In Their Own Words: Trauma and Substance Abuse in the Lives of Formerly Homeless Women With Serious Mental Illness

Deborah K. Padgett, PhD, Robert Leibson Hawkins, PhD, Courtney Abrams, MA, and Andrew Davis, MA
New York University

In-depth interviews were conducted with 13 formerly homeless mentally ill women to capture their individual life trajectories of mental illness, substance abuse, and trauma in their own words. Cross-case analyses produced 5 themes: (a) betrayals of trust, (b) graphic or gratuitous nature of traumatic events, (c) anxiety about leaving their immediate surroundings (including attending group treatment programs), (d) desire for one’s own space, and (e) gender-related status loss and stigmatization. Findings suggest formerly homeless mentally ill women need (and want) autonomy, protection from further victimization, and assistance in restoring status and devalued identity. Avenues for intervention include enhanced provider training, addressing experiences of betrayal and trauma, and more focused attention to current symptoms rather than previous diagnoses.

Keywords: homelessness, gender, mental illness, substance abuse, trauma

Recent years have witnessed remarkable growth in attention to co-occurring mental and substance use disorders (Brady & Sinha, 2005; Drake & Wallach, 2000; Harris & Edlund, 2005; Rach-Beisel, Scott, & Dixon, 1999). Epidemiological evidence has pointed to a 50% lifetime prevalence of substance abuse among those with a serious mental illness, along with disproportionate co-occurrences of childhood abuse, HIV risk, adult trauma, and homelessness (Drake & Wallach, 2000). Homeless mentally ill persons are at higher jeopardy of these as well as other co-occurring conditions (e.g., poor health) (Gelberg & Linn, 1988; Larson et al., 2005).

As might be imagined, the paths to becoming a homeless adult with co-occurring mental and substance use disorders vary depending on a myriad of individual differences as well as the environmental context. Among these, gender stands out. Mentally ill persons in general, and mentally ill women in particular, are more vulnerable to the intoxicating and addicting features of illicit drugs, a phenomenon that may be biological in origin, related to the powerful effects of neuroleptic medications, or both (Gearon & Bellack, 1999). For mentally ill women, the risks of trauma and victimization are double that of women in the general population and invariably higher compared with their male counterparts (Alexander, 1996; Goodman, Dutton, & Harris, 1995; Padgett & Strauening, 1992; Wenzel, Koegel, & Gelberg, 2000).

These concerns underlie a national project—the Women, Co-Occurring Disorders and Violence Study (WCDVS)—that was funded by the federal government’s Substance Abuse and Mental Health Services Administration from 1998 to 2003. The WCDVS implemented and evaluated an innovative model of service delivery for a national sample of women with histories of interpersonal violence and co-occurring disorders (Becker & Gatz, 2005).

Previous studies, including the WCDVS, have had two noteworthy methodological features. First, they drew study samples from patients in treatment settings. Although clearly the most convenient and efficient way to recruit such persons, these studies tend to oversample those who are more seriously ill and those predisposed to use treatment services (Mueser, Drake, & Wallach, 1998). Second, previous studies have been overwhelmingly quantitative in data collection and analyses. Such reliance on standardized measures provides aggregate data that make epidemiological and cross-site analyses possible, but it also tends to parse individual experiences into measurable, discrete units removed from their original context (Padgett, 1998).

Even more challenging are attempts to quantitatively model the complex relationships among the many variables affecting homeless adults with co-occurring disorders. Statistical analyses such as structural equation modeling have facilitated these efforts (Stein, Burden-Leslie, & Nyamathi, 2002), but the on again–off again interwoven trajectories of mental illness, substance abuse, and homelessness can only be approximated. Missing from these equations are unmeasured (and unmeasurable) phenomena as well as the consumers’ own perspectives.

To address these gaps in understanding, the New York Services Study (NYSS) used an inductive approach and life history interviews of formerly homeless mentally ill women who were asked to portray their life experiences in their own words. As described in the Method section, we were also able to capitalize on the availability of a nontreatment sample for the study.

