavits, 2002). Society has a double standard that inflicts far more shame on women with an addiction than men. Society stigmatizes men for addiction, but it rarely attacks their sexuality or their competence as a parent (Covington, 2002). Additionally, drinking alcohol can be seen as "macho" for men, but it conflicts with society's

view of femininity and the roles of the wife and mother (Covington, 2002). Women who use substances or have developed an addiction are often portrayed by society as "amoral, sexually promiscuous, deviant, messy, not able to handle their alcohol, or a bad mother" (Marcellus, 2014; Covington, 2002). Additionally, if a woman has too much to drink or takes drugs and then becomes a victim of violence, sexual harassment, assault, or rape, society blames them rather than the perpetrator, which makes an already incredibly traumatic event feel even more shameful and isolating. Women often internalize this stigma and experience guilt, shame, despair, and fear when they become addicted or dependent on substances (Covington, 2002). Women who enter treatment may come with a heavy burden of shame and they do not need to be shamed further (Covington, 2002). They need to be offered a place of compassion, non-judgement, and hope—where they are seen as more than their addiction—where they are recognized for their strength and resilience and given tools to embark on their own path of healing.

Stigma and the threat of severe consequences often lead women and their families to minimize the impact of substance abuse by using denial (Covington, 2002). Women are also in a unique position due their biopsychosocial needs. Pregnancy and mothering are two factors that make the needs of women different from men. Little attention has been directed to the needs of mothers in the context of co-occurring mental illness, substance use problems, and the experiences of trauma (Hien; CEWH; 2009). Women experience the additional barrier and trauma of the threat of having their children removed or threats from a partner/family to report them to child welfare authorities. There are many heartbreaking incidents of women who use substances being separated from their children. The separation can occur as early as childbirth, when the mother is still in the hospital. This injustice is disproportionately experienced by Black, Indigenous, and Women of colour (Vetam et al., 2019). The stigma attached to violence and

substance use in relation to pregnant and parenting women can prevent many women from seeking the help they need. As a result of the stigma, women struggling with addiction become more isolated than men. They drink at home alone more and are typically more socially rejected (Najavits, 2002).

Bridging the Gap— Applying a Gender-Responsive and Anti-Oppressive Lens to Trauma-informed Substance Use Programs for Women

Clearly, women's treatment services have room for significant improvement from what has traditionally been available: barriers to access must be tackled to broaden women's ability to even seek treatment; a gender-responsive and anti-oppressive lens must be used to ensure treatments are gender-appropriate for women, and to avoid inadvertently worsening women's trauma; and programs must be trauma-informed to ensure that all the biopsychosocial needs of women are looked after, giving them agency to seek the outcomes they want.

This section will define and highlight what it means to work from an integrative trauma-informed lens. It will review some of the existing gender-responsive and anti-oppressive substance use treatment models for women and discuss therapeutic outcomes. It will also propose feminist therapy, person-centered therapy, narrative therapy, and somatic therapy as valuable anti-oppressive therapeutic interventions to specifically address the systemic barriers and intersectional needs of diverse women in recovery. These frameworks together can create a holistic, woman-centered, and resilience-based space for women to engage and embark in the healing process.

A Trauma-informed Lens

Trauma-informed services are those in which service delivery is influenced by an understanding of the impact of interpersonal violence and victimization on an individual's life

and development (Elliot et al., 2005). They take into account the knowledge and impact of trauma on client's physical, psychological, and emotional health, and integrate this knowledge into all aspects and levels of service delivery (CEWH, 2009; Harris & Fallot, 2001). Greaves and Poole (2012) state that such services should create a culture of non-violence, learning, and collaboration, recognizing how the experience of trauma can affect the confidence, beliefs, behaviours, and relationships of people coming for help for substance use and mental health concerns. Moreover trauma-informed services take a strength-based approach and create opportunities for survivors to rebuild a sense of control over their lives by promoting coping skills and resilience-building (Hopper, Bassuk, & Olivet, 2010).

Greaves and Poole (2012) outline four key principles of trauma-informed services: (a) avoid retraumatization, (b) empower women, (c) work collaboratively with flexibility, and (d) recognize trauma symptoms as adaptations (Greaves & Poole, 2012). This means that problem-behaviours are understood as attempts to cope with trauma and oppressive experiences; and mental health diagnoses are viewed as responses (Haskell, 2003). Haskell (2003) states, "the question shifts from 'what is wrong with this person?' to 'what has happened to this person?'" (p.9). Many traditional care providers frame women's mental health problems as arising from internal deficits and focus on individual pathology rather than on understanding contributions of oppressive circumstances to women's problems (Greaves & Pool, 2012). This does not require the disclosure of trauma nor the direct treatment of trauma; rather, it is about working in ways that accept where the woman is at, promote safety, and do not retraumatize (CEWH, 2009). The focus is on building a collaborative therapeutic connection, allowing the client to set the pace, and letting them be in control of their own healing journey (Greaves & Poole, 2012).

Applying an Anti-Oppressive, Intersectional Feminist Lens to Addiction Therapies

Addiction treatment programs should take an anti-oppressive and intersectional feminist lens, working to understand and mitigate power imbalances. They should not only understand women's diverse realities based on sex, gender identity, race, sexual orientation, class, religion, abilities, and any other individual identities that lead to marginalization, but must also work to address the inequalities and power imbalances in our communities and structures. Strier (2007) states that anti-oppressive treatment framework:

> Requires the practitioner to critically examine the power imbalance inherent in an organizational structure, with regards to the larger sociocultural and political context, in order to develop strategies for creating an egalitarian environment free from oppression, racism, and other forms of discrimination. (p.3)

They should also apply an intersectional lens, using a now-standard concept and framework developed by critical race scholar, Kimberlé Crenshaw (1989). Crenshaw coined the term *intersectionality* to explain how oppression is produced structurally, and experienced and resisted individually and collectively, through and across diverse social categories of identity simultaneously (Crenshaw, 1989, Hien et al., 2005).

