Co-Occurrence of and Recovery from Substance Abuse and Lifespan Victimization: A Qualitative Study of Female Residents in Trauma-Informed Sober Living Homes

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Co-Occurrence of and Recovery from Substance Abuse and Lifespan Victimization: A Qualitative Study of Female Residents in Trauma-Informed Sober Living Homes

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ABSTRACT

Despite the co-occurrence of substance use disorders (SUDs) and domestic and/or sexual violence (DSV) in the lives of women, there remains a dearth of research on how and why these phenomena intersect as well as the role that trauma-informed sober living homes (SLHs) may play in promoting recovery. Following a detailed description of a unique trauma-informed SLH (Support, Education, Empowerment, and Directions [SEEDs]), we present findings from a qualitative study that documented the perceptions and lived experiences of 28 female current or former residents of a trauma-informed SLH; all women had histories of SUDs and DSV. Results uncovered four themes (fractured foundations, points of intersection of SUDs and DSV, pervasiveness of SUDs and DSV, resiliency) and a constitutive pattern (moving away from instability and harnessing self-agency). Women noted that their engagement with SEEDs played a significant role in their recovery, specifically through fulfilling their needs for tangible resources (e.g., food, clothing, shelter) and the community’s provision of emotional support (e.g., family, love, consistency) to promote recovery. These findings provide new insights on SUDs and DSV and preliminary support for the effectiveness of a trauma-informed SLH.

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Research documents the high co-occurrence of substance use disorders (SUDs) and domestic and/or sexual violence (DSV) among women (Afifi et al. 2012; Capezza, Schumacher, and Brady 2015; Jason and Ferrari 2010; Liebschutz et al. 2002). SUDs are characterized by persistent use of alcohol and/or drugs that leads to significant impairment (e.g., health problems, failure to keep a job) (American Psychiatric Association 2013). Domestic violence (DV) includes rape, physical violence, and/or stalking that occurs within the context of a current or former relationship; DV impacts 36% of women during their lifetime (Black et al. 2011). Sexual violence (SV) includes completed or attempted forced penetration (i.e., rape) that can happen between individuals within any type of relationship, although SV is most commonly between individuals who know one another; SV impacts 18% of women during their lifetime (Black et al. 2011).

Research drawing on quantitative methodologies suggests that the co-occurrence between SUDs and DSV among women is complex. Drug and alcohol consumption may increase women’s risk for DSV by hindering judgement, inhibiting women’s ability to interpret and act on warning signs, and interfering with their ability to fight off unwanted sexual advances (Crowell and Burgess 1996; Krug et al. 2002; WHO 2002). For example, Parks et al. (2015) found that women who were intoxicated, compared to those not intoxicated, were less likely to detect risk in a video depicting risk for a sexual assault.

Women may also use substances to cope with psychological sequelae resulting from DSV; longitudinal research shows that women are at increased risk to use substances immediately following a DSV experience (Parks et al. 2008). Problematically, using substances to cope can also increase women’s risk for revictimization. In a longitudinal study, Messman-Moore et al. (2015) found that women who used alcohol to cope following a sexual assault experience were more likely to experience a subsequent sexual assault. Moreover, using
substances to cope can exacerbate trauma symptoms, particularly among women with chronic trauma histories (Kayser et al. 2007). Also, researchers have documented that many women with histories of DSV and SUDs often have histories of childhood victimization (Keyser-Marcus et al. 2014; McLaughlin et al. 2012).

Two studies (Macy, Renz, and Pelino 2013; O’Brien et al. 2016) used a qualitative methodology to examine how women perceive their experiences of co-occurring DSV and SUDs. Qualitative data not only give a voice to marginalized individuals, but provide nuances and depth that enrich quantitative findings (Heidegger and Stambaugh 1996; Yilmaz 2013). In the Macy, Renz, and Pelino (2013) study, qualitative analyses indicated that for many women currently in SUD treatment, SUDs predated romantic partnerships and DSV exacerbated SUD severity and chronicity, whereas for other women SUDs began as a way to cope with psychological sequelae associated with DSV experiences. Among a sample of service-mandated women with DSV histories, O’Brien et al. (2016) found women reported that they used substances to cope with psychological sequelae associated with DSV and due to pressure to use substances from an abusive partner. Women perceived the severity of their substance use to be related to the frequency and severity of their partner’s violence. Finally, women noted that they were more likely to be victimized when their partner was under the influence of substances. The present study expands on these two previous studies by examining women’s experiences of co-occurring SUD and DSV and childhood victimization across the lifespan.