Unlike quantitative elicitation techniques, our study design allowed us to learn not only from what these women said but from what they did not say. It is also informative to know how women speak about certain events and the meaning(s) they attach to those events. Although this “wide net” approach has its own limitations,
it is designed to be empowering as well as to afford a more holistic perspective on these women’s lives.

Frameworks for Understanding Mental Illness, Trauma, and Substance Use Disorders Among Women

Two theories have been posited to explain the high prevalence of substance abuse among persons with serious mental illness (Mueser et al., 1998). The first, a substance-abuse-as-secondary model, is congruent with Khantzian’s (1997) self-medication hypothesis in which persons with a serious mental illness drink or abuse drugs to alleviate suffering due to their symptoms. The second approach, a common-factors model, does not depend on the antecedence of one or another disorder, positing instead that both result from common risk factors including genetic loading or antisocial personality disorders (Mueser et al., 1998).

Although empirical support for the self-medication model has generally been lacking (Mueser et al., 1998), a common factors model focusing primarily on genetics and personality type seems unnecessarily limiting (Draine, Salzer, Culhane, & Hadley, 2002). Indeed, recent findings have converged on one particular common factor—trauma. A substantial body of evidence has accumulated that demonstrates that traumatic life events are disproportionately found in the lives of persons with serious mental illness who abuse substances (Harris & Fallot, 2001; Sells, Rowe, Fisk, & Davidson, 2003). Women are particularly likely to have experienced various forms of sexual and physical abuse either before or coincident with mental illness and substance abuse (Gearon & Bellack, 1999; Goodman et al., 1995; Kubisak, 2005; Wenzel et al., 2000).

National surveys have found that the vast majority of affected persons do not receive treatment for both disorders—the most frequent treatment is for the mental disorder alone (Kessler et al., 1995). Although the likelihood of receiving substance abuse treatment increases with the severity of the mental disorder (Harris & Edlund, 2005), unmet need far exceeds service use.

In this study, we used case study analyses of a sample of formerly homeless mentally ill women living in New York City. Our study questions were as follows:

1. What (if any) physical and sexual traumas were reported over the life course of these women?
2. To what factors did they attribute their substance avoidance or abuse?
3. What patterns or themes emerge and cut across their life trajectories?

Method

Our overall goal was to pursue the particulars of each case, then proceed to cross-case, or collective case study, analyses (Stake, 2001). We chose this inductive approach as most appropriate for capturing insider perspectives on phenomena usually measured quantitatively (e.g., substance abuse and trauma). By capitalizing on the strengths of in-depth interviewing, we hoped to provide a deeper and more dynamic perspective on these women’s lives and survival strategies.

Sampling and Recruitment

Our sample consisted of formerly homeless mentally ill women who were recruited as part of Phase 1 of the NYSS, an National Institute of Mental Health–funded qualitative study of homeless mentally ill adults in New York City. Their use or abuse of substances was not an inclusion criterion but part of what we sought to capture in their life stories.

Purposive sampling was used to select study participants from a roster of 225 adults (52 of whom were women) who had been part of an earlier longitudinal study of homeless mentally ill individuals (Tsembrois, Gulcur, & Nakae, 2004). Persons in the earlier study had a documented Diagnostic and Statistical Manual of Mental Disorders (4th ed.; American Psychiatric Association, 1994) Axis I disorder and were referred for housing and services either from the streets or from hospitals; 90% also had substance abuse problems (Tsembrois et al., 2004).

As part of their final interview in the earlier study (which ended in 2002), participants had been asked for contact information and permission to be recruited for future studies. Only individuals who gave permission to be contacted were considered for recruitment into the NYSS. Thus, we did not recruit from treatment settings, and participants’ status as service users or nonusers was an open question (as was their substance use or abuse).

Phase 1 of the NYSS, the life history phase, had a planned sample size of 40, of whom approximately one third would be women. Inclusion in the NYSS study was based on nominations criteria developed to include men and women who had manifested positive and negative outcomes in the earlier study (defined in terms of success in psychiatric rehabilitation, controlling substance use, and maintaining stable housing). Two senior members of the NYSS team, who had been senior interviewers in the earlier study and had first-hand knowledge of its participant population, independently identified with 90% agreement a roster of 60 participants (21 women, 39 men) who met sampling inclusion criteria for the NYSS. Of these 60 considered eligible, 39 were located and contacted, of whom 13 were women; all of those reached agreed to participate in the study.