To work from a trauma-informed and anti-oppressive lens, therapeutic practitioners must expand their framework of care, not only to understand how factors of identity and intersectional violence influence therapeutic interactions, but also to understand how these factors are influenced by time and place (Timothy, 2012). For example, rather than focusing only on the here and now as important (as many traditional therapeutic modalities do), clinicians must understand the influence of the past on clients' lived experiences, including intergenerational trauma, racism, and colonialism (Timothy, 2012). Using an anti-oppression framework to

examine the role of power in those past experiences, the therapist encourages the client to explore who they are holistically, recognizing all aspects of their experiences, so they can feel greater safety (Timothy, 2012). At the same time, the therapist should be aware of how their own personal experiences and social locations may facilitate or strain the therapeutic interaction and relationships with their client. Therapy should support clients to deconstruct their own and other people's biases, noticing assumptions made by others about clients' social locations; it should support clients to identify ways in which they have historically and actively resisted or shown resilience in the face of trauma (Timothy, 2012).

When both clinicians and clients address their own fixed notions of identity, it allows the therapeutic alliance to foster empowerment and lets both see the clients' identities as fluid, containing not only trauma but also resilience and resistance. Timothy (2012) states "exploring clients' identities along with experiences of intersectional, transnational, and transgenerational trauma and their connections to resistance and resilience increases the opportunity for collaborative client-centered care and decreases the potential for re-traumatization" (Timothy, 2012, p. 47). It encourages the client to engage in a collaborative change process with the therapist and strengthens the therapeutic alliance. Feminist theory has been integral to the development of these ideas.

Feminist ideologists have been proponents of trauma-informed care from the earliest writings (Toner & Akman, 2012). A feminist, trauma-informed approach to therapy "assumes that social, economic, and political disadvantages can have a negative effect on women's health and well-being and can contribute to or account for some of the mental health difficulties they experience" (Toner & Akman, 2012, p. 37). Brown (2004) notes that the diagnosis of PTSD owes its existence at least in part to feminist therapists, who identified gender-based violence as

a source of trauma and described the wide range of consequences for its survivors. Feminist theorists and clinicians have consistently maintained a focus on violence against women as a major source of women's psychological and physiological problems and advocated for the need of *gender-responsive* care (Covington, 2008; 2002; Toner & Akman, 2012). Covington (2008) notes that mental health and substance use treatment needs to consider the diverse sociocultural experiences and perspective of gender to better understand and serve their clients as well as respond to their challenges and strengths. Services also need to pay close attention to oppressive factors including economic and political disadvantage, body oppression, gender role expectations, ageism, racism, and other systemic disadvantages (Toner & Akman, 2012; Worell & Remer, 2003).

The Need for Integrative Trauma-Informed Services

In order to provide trauma-informed services, there needs to be integration at all levels: outreach and engagement, screening and assessment, resource coordination and advocacy, crisis intervention, mental health and substance use services, trauma specific services, parenting support, and health care (Greaves & Poole, 2012). All the staff of an organization, from the receptionist to the direct care workers to the board of directors, must understand how violence impacts the lives of the people being served (Elliot et al., 2005). Counsellors and mental health staff should take the impact of trauma into account, meet clients where they are at, and adjust their own behaviour to support the client's coping capacity. This allows survivors to manage their trauma symptoms successfully so that they are able to access, retain, and benefit from the services (Covington, 2008).

Many programs claim to work from a "trauma-informed" lens, but there is a gap between theoretical ideals and what happens in practice. Services may incorporate some trauma-informed

services, but lack cohesion and integration at all levels (Covington, 2002; Elliot et al., 2005; Greaves & Poole, 2012). As discussed, many programs are focused solely on decreasing substance use and helping clients achieve abstinence or sobriety, but do not address the interconnections between gender, trauma, varying levels of oppression, and how it impacts substance use and mental health. Greaves and Poole (2013) highlight how experiences of trauma are mediated by individual and group characteristics such as gender, sex, race, age, class, etc. They discuss how trauma-informed principles must apply BOTH a gender and an equity lens to acknowledge that the distribution of trauma may reflect inequities, which may contribute to the production of ongoing inequities. Consequently, they claim, trauma-informed systems must be designed to respond to these differences, identities, and contexts as a key part of their approach in order to fully understand and implement trauma-informed principles and practices.

Effectiveness of Integrative Services

Over a five-year period, the Substance Abuse and Mental Health Services Administration in the United States studied nine sites over a five-year period, as they developed and tested integrated service models that were comprehensive, trauma-informed, and gender-specific (Covington, 2008). They found that women with complex co-existing problems experienced reductions in trauma symptoms, drug use severity, and mental health symptoms (Cocozza, et al. 2005). There are positive effects, at both the program level and personal level, when trauma counselling and services are integrated with substance abuse treatment (Covington, 2008; Cocozza et al. 2005; Morrissey et al., 2005).

Data gathered at Canadian women's addiction treatment centres over the past decade confirm that a substantial proportion of women entering treatment for substance use problems have experienced violence and abuse as children and adults, underlining the need for an

integrated response (Poole & Greaves, 2012; Poole, 2007). Two studies, using a six-month-outcome, nine-site, quasi-experimental design looked at women with mental health and substance use disorders who had experienced physical or sexual abuse and who were enrolled in integrated trauma-informed recovery services (Cocozza et al. 2005; Morrissey et al. 2005). Results from the Morrissey (2005) study indicated that all women showed improvement over the six months. Women who received services from sites with higher levels of integrated counselling had greater reductions in mental health symptoms and better improved in their substance-use behaviours (Covington, 2008; Morrissey et al. 2005). The Cocozza (2005) results showed that women in intervention programs, which integrated their trauma, mental health, and substance use services, showed increased improvement on posttraumatic symptoms and a reduction in the severity of drug use (Covington 2008; Cocozza et al., 2005). These findings demonstrate the value and positive outcomes associated with integrated trauma-informed services for women. Additionally, costs of integrated services are not higher (Domino et al., 2005). Program collaborations involving clients, service providers, and system planners in all aspects of the policy design implementation and evaluation of services improve the quality of the services and its impacts (Reed & Mazelis, 2005; Mockus et al., 2005).

