Published in final edited form as:

J Ethn Subst Abuse. 2020 ; 19(4): 659–687. doi:10.1080/15332640.2019.1579141.

Transforming responses: Exploring the treatment of substance-using African-American women

Alexis Jemal¹, Alana Gunn², Christina Inyang³

Alana Gunn: agunn2@uic.edu; Christina Inyang: Christinacinyang@gmail.com

¹Silberman School of Social Work at Hunter College, 2180 3rd Ave, New York, NY 10035

²Department of Criminology, Law, and Justice, University of Illinois at Chicago, 1007 W. Harrison ST, Chicago, IL 60607

³Clarity Treatment Center, LLC, 262 State St., Perth Amboy, NJ 08861

Abstract

This paper explores how intrapersonal and structural oppression may impact treatment and the recovery process of 23 self-identified African-American women with histories of incarceration and substance use. Using a Critical Consciousness (CC) framework, researchers used content-based thematic analysis to systematically code and extract themes and patterns from focus group data to evaluate how marginalizing processes - such as race-based discrimination - impact treatment, the therapeutic relationship and service provision. Results indicate that participants' health and treatment were negatively impacted by oppressive factors, specifically the oppressive process of silencing. The authors discuss research and practice implications.

Keywords

Critical consciousness; African-American; Women; Oppression; Treatment; Silencing

Introduction

Substance use treatment for women has greatly improved over the past several decades (Wisdom, Hoffman, Rechberger, Seim, & Owens, 2009; Simpson et al., 1997). One reason for this improvement is that scholars and service providers have increased attention towards understanding gender-specific treatment differences and the unique set of needs for substance-using men and women. For example, women with substance use problems are more likely than men to have poor self-concepts (e.g., low self-esteem and self-blame) (El-Bassel, Caldeira, Ruglass, & Gilbert, 2009), lifetime histories of trauma and abuse, and higher rates of co-occurring mental health problems (Amaro et al., 2005). The increased prevalence of gender specific treatment programs and strategies have improved consumer retention and engagement (Wisdom et al., 2009; Simpson et al., 1997). Client engagement, defined as the intensity and duration of treatment (Fiorentine, R., Nakashima, J., & Anglin, M. D., 1999), has been associated with positive treatment outcomes (Fiorentine, 2001;

Broome, Flynn, Knight, & Simpson, 2007), such as decreased drug use and criminal behavior and improved psychological functioning and employment attainment (Prendergast, Podus, Chang, & Urada, 2006). Evidence indicates that clients who complete treatment are less likely to relapse during or following treatment (Fiorentine et al., 1999).

However, despite these advances, the field of substance use treatment is still chronically underserving African-American women as demonstrated by persistently low engagement and retention rates in treatment. Studies have shown that only one-third of African-American women with mental disorders use professional services (Jackson et al., 2007), and those with co-occurring mental health and substance use disorders are even less likely to use any professional services (Wells, Klap, Koike, & Sherbourne, 2001). Moreover, compared to their white counterparts, African-American women are at increased risk for unsuccessful treatment completion (Green, Polen, Dickinson, Lynch, & Bennett, 2002). Studies have noted that African-American women may terminate treatment early because their ethnic, cultural, and/or gender needs are ignored (Davis & Ancis, 2012; Neighbors et al., 2007; Vega & Rumbaut, 1991). Given the importance of engagement and treatment completion in positive treatment outcomes, it is imperative to improve rates of treatment engagement and retention for African-American women. One strategy is to tailor treatment to reflect the lived experiences and needs of African-American women (Jones et al., 2015).

Since, substance use treatment interventions lack cultural relevance and are inadequate to meet the specific needs of African-American women (Comas-Díaz & Greene, 1994; Jones & Warner, 2011; Smedley et al., 2003; USDHHS, 2001), there is a need for scholarly investigation of racial and gender experiences and treatment needs in substance abuse services (SAMHSA, 2012). Thus, this study aims to explore the substance abuse treatment experiences of African-American women who have past or current substance use treatment to suggest strategies for incorporating and responding to their lived experience for the development of more culturally responsive substance use treatment practices.

Literature Review

Client Engagement and Treatment Outcomes

When studying the differences in health, treatment utilization, engagement, retention and treatment outcomes between White and non-White populations, some may be tempted to blame individual-level factors (e.g., client motivation), allowing socio-structural factors (e.g., lack of culturally congruent treatment services that do not recognize ethnic, cultural, and/or gender needs) to remain invisible and continue unchallenged (Davis & Ancis, 2012; Neighbors et al., 2007). As a result, low engagement and retention rates for African-American women may be interpreted to suggest that African-American women do not value their recovery. However, treatment providers should consider that the problem is not with the African-American female client, but with the way in which African-American women are treated within treatment facilities. When treatment providers use empathy, establish trust, and provide culture-specific psychoeducation, clients remain in treatment longer (Shonfeld-Ringel, 2001). Those who are engaged in treatment are more likely to report favorable perceptions of their counselors (Kasarabada, Hser, Boles, & Huang, 2002), specifically that their counselors care about their well-being (Meier, Barrowclough, & Donmall, 2005).

Moreover, a positive relationship exists between the quality of counselor-client therapeutic engagement and length of stay in services (Joe, Simpson, & Broome, 1998). Studies have shown that focusing on relational factors (e.g., the therapeutic relationship, relationships between clients) have increased the length of stay of women in drug treatment (Comfort et al., 2003). However, African-American women in substance use treatment may not encounter the necessary rapport building with treatment providers (Wyatt, Carmona, Loeb, & Williams, 2005) or other clients due to perceived racism and/or lack of service provider's cultural competence (Rapp et al., 2007). Thus, disparities in health status between socially-constructed groups (e.g., male-identified/everyone else, White/everyone else) in the U.S. may reflect inequity of treatment rather than individual-level differences between members of different racial groups.

When addressing health problems among marginalized populations, it is important to understand health as "a complex phenomenon interrelated with poverty, violence, and low social capital" (Windsor et al., 2014b, p. 2). Treatment of marginalized populations in isolation from their sociopolitical contexts ignores the influence of oppressive forces on the daily experiences of these individuals (Windsor, Benoit, & Dunlap, 2010). However, substance abuse treatments are implemented without attending to issues of race and culture. For example, service providers may be ill-prepared, and thus, reluctant to engage in discussions about racism as an important context for substance abuse and mental health treatment outcomes (Kurtz, et al., 2008). Expectedly, experiencing racism within service provision may create mistrust, promoting unfavorable perceptions of counselors, and jeopardize the client-worker relationship, which then negatively impacts length of time in treatment, leading to poor outcomes (e.g., criminal behavior, relapse and psychological dysfunction) (Prendergast et al., 2006; Meier et al., 2005). With these ideas in mind, two independent, but related, shortcomings of treatment are: 1) interventions lack cultural relevance and are inadequate to meet the specific needs of African-American women (Comas-Díaz & Greene, 1994; Jones & Warner, 2011) and, 2) service providers lack cultural awareness (Briggs, Briggs, Miller, & Paulson, 2011).

Racial Discrimination and Its Link to Health Outcomes

Marginalization refers to the practice of people being positioned on the margins of a dominant culture based on their gender, race and/or economic class (Kurtz, Nyberg, Van Den Tillaart, & Mills, 2008). Marginalized statuses are a result of oppression. Oppression is systemic supported power and violence against a group of people that manifests in social and cultural practices, norms and formal legal systems (Ho, 2007). Scholars have documented the relationship between oppression and negative impacts on individuals' physical and mental health (Abdulrahim, James, Yamout, & Baker, 2012; Carter, 2007; Williams, Neighbors, & Jackson, 2003; Williams & Mohammed, 2013; Williams & Williams-Morris, 2000). Racial/ethnic discrimination, as a chronic stressor or trauma (Bryant-Davis & Ocampo, 2005; Carter, 2007), can greatly compromise psychological and physical health and well-being (Williams et al., 2003; Franklin, Boyd-Franklin, & Kelly, 2006) by arousing physiological responses such as anger, frustration, and helplessness. Extensive evidence of the harmful impact of toxic stress provides insight into causal mechanisms linking adversity (e.g., racial discrimination) to impairments in biopsychosocial

functioning (Barr, 2014; Carter, 2007; Shonkoff & Garner, 2012) such that negative, self-destructive, and maladaptive coping styles may develop to manage toxic stress (Windsor, Benoit, & Dunlap, 2010). In short, oppression makes people sick. As a result, oppressed populations might turn to alcohol and other drugs to anesthetize the mind from the psychological pain of discrimination, oppression, poverty, and hopelessness. The use of substances may intersect with other high-risk behaviors that may lead a person to substance use treatment.