In addition to examining women’s perspectives on the co-occurrence of SUDs and DSV, it is important to listen to women’s voices on the factors that facilitated or hindered their recovery, and the types of services that women found helpful or unhelpful. Services for women with comorbid DSV and SUD that are gender-responsive and trauma-informed are more likely to be effective than services that are not (Covington 2008; Hoersch 2015; SAMHSA 2014, 2015). Trauma-informed services refer to those that consider the role of trauma in etiology, onset, and recovery; avoid triggering reactions or retraumatization; support women’s coping capacities; and promote empowerment so that survivors can manage their trauma symptoms successfully (Covington 2008; Fallot and Harris 2002; SAMHSA 2014). Gender-responsive services for SUDs acknowledge the realities of women’s lives, which include the high prevalence of violence and experiences with sexism and discrimination (Covington 2008; Grella 2008). Gender-responsive services include an “environment—through site selection, staff selection, program development, and program content and materials—that reflects an understanding of the realities of women’s and girls’ lives and that addresses and responds to their challenges and strengths” (Covington 2008, 377–378). Gender-responsive and trauma-informed services are more likely to prevent SUD relapse and DSV revictimization than services that are not gender-responsive and trauma-informed (Covington 2008; Grella 2008).

Although a number of evidence-informed, gender-responsive, and trauma-informed SUD interventions (e.g., Seeking Safety, Atrium) have been evaluated (Baker, Niolon, and Oliphant 2009; Bennett and O’Brien 2007; Najavits 2002; Najavits et al. 1998), no research has evaluated a gender-responsive and trauma-informed sober living home (SLH) for women with SUDs and DSV. This is surprising, given the fact that (1) for many individuals, SLHs are critical in promoting sobriety (Jason and Ferrari 2010; Jason, Olson, and Foli 2008; Polcin and Henderson 2008); (2) the majority of women seeking residence at a SLH have a history of DSV (Hunter, Robison, and Jason 2012; Liebschutz et al. 2002) and (3) recognition by 24 federal agencies (e.g., DHHS, DOJ) of the importance of trauma-informed approaches via the Federal Partners Committee on Women and Trauma (Hoersch 2015). Whereas we know little about characteristics of SLHs that promote long-term recovery among women with SUD and DSV, we do know that the thousands of SLHs in the U.S. vary widely in terms of their size, organization, and target population (National Association of Recovery Residences 2012).

**Study aims**

This study used qualitative methods to document the lived experiences of women in recovery from both SUDs and DSV with a specific focus on: (1) the co-occurrence of SUDs, DSV, and other forms of interpersonal traumas (e.g., childhood victimization); and (2) the role of a trauma-informed SLH in promoting women’s recovery. Before presenting the qualitative methodology and results, we provide a detailed overview of the Support, Education, Empowerment, and Directions (SEEDs) SLH to inform future scholarship and potential replications. Also, it is critical to underscore that the sole responsibility of DSV lies with the perpetrator, and the identification of effective prevention efforts is of utmost importance. However, until DSV is eradicated from our society, it is also important that we allow a space for survivors to share their experiences, and use their experiences to inform research, practice, and policy.
Overview of SEEDs SLHs

SEEDs in Phoenix, Arizona, is a unique SLH specifically for women with histories of SUDs and DSV. The majority (60%) of women come to SEEDs from an inpatient substance abuse treatment facility or detox; the remainder come from prison or jail (10%), word of mouth (e.g., women living in SEEDs tell other women in need of safe and sober living, often living in a Traditional-Sober Living Home (T-SLH), about SEEDs; 20%), or fleeing from a DV abuser or human trafficking (10%).

