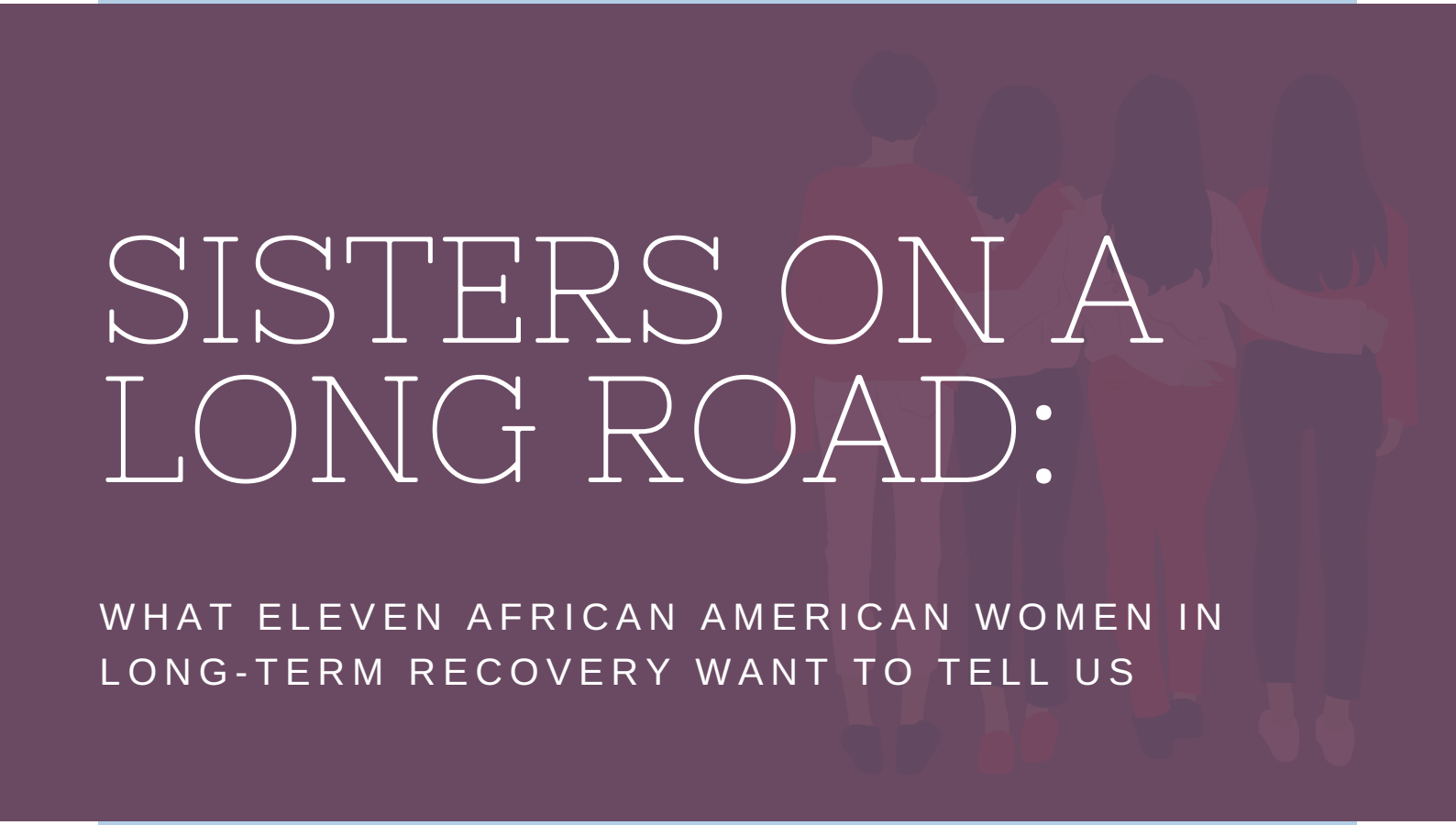
INTERVIEWS FROM THE FIELD



SISTERS ON A LONG ROAD:

WHAT ELEVEN AFRICAN AMERICAN WOMEN IN LONG-TERM RECOVERY WANT TO TELL US

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TABRICEA'S STORY

RECOVERY IS A REALITY

When Tabricea walked into her first treatment facility, her expectations came down to two very basic necessities. "I was looking for a program that would have beds," she said, "and one that would work with my DFACS [Child Welfare] case plan." Tabricea's first treatment was on a psychiatric hold in a 30-day short-term inpatient program. She didn't really feel valued or addressed as a person, she said, and much less as an African American woman. But they would work with her case plan, and she did have a bed.

Later, Tabricea went on to participate in two long-term residential programs, the most effective being a spiritual therapeutic community for women with substance use disorders (SUD) and their children. Among other things, that program taught women safe, nurturing parenting skills—skills that probably did as much to heal the wounds of the women learning them as they did to prevent new challenges for their children.

"My recovery change process started in that program," said Trabricea. There she was immersed in the spiritual aspects of recovery, learning and practicing activities that would continue to expand the reach of spirituality in her life. She also learned how important it was to be actively included by her fellow participants. She basked in her connection with the other moms in the program, sharing her feelings with confidence, knowing that no one would invalidate the way she felt.

But when she left the therapeutic community, Tabricea settled in a largely white area with a recovery community that offered no real sense of community. People in the recovery groups there neither tried to make connections with her nor reminded her that what she was going through in early recovery was normal. She had virtually no peer support, which left her to cope with racial trauma and the trauma of recovery all at once. Still, she persevered, went to meetings, found a sponsor, and did what she needed to do. And it worked.

Tabricea's Story (cont'd.)

At six years' recovery, Tabricea was the relative newcomer in a group of eleven African American women interviewed for a small qualitative study centered at Morehouse School of Medicine—women whose longevity in recovery totaled 242 years when the interviews took place in 2018. The investigator, co-author Dawn Tyus, sought to learn about the realities, needs, strengths, and challenges of African American women in treatment and recovery. And she did it by asking women in long-term recovery about their own experiences and observations in treatment and early recovery, and about the wisdom they had earned through the years.

Those interviews yielded a wealth of knowledge, experience, and ideas for treatment and recovery support. They will form the backbone of a collection of Guidelines for treatment and peer-based recovery support for African American women, to be published this year (2020) by the Southeast Addiction Technology Transfer Center (Southeast ATTC) at Morehouse School of Medicine in Atlanta. But first, this article introduces eleven extraordinary women and some of their early treatment and recovery experiences and lessons.

The Women

Asked if they'd like to choose a "theme" for their interviews, many of the women were happy to oblige. Mary had a hard time choosing between "The choice is mine" and "Unlock endless possibilities to unlock my heart." Doreen chose the mysterious "Secret women don't share." Dorad kept it simple with "30 years"—her recovery span at the time—and Lucy picked "Living the promises." Tawanda had little doubt, immediately choosing "Blessed by recovery."

A diverse group, these women had entered the treatment and recovery world through a number of portals, including an emergency room in suicide risk, a three-day hospital detox program, a psychiatric hold at a hospital, a mental health center, an inpatient SUD treatment unit, an employee assistance program (EAP), and the judicial system.

Mary didn't know how to stop using and was staring down some likely jail time. Rozell was afraid she would take her own life, so she went to the local emergency room. Doreen was intoxicated and not performing well at work. Someone there knew the signs and—with a little extra persuasion from the boss—sent her to the EAP. Lucy had lost family members to addiction, but she didn't know there was a solution until a conversation with her parole officer led the officer to make some phone calls on her behalf.

These women started out with everything from a complete lack of knowledge of treatment and recovery to the prominent positive role model of a mother in recovery. They also came from a wide variety of financial and professional circumstances—from unemployment to full employment, and from broke-with-no-insurance to their own or their husbands' ample employer-sponsored plans.