Examples of Integrative Trauma-Informed Services

The following are several examples of specific, integrative, trauma-informed substance use services used in Canada that apply a gender-responsive and anti-oppressive lens and have been researched for their effectiveness. This section aims to illustrate that such programs can be adapted and implemented in all different treatment settings, including mutual support step programs, inpatient, residential, and outpatient programs.

Jean Tweed Centre

The Jean Tweed Centre was established in Toronto in 1983 as a residential substance use treatment centre for women, at a time when the understanding of the relationship between trauma and substance use was just starting to emerge (Bloomenfeld & Rasmussen, 2012). The centre always applied a gender-specific lens but, over time, clients' stories of using substances to cope with trauma highlighted the impact of trauma on women's experience in treatment/recovery. Clinical reviews confirmed that 80% of the women using Jean Tweed's services had experienced some form of abuse (Bloomenfeld & Rasmussen, 2012). In response to this, the centre evolved to incorporate a trauma-informed approach in the 1990s (Bloomenfeld & Rasmussen, 2012; BEWH, 2009).

The Jean Tweed Centre went through a pivotal paradigm shift: strongly influenced by the work of Herman (1992), they left behind the notion that substance use and trauma are unconnected and should be dealt with separately (Bloomenfeld & Rasmussen, 2012; BEWH, 2009). Their leading principle became: an understanding of the impact of trauma must be braided into all levels of programs and services (Bloomenfeld & Rasmussen, 2012; BEWH, 2009). Additionally, as the treatment centre's understanding of diversity and anti-oppression grew, "they became aware of a much wider spectrum of oppression, violence, and other forms of trauma, politically and socially driven, that affect women on varied levels—especially within marginalized groups such as immigrants, indigenous groups, racialized groups, and across generations" (Bloomenfeld & Rasmussen, 2012, p. 137). The program acknowledged that many marginalized women do not see their unique needs reflected in mainstream services and programming, so the centre aimed to address this in their services.

The Jean Tweed Centre's process of therapeutic change around substance use problems has commonalities with the three stages outlined in Herman's (1992) trauma model—safety, remembrance and mourning, and reconnection (Bloomenfeld & Rasmussen, 2012). In early-stage work for both trauma and substance use services, the emphasis is on creating safety and supporting women to process their experiences and emotions in their own ways and in their own time. Instead of diving into women's stories and having them share painful memories that could be re-traumatizing, the focus is on the impact of the trauma in the present. Services focus on orienting clients in the present moment, promoting self-care, and developing new coping strategies (Bloomenfeld & Rasmussen, 2012).

Women's Inpatient Unit

The Women's Inpatient Unit (WIU) at the Centre for Addiction and Mental Health (CAMH) is a residential service for women in Canada who have complex mental health problems and a history of trauma and substance use issues. The WIU model of care is trauma-informed and feminist-informed, with an emphasis on safety and empowerment through validation, skill development, and self-determination (Aikman & Rolin-Gilman; 2012). The WIU program is unique in Canada: the only all-women inpatient psychiatric service dedicated to clients with a history of trauma (Aikman & Rolin-Gilman; 2012). The WIU holds a broad lens for trauma. They inquire about women's experiences of past or current physical, sexual, and emotional abuse, as well as experiences of gender-based violence and other intersecting oppressive social circumstances. Rather than focusing solely on symptom reduction or psychiatric stability, the WIU aims to help clients move towards wellness by identifying and validating their strengths and resilience (Aikman & Rolin-Gilman; 2012). The services

encourage women to harness both internal and external resources to increase personal and social empowerment.

Sixteen-steps for Discovery and Empowerment Model

Dr. Charlotte Kasl developed the 16-step empowerment model as a gender-responsive and anti-oppressive alternative to the 12-step mutual support model offered by Alcoholics Anonymous/Narcotics Anonymous. It was developed in the U.S., but has expanded across North America into Canada. The model takes a holistic and person-centered approach to overcoming addiction and views people in their wholeness—mind, body and spirit (Kasl, 2021). Kasl says the program evolved from both her experience as a recovering addict who attended 12-step programs for many years, and her background working as a therapist to support other women in the mental health and substance use space (White, 2012). Kasl explains that, with this in mind, "the 16-step empowerment model addresses the basic socialization of women in this society that is detrimental to their health and sense of wholeness (White, 2013. p.1) She also explains that the program developed in response to some of AA/NA's shortcomings and patriarchal religious roots, including the failure to acknowledge trauma histories and abuse and asking survivors of violence, oppression, and sexual assault to admit powerlessness and take a moral inventory when really it should be someone else's moral inventory" (White, 2013, p.2).

While Kasl developed the program with women in mind, she highlights that it is for anyone who might benefit from its approach, especially marginalized populations who experience internalized oppression stemming from sexism, racism, classism, and homophobia (Kasl, 2021). She writes: "At its core, this model is based on love not fear; internal control not external authoritarianism; affirmation not deflation; and trust in the ability of people to find their own healing path when given education, support, hope and choices" (Kasl, 2021, p. 1). The

program has had positive results for women. In a survey conducted, female respondents most often listed: improving self-esteem; helping them believe in their own wisdom; giving them permission to be creative; expressing and validating their personal beliefs and feelings; and helping them to be more courageous, as being the positive effects of the 16-step group (Kasl, 2021).