The interpersonal and structural failures of the health care system compound the daily lived experience of occupying marginalized statuses. Researchers report that minority health care seekers have problems accessing services, experience lower quality of care, and must contend with the oppressive beliefs and behaviors of health care providers (Mead et al., 2008). Studies have documented how health care professionals have shown prejudice against women from non-white ethnic groups, judging them on factors such as their race, ethnicity, or socioeconomic status (Kurtz et al., 2008; Alexander, 2004; Johnson et al., 2004) and have provided discriminatory treatment in mental health and substance abuse services (Davis & Ancis, 2012; Ehrmin, 2005). The prejudice and discriminatory treatment erect substantial barriers to adequate mental health and substance use service provision (Wells, Klap, Koike & Sherbourne, 2001). For African-American women, oppression presents a triple-edged sword leading to poor health: oppression-related stressors, lack of healthy available options to manage oppression-related stressors; and inadequate treatment.

Silencing.—A major tool of the continuous oppression, trauma and disempowerment of African-American women is the silencing of African-American women's voices. "Silencing" is a type of oppression and structural and interpersonal violence that prevents marginalized groups from fully engaging in self-assertion and expression (Houston & Kramarae, 1991). As structural violence, it is "enacted through political, economic and social structures that are ignorant of, or that disregard, certain values and beliefs" (Kurtz, 2008, p. 55). As interpersonal violence, it is the disallowance of one's primordial right to speak (Freire, 2000; Quintana & Segura-Herrera, 2003). Examples of destructive forms of silencing that women experience, include: namelessness, denial, secrets, taboo subjects, omission, veiling, fragmentation, and lying (Houston & Kramarae, 1991, p. 388). Unfortunately, this silencing may cause African-American women to set aside their health concerns or delay seeking health services and treatment to avoid racist interactions. These decisions subsequently endanger African-American women's personal health and—as African-American women tend to be the household decision-makers—the health of their families (Kurtz, 2008).

Due to intersecting marginalized, racialized and gender statuses, African-American women face heightened experiences of violence that are rooted in complex historical, systemic, structural, interpersonal and intrapersonal racial stressors (Gunn, Sacks, Jemal, 2016; Jones et al., 2015; Richie, 2016). Past exposure to traumatic events, harsh life circumstances, social vulnerabilities and co-occurring mental health disorders have been linked to decreased treatment completion and engagement (Comfort, Loverro, & Kaltenbach, 2000). Although some studies have examined mental health and substance abuse barriers to treatment among African-American women, few have explored their experiences and perceptions of

discrimination and racism when receiving treatment (Jones et al., 2015). Thus, there is a critical need to consider racialized and gendered experiences of oppression when developing and implementing substance use treatment (Ehrmin, 2005; Meyer, Springer & Altice, 2011; Wallen, 1992; Weiss, Kung, & Pearson, 2003). Yet, scant “attention has been paid to cultural variations that may have important implications for strengthening service provision for African-American women” (Jones, et al., 2015, p. 69). An investigation into African-American women’s treatment experiences, that may involve racial oppression, will allow researchers and clinicians to develop culturally relevant interventions to meet the specific needs of this population that will improve treatment engagement and retention strategies, and ultimately, treatment outcomes. As such, this study aims to examine the treatment of substance using African-American women by exploring the perspectives of African-American women on how marginalization and oppression potentially shape their substance use treatment experiences. Such inquiry will suggest strategies for incorporating the lived experience in the development of more culturally attuned treatment practices for substance-using African-American women.

Methods

Design

The original mixed methods study, from which this analysis emerges, was designed by the lead researcher (first author) to explore the development of a future Critical Consciousness (CC) health intervention to reduce Black women’s risks of HIV/STI exposure and problem drug use. As part of the original study, the research team employed grounded theory methods to explore how being an African-American woman affects health (e.g., one’s substance use, HIV/STI risk behaviors). However, through this inquiry, a theme emerged regarding African-American women’s treatment experiences, whether treatment experiences have been affected by oppression; and, how these treatment experiences shape ability to navigate healthy responses and substance use recovery.

Sample

Self-identified African-American women who received substance abuse treatment services in a city in the northeastern region of the United States were recruited via flyers, word-of-mouth, and service provider referrals for a study seeking to explore how being an African-American woman affected health, specifically substance use and HIV/STI risk behaviors. Eligibility criteria included: (1) age 18 and over; (2) self-identified as African-American; (3) had current or past experiences of problematic substance use; and, (4) were engaged or had engaged in substance use treatment services.

Three focus groups consisting of six to nine participants, for a total of 23 participants, were conducted between February 2016 and April 2016, and were held at a community-based organization site that offered substance abuse, mental health, and HIV services. As shown in Table 1 below, study participants’ ages ranged from 21 to 62, with an average age of 44. Approximately 12% (4 out of 33¹) of the sample used drugs within the last three months and 25% (8 out of 33) of the study sample had been diagnosed with a mental health disorder.

Procedures

The research team consisted of two PhD-level investigators (first and second author) and a graduate research assistant (third author). The first and second authors were trained in qualitative research methods by their respective doctoral programs; participation in research trainings through a research fellowship for early career investigators; and as co-researchers on other research projects under mentorship of senior investigators. The third author received general research training from her MSW program and several hours of training from the first author regarding qualitative data collection and analysis.

The study included three, two-hour focus groups, co-facilitated by one or two PhD level researchers (first and second authors) and one graduate research assistant (third author). All participants provided informed consent and were compensated \$25.00 for their participation. Focus groups were audio-recorded and transcribed. Transcriptions were uploaded to Dedoose for analysis. Using a grounded theory approach (Corbin & Strauss, 1990; Glaser & Strauss, 1967), focus group scripts - developed through review of the literature and processing sessions with research team members (Burrow-Sanchez, Martinez, Hops, & Wrona, 2011; Krueger & Casey, 2009; Morgan, 1997) - were used to explore participants' thoughts, feelings, and beliefs regarding substance abuse services with the purpose of informing a conceptual model of oppressive factors that affect treatment experiences for African-American women. Across focus groups, women were asked questions about how being an African-American woman affects their mental, physical, and emotional health, specifically in relation to their substance use and HIV/STI risk behavior. Participants in each focus group discussed their substance abuse treatment experiences. Two open-ended questions were used to follow-up:

1. Tell us your thoughts about your substance use treatment experiences as an African-American woman?
2. If in any ways, how has your race and/or gender affected your substance use treatment experiences?

Data Analysis—Data analysis utilized a constructivist grounded theory (CGT), as a culturally competent research approach, to highlight the lived experiences of consumers and the socially-constructed nature of one's reality. This type of inquiry seeks to answer questions of how social and psychological experience is co-created and interpreted (Denzin & Lincoln, 2005) and how social, political, economic, and psychological factors compose the holistic experience of African-American women (Jones, et al., 2015). Tillman (2002, p.5) describes these approaches as “interpretive paradigms that offer greater possibilities for the use of alternative frameworks, co-constructions of multiple realities and experiences, and knowledge that can lead to improved outcomes for African Americans.” Grounded theory and culturally competent research approaches were used in this study to provide a richer

¹The larger study was a mixed methods study in which participants first responded to an online survey that collected demographics information and then, on a later date, attended focus groups; however, not all participants who completed the survey elected to attend the focus groups. Thus, the discrepancy between the number of participants who completed the survey (N=33) and the number of participants who attended focus groups (N=23).

understanding of the multiple factors that impact substance use treatment for African-American women.

With CGT, knowledge is not only generated from the data shared by respondents, but by the researcher's pre-existing knowledge, understanding of the social phenomenon and previous research experiences (Charmaz, 2006). From the questions developed to the presentation of data findings, all research, regardless of method, is shaped by the investigators engaged in the research process (Alcoff, 1991; Hardesty & Gunn, 2017; Iphofen & Tolich, 2018). The researchers and authors are African-American women who collectively have an educational and professional background in social work and criminology and have expertise in substance use treatment with African-American women, the etiology of female crime, stigma, critical consciousness, and intervention research. To promote analytic credibility, the authors engaged in ongoing self-reflexivity, sought critical feedback from senior mentors, and reflexively drafted memos throughout the study (Charmaz, 2006).

Data analysis followed an iterative and systematic process, which includes: initial coding, continuous memo writing, focused coding, summarizing primary themes, and theoretical coding (Charmaz, 2006; Radin, Kutz, La Marr, Vendiola, Vendiola, Wilbur, Donovan, 2015). This study used a data-driven inductive approach and a deductive a priori template of codes, involving the use of preexisting research to create a grounding orientation to the social phenomenon, while allowing themes to directly emerge from the data to expand upon previous understanding (Crabtree & Miller, 1999). Thus, all three co-authors worked from a pre-existing list of potential codes derived from the literature on oppression, trauma and health risks within the African-American community. Examples of some pre-existing codes include: self-love, self-esteem, and caregiving. With that guide, the authors then inductively immersed themselves in the data to illuminate instances that confirmed the a priori codes, as well as instances where they identified nuances and new emerging codes that extended or disconfirmed the pre-existing codes.