The sample size for Phase 1 was considered large enough to capture the diversity of life experiences but not overly burdensome in resource intensity as we elicited in-depth life histories collected during two interviews with each participant.

Interviewers were given extensive training and supervision throughout the study to minimize bias and maximize candor and trust by demonstrating respect for the participants. None subsequently reported any adverse reactions to the interviews. Each participant gave informed consent and was given a $30 incentive payment and transportation costs per interview. All study protocols were approved by our university-based Human Subjects Committee.

Study Design and Data Collection

The study design included two life history interviews, the first an open-ended query eliciting life stories with probes when relevant for experiences related to mental illness and substance abuse, treatment and service use, and any other life events deemed relevant by the study participant. The second interview, which was individually tailored and focused on content areas derived from the first interview, elicited further detail or accuracy checks. Although we occasionally sought factual information related to substance use, homelessness, and use of services, we maintained a strong emphasis on respecting participants’ own “narrativizing” of what had happened to them.

Interviews, which lasted from 45 minutes to 3 hours, were scheduled at a private location of the participant’s choice (her current residence or the NYSS offices). Each interview was audiotaped and transcribed verbatim for entry into ATLAS/ti software (Muhr, 2004). Interviewers also filled out interview feedback forms after each interview. The interview feedback forms elicited observations about the participant’s nonverbal communication, dress and demeanor, and emotional reactions (if any) resulting from the interview. Interviewers met weekly to discuss any follow-up actions needed and debrief about their own feelings and reactions regarding the participants and their difficult life stories. In addition to verbatim transcriptions and interview feedback forms, we compiled case summaries for each participant and created life trajectories, charting the timing and sequencing of key life events.
Within- and Across-Case Analyses

Case study analyses proceeded in two stages, the first within case and the second across case. Reading through all sources of data and keeping analytic memos (Stake, 2001), the study team met and discussed each woman’s life story, focusing on (a) previous experiences of mental illness and substance use; (b) the woman’s own perspectives on her life problems, strengths, and weaknesses; and (c) remarkable life events or turning points (positive or negative). Data sources used in the analyses of each case are summarized as follows: transcripts of two interviews (A and B), interviewer feedback forms, case summary, life trajectory chart, and selected codes and quotes from ATLAS/ti files. We note that the codes in the current analyses (which are part of grounded theory analyses still being conducted) were primarily used as organizing devices for retrieving quotes for the case study findings.

We then examined results across cases to identify patterns and themes. According to Patton (2002, p. 453), thematic development involves a search for “core consistencies or meanings.” Although grounded in each woman’s life story and its idiosyncrasies, themes are across wide swaths of the data.

To optimize study rigor, we adopted several strategies (Padgett, 1998), including regular team debriefings (for interviewer supervision and attention to bias as well as any ethical concerns), triangulation and saturation of data and analyses, and auditing (recording all analytic decisions and interim steps in analyses). In keeping with qualitative approaches emphasizing giving voice to participants (Lather & Smithies, 1997), we relied on direct quotes as much as possible to ground our findings and interpretations.

Results

Characteristics of the Sample

The women in the sample had an age range of 31 to 62 years, with an average age of 50. The sample’s racial–ethnic composition was 6 African American, 5 White, and 2 Latina. Axis I diagnoses were schizophrenia (n = 5), schizoaffective disorder (n = 2), major depression (n = 3), and bipolar disorder (n = 3). Six of the 13 women had never had children. By virtue of their earlier inclusion criteria, all of the women had to have been literally homeless for at least 2 weeks in the past.

Traumatic Life Experiences

In assessing traumatic life experiences, we focused on unambiguous events such as childhood sexual abuse, rape, and physical attacks incurring serious bodily injury. This is not meant to infer that other life stressors such as foster care neglect and chronic partner abuse do not also have emotional consequences. However, because research has shown that traumatic experiences are an all-too-common part of the lives of homeless mentally ill people, we reasoned that a focus on discrete memorable events would be more readily documented.