Two of the three SEEDs SLHs are reserved for women with children in their custody. Residents are offered a variety of supports to enhance their ability to live independently, such as peer support, DSV support groups, and culturally appropriate case management services. Residents enhance basic living skills, such as cooking and cleaning, along with money management skills. Residents also learn business and service skills in the coffee shop operated by SEEDs. The house rules and regulations were initially developed and are continually reviewed by women residing in the SLH, as well as previous residents who make up the Resident Advisory Committee.

Admission criteria require that individuals identify as female, are 18 years of age or older, report a history of SUDs, report a history of DSV, and report a commitment to working on goals of safety, sobriety, and self-sufficiency. To ensure the safety of residents, women reporting child sex offenses, felony assault convictions (excluding convictions related to DSV history; e.g., wrongful self-defense convictions), and/or arson convictions are ineligible for a SEEDs SLH. Although women can stay for up to two years, the length of stays range from a few days to two years, with most women staying a few months. The majority of women who successfully leave a SEEDs SLH stay connected to the SEEDS community (e.g., work at the SEEDS coffee shop, become a house manager, become an active member of the SEEDS “alumnae” group). Success is defined as women who secure permanent and safe housing, obtain and maintain employment (or another source of income such as Social Security Disability Insurance [SSDI]), remain sober, abstain from criminal offending, engage in healthy, non-abusive relationships, and when applicable, regain or maintain custody of children.

In addition to adhering to trauma-informed and gender-responsive models of recovery, SEEDS is grounded in relational-cultural theory (Jordan and Hartling 2002) and stress and coping theories (Cohen and Wills 1985; Flannery 1990; Frazier, Steward, and Mortensen 2004; Guay, Billette, and Marchand 2006). These theorists explain that the primary motivation for women throughout life is the establishment of a strong sense of connection with others, and women’s use of substances is often tied to the loss of a relationship, to maintaining a relationship, and/or to denying the pain from an abusive relationship (Covington 2008; Grella 2008). Gender-sensitive and trauma-informed services help reformulate women’s desire for connection as a strength and build and foster connections that promote a life free of DSV and SUDs. Social support plays a critical role in both coping with trauma and recovery from SUDs. Members of one’s support network may model effective coping strategies, provide information and tangible support, assist with emotional expression, aid in problem solving, and directly challenge maladaptive coping. Finally, SEEDs SLHs promote empowerment-based pathways to sobriety, including culturally congruent abstinence-based pathways. Figure 1 provides an overview of the mechanisms by which trauma-informed SLHs may be effective for women with SUDs and DSV. Table 1 provides a summary of characteristics of SEEDS SLHs that may buffer against factors that often predict relapse among women.

Method

Participants

Participants were 28 women recruited between January and May 2014. Participants ranged in age from 27 to 59, with a mean age of 43.64 (SD = 9.44). The sample was predominantly White (85.7%), heterosexual (64.3%), low income (71.4% <$20,000 per year), had children (67.9%), and reported a history of incarceration (71.4%). A majority (63.6%) currently resided in a SEEDs SLH, whereas

Figure 1. Proposed theoretical model of SEEDs SLH effectiveness.

Note: SUD = substance use disorder; DSV = domestic and/or sexual violence victimization.
Table 1. Risk factors for SUD relapse and buffering characteristics of the SEEDs program.