Seeking Safety Model

The most widely known, evidence-based integrated model for treating the co-occurrence of substance use and trauma is the Seeking Safety model (Greaves & Poole, 2012; Najavits, 2008;2002;1998). It is a manualized, low-barrier treatment program that covers 25 topics and can be implemented in individual or group therapy and in residential or outpatient programs. It draws from feminist theory and is cognitive-behavioural in its orientation (Hien et al., 2005). It focuses on the recognized need to establish safety and stability in the process of recovering from both trauma and substance use (Poole & Greaves, 2012; Hien et al., 2005). In the Seeking Safety model, women are provided with an affirming environment where they are given the opportunity to make an informed choice about their readiness to commit to the program. They are given a safe space to be able to discuss openly the connection between their substance use with experiences of trauma, the effects of trauma, and their coping skills (Greaves & Poole, 2012; BEWH, 2009). They are also given the opportunity to connect with other women, work through stigma and shame to increase self-acceptance, and develop hope for the future and their healing journey (Greaves & Poole, 2012; BEWH, 2009). While most studies on PTSD exclude women with complex problems, Seeking Safety research has been conducted with such populations (Najavits, 2021). A 2008 study conducted among 359 women living on the streets, revealed significant improvement on most clinical outcomes, including employment, social support,

decrease of symptoms of psychiatric distress, and symptoms of posttraumatic stress disorder (Desai et al., 2008). Additionally, Seeking Safety has shown clinical improvements for women with substance use, trauma-related symptoms, suicide risk, suicidal thoughts, social adjustment, family functioning, problem solving, depression, and cognitions about substance use (Najavits et al.,1998).

Therapeutic Interventions

The academic literature and research reviewed above points to several themes that are important in bridging the gap between most women's substance use services currently operating in Canada, and the ideal of trauma-informed, gender-responsive, and anti-oppressive care. The themes include valuing and centering the experiences of women and their diverse realities, acknowledging gender differences in addition to other intersecting social locations of privilege/oppression, addressing power imbalances, and allowing each woman to be the expert in their own life—that is, working against pathologizing and oppressive practices so women have choice and agency in the therapeutic process and their recovery (Greaves & Poole, 2012; 2015; Covington, 2002, 2008; Najavits, 2002; Kasl, 202). The ideal that emerges from the research reviewed is taking a holistic, or whole-person, approach to addiction to understand every aspect of an individual equally—the spiritual, emotional, mental, and physical—as well as the environmental and sociopolitical aspects, in order to better understand the intersections between mental health, physical health, substance use, and trauma to better support women in their recovery (BC Mental Health and Substance Use Services, 2021; Greaves & Poole, 2012; Covington, 2002, 2008). This section will provide an overview of feminist therapy, person-centered therapy, narrative therapy, and somatic therapy; it will outline how each of these modalities supports the themes above in order to provide a gender-responsive and anti-

oppressive framework to address specifically the systemic barriers and intersectional needs of diverse women. These particular therapeutic interventions can be used to facilitate a holistic, woman-centered, and resilience-based recovery space for women.

Feminist Therapy

Feminist therapy came into existence toward the end of the 1960s and coincided with the second wave of feminism in the United States (Brown, 2018). It developed in response to the sexism, misogyny, and patriarchal attitudes that were then rampant in Western psychology, medicine, and mental health services (Brown, 2018; Evans et al., 2011). Feminist therapy aimed to acknowledge the broad social and political contexts of women's lives and situate them in the psychotherapy experience to explore constructions of gender, power, and oppression (Brown, 2018). In the 1980s, among other influential black, queer, and trans activists, bell hooks, Audre Lorde, and Angela Davis published work acknowledging that feminism and feminist theory up to that point in time, had centered the voices of privileged cisgender and heterosexual white women, and was missing the diverse perspectives, knowledge, and realities of women on the margin (hooks,1984; Lorde,1984; Davis; 1981).

This resulted in the third wave of feminism in the 1990s and an emergence of black feminism, queer feminism, radical feminism, and intersectional feminism (Kang et al., 2017). As noted previously, Crenshaw (1989), a critical race scholar and black feminist, coined the term "intersectionality" to understand women's overlapping social locations of privilege and/or oppression based on race, class, sex, gender identity, sexual orientation, ethnicity, religion, disability, etc. Intersectional feminism plays an important part in understanding different women's experiences, especially in acknowledging the overlapping levels of oppression and marginalization that BIPOC and LGBTQ+ women face.

Feminist therapy aims to value the experience of women, recognize intersectional sociocultural factors that create barriers and cause ongoing trauma, and attend to power within the therapy relationship with the goal of developing equality (Corey, 2012; Hill & Ballou, 1998). It works to ensure that power dynamics in the client's life are not being replicated in the therapy room and offers an integrated analysis of oppression that, in addition to gender, attends to other intersections of marginalization such as race, class, sexual orientation, disability, age, etc. Additionally, it aims for change, not just within the individual, but also in society, which is the ultimate goal of feminist therapy (Corey, 2012; Hill and Ballou, 1998). As demonstrated, feminist therapy provides a framework that centers women's diverse experiences, addresses intersectional oppressive barriers, and attends to power imbalances to create individual and social change. The integration of feminist therapy into women's substance use treatment offers an effective, gender-responsive, and anti-oppressive alternative to traditional substance use services.

Person-centered Therapy

Person-centered therapy, also known as Rogerian therapy, was developed by Carl Rogers, one of the founders of the humanistic approach in the 1940s (Prochaska & Norcross, 2018). Person-centered therapy diverged from the traditional model of the therapist as expert and moved instead toward a nondirective, collaborative approach that empowers and motivates the client in the therapeutic process (Rogers, 1951). The key, for Rogers (1951; 1957), was to create a warm, nonjudgmental space in which genuineness, accurate empathy, and positive regard are the focus of therapy, allowing for honest reflection to occur. The therapist's role is to be reflective rather than directive, thereby centering the client and their experiences. Rogers (1951) believed that a person cannot teach another person directly; a person can only facilitate another's learning. This

stems from his personality theory: that everyone exists in a constantly changing world of experience in which they are at the center—each person reacts and responds based on their own perception and experience (Rogers, 1951).