Their intervention, assessment, and treatment experiences took place in criminal justice commitment centers, emergency rooms, inpatient hospital programs, inpatient community-based programs, long-term residential programs for women and children, private treatment centers, treatment centers for indigent patients, aftercare programs, halfway houses, and recovery homes. Their sources of recovery support have included 12-step programs like Narcotics Anonymous (NA) or Alcoholics Anonymous (AA), families, friends, faith communities, and faith-based support programs.

Choosing This Study Population

For the investigator, African American women in long-term recovery who had been through treatment seemed to offer an excellent set of perspectives, for several reasons:

- In the past two decades, the substance use disorder treatment field has been shifting away from a primary focus on the illness itself, toward an acknowledgement and exploration of the experience, wisdom, and lessons of recovery:[1] What is this thing that can replace the pain and chaos of addiction, and what can we learn from people in long-term recovery about how to get there?
- Focusing on the needs and realities of women seemed particularly important, given the outstanding strengths, resilience, and vulnerabilities of many women with SUD.[2] This is even more the case with many African American women, whose histories, environments, experiences, and physical and social burdens often leave them with complex collections of challenges to navigate.[3]
- Both early and more recent experiences of trauma can add many layers of pain and complexity to life, health, behaviors, relationships, illnesses, treatment, and recovery. The kinds of traumas women experience tend to be more intimate, more humiliating, and more often linked to betrayal of trust within relationships. And, statistically speaking, African American women and women with SUDs experience significantly more trauma of many kinds, including more intimate betrayal trauma.[4]
- Women are also more likely than men to place a high—even primary—importance on relationships. These might include relationships with families of origin, with all their strengths and struggles; marriages and intimate relationships that might be sources of support, disruption, or danger; and caregiving responsibilities with children and/or ailing family or friends—responsibilities that often keep women from getting help for far too long.[5]

Choosing This Study Population (cont'd.)

All these factors can follow women into treatment or recovery support services, adding layers of vulnerability and strengthening their desire to give up, run away, kill the pain, and fight or hide from anyone who tries to help. Things that help quell those urges have often included:

- a sense of safety and welcome in the facility;
- consistent respect and compassion from staff at all levels;
- strategies and activities that offer help and hope; and
- the ability to see themselves and their struggles mirrored in their fellow participants, peer supporters, staff who have overcome similar challenges, and visiting alumni.[6]

You might recognize in those qualities some of the components of trauma-informed care and recovery-oriented services. We could say that trauma-informed and recovery-oriented approaches are important for women, and for people from underserved communities—and that would be abundantly true. But another truth is that even the most perceptive service provider will never be able to pinpoint everyone who needs these approaches. The numbers of people affected by trauma are high, they vary widely from study to study, and they are probably vastly underreported. And these wounds often hide behind things like shut-down numbness, silent rage, quiet compliance, defensive outbursts, and “class clown” behavior. You’ll never identify everyone who needs them, so trauma-informed and recovery-oriented approaches are essential for everyone you serve.[7]

For some African American women, landing in a primarily white facility can also add a few layers of vulnerability, unless the program and its staff have been well trained in attitudes and practices of cultural humility and the potential impact of common white behaviors on people of color. Differences in norms and communication that people take for granted in the outside world can become obstacles to the senses of welcome, identification, and belonging that are so important in the early days of treatment and recovery.[8] African American women are also used to navigating all the subtle cross-racial undercurrents they encounter in white society, even among people who mean them no harm or insult.[9] But how might those undercurrents threaten a woman’s sense of social and psychological safety if they show up in a service setting that’s supposed to be a refuge, when her sense of safety is still so frayed and so fragile?

Choosing This Study Population (cont'd.)

Of the eleven women interviewed for this study, four said there were race-related factors in their treatment programs that made the process more difficult for them. Three more said they avoided many of those challenges because of their social class (e.g., higher education, property, career, prestige). An additional woman said it was easier because a close family friend worked on staff, one said staff “met her where she was,” and another said she might have experienced difficulties, but an African American woman chairing a recovery meeting had challenged her to make it work—and so she did.