Data was also analyzed using content-based thematic analysis; this involved an iterative process of reviewing and line-by-line coding (Strauss & Corbin, 1994) the transcribed data (Braun & Clarke, 2014; Patton, 2005) to generate additional codes related to oppression, discrimination and health. To enhance the validity of the initial thematic analysis, the research team read the transcripts and, using an open-coding approach, co-coded independently by identifying themes from the data and attaching the codes to corresponding segments of text (Boyatzis, 1998). Examples of some open codes include: identity, abuse, broken and silencing. The research team reviewed the open coding using a constant comparison method (Glaser, 2002; Strauss & Corbin, 1994) and discussed any coding differences until they reached consensus. When differences were identified the researchers sought a consensus that resulted in refining codes, collapsing redundant codes, or replacing codes with codes more depictive of the themes in the data. This verification of interpretations is one approach used to improve reliability of findings - that different researchers would produce similar findings from the data - and validity of findings - that the analysis accurately represents the views of participants (Franklin & Ballan, 2001; Jones et al., 2015). The final analysis step involved theoretical coding in which the team collectively developed and evaluated proposed relationships among the codes and discussed how themes

were interrelated and whether or not the codes adequately represented the data across focus groups (Charmaz, 2006; Glaser, 1992); for example, how one's exposure to trauma and violence may relate to how they feel about themselves (i.e., self-shaming, internalized stigma). Relationships among themes and their subthemes served as the basis for drawing conclusions about the experiences of the women in this study and how those factors shaped their treatment experience.

Upon completion of the coding process, the research team met with another group from the target population to review the findings. This process of peer debriefing and member checking was used to validate the research team's interpretation of the data, and thus, to promote rigor and trustworthiness (Lincoln & Guba, 1985; Padgett, 2016). These efforts may promote rigor in qualitative research in ways more critical than traditional strategies of seeking agreement among "judges" as in with inter-rater reliability techniques, which may not always complement the underpinnings of qualitative research and the exploration of intersubjective realities (Grayson, 2001; Lietz & Zayes, 2010). The members reviewed the themes and reported that the themes resonated with their treatment experiences as African-American women.

Findings

When discussing their substance use treatment experiences, participants within the three focus groups described similar experiences. Thematic analysis of the focus groups suggested that the participants had perceptions and experiences related to service delivery that were impacted by race-based oppression. During each focus group, participants shared their experiences of isolation, discrimination, pain, and anger; many showed their support and agreement through verbal and non-verbal modes of communication. For some members, their silence seemed to indicate that they recognized their personal story being told in someone else's voice.

The following four themes emerged from the analysis: (1) Perceived differential treatment towards clients of different racial background, (2) Identification of intrapersonal oppression and the relationship between intrapersonal oppression and oppressive treatment, (3) Silencing practices by treatment providers, acceptance of the status quo, and the impact on health, and (4) The need for critical consciousness development. In discussing substance abuse services, participants described experiences they felt were unique to being African-American women in treatment.

Theme 1: Perceived differential treatment towards clients of different racial background.

Participants discussed institutional racism more broadly. They focused on the negative perceptions of African-American women that are prevalent within society, stigma, being made to feel inferior, and the blatant disregard for their voice. In response to a question about how people perceive black women, Ronnie² stated: "Black women are all – black women are angry, bitter, like ghetto, or they use the word ghetto, ratchet."

²All names are fictitious to protect the identity and confidentiality of respondents.

Anika: It [racism] is so prevalent and just because of the stigma because of the inequality of – in all areas... especially in organizations or institutions. You know like we don't have a voice, like we're looked upon as if... we don't know what we're talking about. You know, like to make us feel inferior...

After speaking in general terms, the participants focused on their substance use treatment experiences. The women shared narratives of being treated differently than the White clients in the treatment program. Some of the women in the study described encounters of racism, where their race determined the receipt of differential treatment.

Brenda: Like I was in [name of treatment facility] and versus to the way the White people got treated – the White girls and the Black girls got treated, it was totally different. Like the White girls could do some shit and they'd get away with it, but let one of us do it and it was – you can see the division even in [treatment] programs when you go and you're supposed to be there to help yourself and it's supposed to be that we all get treated equally, but it is not. We got treated different than the White girls did.

Another participant, Candice, recounted similar experiences and most participants confirmed her account.

Candice: Like [name] said, I went through [name of treatment facility] and like I went through part one and part two and when I first came in - I think I was the only Black girl. I was big, like real big, like fleshy when I just got out of jail...And I could walk by past somebody and not say nothing, and then be conflicted [a specific encounter technique used at the facility] the next day for aggressively looking at somebody, you know what I mean? And I'm like, "*What did I do?*" And they're [the White clients] like very intimidated by you, and I'm like, "*What did I do? What did I do?*"

Danielle: I got that a lot.

Candice: Like how am I intimidating – is it because I'm Black, like why are you so afraid of me? I'm a freaking – like I'm a big teddy bear, like I wouldn't hurt a fly unless you pushed me to, you know what I'm saying? Like I don't – that's just not like – like again, like I was the aggressive one. If I said something to somebody again I was conflicted because I was being mean, and I said something, and I hurt somebody's feelings because I was aggressive. And –

Ebony: They [White clients] could say whatever they want.

Candice: Exactly and like –They could say whatever they want but the moment you say something to them – Say something back to them, I'm angry, I'm bitter –

Ebony: Exactly, exactly.

Danielle: I'm this or I'm that, what you just said

Many of the women discussed the treatment facility's policy of requiring its residents to obtain employment. However, as they discussed the various opportunities that the treatment facility provided, they noticed a pattern.

Felicia: They wouldn't try to get us into a restaurant. We had to go to the warehouse because they won't help us get into the restaurant. We could go to the factory, you know, because they [the service providers] didn't help us, but they helped all the little Caucasian ladies in the house. And I think that was – you know a racist thing.

Participants' narratives identified common experiences of being hyper-visible for negative reasons and, in response, treated as inferior within the treatment setting. They received messages that reinforced racialized stereotypes (e.g., that black people are scary and aggressive), and, specifically that black women are angry. The differential treatment created conflict within the women about whether their authentic voice, presence, and feelings are innately problematic. The participants seemed to perceive that the way they were treated within the treatment environment created a sense of inferiority by reinforcing stereotypical views of African-American women. They also experienced and/or witnessed the staff responding to clients that provided disproportionate levels of support based on race.

Theme 2: Identification of intrapersonal oppression and the relationship between intrapersonal oppression and oppressive treatment.

Another theme that seemed to emerge from the data was the identification of intrapersonal oppression (also known as internalized oppression), and the connection between intrapersonal oppression and oppressive treatment of the African-American consumers. Here, intrapersonal oppression is the verbal or behavioral expression of the socialization process that creates belief(s) in negative messages or stereotypes about a group to which one belongs that comprises a salient identity (i.e., race, ethnicity, gender, sexuality) for that person. Intrapersonal oppression can often be identified when group members blame other group members for circumstances in ways that align with or reinforce negative societal messages about group members.

Joy: I live in the – you know, I moved out the halfway house. I live in a basement. I've got my own basement apartment. The upstairs, I come home, with my basement is flooded because you too trifling and too lazy - but you're a black woman, you in the household all day long, you don't do nothing, you don't go to school, you don't work, you do nothing for yourself. But you want to argue all night. You want to get drunk, you want to get high, and just keep confusion going. I had to go upstairs and knock on the door like, what's wrong with you. I mean, you see a puddle of water on the floor. When I went up there, the water was soaked on the floor - like you seen the shit - why you can't get it. Just mop it up, but... the person we become. You see [Black] women don't even care about them self anymore.

Some of the participants in the focus groups were peer counselors in their agencies.