Rather than viewing people as inherently flawed, with problematic behaviors and thoughts that require treatment, person-centered therapy identifies that each person has the capacity and desire for personal growth and change (Rogers, 1951). According to Rogers (1980): "Individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behavior; these resources can be tapped if a definable climate of facilitative psychological attitudes can be provided" (p.115). Rogers recognized that every person has unique strengths and resilience in the face of adversity. Inherent in his approach is a recognition of the power imbalance in therapy. It is the therapist's role to offer a supportive, collaborative, and nonjudgmental space, allowing the clients to be the experts in the room, who then set the pace, and exercise their own agency and choice in their individual healing journey. This aligns neatly with gender-responsive and anti-oppressive principles, in centering the diverse and unique experiences of each individual woman and addressing existing power imbalances, so that women have agency, control, and choice in the therapeutic process.

Narrative Therapy

David White and David Epston developed narrative therapy in the 1970s and 80s, as a therapeutic approach that aims to center the person as the expert in their own life and allow them to create personal narratives that help them identify their strengths, skills, and values so they can effectively confront problems or barriers they face (White & Epston, 1990). White and Epston criticized how traditional psychology and psychiatric language tends to pathologize the

individual as the source of the problem, by referring to someone primarily by their diagnosis or problem behaviour (1990). They described this as an "oppressive narrative," where the dominant societal discourse frames people with particular psychological issues as inherently problematic, then fuses their problem with their identity and, thus, diminishes their personal power in society and their sense of personal agency in their own lives. They wanted to deconstruct these dominant and oppressive narratives and give clients more power and choice over their own stories and experiences. Pozutto, Angell, and Dezendorf, (2005) suggest that narrative therapy is able to destabilize dominant discourse and power relations and create opportunity for alternative human actions that facilitate growth and development.

Through a process called externalization, narrative therapy involves deconstructive elements in the unpacking of people's stories and the re-authoring of preferred counter stories: "externalization in narrative therapy includes unpacking, contextualizing, and politicizing foundational concepts such as gender, race, ability, self, experience, power, sexual orientation, addiction, eating disorders, and depression in the process of situating the problem story outside the individual" (Brown, 2012, p. 34). Instead of blaming individuals for their problem behaviour and making limiting and pathologizing identity conclusions, narrative therapy separates the person from their problem. For example, instead of calling someone an "alcoholic" or "addict", narrative shifts the language to "a person who has a drinking problem" or "a person who is using substances as a way to cope with their trauma" (Brown, 2012; Williams & Baumgartner; 2014). The question shifts from "what is wrong with this person?" to "what has happened to this person?" (Williams & Baumgartner, 2014, p. 4). Thus, narrative therapy offers a trauma-informed, client-centered and anti-oppressive approach to better understand the systems of power that have harmed people and influenced some of their actions and behaviors.

Baumgartner & Williams (2014) discuss how narrative therapy can be an effective and collaborative approach for supporting front-line workers and recovering clients with substance abuse and mental health challenges. It allows people to deconstruct stigmatizing language, externalize their problem, and helps individuals recover and identify resilience, resistance, and strength within themselves (Williams & Baumgartner, 2014). It is a powerful approach that gives people voice and autonomy in how they share their stories and create meaning.

There are many aspects of narrative therapy that overlap and are congruent with feminist therapy and values (Russel & Carey, 2003; White, 1995). Russel and Carey (2003) highlight some of the overlapping themes, including deconstructing dominant discourses, attending to power imbalances, using storytelling to co-construct alternative stories, externalizing problems, identifying important personal values, and building community through shared stories and experiences. Feminist ideas and practitioners have made many valuable contributions to narrative therapy and have used narrative frameworks to influence meaningful change on issues such as violence against women, survivors of sexual abuse, disordered eating, stories of survival and resistance in the face of oppression, addiction and substance use, mothering, mental illness, and more (Brown, 2012; Russel & Carey, 2003).

Somatic Therapy

Somatic Therapy offers a holistic approach to therapy, focusing on a person's physical, mental, emotional, and spiritual connection (Haines, 2019; Hartley, 2004). Somatics comes from the Greek root soma, which means "the living organism in its wholeness" (Haines, 2019; p. 19). Somatics focuses on an integration of head, body, heart, and spirit, aiming to help clients tap into the knowledge in their own body and sensations (Haines, 2019; Hartley; 2004). Haines (2019) states that somatic therapy "engages our thinking, feeling, sensing, and actions; and is effective

in both healing trauma and embodying new skills for leadership, organization building, and social change" (p. 18).

Over the last two decades, somatic therapy has been widely used in treating clients with trauma and posttraumatic stress (Haines, 2019; Levine & Frederick, 1997; Van der Kolk; 1994). Trauma and oppression train people to ignore their own bodily sensations (Haines, 2019). The resulting dissociation, minimization, and numbing are all normal responses to trauma, oppression, and difficult life experiences that eventually become maladaptive and cause further psychological and social problems (Haines, 2019; Van der Kolk; 1994). Haines (2019) discusses how returning to sensing and feeling, after experiencing trauma, can be difficult and overwhelming for clients. Somatic therapy and techniques can support clients to reconnect to their body, sensing, and feeling, and provide purposeful healing (Haines, 2019). Van der Kolk (1994) and Haines (2019) each describe how trauma is stored in the body. Haines (2019) says "our bodies tell stories and our muscles hold memories. Our deep patterns, survival strategies, beliefs, and reactions live in our somatic structures" (p. 26). Somatic awareness and ongoing embodiment, or being more present in one's own body, gives individuals more choice, safety, and control (Haines, 2019). In its simplest form:

> Somatic healing is the embodied ability to reconnect safety, belonging, and dignity and have them serve one another, rather than be at odds with one another. It brings one's body, actions, emotions, and relations into current time... not as a concept, but as a felt reality. (Haines, 2019, pg. 134)

Understanding and addressing power dynamics is something that many somatic psychotherapists have in common with other anti-oppressive and feminist therapists and researchers (Johnson, 2014; Chambers, 2008). Somatics is fascinated with articulating a deep,

clear experience of *what is* and *how*, rather than *what should be* (Haines, 2019; Johnson, 2014). Through somatic techniques, change is revealed from the body up, not from the thinking down (Haines, 2019): in other words, allowing information to arise from the subjective experience of a client and letting themes and meanings emerge organically, rather than imposing an interpretation (Johnson, 2014). Some somatic techniques include *somatic awareness*, or teaching clients how to cultivate body awareness and tune into bodily sensations, feelings, thoughts, and behaviours; *resourcing*, which allows clients to strengthen their sense of safety and stability, by identifying positive resources in their life, such as a person, place, or pet, and bring the sensations associated with that resource into therapy to evoke a sense of strength, trust, and warmth, especially when a client is working through trauma, in order to anchor them and replenish their energy (Goldstein, 2021). Finally, *co-regulation* and *self-regulation* are also taught and practiced in session, to provide clients with tools to help regulate their emotions and soothe their nervous system, both individually, and while connecting and attuning with someone else.