<table>
<thead>
<tr>
<th>Risk factors for SUD relapse among women</th>
<th>Characteristics of SEEDs SLH</th>
</tr>
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<tbody>
<tr>
<td>Interpersonal problems</td>
<td>Female-only, safe and sober housing</td>
</tr>
<tr>
<td>Mental health issues</td>
<td>Opportunity to form close relationships with other women at similar and different places in the healing and recovery process</td>
</tr>
<tr>
<td>Childhood abuse</td>
<td>Case management and other skills training (e.g., job training, support and psychoeducation groups), services in the SEEDs SLH and assistance accessing mental and physical health care in the broader community</td>
</tr>
<tr>
<td>Poverty</td>
<td>Democratically self-governed</td>
</tr>
<tr>
<td>Homelessness</td>
<td>Opportunity to mentor and be mentored by others</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>Non-judgmental, compassionate, gender-responsive, and trauma-informed environment</td>
</tr>
<tr>
<td>Lack of social support</td>
<td>Shame and stigma related to DSV and SUD</td>
</tr>
<tr>
<td>Lack of sense of community</td>
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<tr>
<td>Lack of empowerment and self-efficacy</td>
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</table>

The qualitative interviews were grounded in Heideggerian Hermeneutic Phenomenology (HHP) (Heidegger and Stambaugh 1996). Phenomenology focuses on how an individual makes sense of her world and assists the researcher in eliciting the meanings each woman attaches to her experience. We were interested in women’s perceptions and meaning making of their lived experiences of DSV and SUDs and the role of SEEDs SLHs in their recovery (Benner 1994). Examples of guiding questions included: (1) “Tell me a story about one of the relationships where you experienced abuse or violence that stands out for you”; (2) “Your story contains a history of substance use problems along with victimizations. Do you see connections between these things in your life or are they more separate?”; and (3) “What role, if any, has the SEEDs community played in your recovery and understanding of the experiences we have discussed?” To elicit more details in women’s stories, follow-up probes such as “Could you tell me a story about that experience?” and “When you think back to that experience, how do you make sense of it now?” were used frequently.

Each interview lasted approximately 2.5 hours and was held at a location selected by the participants (e.g., one of the SEEDs SLHs, the public library, a participants’ private home). All of the interviews were conducted by the second author (SM), a professor in social work. Although she has no prior relationship with the participants, she built rapport with participants as a phenomenologist using active listening techniques, thoughtful probing when more information was sought, and expressing care and concern for each woman and her story. Twenty-eight interviews were audio recorded and transcribed and checked verbatim by research assistants at UNH. Following completion of the transcriptions, the audio recordings were destroyed. The 28 interviews yielded 1,212 pages of transcription. Fictitious names were assigned to participants.

The method and stages of analysis followed the tenets of HHP (Heidegger and Stambaugh 1996), which is concerned with the meanings that individuals make of their experiences. This methodology and philosophy focuses on understanding the world of lived experience from the perspective of those who experienced it. It is a theory of research that seeks situation-specific meaning from phases. In the present article, we present data from the qualitative portion of the interviews.

Procedure

Following approval from the University of New Hampshire’s (UNH) Research Integrity Services, women were recruited for the study if they were currently living, or had lived in, one of three SEEDs SLHs. A SEEDs staff member distributed a letter to all women (N = 41) eligible to participate, which included current (N = 17) or former (N = 24) residents of a SEEDs SLH. Only former residents who lived in the greater Phoenix metropolitan area and former residents for whom SEEDs had current contact information were invited to participate. The letter was from the research team and included information about the study and how to enroll in the study. The second author (who completed all data collection) also attended a house meeting to introduce herself and answer questions about the research project. Additionally, women were recruited via fliers hanging in the SEEDs-owned coffee shop and via snowball sampling.

Twenty-eight women enrolled and completed the study (15 current residents [88% participation rate] and 13 former residents [54% participation rate]), for an overall participation rate of 68%. The study was divided into two phases. The first phase involved informed consent and survey measures, and the second phase involved the completion of a Life History Calendar (LHC; DeHart et al. 2014; Freedman et al. 1988) and participation in a qualitative interview. Women were compensated for participation in both the remainder (36.4%) had previously resided in a SEEDs SLH and were currently residing in the Phoenix metropolitan area.
specific actors (e.g., research participants) in a given time and place (Schwandt 1994). Proponents of this theory of research ascribe to the belief that in order to understand the lived experience, it must be interpreted by the researcher. This requires construction of meaning through careful attending to the practices, language, history, and context of the participants. The goal of the current research was the unfolding of description and exploration of the meanings of the co-occurrence of SUDs and DSV. Between July 2014 and January 2015, the authors of this article engaged in over 50 hours of analysis over 10 research team meetings to reflect on and interpret the transcripts.