Traumatic life experiences were reported by 9 of the 13 women. Of these 9 women, 7 had been raped (all but 1 multiple times). Three of the women reported childhood sexual abuse by family members or foster parents. Indeed, we were struck by the cumulative adversity in these women’s life stories (Kubiak, 2005).

The study participants told us about their traumatic experiences with intense emotions accompanied by grim satisfaction in having survived such horrific abuse. Many also related their experiences in living on the streets, including beatings, sexual predation, and exposure to HIV/AIDS.

Substance Abuse Experiences

Nine of the 13 women reported a lifetime history of substance abuse, primarily alcohol, marijuana, and crack cocaine. Despite the small sample size, distinct ethnic and social class patterns emerged such that all 6 African American women had abused substances (compared with 2 of 5 White women and 1 of 2 Latinas), and all 8 women from poor or working-class backgrounds were lifetime substance abusers (see Table 1).

Of the 4 women who reported abusing substances at the time of the study, 3 were African American, 1 was White, and all were of poor or working-class background (see Table 1). The 3 women who were abusing alcohol said that they were problem drinkers and in and out of rehab; the marijuana smoker described her use as not being a problem.

Of the 4 who had never used substances, 1 mentioned her husband’s heroin addiction as a reason, but the other 3 stated in various ways that they had had enough problems without adding more. As noted, these lifetime abstainers were all from middle-class backgrounds.

Substance abuse, which typically began in the women’s early teens, was made relatively easy given the availability of drugs in poor neighborhoods and proximal use by siblings and peers. One woman, for example, began smoking marijuana at age 12 to join her older sisters, then went on to abuse crack cocaine with male partners. Interestingly, cohort effects were noted in those in late middle age (exposure to rising drug use in the 1960s and 1970s), as well as in those in their younger years (the crack epidemic of the 1980s).

In addition to the influence of social relationships and larger social trends, the women attributed their substance abuse to inner turmoil (anxiety and emotional anguish), multiple losses (child custody, deceased friends, and family), and the cumulative effects of homelessness and extreme deprivation (including poor health).

In addition to the 4 women who reported current substance abuse, another 4 reported having stopped using substances sometime between the past month and the past year. Put another way.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>History of use</th>
<th>Current use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>100</td>
<td>6</td>
</tr>
<tr>
<td>White</td>
<td>40</td>
<td>2</td>
</tr>
<tr>
<td>Latina</td>
<td>50</td>
<td>1</td>
</tr>
<tr>
<td>Socioeconomic background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor/working class</td>
<td>100</td>
<td>8</td>
</tr>
<tr>
<td>Middle class</td>
<td>20</td>
<td>1</td>
</tr>
</tbody>
</table>
only 5 of the 13 women had long-term abstinence, and 4 of them had never used substances. This left only 1 woman in our sample who had recovered enough to remain abstinent longer than a year.

All but 1 of the 9 substance-abusing women had received formal substance abuse treatment (some multiple times). These episodes, which involved stays from 30 days to 1 year, involved therapeutic groups as the dominant modality. Several of the women had the rare experience of an inpatient stay at a private hospital with a substance abuse treatment program. These private substance abuse treatment programs were praised for affording greater access to one-on-one therapy and “time to relax your mind” in a pleasant setting.

**Emergent Themes From the Cross-Case Analyses**

Five themes emerged as significant across the case study analyses. Although obviously interrelated, these themes represent different facets of the women’s lives. Table 2 presents these themes along with illustrative quotes.

**Theme 1: Betrayal of trust.** Stories of betrayal infused the narratives, many evoked by horrific incidents. As noted by Janoff-Bulman (1992), deeply held assumptions about a just world can be shattered when bad things happen, especially when perpetrated by trusted others. Children, for example, have simple assumptive worlds rooted in basic human needs for security and trust that can be breached, as the quotes cited in Theme 2 below illustrate.

For most of the women in our study, assumptive worlds were recalibrated early on to include bad things—family violence, neglect, poverty, and crime. Yet certain incidents occurred that shattered even these hardened worldviews—most involving men in whom the women had placed their trust, whether a foster parent or a hospital security guard (see Quotes 1a and 1b in Table 2).