Chapter 2 Summary

The literature illustrates that the link between trauma, substance use, and other concurrent mental health challenges is complex and multifaceted, leaving significant and detrimental impacts on women's physical, mental, emotional, relational, and spiritual health. Research reveals that the majority of women who enter into substance use treatment have experienced some forms of trauma, gender-based violence, oppression, or marginalization in their lifetime; and that these experiences vary based on women's intersecting locations of diversity. Additionally, women's individual experiences of oppression can intersect and compound,

contributing to increased risks of substance abuse and dependence as a way to cope with the adverse effects of trauma.

In reviewing traditional and conventional addiction programs and treatment models, such as 12-step, inpatient, residential, and outpatient programs, a significant gap still exists in treatment models meeting the needs of women who are experiencing trauma, substance use, and co-occurring mental health challenges. The existing research illuminates that women face unique challenges and more significant barriers than men, both in accessing and receiving substance use treatment: including stigma, patriarchal frameworks that do not acknowledge women's diverse realities and biopsychosocial needs, and programs that fail to hold a truly trauma-informed framework. The research suggests that integrative trauma-informed models have the best treatment outcomes for women; and, in order to support diverse women's experiences, they should also hold a gender-responsive and anti-oppressive framework.

Today, there are some existing examples of treatment programs in Canada that have adapted to implement more of a gender-responsive and anti-oppressive approach to substance use treatment, but they are few and far between. Research on the following types of programs suggest that women experience more agency, control, and self-empowerment in their healing journey, demonstrating a crucial need for more integrative treatment programs that work from this lens. Lastly, this chapter reviewed therapeutic modalities including feminist therapy, narrative therapy, person-centered therapy, and somatic therapy as a way to specifically address the systemic barriers and intersectional needs of diverse women in recovery and support the core principles of trauma-informed, gender-responsive, and anti-oppressive care.

Chapter 3 will combine aspects of each of these therapeutic approaches and incorporate them into a 16-week recovery program for women, called WHOLE HEART Recovery—a

therapeutic treatment model designed to support women with substance use challenges on their healing journey through a holistic and integrative trauma-informed approach.

Chapter 3: Summary, Recommendations, and Conclusion

Summary

Historically, women have been left out of the research on substance use and addiction. The majority of substance use treatment programs that exist today still have patriarchal and pathologizing models that were created for the needs of men, ignoring the gender-specific treatment needs of women and the impact of women's diverse experiences of trauma, violence, and oppression. As a result, conventional and traditional recovery programs and treatment services have been largely unsuccessful in supporting women, especially those most marginalized, to overcome substance use challenges and heal. A crucial treatment gap remains in both traditional programs and trauma-informed care and women still experience stigma and harm, both in accessing and in receiving treatment. The cost of ineffective and inaccessible women's substance use treatment is a public health crisis, leaving devastating impacts not only on women, but also children, families, communities, and society as a whole.

Limitations

Several limitations exist in the scope of this capstone. While this capstone aimed to review mainstream traditional and conventional substance use treatment programs for women, there are many different treatment programs and recovery models that exist and not all are reviewed here. Additionally, the literature and research on women's substance use treatment is limited and contains many gaps, especially for diverse and marginalized women with coexisting trauma, substance use, and mental health challenges (Greaves & Poole, 2012; Covington 2002; 2008; UN, 2004). This has made it difficult to find research on the efficacy of substance use programs for diverse populations of women. Other potential limitations are my personal biases and the social locations of privilege that I occupy, that could lead to important pieces being overlooked

or missed. Finally, this capstone aimed to include voices of diverse women throughout, however due to the length of the project, it could not represent all populations. Future research is needed to explore clinical outcomes for diverse and marginalized women in substance use treatment.

Recommendations

The following 16-week out-patient, day recovery program, called WHOLE HEART Recovery is proposed to provide an integrative trauma-informed recovery program for women with substance use challenges. This program would be available to women 19 years of age and older. It will utilize and integrate therapeutic models from feminist therapy, narrative therapy, person-centered therapy, and somatic therapy to provide a gender-responsive, anti-oppressive, and holistic approach to trauma-informed substance use treatment and recovery.

The program will take a harm-reduction approach to substance use, meaning that it would not require women to meet a minimum length of sobriety before being admitted or "considered" for the program. Additionally, the objective of the program would be to support women with whatever they have self-identified as their recovery goal, whether that is abstinence from all substances, some substances, or minimizing/decreasing substance use and gaining more control and agency over their life. It would also aim to de-stigmatize relapse and let participants know that this is a normal part of recovery and that they will not be kicked out of the program, but supported throughout the process. The program will aim to foster an environment of choice, collaboration, community, advocacy, and support.

The women's recovery group will meet twice a week. Each session will have a 90-minute duration, with a 15-minute break mid-session. Each session will start with an opening circle to check in and end with a closing circle to provide space for clients to share things that might have

come up during the session and provide some containment to help them transition from the session back to their various locations or residences.

There will be a third optional hour-long mid-week meeting, or *Heart Check-in Circle*, in between the two sessions where participants, especially those who feel like they need additional support, can join and talk through challenges with the facilitators and other peers in attendance. This will be part of creating an environment of choice and allowing women to decide and voice what they are needing instead of being asked to meet rigid and strict meeting schedules without any flexibility.