Although they acknowledged the presence of the reported oppressive practices by the consumers, they seemed to lack awareness of how they had been socialized into the oppressor role. A service provider who was also an African-American woman in recovery

explained how she counsels her African-American female clients to speak to her about any racial issues, specifically when issues involved tension with the White clients, rather than confronting the White client. The service provider stated:

Grace: I feel this -- their [the African American female clients'] feelings are valid, don't get me wrong, but I just try to tell my women, "*come down and give it to me,*" you know what I mean? It takes time, you know, nobody is perfect; but, I tell them that, "*Don't be labeled as that angry Black sister.*"

The quotes exemplify the socialization process which suggests that external oppression can eventually affect the intrapersonal level. Both respondents ascribed to the stereotypical characterization of African-American women. Although, the responses that stemmed from the intrapersonal oppression were different, both responses could be described as oppressive. For example, Joy treated her neighbor according to her stereotypical characterization, speaking to the neighbor in a caustic manner. The service provider, who is an African-American woman in recovery, invoked the angry Black woman stereotype. Perhaps, in wanting to be helpful, the service provider advises the Black woman how to navigate the institution's boundaries of inequity. Knowing that African-American women are treated differently, from having experienced similar treatment when she went through the program, she understands that African-American women, unlike the White clients, can be violated and sent back to prison for expressing their anger. Thus, by offering a private space for the African-American woman to express her feelings safely, she is trying to protect and help, but simultaneously silencing and reinforcing stereotypes of African-American women. In her efforts to help her client avoid being negatively labeled, she gives credibility to the stereotypes as opposed to resisting the oppression and letting the African-American women speak their truths. Her actions silence the women, reinforce the status quo, and create a space of judgement and labeling, bolstering the message that their feelings are not valid; and, as an extension, they are invisible.

Theme 3: Silencing practices by treatment providers, acceptance of the status quo, and the impact on health.

The participants provided examples of the ways in which they were silenced by treatment provider rules. Marie stated:

When I was in a program, when I talked to [name of service provider], I cursed and expressed myself. I like to curse. I've been cursing all my life. My mother cursed a lot. That was her way of showing us she loved us. The first thing [name of service provider] said, "You all can't curse." I said, "Why? I'm not going to be able to express myself. I wouldn't be able to tell my story."

The participants described how their voices are often silenced and how this can cause them to either delay seeking needed health advice or accept the status quo. One participant, Heather, stated: "I think it's traumatizing...It plays a big impact on who we become as women, you know, not being able to share, voice our pains; so, I'm not to talk about it, but maybe I need an outlet to talk about it, so I can get through it...and they [the issues] are not dealt with." Another participant, Imani, stated, "Sometime, you just be like, okay-Like, you

know I'm just going to end this right here. I'm not going to say nothing; just forget about it, we're not getting nowhere. You know what I'm saying?"

The women's experiences stress the importance and power of voice. Several women took issue with being instructed to stay silent or to speak in a certain manner. The terminology used to keep silent was "hold your gut." Candice stated: "And now I've got to hold my gut? Why do I have to hold my gut and bite my tongue? Because like, I know how to say things nicely... But the moment I do that I'm angry, aggressive, bitter, you know?" A common theme was that the women experienced oppression as a strong stressor or trauma and their emotional response to that trauma (whether sadness, frustration or anger) was met with punishment or silencing. Several women's responses connected the experience of inferior treatment and being silenced with having a negative impact on their health and treatment experience.

Joy: I don't know if it's intimidation, or they're getting paid more money for them [white women in the halfway house]. But it's – they are treated so much differently than we are and it's sad. It's sad and – you're somewhere that you're supposed to be getting help to build back up your self-esteem, to do things in a positive way. And it's just like something negative will come up, most of the time, I just stayed in my room and if I came out of my room, if I – if I might have looked in that direction and you were sitting there, "*Oh, she's looking at me in a threatening way.*" How am I looking at you in a threatening way? It was like a constant dagger, like they just kept coming for me; and it got to the point where I had to like sit down ... or stand my ground. Like I want out of this half way - how is this – this is not benefiting me. It's not giving me what I need, and it's more stress than anything, and I'm diabetic so I would get sick, you know? It was just too much to deal with. Then I'm the type that I get attitudes and when I get angry sometimes I don't know how to express myself the proper way, and I say what is on my mind. And it escalates into something that it's not, when the problem is with that person but you just...

This type of oppressive treatment may impede the substance use treatment and recovery process. Participants discussed how a lack of an outlet for the emotional and psychological pain they experienced lead them to use substances.

Kendra: But it goes back to just being broken, being hurt and not having an outlet to get rid of that pain. It plays a big impact on who we become as women you know not being able to share, voice our pains... so I'm not to talk about it...but maybe I need an outlet to talk about it, so I can get through it. Not having nobody that you can trust or talk to... That's why a lot of people turn to drugs, a lot of people turn to sex, a lot of people turn to different addictions to release what they're really feeling instead of just getting [it] out in the open. Because we're so used to being told that we can't talk about it. But it goes back to just being broken, being hurt and not having an outlet to get rid of that pain.

These quotes seem to outline a pathway from experiencing inferior treatment to feeling silenced by the social context within treatment, leading to a negative impact on physical and mental health. The consequent impact on women's health shapes their use of substances to numb the pain that cannot be voiced. The women seem to perceive that stereotypic beliefs

are imposed upon them. Whether they try to avoid the labels or not, these characterizations shape their treatment engagement and how they navigate their treatment experience, including relating to other clients and their service providers, and whether they decide to continue treatment. They are told that they cannot divulge their pain. This message is reinforced by unhealthy treatment spaces. Thus, it seems that the women do not feel safe in treatment environments meant to create safety, and they cannot trust their service providers, with whom they are supposed to learn how to navigate their recovery. As a result, the women link the inability to have an outlet or a non-judgmental and trusting space to release their pain to active substance use and other self-destructive behaviors. The treatment experience, when tainted with oppression, is psychologically, emotionally, and physically draining – and possibly another pathway to substance use.

Theme 4: The need for critical consciousness development.

By the end of each focus group, all the participants seemed to value the discussion of shared experiences. The participants noted that the focus group discussion that identified oppressive elements within their shared narratives was helpful and most would like the opportunity to continue similar discussions and to organize action against the oppressive realities in their lives.

Jocelynn: I think the women that are willing to stand up and get together, just start with them. At the end, we need to get together like th[is], make it a regular meeting in every week that we come to, everybody present ideas together, you know, and see what we're going to put together a fight for this week. We can help each other, we just don't really want to get together and do it like, we're so busy, so into social media and everything else. Like everybody's in a rush, where are we going, at the end of the day?

The participants noted that critical consciousness raising discussions in which they focused on issues of oppression would be helpful because the discussion was an “eye-opener,” in that “some people can learn something” “just by listening” and the discussions would be “a way to voice their own opinions.” Candice noted that the discussions would be “no judgment, there's no right or wrong answer. You're just talking from your heart and from what you feel within, you know.” All agreed that such discussions would build relationships, community and increase intimacy and self-esteem among group members which would facilitate stress management and provide appropriate safe spaces and outlets for expression of emotion, particularly, anger. More specifically, discussions and practices grounded in critical consciousness theory would “unite them, bring them together” and “and teach them how to talk to each other.” When discussing oppression, Robyn noted:

“It's something that has not really been brought to the table. It's not really talked about. And it takes women in the community to come together in this kind of forum to communicate and discuss some things, to bring that unity to build us because like [name] said, we're strong women. We've been through a whole lot of trials and tribulations and we still stand. We have a voice.

Ebony: That's right.

Joy: We're not always heard because it -- we have to come together as a whole, because sometimes things don't get done when one tends to complain...let this be a topic where we could come together more and do some more things together as women, as Black women.

The participants recounted harmful, racialized differential treatment. The racism experienced at the intrapersonal, interpersonal and institutional levels created a treatment environment in which the women were characterized as angry and/or silenced. The oppressive treatment experienced within substance use treatment settings could lead to disengagement or early termination, and thus, poor treatment outcomes, including substance use. Without using the term "critical consciousness," the participants identified the need for critical consciousness development. They expressed the importance of supportive relationships, collective action, building upon localized knowledge, reclaiming their voices, and affirming their identity as separate from stereotypical characterizations.

Discussion

This study highlights how oppressive organizational and clinical practices within substance use treatment promotes acts of structural and interpersonal violence, including racism, discrimination and silencing. These acts are evidenced in the women's differential treatment and the difficulties that arise when they try to communicate their frustrations and needs. The focus groups revealed themes consistent with other research, particularly that the women experienced emotional and psychological injury from being treated as inferior persons and how issues of prejudice and discrimination impact treatment of substance-using African-American women (Glass, 2012).