Connections and Recovery

From the moment human beings are born, our best and most important source of instruction in how to manage the pain and stress of living is trustworthy human connection. From the loving gaze that passes between parent and baby to the gentle hand that strokes an aging patient's feeble wrist, we absolutely need one another. This is how our stress systems learn to calm us down, how our immune systems stay in tune, how we muster hope and courage, and how we learn to believe in ourselves.

For many people—perhaps most people—recovery is built on connection. So the women in this study were asked to speak about their most important connections. For example, Mary knew she needed to connect with someone who understood her, someone with whom she could identify. In treatment, Tabricea considered her counselor her most important connection, then shifted to her sponsor in the world beyond treatment. Rozell's most important connections were finding a sponsor—someone who believed in her—and forming a support network of people who were going to meetings regularly and weren't using.

Karen said she was lucky to have friends who had found recovery before she did, but she also needed connections within her faith community. Linda needed to connect with her family, with her church community, and with her own personal goal, which led her to make meaningful connections at school, too. Doreen needed and formed a wealth of connections—first with her mother, who was in recovery and served as a safe and accepting confidant. She also found connections within her faith community important, along with the connections she formed at conferences.

Anita learned from mentors in her 12-Step community, who helped her redefine "normal," but her primary connection was with God. Lucy said her fear was so great that she knew her first and most important connection would be with God. She needed an unshakeable faith—and people to help her learn that faith—and she had to hold onto hope. She used to repeat to herself, "I Love Lucy," an affirmation she hoped someday to believe. Her connection with her sponsor, an older white woman, was also important, helping her learn how to be a woman and a mother. Tawanda also affirmed her Higher Power as her most important connection, meeting her no matter where she was and giving her the tools she needed from day to day.

Lessons for Treatment and Recovery Support

Of course, a quick look at the lives of eleven successful women in recovery is only the beginning. Their experiences, their suggestions, and some suggestions from the literature will yield a far more detailed collection of guidelines for treatment and recovery support programs and practitioners. Apart from the questions about their own pathways and experiences in treatment and recovery, here are the more objective topics these women were asked to address in their interviews:

- Ways of empowering African American women
- The importance of including family in the treatment and recovery support process
- Generational elements that service providers should be aware of
- Strategies for engaging African American women in services
- Ways of encouraging African American women in treatment and recovery support
- Important components of treatment for African American women
- Ways of making African American women feel comfortable in service settings
- Barriers to treatment and recovery support for African American women
- Ways of helping women overcome those barriers
- The importance of language in services for African American women
- What being “culturally responsive” really means
- How programs might make sure they are culturally responsive
- How important it is to see other African American women on staff
- How to ensure that programs are providing trauma-informed care

Each of the interviewees had experienced treatment and recovery and had later heard hundreds—in most cases thousands—of stories from their fellow travelers. Women in extremely vulnerable positions have some of the best “radar” on earth. When they’re finally safe to speak their truth, it is truth well worth hearing. Their ideas will have a prominent place in the Guidelines document that will be published later this year by the Southeast ATTC.

During the 2018 interviews, each woman was asked to name what stood out for her as significant in her recovery journey. For Anita, “All of it was significant!” She had found it hard to get to a breakthrough—“fighting every day to stay away from drugs”—until she had what she called her “Resiliency Transformation.” That transformation allowed her to move away from the woman she had been and start to build up her morals, her values, and her sense of integrity. She even learned to tolerate the fact that she wasn’t perfect.

Lessons for Treatment and Recovery Support (cont'd.)

For Linda, what stood out was that she walked into a 12-Step meeting, immediately felt a sense of connection, and then found what she called “right sponsorship.” For Dorad, it was her success in being a good mother and becoming a human being and a productive member of society again. She prizes it even more highly than her college degree.

“Through recovery,” she said, “I’ve been able to accomplish my dreams!”

Endnotes

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