Additionally, once the program wraps up after 16 weeks, participants will have the option to continue to attend the *Heart Check-in Circle* that happens weekly to join present and past women of the program and continue to share stories of hope and connection. The intention is to provide on-going support, when needed, and create a community of women supporting women, so that no one feels alone after they finish, as recovery is an ongoing journey.

WHOLE HEART Recovery Program

The program name stands for a (WHOLE)-istic approach to (H)onouring (E)very woman's experiences (A)nd recognizing (R)esilience in the face of (T)rauma (HEART).

Table 1: An overview of the 16-week program, including goals, themes, and activities, is listed on the next page.

Week 1-2	***Week 1*** *Opening Circle and Welcome* ▫ Group facilitators and participant introductions ▫ Go over group guidelines, informed consent, and confidentiality ▫ Sharing in a trauma-informed way: participants always have the option to pass on sharing and when sharing, be mindful of not giving specific details about substance use and challenging life experiences that could potentially re-trigger clients ▫ Establish collective group agreement ***Theme 1****: Creating a Person-Centered and Woman-centered Roadmap to Recovery...* ▫ You set the pace. You are the expert of your life and recovery. Creating an environment of safety, choice, and collaboration ▫ Walking through stages of recovery (withdrawal, early recovery, readjustment, relapse) and naming/normalizing some challenges you may face along the way ▫ Identifying personal and individual goals for the program *Building Connection - You are not alone.* Sharing stories of strength, resilience, and hope **Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** *Closing Circle* ***Week 2*** *Opening Circle and Welcome* ▫ Group Check-in ***Theme 2****: Taking an Intersectional Feminist Approach to Recovery and acknowledging that healing comes in many forms* ▫ Acknowledging women's diverse experiences, barriers, and resilience in their recovery journeys…. what has been helpful and what has not? ▫ Journal exercise: What are your preferred forms of healing? Recognizing alternative and culturally informed practices *Feminist Therapy and Art Therapy Exercise:* ▫ Draw yourself, include strengths, characteristics, and qualities that you like about yourself ▫ Draw and identify the intersections of social locations you occupy - identifying locations of privilege and/or oppression ▫ Draw societal barriers or challenges you've encountered due to the social locations you occupy mentioned above ▫ Draw messages you've received from media, society, and culture that have shaped how you and think about yourself and other women ▫ Draw, celebrate, and identify ways you might have resisted or rejected traditional and harmful heteropatriarchal "norms"

Week 3-4	***Week 3:*** *Opening Circle* ▫ Group Check in: Mind, Body, Heart, Spirit check-in ▫ Grounding exercise ***Theme 3:*** *Taking a Holistic Approach to Addiction - Incorporating Mind, Body, Heart, and Spirit* ▫ Taking a whole-person approach using somatic embodiment techniques to tune in to internal and external body sensations *Identifying Internal and External triggers, Coping Mechanisms, and Resources* ▫ Go over somatic tools for self and co-regulation, including somatic resourcing to help soothe the nervous system ▫ Mindfulness activity: identify a person, place, pet, or thing that you associate with positive sensations and puts you at ease. Invite in those sensations and notice where you feel them in your body... **Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** *What's one thing you can do for your mind, body, heart, and spirit this week? Name one thing for each...* *Closing Circle* ***Week 4*** *Opening Circle and Welcome* ▫ Group Check-in ▫ Grounding exercise ***Theme 4:*** *The Interconnections of Trauma, Gender, Substance Use, and Mental Health* ▫ Shifting the focus from problem behaviour and diagnoses to an understanding of substance use as a way to cope with challenging life experiences *Re-authoring Your Story* *Narrative Exercise: I am more than my substance use problem/addiction* ▫ I am someone who enjoys doing… ▫ I am someone who loves.... ▫ I am someone who is inspired by… ▫ I am someone who has overcome …

Week 5-6	***Week 5:*** *Opening Circle and Welcome* ▫ Group Check-in ▫ Mindfulness exercise ***Theme 5****: Normalizing the potential of Relapse--Breaking the stigma and seeing relapse as an opportunity for self-reflection, growth, and progress* *Creating a community support plan for potential of relapse:* ▫ Identifying your peer and/or family supports who you can call if you're thinking of using ▫ Identifying a safe environment where you can use so you're not alone ▫ Ensuring you have the list of resources and crisis lines (would be included in recovery program manual) with shelters and safe injection sites/spaces for women *Reflections and celebrating that you are here now…* ▫ Have you experienced a relapse or near relapse in that past? ▫ How were you able to get through it? ▫ Acknowledging the strength and resilience in being where you are right now and that there will be bumps and challenges along the way **Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** *Closing Circle* ***Week 6:*** *Opening Circle* ▫ Group Check-in ▫ Grounding exercise ***Theme 6****: Addressing Power, Oppression, Intersectionality, Collective Healing, and Collective Resilience* *Attending to Privilege and Oppression Exercise* ▫ Go over the Intersecting Axes of Privilege, Oppression, and Domination Diagram - (Crenshaw, 1991; Morgan, K.P; 1996) ▫ Individual journal time to identify intersecting social locations and reflect *Sharing circle on the diverse and varying experiences and barriers women have encountered in their recovery journeys and discussing collective resilience and healing* **Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** *Closing Circle*

Week 7-8	***Week 7*** *Opening Circle* ▫ Group Check-in ***Theme 7***: *Learning about adaptive responses to trauma—substance use as a way to cope with trauma, violence, and oppression* *Understanding the Window of Tolerance (Siegel, 2012)* ▫ Going over fight, flight, freeze responses as adaptive strategies to cope with trauma ▫ Practicing self-regulation and co-regulation skills including mindfulness, breathing, movement, and connection **Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** *Closing Circle* ***Week 8*** *Opening Circle and Welcome* ▫ Group Check-in ▫ Grounding exercise ***Theme 8:*** *Cultivating Self-Compassion and Empathy to Counter Shame* *The Four Attributes of Empathy* ▫ Developing empathy, courage, and compassion to counter shame (from Brene Brown's Shame-Resilience Curriculum, 2011) **Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** *Closing Circle*
Week 9-10	***Week 9*** *Opening Circle and Welcome* ▫ Group Check-in ***Theme 9:*** *Exploring Relational Patterns and Attachment* ▫ Go over different styles of attachment ▫ Journal reflection: is there an attachment style or styles that you identify with? How has this pattern shown up in your life and relationships? How has it helped you? How has it hindered you? ▫ Acknowledge external factors or barriers that may have led to this adaptive coping pattern ▫ Discuss benefits and limitations of these categories: How might they be helpful in explaining patterns? How might they fall short in acknowledging sociocultural and other environmental factors?

	Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** *Closing Circle* ***Week 10* *Opening Circle and Welcome* ▫ Group Check-in ***Theme 10:*** *Boundaries and Relationships* ▫ What do boundaries look like and feel like? ▫ Journal reflection: What are some examples of boundaries you have set or others have set in your life? ▫ Going over language and practices to help set boundaries and voice your needs **Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** *Closing Circle*
Week 11-12	***Week 11*** *Opening Circle and Welcome* ▫ Group Check-in ***Theme 11****: Taking agency over your life and letting go of old patterns that no longer serve you…* *Narrative Exercise* ▫ Write a letter to your substance explaining why you are choosing no longer to let it control your life. **Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** *Closing Circle* ***Week 12*** *Opening Circle and Welcome* ▫ Group Check-in ▫ Grounding exercise ***Theme 12****: Self-esteem and Body Image* *Feminist Therapy and Art therapy Exercise* ▫ Draw a picture of yourself ▫ Draw your body, draw your heart, your hands, arm, legs, head, mouth, etc. ▫ Label one thing you love that each part allows you to do. ▫ Example: hands allow you to write, heart allows you to love, mouth allows you to sing/have a voice

	**Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** *Closing Circle*
Week 13-14	***Week 13*** *Opening Circle and Welcome* ▫ Group Check-in ▫ Mindfulness exercise ***Theme 13****: Dual recovery - working through challenges of substance use and co-occurring mental health challenges (Najavits, 2002)* *Normalizing that substance use dependence can overlap with other mental health challenges including anxiety, depression, and more…* *The benefits of an integrative approach:* ▫ Go over dual coping strategies and community resources that offer integrative care **Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** *Closing Circle* ***Week 14*** *Opening Circle and Welcome* ▫ Group Check-in ***Theme 14****: Honouring Grief, Mourning, and Reconnection (Herman, 1992)* *Grief comes in many forms and every person experiences it in their own way....* ▫ Journal exercise to reflect on experiences of grief and then come together to discuss in group Remembrance, Mourning, Reconnection *Narrative exercise*: How to make meaning out of different experiences of grief **Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** *Closing Circle*
Week 15-16	***Week 15:*** *Opening Circle and Welcome* ▫ Group Check-in ▫ Grounding exercise **Theme 15***: Goal Setting and Looking forward…*

	Values Worksheet: ▫ Going over values and discuss individual hopes and goals as each woman looks forward and beyond the program. **Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** *Closing Circle* ***Week 16*** *Opening Circle and Welcome* ▫ Group Check-in ▫ Mindfulness exercise ***Theme 16:*** *Celebration and Closing* Sharing learning and reflections **Mid-week optional HEART Check-in Circle w/ facilitators and peers (1 hr.) ** Potluck Celebration and giving each client a Heart tile to recognize their accomplishment and completion of the program ***Final Closing Circle*** *Recovery doesn't end here… you will always be a part of the WHOLE HEART family and community*

Clinical and Practical Considerations

The program is recommended to be run by two female or femme-identifying clinical counsellors, who ideally bring diverse perspectives and experiences. They would hold specialized training in trauma-informed work and practice. They would also have experience, training, and knowledge, in an intersectional feminist anti-oppressive framework that understands and acknowledges the intersections between gender, substance use, and mental health, as well as other social locations of oppression/marginalization.

The program would ideally receive public funding, or be "housed" under an agency that could offer funding, in order to make the program free and accessible to all women in the

community who are interested. It would aim to partner with local women's community services to offer low-barrier and free child-care services on the same premise as the recovery program, but in a separate room, while women attend the recovery meeting. Additionally, it would aim to connect program participants to other women's community and mental health services, including individual counselling, family counselling, housing resources, employment resources, health resources, legal services, and other low-barrier substance use resources that take a trauma-informed, harm-reduction, gender-responsive, and anti-oppressive approach.

Conclusion

The purpose of this capstone was to consider the question: *What impact do integrative trauma-informed substances use services, that hold a gender-responsive and anti-oppressive lens, have on promoting positive therapeutic outcomes for diverse women in recovery?* The findings of this capstone suggest that implementing an integrative gender-responsive and anti-oppressive trauma-informed framework would equip counsellors and mental health professionals to better support the complex treatment needs of women experiencing substance use, trauma, and mental health challenges. It would also promote positive therapeutic outcomes for women, by acknowledging their diverse experiences of trauma, gender-based violence, and oppression/marginalization, thereby contributing to the creation of an environment that promotes a greater sense of safety, collaboration, choice, and empowerment for women on their recovery journey. Additionally, the research considered: *How can taking a holistic and trauma-informed approach to addiction support women's physical, mental, emotional, and spiritual health?* The literature revealed that in taking a holistic, or whole-person approach to addiction, the spiritual, emotional, mental, relational, and physical aspects of women, as well as the environmental and sociopolitical aspects, are all considered in treatment in order to better understand and support

each individual woman in their treatment and healing process. Finally, the capstone explored: *How can applying an anti-oppressive and gender-responsive lens to substance use services help bridge the gap between trauma-informed theory and clinical practice?* The research suggests that, by applying this framework, treatment programs can work against pathologizing and oppressive practices to address power imbalances and structural barriers that are preventing women from getting the treatment they need. It would help pave the way for more accessible, woman-centered care that values women's experiences, strengths, and resilience in the face of oppression.

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