Exploring the oppression-related barriers in treatment that substance-using African-American women may encounter highlights the belief that "all Americans have been exposed to the Cultural Ethnocentric School of thought" - which espouses that African-American people are pathological and dysfunctional - "and are predisposed (albeit sometimes unconsciously) to view African-Americans in a negative or pejorative manner" (Roberts, Jackson, & Carlton-Laney, 2000, p. 907). Unless constantly challenged, these conscious and unconscious beliefs will manifest in discriminatory practice, however slight or unintentional. African-American women who are addicted to drugs are bombarded daily, along with the rest of America, with the controlling images (e.g., mammy, matriarch, welfare mother or queen, Jezebel, angry Black woman) (Roberts et al., 2000). The manifestations of these images and stereotypes compound the difficulty of recovery processes for women who are already suffering with internal (i.e., shame, guilt, etc.) as well as external barriers to acquiring a positive image for themselves (Roberts et al., 2000). These types of racist and discriminatory perceptions of African-American women are linked to their continued oppression and poor health status (Kurtz et al., 2008). Similar women in other studies (e.g., Alexander, 2004; Johnson et al., 2004) that have documented prejudice and discriminatory treatment by service providers, these clients described feeling inferior, unimportant and disregarded: when treated negatively and differently than the white women; when perceived as "angry," "bitter," or "intimidating"; and, when told to "hold their gut". This type of treatment seemed to cause psychological and emotional injury.

Another form of interpersonal and structural violence experienced by the women in this study included silencing of their voices – i.e., when a person speaks, and their concerns are ignored or disregarded (Kurtz et al., 2008). Those in the listener's role (including the counselors, other staff, White clients) denied, negated, and rendered irrelevant the African-American women's experiences or redefined their experiences in terms of the majority race (e.g., white) or sex/gender (e.g., male/man) (Dodgson & Struthers, 2005). For example, the use of the term "confrontational" as a criticism of the African-American woman's speaking style sends the message to African-American women to speak like a White woman or you won't be heard, or perhaps, allowed to speak at all (Houston & Kramarae, 1991). This idea is comparable to the participants' experiences that insinuated the way in which an African-American woman should look at a White woman to not be "intimidating," when the unaddressed issue is racism.

In our personal lives also, the power to silence another is not simply the power to *prevent* her talk; it is also the power to *shape and control* her talk, to restrict the things that she may talk about and the ways she is permitted to express them, to permit her to speak, but to suppress her authentic voice. (Houston & Kramarae, 1991, p. 389).

The findings extend this idea to include to *whom* a person is permitted to speak. The women were advised to refrain from discussing issues of racism with their White counterparts and, when they did speak up, they were confronted ("conflicted) in a group setting for being aggressive. The little power that the African-American women had to use their voice was constantly challenged and contested (Kurtz et al., 2008). When individuals are prevented from speaking out about their victimization, pain, experience, truth, for example, they are pushed further to the margins of society, where they face additional racism and discrimination (Kurtz et al., 2008). Thus, oppression in the form of silencing in and of itself can be traumatic and can place the person at higher risk of experiencing more trauma and oppression, creating a painful cycle of victimization.

Women whose abuse has been ignored, disregarded, or downplayed (e.g., you're being too sensitive) when voiced may feel silenced and blamed for their victimization and may be more likely to internalize their pain (Moe, 2007). Thus, it makes sense that African-American women are silenced when there is internalized racism in their own families and communities (Houston & Kramarae, 1991). Perhaps past oppressive abuse experienced by the counselors contributed to the internalization of the "angry Black woman" stereotype, explaining the counselors' attitude and behavior toward their African-American clients, following the principle: hurt people hurt people. Aligned with this principle, considerable research links forced silence about specific types of trauma (historical or otherwise) to diverse psychological consequences (Liem et al., 2007). "Psychologists have widely acknowledged the potentially harmful effects of failure to disclose traumatic experiences, including compromised physical and mental health (Lepore & Smyth, 2002), disruption of social networks and social adjustment (Pennebaker & Chung, 2006), and diminished cognitive capacity (Klein & Boals, 2001)" (Liem, 2007, p. 155). The women's statements aligned with these ideas as they noted that the pain of being silenced led to substance use and risky sex as outlets for emotional and psychological unexpressed pain. Moreover, forced

or involuntary silence impedes the healing and recovery process and serves as a mechanism for the transmission of interpersonal oppression and trauma (Liem, 2007). Importantly, these experiences of racism and discrimination affected these women at times when they were most vulnerable and least able to protect themselves (Kurtz, 2008). In response, several participants noted that the services that should facilitate their recovery, were making their lives more difficult; and, for protection, disengaged from treatment services by barricading self in room and/or wanted to exit the program. Kerrison (2017) indicates that African-American participants have more negative experiences in treatment than their White counterparts perhaps because treatment models do not consider how structural oppression and discrimination disproportionately shape the lives of African-American substance users. African-American women must negotiate health care services that are aimed at, and delivered by, the Western culture, where their “Blackness” labels them as “Other” (Kurtz et al., 2008). Unequal power relations can lead to oppressive interactions that silence women’s voices and can decrease their “self-esteem [and] autonomy and thereby restrict choice” (Wittmann-Price, 2004, p. 441). The lack of culturally congruent treatment services that are inadequate to meet the specific needs of African-American women (Comas-Díaz & Greene, 1994; Jones & Warner, 2011) may be the cause of underutilization and diminished treatment engagement and retention by African-American women.

Limitations

The present study provided rich descriptions of the treatment experiences of the women who participated in the focus groups. While focus groups are an effective data collection strategy to observe individuals’ exchange of ideas, this study’s findings are limited. For one, there may be potential concerns of confidentiality. While the first author extensively communicated expectations of confidentiality within the group to create a safe, non-judgmental space, there is the possibility that group members did not disclose due to privacy concerns. Many of the women attended treatment groups together; thus, this level of familiarity may have complicated the sense of being able to disclose and remain anonymous. Moreover, the study may be limited in its findings due to the convenience sample nature in which the participants were recruited. Participants were self-selecting, and thus, may have specific experiences and characteristics that are not indicative of experiences of other African-American women with substance use histories. Additionally, this sample represents those receptive to care rather than those who are unwilling or disengaged. Lastly, the participants’ experiences are not generalizable and may not be indicative of treatment in facilities that were not represented. Despite these limitations, the findings highlight the challenges faced by a marginalized population navigating various oppressions within a treatment context and underscore the importance of recognizing how issues of racism and other oppressions influence the treatment experience for African-American women in ways that have significant implications for promoting racially-sensitive, culturally-responsive service provision.

Implications and Future Research

This study demonstrates a need for urgent action to end the perpetual cycle that supports such violence that may lead to early termination of treatment services, substantiates the need for more culturally-responsive treatment modalities, and suggests several practice and

research implications for future work. Drug treatment programs should adhere to the NASW Code of Ethics – counselors (regardless of culture, race, gender) should make every effort to be sensitive to the cultural and gender needs of the client. Although social workers follow ethical standards which include a standard of cultural competency, many may be unaware of how their practices and interactions with clients may unintentionally demonstrate discriminatory attitudes (Kurtz et al., 2008; Johnson et al., 2004). For instance, service providers with a minimal understanding of historical anti-Black policies and practices are less able to contextualize how these experiences may impact current attitudes, behaviors and health practices (Kurtz et al., 2008). “This lack of awareness may be due to the fact that the concept of cultural safety—which acknowledges how issues of racism and discrimination can affect interactions between patients and health care professionals—is not generally considered a priority within the post-colonial health care education system (Smye, Rameka & Willis, 2006)” (Kurtz, 2008, p. 59). Health care professionals, including social workers and substance use treatment providers, working with African-American women would benefit from an increased awareness of the lived experiences of this marginalized group. Clinicians, even those who are growing in their own cultural sensitivity, must continue to unpack and challenge their own stereotypical thinking throughout their personal and professional lives (Dovidio, Kawakami, & Gaertner, 2000). With such an understanding and awareness, these professionals would be more apt to listen to, and less likely to silence, their clients. This, in turn, could facilitate safe spaces for people to share their voices. Program directors should ensure that their workers are demonstrating cultural sensitivity through deeper attunement to the complex gendered and cultural needs of marginalized women. In addition, service providers need to be equipped with the tools to execute culturally competent services. Thus, education programs should make cultural education available to service providers and integrate cultural safety concepts into educational curricula across the professional health disciplines and throughout community organizations and agencies. The academy can add these ideas to syllabi and requisite curricula (Roberts et al., 2000). Moreover, cultural sensitivity must be embedded within the treatment model.

The development and testing of interventions, education, methods and strategies grounded in critical consciousness (CC) theory - one’s awareness of and action against oppressive realities (Freire, 2000) - may address the disempowerment of clients with enforced hierarchies and conflicting program norms that promote silencing and devaluation (Jemal, 2017; Jemal, 2018; Jemal & Bussey, 2018).). Critical consciousness-informed spaces create contexts for hearing and honoring, rather than silencing and discounting, another’s personal lived experiences. Critical consciousness development helps marginalized populations uncover and unpack the dilemmas that may undergird the reasons they are in treatment, while simultaneously engaging participants in dialogue, breaking the silence, and generating agency over the content and the way in which one chooses to share their authentic voice.