A seven-step process of analysis was used, consistent with the HHP analysis method (Diekelmann, Allen, and Tanner 1989). More specifically, each team member read all of the transcripts as part of the first stage of the HHP process, thus providing the group with emergent themes. During team meetings, members took note of excerpts that supported these themes, while engaging in a process of constant comparison during which categories with the strongest agreement were selected. Over the period of analysis, categories were collapsed, expanded, or eliminated to represent all transcripts and a constitutive pattern, an overarching theme found across all stories, was identified. The data were consistently warranted through all steps of analyses by returning to the text to clarify interpretation. The final stage of the HHP process included involving content experts to validate the themes and constitutive pattern, and write the analyses that became our findings.

Results

Four primary themes were uncovered (i.e., fractured foundations, pervasiveness of SUDs and DSV, points of intersection of SUDs and DSV, and resiliency) and one constitutive pattern that encompasses all of the themes (i.e., moving away from instability and harnessing self-agency). For additional quotes, please visit http://unh.edu/ivrl/publications.html

Fractured foundations

Women’s lives were marked by multiple forms of trauma, such as childhood victimization and living with caregivers who suffered from mental illness, including SUDs. As Monique told us: “My mom would do just horrible things to me, leave me outside from the morning to the nighttime, not let me in, not let me have food, not let me have anything to drink.” As Jessica said: “My mom, especially being an alcoholic, she just was really depressed all the time.” The toll these experiences took started early; as Zeena said: “I’ve been depressed since I was a little girl.”

These fractured foundations were exacerbated by non-supportive and negative responses to women’s disclosures of victimization as a child. In a situation in which the police had been notified of suspected child abuse, Trisha disclosed: “[Child protective services knew] but [thought] they’re just a bunch of hillbillies, and it’s a family matter. Nobody was willing to help me.” Emotionally unavailable caregivers also contributed to the lack of safety and stability. Joann stated:

And, he took my hand... and put it on his private area and it was, you know, erect or whatever, and I was like, “Ewww that’s gross!” [I] freaked and ran out of that house. I didn’t tell my mother though because I just thought she would beat the shit out of me. You know? I didn’t trust her enough to tell her what he did.

The pervasiveness of SUDs and DSV

Fractured foundations fostered the development of interpersonal schemas in which women viewed SUDs and DSV as normal, inevitable, and an unavoidable aspect of life. As Natasha told us: “I accepted [the SUDs and DSV] because, in my brain, that was accepted in my [immediate] family, and the [generations] before me. My dad was a violent alcoholic, his dad was a violent alcoholic, so, you know, it just went on and on and on.”

Susan described a situation where she normalized the abuse by describing how the habitual and pervasive nature of the abuse determined her actions:

When I was talking to the attorney, I wasn’t going to do anything about [the DSV]. I’m an adult, you know. I had all the scenarios of what rape is and what it’s not. It’s not like he forced himself or hurt me, or you know, anything like that. Because he never did penetrate me, so it was like molesting me. But it was every day. Sometimes three or four times a day. I didn’t believe it was rape because it was just something that, you know, I always thought rape was a stranger raping somebody.

Additionally, the nature of DSV was reflected in how women bargained for their lives. Monica told us: “I was in desperation when you think about it because I didn’t have a home, I didn’t have my family. I lost my girls... I put up with [the abuse]. I needed a place to live... growing up, I never saw anything healthy, so I just didn’t really think it was even that bad.”