Of course, not all relationships with men were abusive and victimizing. Similarly, betrayal could come from girls or women, for example, the mother who kicked a participant out of the house at age 13 to protect the abusive father, or the aunt who introduced a participant to illicit drug use. However, of all severe traumatic events recalled, only one involved a female perpetrator (a foster mother sexually abused 1 participant as a young girl).

**Theme 2: Horrific nature of traumatic events.** Underlying the arid landscape of statistical reports on victimization and trauma are personal stories of suffering. Below is a partial list of reported incidents, all characterized by their graphic nature and gratuitous viciousness.

- One woman was dragged from her bicycle during a vacation trip abroad, raped, beaten, and left for dead.
- Another participant was raped by her stepfather, uncle, brother-in-law, and numerous sex clients. Her pimp, the father of her daughter, died in her arms of shotgun wounds inflicted by a drug dealer.
- Yet another participant reported intense physical violence and abuse by her husband (see Quote 2a in Table 2).
- Finally, another woman and her girlfriend were drugged with LSD and abducted to a forested area by two men who raped, beat, and stabbed them (including genital mutilation). Her friend bled to death (see Quote 2b in Table 2).

Perhaps not surprisingly, we also heard accounts of witnessing trauma—I participant saw the murder and dismemberment of an elderly woman by drug dealers living in her crack-infested hotel. Virtually all of the women had witnessed brutal beatings, rapes, and even murders during their lives on the streets or in shelters.

**Theme 3: Anxiety related to getting out and speaking up.** Anxiety about leaving their apartment in general, and about attending treatment groups in particular, was common among the women interviewed. Leaving one’s comfort zone (whether the apartment or surrounding neighborhood) raised concerns about being preyed on or getting lost (see Quotes 3a and 3b in Table 2). With regard to attending treatment groups, participants were concerned about the emphasis on public speaking and private disclosure (see Quote 3c in Table 2).

**Theme 4: The desire for a place of one’s own.** At the time of the interviews, 9 of the women lived in their own apartments, and 4 were in adult homes or other congregate living programs. Although these 4 women had housemates, all of the women in our sample lived without friends, partners, children, or family. For those in adult homes, a yearning for autonomy and freedom from rules and supervision was palpable (see Quote 4a in Table 2).

All of the women had vivid memories of the struggle for shelter when they were homeless. For some, these included bartering a “resource” (see Quote 4b in Table 2). At other times, submitting to provider restrictions was the only way to get off the street, even if it meant sleeping on metal chairs (see Quote 4c in Table 2).

**Theme 5: Outcasts versus outlaws: Status loss and gender.** Although any of the preceding themes could ostensibly apply to men, the final one is gender specific, that is, the greater impact of stigma and status loss over the life course of homeless mentally ill women. For comparable men, the loss of life opportunities (a job or career) and the impact of stigma can also be profound, but such losses still leave open compensatory roles on the margins of society, for example, pimp, drug dealer, gambler, or hustler. Such activities, often valorized in movies, hip-hop, and country music, enable men to earn income as long as they can avoid getting arrested (although serving prison time is also viewed favorably in youth culture as conferring “street credibility”).

In contrast, women’s options for earning money off the books were largely confined to prostitution and shoplifting—or to assisting male partners in their illegal activities. Those with children were particularly dependent on the latter recourse.

Although homeless men are rarely considered “unmasculine” as a result of having a mental illness, homeless mentally ill women suffer social opprobrium for being “unladylike,” that is, not being mothers (or for being bad mothers), drinking and using drugs, and engaging in fights. (One participant spoke with amusement of how a male transsexual friend sought in vain to teach her how to be more feminine.) The masculine world of bars was one of the few places a homeless woman might feel welcome (see Quote 5a in Table 2). The sense of status loss was cumulative and often combined with self-blame (see Quote 5b in Table 2).

It would be misleading to focus entirely on losses in the absence of resilience and compensatory actions pursued by the women in this study. Indeed, 1 woman turned to wicca, or witchcraft, after leaving Orthodox Judaism and an abusive husband who had refused to give her a get (divorce) and took full custody of their two young sons. For her, wicca provided a sense of empowerment (see Quote 5c in Table 2).