Interventions grounded in CC theory with African-American populations have sought to increase understanding of the societal factors that perpetuate poverty, unemployment and low levels of social capital (Campbell & MacPhail, 2002) and to act against these oppressive forces (Keslo et al., 2014). Pilot data(successive cohort design using pre- and post-tests, N=56), testing *Community Wise*, a 12-week intervention that applied CC to help offenders cope with and overcome structural (e.g., lack of opportunity, discrimination) and

intrapersonal (e.g., beliefs of inferiority, misplaced anger) oppression, indicated significantly higher critical thinking and significantly lower psychological distress, cigarette smoking, illicit drug use and re-arrest (Windsor et al., 2014a; Windsor et al., 2014b). The *Community Wise* study provides some evidence that a greater understanding of discrimination and oppression to promote social change may improve substance use outcomes (Windsor et al., 2014a). Moreover, CC develops awareness of oppressive, socially transmitted, cultural messages that have infiltrated individuals' belief systems and advance risky behaviors (Harper et al., 2016). An intervention informed by CC could serve as a culturally-affirming vehicle for emotional expression, community building and social support which have been linked to improved health outcomes (Campbell & MacPhail, 2002; Windsor et al., 2014a; Windsor et al., 2014b).

Service provider training, grounded in CC development incorporating an awareness of oppression as structural violence (Jemal, 2017a) would allow clinicians to challenge their own biases and develop the skills to incorporate discussions of oppression, structural violence and racism into theoretical paradigms, transforming the taboo status of these discussions to necessary for competent treatment provision. Moreover, Covington et al., (2008) have emphasized the importance and impact that trauma-informed, gender-specific, recovery-oriented services can have for women with histories of substance use disorders. Trauma-informed interventions could integrate CC to address the trauma caused by oppression.

Lastly, since limited research is available on interventions geared toward ameliorating the effects of trauma related stress stemming from oppressive experiences impacting women from ethnic/racial minority groups (Amaro et al., 2005; Wisdom et al., 2009), the development of anti-oppressive, trauma-informed interventions that incorporate critical consciousness theory should utilize critical participatory action research (CPAR) as it may be the only ethical approach for intervention development with marginalized or underprivileged communities (Hatcher et al., 2011). Unfortunately, the development of evidenced-based recommendations to improve access and utilization has been impeded by the disparities in racial and ethnic minority representation in treatment and intervention studies (Neighbors et al., 2007). "Thus, any bearing that race and culture may have on the manifestation, perception, recognition, and salience of psychosocial symptoms and substance abuse risk factors continues to be overlooked in service utilization research" (Jones, 2015, p. 609). For example, studies have suggested that a culturally competent adaptation to address cultural incompetence of service providers may include pairing clients with African-American female counselors. However, including the input of the African-American women from this study may indicate that African-American counselors who have not addressed their own intrapersonal oppression may not provide culturally competent treatment. Interventions developed through collaborative processes with the target population should create culturally-congruent interventions that reflect the lived realities and are more meaningful and responsive to the needs of African-American women; which may improve engagement and retention rates (Williams, 1999). Research has shown that CPAR fosters trusting relationships between researchers and community members while drawing from both scientific and indigenous knowledge (Pinto, McKay, & Excobar, 2008), and thus,

it may be most appropriate when developing evidence-based health interventions for oppressed populations (Golden & Earp, 2012; Wallerstein, Yen, & Syme, 2011).

Conclusion

The purpose of this qualitative exploratory research was to gain firsthand data on African-American women's experiences in substance abuse treatment services and to inform future critical consciousness, intervention development. The women described experiences of oppression and inequity experienced during treatment provision. Particularly, the women reported experiences of racism and recounted how their voices were silenced. Although, researchers and practitioners have improved the quality of drug treatment services for women, traditional models of treatment for African-American women with co-occurring disorders may not adequately incorporate lived experiences, culture-specific issues, or address the needs of African-American women (Amaro et al., 2005). Considering the potential for both racial and gendered differences in treatment, it is critical to explore the ways in which racial/ethnic minority women engage in and experience substance use recovery programs (Constantine, 2006; Roberts, et al., 2000).

To understand the injustices that they face, it is crucial to consider some of the ongoing impacts of racism on the lives of African-American women. People make bad choices if they are mad, sad or stressed, but social workers cannot afford to ignore the context that: 1) oppressive treatment makes people mad, sad, or stressed; 2) oppression limits people's access to available good choices so many bad options are easily accessible; and 3) oppression creates inadequate treatment. Thus, oppression may lead to the need for treatment and explain treatment ineffectiveness. Therefore, transforming responses has two meanings: 1) changing the response itself – that is, changing service providers' response toward substance-using African American women to be less oppressive and more liberating; and 2) responses that transform – that is, responding in ways that address hidden socio-structural injustices and issues of racism underlying interpersonal and social problems that, ultimately, impact the treatment of substance using African-American women.

Acknowledgments

The authors acknowledge the Center for Drug Use and HIV/HCV Research for the grant award (P30DA011041) that funded this study.

First and second authors were supported as a predoctoral and postdoctoral fellows, respectively, in the Behavioral Sciences Training in Drug Abuse Research program sponsored by Public Health Solutions and National Development and Research Institutes with funding from the National Institute on Drug Abuse (5T32 DA007233).

References

- Abdulrahim S, James SA, Yamout R, & Baker W (2012). Discrimination and psychological distress: Does Whiteness matter for Arab Americans? *Social science & medicine*, 75(12), 2116–2123. 10.1016/j.socscimed.2012.07.030 [PubMed: 22901668]
- Alcoff L (1991). The problem of speaking for others. *Cultural critique*, (20), 5–32.
- Alexander IM (2004). Characteristics of and problems with primary care interactions experienced by an ethnically diverse group of women. *Journal of the American Academy of Nurse Practitioners*, 16(7), 300–310. DOI:10.1111/j.1745-7599.2004.tb00453.x [PubMed: 15291047]

- Amaro H, Larson MJ, Gampel J, Richardson E, Savage A, & Wagler D (2005). Racial/ethnic differences in social vulnerability among women with co-occurring mental health and substance abuse disorders: Implications for treatment services. *Journal of Community Psychology*, 33, 495–511. DOI: 10.1002/jcop.20065
- Barr DA (2014). *Health disparities in the United States: Social class, race, ethnicity, and health*. JHU Press.
- Boyatzis RE (1998). *Transforming qualitative information: Thematic analysis and code development*. London, England: Sage Publications, Inc.
- Braun V, & Clarke V (2014). What can “thematic analysis” offer health and well-being researchers? *International journal of qualitative studies on health and well-being*, 9: 26152 DOI:10.3402/qhw.v9.26152 [PubMed: 25326092]
- Briggs HE, Briggs AC, Miller KM, & Paulson RI (2011). Combating persistent cultural incompetence in mental health care systems serving African Americans. *Best Practice in Mental Health*, 7, 1–25.
- Broome KM, Flynn PM, Knight DK, & Simpson DD (2007). Program structure, staff perceptions, and client engagement in treatment. *Journal of Substance Abuse Treatment*, 33(2), 149–158. doi:10.1016/j.jsat.2006.12.030 [PubMed: 17434709]
- Bryant-Davis T, & Ocampo C (2005). Racist Incident–Based Trauma. *The Counseling Psychologist*, 33(4), 479–500. doi:10.1177/0011000005276465
- Burrow-Sanchez JJ, Martinez CR Jr, Hops H, & Wrona M (2011). Cultural accommodation of substance abuse treatment for Latino adolescents. *Journal of Ethnicity in Substance Abuse*, 10(3), 202–225 [PubMed: 21888499]
- Campbell C, & MacPhail C (2002). Peer education, gender and the development of critical consciousness: participatory HIV prevention by South African youth. *Social Science & Medicine*, 55(2), 331–345. doi:10.1016/s0277-9536(01)00289-1 [PubMed: 12144146]
- Carter RT (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist*, 35(1), 13–105.
- Charmaz K (2006). *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London: Sage Publications 2006 Chicago: Aldine 1967.
- Comas-Díaz L, & Greene B (1994). Overview: Gender and ethnicity in the healing process In Comas-Díaz L & Greene B (Eds.), *Women of color: Integrating ethnic and gender identities in psychotherapy* (pp. 185–193). New York, NY: Guilford.
- Comfort M, Loverro J, & Kaltenbach K (2000). A search for strategies to engage women in substance abuse treatment. *Social Work and Health Care*, 31(4), 59–70.
- Constantine MG (2006). Institutional racism against African Americans: Physical and mental health implications In Constantine MG & Sue DW (Eds.), *Addressing racism: Facilitating cultural competence in mental health and educational settings* (pp. 33–41). Hoboken, NJ: John Wiley.
- Crabtree BF, & Miller WL (Eds.). (1999). *Doing qualitative research*. Thousand Oaks, CA: Sage Publications, Inc.
- Covington SS, Burke C, Keaton S, & Norcott C (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs*, 40(sup5), 387–398. doi:10.1080/02791072.2008.10400666
- Davis TA, & Ancis J (2012). Look to the relationship: A review of African American women substance users’ poor treatment retention and working alliance development. *Substance Use and Misuse*, 47, 662–672. [PubMed: 22329365]
- Denzin NK, & Lincoln YS (2005). *The SAGE handbook of qualitative research*. Thousand Oaks: Sage Publications.
- Dodgson JE, & Struthers R (2005). Indigenous women’s voices: Marginalization and health. *Journal of Transcultural Nursing*, 16(4). DOI: 10.1177/1043659605278942
- Dovidio JF, Kawakami K, & Gaertner SL (2000). Reducing contemporary prejudice: Combating explicit and implicit bias at the individual and intergroup level. *Reducing prejudice and discrimination*, 137–163.
- El-Bassel N, Caldeira NA, Ruglass LM, & Gilbert L (2009). Addressing the unique needs of African American women in HIV Prevention. *American Journal of Public Health*, 99(6), 996–1001. doi:10.2105/ajph.2008.140541. [PubMed: 19372518]