Points of intersection of SUDs and DSV co-occurrence

Although all women had histories of SUDs and DSV, the etiology of these co-occurrences manifested
differently in their lives. SUDs and DSV often intersected, as in Cheryl’s story:

*Drugs were a normal thing in the neighborhood... Everybody was using drugs. It’s just how we lived. And, it was a normal thing for the guys to beat on their girlfriends, whether they were pregnant or not.*

For many of the women, DSV preceded SUDs, and substances were used to cope with the psychological and physical sequelae of DSV. Tammy said: “I guess the violence started first. Or seeing and witnessing problems in my family... when I drank, I was happy and everything was wonderful.” For other women, SUDs increased risk for DSV by placing women in situations where DSV was more likely to occur (e.g., drug houses) and/or by inhibiting women’s ability to interpret and effectively act on warning signs of impending violence, as the following examples underscore. Jane said: “[Abuse is] more prominent when you’re in the drug world... relationships are going to be more abusive [if you are doing drugs].” Describing the difficulty of leaving an abusive relationship with SUDs, Denise said: “I never did anything about [the abuse] cause I was using drugs at the time.” Women described using substances to cope with negative life experiences, and being taken advantage of for the SUDs. Wendy stated: “I used drugs to self-medicate... I didn’t think I deserved very much, or I was never going to amount to much.”

Stacy described the relationship between SUDs and DSV in the following way: “Drugs were involved in what we’ve gone through... drugs led us to believe that we were just bad people and that we deserved to be beaten by men because we were doing something bad.” Another woman, Gina, described this belief when she said: “I used to say if we’re the ones that got high, we’re the ones that allowed it, we’re the ones that did this.”

In a number of cases, substance use was part of the DSV incidents. Some women reported that perpetrators forced them to use substances. Jennifer stated, “My hands were bound, and there was a pile of cocaine and he threw it in my face and made me snort it.” Other women reported that perpetrators would supply them with alcohol and/or drugs to apologize for the violence. Claire stated: “he [was] beating me almost on a daily basis, and his way of apologizing is to supply me with alcohol.” Women also identified the perpetrator’s SUDs as a contributor to the violence; Lucinda said: “We started smoking [crack] every night, and every time he came down, he’d start hitting me, kicking me... he broke my leg, he caused me a concussion... every night when he came down [he beat me].”

**Resiliency**

**Intrinsic**

Despite the high frequencies of repeated trauma, including DSV, across the lifespan, all women in our study demonstrated extraordinary intrinsic resiliency (i.e., personal characteristics that buffer individuals from the deleterious effects of DSV; Barron, Miller, and Kelly 2015). Cory stated:

*I don’t have to be bound by victimization... I don’t have to be bound by any of the addictions. I don’t have to. There’s always a way; that’s really what’s the most important. That is the most important thing... that there’s always hope.*

Another woman, Heidi, reflected on her strengths:

*I would definitely say a sense of humor. You gotta’ be able to laugh at yourself. And perseverance. And, you have to know that in, in your core... we all have this... this strength in our core, that we know that we’re better than [the DSV and SUDs]. Like, when you’re with someone that’s beating you, you know deep down in your core that you’re better than that. Nobody deserves that kind of stuff.*

**Extrinsic.** Women identified the SEEDs community as the primary source of their extrinsic resiliency (i.e., environmental factors that decrease vulnerability to DSV; Barron, Miller, and Kelly 2015). Indeed, women perceived SEEDs as a community that fulfilled many of their previously unmet needs, both basic needs (e.g., food, clothing, shelter) as well as needs for family, support, love, and consistency. Whereas many women entered the SEEDS community with few of these needs being met, the SEEDS community provided women and their children with important tangible and emotional resources to promote sobriety and healing from DSV. Women also commented that the SEEDS community provided them with a sense of community, hope, the ability to develop a sense of empowerment and agency, and education around healthy relationships and the intersection of trauma and addiction.

As Mindy told us:

*I’m learning in the SEEDs program about self-esteem and healthy relationships. I remember clearly when [a former SEEDs resident] did a group on healthy relationships, and... I was floored at... what a healthy relationship should look like. She described healthy [as]: I have my own life... a career, family; I have a healthy balance in all areas of my life. He’s got that same thing*
Similarly, the SEEDs community helped to heal the wounds that started with fractured foundations and continued into adulthood, as Ginger stated:

They’re my family. Yes, we’re the ones who worked our asses off [to stay sober], but if it wasn’t for [the SEEDs women’s] love and support, I don’t think I would’ve gotten my daughter back. They’re the supports that enable you to work your ass off and stay clean and sober, get a place to live so your child can come back.