The contrast between positive images accorded male “outlaws” and the negative imagery of female “outcasts,” while more suggestive than conclusive, highlights the greater vulnerability of women even at the lowest rungs of society.
Table 2  
Emergent Themes and Illustrative Quotes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Betrayal of trust</td>
<td>1a. “Foster care. . . now, you wanna talk about learning? That’s how you learn not to like or trust anyone. Six months here, 6 months there. Now, you’re my mother, I start to like you. You’re a decent human being. You care about when I’m hungry or not hungry. . . . So, I start to like you . . . the social worker’s here and I’m off to another house. Now, the man in the house, he’s raping me. Pulling my legs open, jumping up and down. You don’t know when you’re a kid what the hell’s going on.”</td>
</tr>
<tr>
<td></td>
<td>1b. “I wasn’t a patient, I was just visiting Manhattan State Hospital. This guy [hospital security guard] says, ‘Here’s a soda, come with me.’ And when we got around the corner, he pulled a knife on me, and cut me. Right here [shows scar].’ Interviewer: ‘This was while you were at the hospital?’ ‘And he raped me, and my guts were hanging out, man.’</td>
</tr>
<tr>
<td>2. Horrific nature of traumatic events</td>
<td>2a. “You try not to be in the house. Because if you are . . . boom! Up against the wall. My blood would be everywhere on that wall. The neighbors used to call the cops and went, ‘Get her out of there. He’s gonna kill her.’ He took me off the terrace with my feet. Hung me from the damn terrace. I thought I was dying that time. There’s so many times you almost died.”</td>
</tr>
<tr>
<td></td>
<td>2b. “So they take us up so high in the sticks . . . And then the acid started . . . it was a horrible experience. Then they, they knocked us out. They took all our clothes off . . . they put leather things on, in the ground, they did that to our feet and hands. They sodomized us, they, they put their penises in our mouth. They raped us. And then they, they took a tree branch. . . My friend didn’t make it the whole day. They cut up our vaginas. They made all kinds of slashes in it. You want to know about pain? Oh, I was praying for death! I lost over half my blood.”</td>
</tr>
<tr>
<td>3. Anxiety related to getting out and speaking up</td>
<td>3a. “Like guys be standing outside on the corner just standing there. . . . And it’s like sometimes like when I walk out the door it’s like I don’t know what to expect from other people. And . . . lot of things happen outside. People get robbed, people get mugged. People get raped. Sometimes things get scary.”</td>
</tr>
<tr>
<td></td>
<td>3b. “I don’t like to get lost. . . . I’ll panic. Me and lost don’t mix. . . . I got lost the other day. I ended up on the wrong train. . . and I ended up in Queens [laughter] . . . then I got lost again and I ended up on the wrong side, you know?” Interviewer: “You find your way back?” “I found my way. It took me all day. . . . I bought me beer then” [laughter].</td>
</tr>
<tr>
<td></td>
<td>3c. “I’m quiet in groups cause, you never know who can turn against you and throw it up in your face, and stuff like that. So, I’m not used to that. One on one is better for me, because I could talk.”</td>
</tr>
<tr>
<td>4. Desire for a place of one’s own</td>
<td>4a. Interviewer: “What do you think would help you to feel better?” SP: “Something that’ll never happen.” Interviewer: “And what’s that?” SP: “To have my own place and I, I, and I mean not associated with [adult home] at all. ‘Cause you know even when you get your own place, they still check up on you and they’ve got a key to your place. You can’t have any animals. I really want two or three cats. . . . I can never have pets. I’ll never truly be my own.”</td>
</tr>
<tr>
<td></td>
<td>4b. “Do you know when you’re out on the street, I couldn’t get a man to give me a roof over my head for one night. They would promise you: ‘I’ll give you a shower, I’d get you one night’s sleep, if you just give me a blow job.’ OK, alright already. You know, I figure 10 minutes of my life, hurry up.”</td>
</tr>
<tr>
<td></td>
<td>4c. “To get a bed, to get a meal, and whatever, you gotta say you’re crazy as a bedbug [laughs]. They said, ‘To get accepted in here [drop-in center], you must sleep on three of these chairs a night.’ They put ’em together, you could sleep on that. ‘Are you willing to do that?’ Yes. ‘OK. Well, Ms. [SP], there’s another thing here—we only allow people to stay here if they have a mental problem.’ OK . . . We knew that from the street, in the park I lived in. . . . You gotta play the role that they want you to play. I’m depressed, I’m homeless, I’m out in the snow. I’ve been robbed. . . . You know, you go through this whole role play, and then they say, ‘Would you accept medication?’ Yes, you would accept medication. Like, medication would do me any good.” [laughs]</td>
</tr>
<tr>
<td>5. Outcasts vs. outlaws—Status loss and gender</td>
<td>5a. “I was in a bar one day. . . . You know, I used to cruise around. That’s the only place a social person like me would go. Where am I gonna go, to the PTA meeting or something? No, no, you go to a bar and you talk with people.”</td>
</tr>
<tr>
<td></td>
<td>5b. “I have so much to really dominate me. . . . I let drugs and alcohol control my life. I was so weak for so long. . . . I won’t ever get back. . . . you know I only went high school. I almost joined the army and then I didn’t. ‘Cause I’d always get depressed and I would have been, I would have . . . maybe more than one trade. I would have seen the world. I think about that quite a bit too. Fifty-four years old, living in a home for women over 50. I think, I shouldn’t be here.”</td>
</tr>
<tr>
<td></td>
<td>5c. Interviewer: “So tell me more about witchcraft.” SP: “Well it just seems, first of all you’re worshipping a Goddess instead of a, instead of a God. . . . I seem to relate more. . . . It helps me to be more powerful and more assertive because, before, it seemed like I was always a victim.” Interviewer: “Okay. Any other ways it has helped you cope with things?” SP: “Well it, in a way a, a lot of, see people seem to treat me with more respect.” Interviewer: “Any people in particular?” SP: “No, just people in general.”</td>
</tr>
</tbody>
</table>
Discussion