- Ehrmin JT (2005). Dimensions of culture care for substance-dependent African American women. *Journal of Transcultural Nursing*, 16, 117–125. 10.1177/1043659604273549 [PubMed: 15764634]
- Fiorentine R (2001). Counseling frequency and the effectiveness of outpatient drug treatment revisiting the conclusion that “More is Better”. *The American Journal of Drug and Alcohol Abuse*, 27(4), 617–631. doi:10.1081/ada-100107659 [PubMed: 11727880]
- Fiorentine R, Nakashima J, & Anglin MD (1999). Client engagement in drug treatment. *Journal of Substance Abuse Treatment*, 17(3), 199–206. 10.1016/S0740-5472(98)00076-2. [PubMed: 10531626]
- Franklin C, & Ballan M (2001). Reliability and validity in qualitative research In Thyer B (Ed.), *The handbook of social work research methods* (pp. 273–292). Thousand Oaks, CA: Sage.
- Franklin AJ, Boyd-Franklin N, & Kelly S (2006). Racism and invisibility: Race-related stress, emotional abuse and psychological trauma for people of color. *Journal of Emotional Abuse*, 6(2–3), 9–30.
- Freire P (2000). *Pedagogy of the oppressed* (30th anniversary ed.). New York: Continuum (original work published 1970)
- Glaser BG (2002). Conceptualization: On Theory and Theorizing Using Grounded Theory. *International Journal of Qualitative Methods*, 1(2), 23–38. doi:10.1177/160940690200100203
- Glaser BG (1992). *Basics of grounded theory analysis*. Mill Valley, CA Sociology Press.
- Glaser BG & Strauss A (1967). *The discovery of grounded theory: strategies for qualitative research*. Chicago: Aldine.
- Glass L (2012). Help seeking: Perceived risks for African American women. *Affilia: Journal of Women & Social Work*, 27, 95–106.
- Golden SD, & Earp JAL (2012). Social ecological approaches to individuals and their contexts: Twenty years of health education & behavior health promotion interventions. *Health Education & Behavior*, 39(3), 364–372. [PubMed: 22267868]
- Grayson K (2001). “Interrater reliability.” *Journal of Consumer Psychology* 10 (1), 71–73.
- Green CA, Polen MR, Dickinson DM, Lynch FL, & Bennett MD (2002). Gender differences in predictors of initiation, retention, and completion in an HMO-based substance abuse treatment program. *Journal of substance abuse treatment*, 23(4), 285–295. 10.1016/S0740-5472(02)00278-7. [PubMed: 12495790]
- Gunn AJ, Sacks TK, & Jemal A (2016). “That’s not me anymore”: Resistance strategies for managing intersectional stigmas for women with substance use and incarceration histories. *Qualitative Social Work*, 17(4). DOI: 10.1177/1473325016680282.
- Hardesty M, & Gunn AJ (2017). Survival sex and trafficked women: The politics of re-presenting and speaking about others in anti-oppressive qualitative research. *Qualitative Social Work*, 1473325017746481.
- Harper GW, Tyler AT, Bruce D, Graham L, & Wade RM (2016). Drugs, sex, and condoms: Identification and interpretation of race-specific cultural messages influencing black gay and bisexual young men living with HIV. *American Journal of Community Psychology*, 58, (3–4), 463–476. DOI: 10.1002/ajcp.12109 [PubMed: 27883219]
- Hatcher A, De Wet J, Bonell CP, Strange V, & Hargreaves JR (2011). Promoting critical consciousness and social mobilization in HIV/AIDS programmes: lessons and curricular tools from a South African intervention. *Health Education Research*, 26(3), 542–555. doi:10.1093/her/cyq057 [PubMed: 20965911]
- Ho K (2007). Structural violence as a human rights violation. Retrieved from <http://projects.essex.ac.uk/ehrr/V4N2/ho.pdf>
- Houston M, & Kramarae C (1991). Speaking from silence: Methods of silencing and of resistance. *Discourse & Society*, 2(4), 387–399.
- Iphofen R, & Tolich M (2018). *The SAGE Handbook of Qualitative Research Ethics*. SAGE.
- Jackson J, Neighbors HW, Torres M, Martin LA, Williams DR, & Blaser R (2007). Use of mental health services and subjective satisfaction with treatment among Black Caribbean immigrants: Results from the National Survey of American Life. *American Journal of Public Health*, 97, 60–67. [PubMed: 17138907]

- Jemal A (2017a). Critical consciousness: A critique and critical analysis of the literature, *Urban Review*, 49, 4, 602–626. DOI: 10.1007/s11256-017-0411-3 [PubMed: 29657340]
- Jemal A (2017b). The opposition. *Journal of Progressive Human Services: Radical Thought and Practice (JPHS)*, 28(3), 134–139. DOI: 10.1080/10428232.2017.1343640.
- Jemal A (2018). Transformative consciousness: Oppression is a virus and critical consciousness is the antidote. *Journal of Human Rights and Social Work*. <https://rdcu.be/2Cxm>.
- Jemal A & Bussey S (2018). Transformative action: A new theoretical framework for breaking new ground. Manuscript under review.
- Joe GW, Simpson DD, & Broome KM (1998). Effects of readiness for drug abuse treatment on client retention and assessment of process. *Addiction*, 93(2), 381.
- Johnson JL, Bottorff JL, Browne AJ, Grewal S, Hilton BA, & Clarke H (2004). Othering and being othered in the context of health care services. *Health Communication*, 16(2), 255–271. 10.1207/S15327027HC1602_7. [PubMed: 15090288]
- Jones LV, & Warner LA (2011). Culturally responsive group work with Black women. *Journal of Research on Social Work Practice*, 21, 737–746.
- Jones LV, Hopson L, Warner L, Hardiman ER, James T (2015). A qualitative study of Black women's experiences in drug abuse and mental health services. *Affilia: Journal of Women and Social Work*, 30(1) 68–82.
- Kasarabada ND, Hser YI, Boles SM, & Huang YC (2002). Do patients' perceptions of their counselor's influence outcomes of drug treatment? *Journal of Substance Abuse Treatment*, 23(4), 327–334. [PubMed: 12495794]
- Kerrison EM (2017). Exploring how prison-based drug rehabilitation programming shapes racial disparities in substance use disorder recovery. *Social Science & Medicine*.
- Keslo GA, Cohen MH, Weber KM, Dale SK, Cruise RC, & Brody LR (2014). Critical Consciousness, Racial and Gender Discrimination, and HIV Disease Markers in African American Women with HIV. *AIDS Behavior*, 18, 1237–1246. [PubMed: 24077930]
- Krueger R and Casey M (2009) *Focus Groups: A Practical Guide for Applied Research*. Sage Publications, Thousand Oaks, CA.
- Kurtz DL, Nyberg JC, Van Den Tillaart S, & Mills B (2008). Silencing of Voice: An act of structural violence. *Journal of Aboriginal Health*, 14(1). DOI:10.18357/ijih41200812315
- Liem R (2007). Silencing historical trauma: The politics and psychology of memory and voice. *Peace and Conflict: Journal of Peace Psychology*, 13(2), 153–174. 10.1080/10781910701271200
- Lietz CA, & Zayas LE (2010). Evaluating qualitative research for social work practitioners. *Advances in Social Work*, 11(2), 188–202.
- Lincoln YS. & Guba EG. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.
- Mead H, Cartwright-Smith L, Jones K, Ramos C, Woods K, Siegel B. *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook*, The Commonwealth Fund 2008
- Meier PS, Barrowclough C, & Donmall MC (2005). The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature. *Addiction*, 100(3), 304–316. doi:10.1111/j.1360-0443.2004.00935.x [PubMed: 15733244]
- Meyer JP, Springer SA, & Altice FL (2011). Substance abuse, violence, and HIV in women: a literature review of the syndemic. *Journal of women's health* (2002), 20(7), 991–1006.
- Moe AM 2007 *Silenced voices and structured survival: Battered women's help-seeking*. *Violence Against Women*, 13(7), 676–99. [PubMed: 17600305]
- Morgan DL (1997). *Focus groups as qualitative research*. California: Sage Publications
- Neighbors HW, Caldwell C, Williams DR, Nesse R, Taylor RJ, Bullard KM, ...Jackson JS (2007). Race, ethnicity, and the use of services for mental disorders: Results from the National Survey of American Life. *Archives of General Psychiatry*, 64, 485–494. doi:10.1001/archpsyc.64.4.485. [PubMed: 17404125]
- Padgett D (2016). *Qualitative methods in social work research* (Vol. 36). Sage Publications.
- Pinto RM, McKay MM, & Excobar C (2008). "You've gotta know the community":
- Patton MQ (2005). *Qualitative research and Evaluation Methods*. Thousand Oaks, CA: John Wiley & Sons, Ltd.