Another woman, Stephanie, said:

I think [SEEDs] had almost everything to do with my recovery. [SEEDs] gives you so much more than just structure. They give you a family; they give you hope. It’s structure and stability, but they guide you in a very gentle, kind of loving way, that is, is a way that we all need so badly to feel.

SEEDs also gave some women the knowledge of how to manage daily living. Whereas all of the women felt that SEEDs played an important role in their recovery, several women had critiques of SEEDs. For example, Bridget said that she “didn’t like the rules.” Mary said that although SEEDs “provided a safe environment for me and my kids to come rather than an unsafe situation,” she felt that SEEDs could have “a bad energy” and that “it doesn’t feel like [SEEDs is] helping you with sobriety” like a more intensive treatment facility. Finally, Marianna said she felt that there some things she couldn’t tell other women: “[a] couple girls in the house don’t even know that I am [HIV] positive.”

**Constitutive pattern: Moving away from instability and harnessing self-agency**

From women’s stories, a constitutive pattern emerged that encompasses the four themes. The constitutive pattern, *Moving Away from Instability and Harnessing Self-Agency*, fits each woman’s story. Regardless of whether the women felt that the SEEDs program was perfect for them in all ways possible, all of them felt that that the SEEDs SLHs helped them to find recovery from SUDs and DSV, gain employment, and secure a supportive network. In the SEEDs women’s stories, we heard descriptions of childhood adversities, most commonly abuse and neglect at the hands of caregivers. Across multiple developmental periods, women’s lives were characterized by instability, largely associated with SUDs and DSV. Nevertheless, all women, through sources of intrinsic and extrinsic resilience, harnessed self-agency to create a stable life they felt was worth living.

**Discussion**

Our results shed in-depth light, among women in SEEDs SLHs, on the devastating impacts of fractured foundations in childhood and the pervasiveness of SUDs and DSV. Our findings highlight that childhood victimization, DSV, and SUDs occurred along a complex developmental trajectory rather than as discrete events among SEEDs women. The results provide preliminary data on the potential utility of T-SLHs in promoting recovery among women with co-occurring DSV and SUDs. Fractured foundations may make SLHs like SEEDs particularly helpful to women with DSV and SUDs, since participants note the importance of emotional support; sense of community connection, agency, and empowerment; and validation of emotional pain associated with past traumas in their recovery process. Furthermore, women found it helpful that the SEEDs program provided opportunities to develop job skills, having designated housing for women with children in their custody, and the ability to maintain involvement with the SEEDs community.

Some limitations need to be noted. The sample size was relatively small. Nevertheless, there was evidence of qualitative data saturation (i.e., the collection of additional information would not have provided any new information). There was potential selection bias, such that women who agreed to participate may be more successful in their recovery and/or hold more positive views of SEEDs than women who did not agree to participate. Additionally, analyses were limited to women who self-selected into the SEEDs program; thus, there may be differences among women who choose to enter SEEDs and those who do not. We suggest that future research use more rigorous methodologies (i.e., longitudinal, comparison group) to evaluate SEEDs and other trauma-informed SLHs.

When treating women with histories of SUDs and DSV, it is presumed that treatment outcomes will be more favorable if treatment providers have an understanding of how and why SUDs and DSV co-occur and use this in selecting and tailoring treatment. Our preliminary findings suggest that characteristics unique to T-SLHs (e.g., empowerment-based pathways to sobriety, the opportunity to bring one’s children to a SLH residence, the opportunity to form close relationships with other women at similar yet different places in the SUD recovery and DSV healing process) may be especially impactful in promoting long-term positive outcomes among women with DSV and SUD histories.
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Note

1. The 2.5 hours included the LHC and HPP procedures.

References