This study has provided greater depth of understanding regarding the cumulative impact of substance abuse and trauma in the lives of mentally ill women. Although many of our findings are congruent with previous research, others were divergent or provided a more nuanced understanding. First, the sequencing of life events does not support a self-medication hypothesis but instead points to a bundle of common factors—poverty, family disorganization, and trauma and abuse. In a sense, the women in our study were self-medicating extreme stress accumulated over the life course.

Second, previous studies have focused on the motherhood role of seriously mentally ill women (Bassuk, Buckner, Perloff, & Bassuk, 1998; Mowbray, Oyserman, & Bybee, 2001; Zima, Wells, Benjamin, & Duan, 1996). In our study, almost half of the women had never had children; this was the same proportion as in the previous study from which the sample was drawn. Only 1 participant was able to maintain an unbroken custody of a child until adulthood. Thus, the role of mother—although absolutely critical at some points in the life course for some of the women—does not capture the totality of these women’s lives and experiences.

Third, substance abuse is multidetermined and contextual, the product of a desire to belong, to please a male partner, and to escape from painful realities. Despite regular reminders of the dangers of drugs and alcohol, the proximal incentives often outweighed the more distal disincentives. Proximity to liquor stores, drug dealers, and fellow substance abusers (in and out of treatment settings) was one of the few constants in these women’s lives.

Fourth, previous research on homeless women with Axis I diagnoses led us to expect mental illness to be a defining feature of their lives. Yet, the foreground of their stories, that is, the attributions they made about their life problems, was not one of severe mental disability but of psychological distress, abuse, and regrets over lost opportunities. For some, earlier experiences of psychosis, such as hearing voices and hallucinating, had long since given way to depression and anxiety. Thus, posttraumatic stress symptoms were a better fit than the original Axis I diagnosis.

Finally, this group of women was far from homogeneous—White and middle-class women were less likely to have substance abuse problems, and 4 of our study participants reported no trauma experiences at all. Although all were models of survivorship despite the social limbo into which they had been cast, a sense of personal agency was stronger among those who had attained independent housing. Although sometimes plagued by anxiety about getting out and about, women with their own apartments had personal havens and retreats from the turbulence that marked their lives.