- Prendergast ML, Podus D, Chang E, & Urada D (2006). Erratum to “The effectiveness of drug abuse treatment: a meta-analysis of comparison group studies” [Drug Alcohol Depend. 67 (2002) 53–72]. *Drug and Alcohol Dependence*, 84(1), 133. doi:10.1016/j.drugalcdep.2006.02.002
- Pinto RM, McKay MM, & Excobar C (2008). “You’ve gotta know the community”: Minority women make recommendations about community-focused health research. *Women & Health*, 47(1), 83–104. [PubMed: 18581694]
- Quintana SM, & Segura-Herrera TA (2003). Developmental transformations of self and identity in the context of oppression. *Self and Identity*, 2(4), 269–285. doi:10.1080/714050248
- Radin SM, Kutz SH, La Marr J, Vendiola D, Vendiola M, Wilbur B, ... & Donovan DM (2015). Community perspectives on drug/alcohol use, concerns, needs, and resources in four Washington State tribal communities. *Journal of ethnicity in substance abuse*, 14(1), 29–58. [PubMed: 25560464]
- Rapp RC, Xu J, Carr CA, Lane DT, Redko C, Wang J, & Carlson RG (2007). Understanding treatment readiness in recently assessed, pre-treatment substance abusers. *Substance abuse*, 28(1), 11–23. [PubMed: 19274847]
- Roberts A, Jackson MS, & Carlton-Laney I (2000). Revisiting the need for feminism and Afrocentric theory when treating African-American female substance abusers. *Journal of Drug Issues*, 30(4), 901–918.
- Shonkoff AS & Garner AS (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, 129(1), e-232–e-246. DOI: 10.1542/peds.2011-2663. [PubMed: 22201156]
- Shonfeld-Ringel S (2001). A re-conceptualization of the working alliance in cross-cultural practice with non-western clients: Integrating relational perspectives and multicultural theories. *Clinical Social Work Journal*, 29(1), 53–63.
- Simpson DD, Joe GW, Rowan-Szal G, & Greener J (1997). Drug abuse treatment process components that improve retention. *Journal of Substance Abuse Treatment*, 14(6), 565–572. [PubMed: 9437628]
- Smedley BD, Stith AY, & Nelson AR, & Institute of Medicine (U.S.) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press.
- Smye V (V.), Rameka M, & Willis E (2006). Indigenous health care: Advances in nursing practice. *Contemporary Nurse*, 22(2), 142–154. [PubMed: 17026421]
- Strauss A, & Corbin J (1994). Grounded theory methodology. *Handbook of qualitative research*, 17, 273–85.
- Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 national survey on drug use and health: Mental health findings. Rockville, MD: Author Retrieved 12/25/18 from <https://www.samhsa.gov/data/sites/default/files/2011MHFDT/2k11MHFR/Web/NSDUHmhfr2011.htm>.
- Tillman L (2002). Culturally sensitive research approaches: An African-American perspective. *Educational Researcher*, 31, 3–12
- U.S. Department of Health and Human Services. (2001). *Mental health: culture, race, and ethnicity: A supplement to mental health: A report of the surgeon general*. Washington: Department of Health and Human Services, U.S. Public Health Service.
- Vega W, & Rumbaut G (1991). Ethnic minorities and mental health. *Annual Review of Sociology*, 17, 351–383.
- Wallen J (1992). Providing culturally appropriate mental health services for minorities. *Journal of Mental Health Administration*, 19, 288–295. [PubMed: 10123308]
- Wallerstein NB, Yen IH, & Syme SL (2011). Integration of social epidemiology and community-engaged interventions to improve health equity. *American Journal of Public Health*, 101(5), 822–830. [PubMed: 21421960]
- Weiss SR, Kung HC, & Pearson JL (2003). Emerging issues in gender and ethnic differences in substance abuse and treatment. *Current Women’s Health Report*, 3, 245–253.
- Wells K, Klap R, Koike A, & Sherbourne C (2001). Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *American Journal of Psychiatry*, 158(12), 2027–2032. [PubMed: 11729020]

- Williams CB (1999). African American women, Afrocentrism and feminism: Implications for therapy. *Women & Therapy*, 22, 1–16.
- Williams DR, & Mohammed SA (2013). Racism and health: Pathways and scientific evidence. *American Behavioral Scientist*, 57(8), 1152–1173.
- Williams DR, Neighbors HW, & Jackson JS (2003). Racial/ethnic discrimination and health: Findings from community studies. *American Journal of Public Health*, 93(2), 200–208. doi:10.2105/ajph.93.2.200 [PubMed: 12554570]
- Williams D, & Williams-Morris R (2000). Racism and mental health: The African American experience. *Ethnicity and health*, 5(3–4), 243–268. [PubMed: 11105267]
- Windsor L, Benoit E, & Dunlap E (2010). Dimensions of oppression in the lives of impoverished black women who use drugs. *Journal of black studies*, 41(1), 21–39. [PubMed: 21113410]
- Windsor LC, Jemal A, & Benoit E (2014). Community Wise: Paving the Way for Empowerment in Community Reentry. *International Journal of Law and Psychiatry*, 37(5), 501–511. DOI: 10.1016/j.ijlp.2014.02.023 [PubMed: 24630737]
- Windsor L, Pinto RM, Benoit E, Jessell L, & Jemal A (2014). Community Wise: The Development of an Anti-Oppression Model to Promote Individual and Community Health. *Journal of Social Work Practice in the Addictions*, 14(4), 402–420. doi:10.1080/1533256x.2014.962141
- Wisdom JP, Hoffman K, Rechberger E, Seim K, & Owens B (2009). Women-Focused Treatment Agencies and Process Improvement: Strategies to Increase Client Engagement. *Women & Therapy*, 32(1), 69–87. doi:10.1080/02703140802384693 [PubMed: 20046914]
- Wittmann-Price RA (2004). Emancipation in decision-making in women's health care. *Journal of Advanced Nursing*, 47(4), 437–445. [PubMed: 15271163]
- Wyatt GE, Carmona JV, Loeb TB, & Williams JK (2005). HIV-Positive Black Women with Histories of Childhood Sexual Abuse: Patterns of Substance Use and Barriers to Health Care. *Journal of Health Care for the Poor and Underserved*, 16(4B), 9–23. doi:10.1353/hpu.2005.0120. [PubMed: 16327104]

Table 1.

Sociodemographic characteristics of focus group participants (N=33)

Characteristics	N (% of sample)
Average Age	44
Education	
Less than High School	10 (30)
High School or GED	10 (30)
Some College/Trade School	9 (27)
College Degree	4 (12)
Annual Income	
Less than \$10,000	13 (39)
\$10,000-\$20,000	11 (33)
More than \$20,000	9 (27)
Crime Conviction	
Yes	22 (66)
No	11 (34)
Drug Use in the Last 3 months (including alcohol)	
Yes	4 (12)
No	29 (78)
Romantic Relationship Status	
Dating	12 (36)
Domestic Partnership	4 (12)
Married	1 (3)
Not Dating/Single	16 (48)
Sexual Identity Status	
Heterosexual	18 (55)
Homosexual	2 (6)
Bisexual	2 (6)
Don't Know	4 (12)
Employment	
Full-Time	10 (30)
Part-Time	6 (18)
Disabled	3 (9)

Characteristics	N (% of sample)
Unemployed	14 (42)
Diagnosed with mental health disorder	
Yes	8 (24)
No	20 (61)
N/A	5 (15)