Recommendations for Practice, Policy, and Research

Overall, the study findings reveal that formerly homeless mentally ill women need and want autonomy, protection from further victimization, and assistance in restoring lost statuses and devalued identities. These case study analyses identify themes that include avenues for intervention, including enhanced provider training to address (and offset) experiences of betrayal and trauma and more focused attention to current symptoms as opposed to previous diagnoses. We do not wish to imply that the Axis I diagnosis is irrelevant. This powerful and enduring label is, however, too often given priority over problems that are more immediate and disabling from the perspective of the consumer. As I study participant asked during an interview, “Wouldn’t you be depressed if you had my life?”

The study findings underscore the need for safe, affordable, independent housing for homeless persons with co-occurring disorders to restore their lost autonomy and enable recovery by normalizing their circumstances. Women’s desire for a haven from further victimization afforded by a place of their own is especially noteworthy.

Research has shown that assertive community treatment and harm reduction approaches are more successful in producing housing stability when consumers reside in independent apartments (Padgett, Gulcur, & Tsemberis, 2006; Tsemberis, Gulcur, & Nakae, 2004). The evidence is less clear on what additional factors enhance or impede recovery and improve quality of life. Current policies and service provision should include a “whole-person” approach that takes into account each client’s experiences with treatment and his or her views of recovery. For women, this approach should consider prior histories of trauma and the impact of cumulative trauma, both of which may help explain their lack of trust and social isolation.

Because many women expressed anxiety about personal disclosures in groups and traveling about the city freely on their own, services could focus (at least initially) on one-on-one encounters and community outreach to enhance engagement. Although such programs require funds for staff training and resources, they still remain far less costly than inpatient or residential care.

Future research might focus on (a) how some mentally ill homeless women (and men) are able to withstand environmental incentives promoting substance abuse and how (if at all) socioeconomic status is a protective factor; (b) whether (and how) symptoms of anxiety and depression are posttraumatic sequelae or comorbid features of the original Axis I diagnosis; (c) how gendered role expectations influence exposure to trauma and adaptive responses to adversity over the life course; and (e) how service utilization is affected by the changing mix of problems over the life course.

Strengths and Limitations of the Study

Generalizability (or the lack thereof) is often considered a limitation of qualitative studies, but this assumption is misplaced because case studies are designed to yield depth over breadth and representativeness (Feagin, Orum, & Sjoeborg, 1991). Thus, although our sample size was small from a quantitative perspective, the amount, texture, and quality of data were robust. At the same time, we acknowledge that our sample was skewed toward an older urban population with the potential for higher levels of disability, health problems, and exposure to trauma.

This study has a number of strengths, including its deployment of strategies for rigor, that is, debriefing and interviewer supervision, two interviews per person, auditing, and triangulated sources of data. Our strong emphasis on rapport and trust made us rarely doubt the veracity of what we were told—it is more likely that the participants underreported than misled or lied to us. We attempted at every step of the analyses to stay closely grounded to the data in making interpretations.
Of particular interest in cross-case analyses are insights that rise above (or go beyond) the obvious. For example, a theme of trauma would not have offered anything new given our study population, but our finding of the horrific nature of the traumas—involving near-death beatings, genital mutilation, and incest—points to a degree of personal suffering that goes well beyond the usual aggregate reports of victimization.

Conclusion

The women in our study recounted vivid life stories of survival amid a backdrop of family turbulence, emotional anguish, and social devaluation. Their perspectives provide useful balance to the provider’s-eye view that pervades the expansive literature on persons with co-occurring mental and substance use disorders. Recent innovations in integrated treatment models that address co-occurring mental illness, substance abuse, and trauma (Markoff, Finkelstein, Kammerer, Kreiner, & Prost, 2005) can be further enhanced by an inductive understanding of patients’ views on what is wrong, how it got that way, and what will make their lives better.

References


Received September 14, 2005
Revision received March 15, 2006
Accepted June 3, 2006