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STUDY GUIDE CE QUIZ

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The Need for LGBTQ-Specific Twelve Step Meetings

Though the higher rate of substance use disorders (SUDs) among sexual minorities— whether lesbian, gay, bisexual, transgender, and/or queer (LGBTQ)—is well-documented (Hicks, 2000), clients benefit from Twelve Step meetings and group therapy settings specifically designated for their community. This has not been definitively established due to a lack of research in this area, though researchers such as MacEwan (1994) and Senreich (2009, 2010a, 2010b) have begun building the foundation. For clinicians looking for evidence-based recommendations to make to their clients, this presents a conundrum. Their intuition may tell them that SUD clients in the LGBTQ community would benefit from attending LGBTQ-friendly meetings and/or group therapy sessions, but a solid foundation of data has not yet been built. And as a cautionary note, a gay member of both traditional and LGBTQ-friendly Twelve Step meetings points out, sexual attraction can be a distraction, though this is an issue that would also confront heterosexual clients attending traditional Twelve Step meetings. The authors of this article are attempting to aid clinicians in this effort by conducting research inside Twelve Step meetings in St. Louis, Missouri, as well as performing a review of the literature to bring to light whether existing data suggest there are benefits to LGBTQ-friendly meetings and groups. Furthermore, the research that has been done on sexual minorities and SUD treatment offers a path for how future researchers may establish whether this should be considered an evidence-based treatment.

Qualitative Field Research

With the permission of facilitators of LGBTQ-friendly Twelve Step meetings at the Steps Alano Club in St. Louis, Missouri, one of the authors was allowed to sit in on Narcotics Anonymous (NA) and Crystal Meth Anonymous (CMA) meetings in February 2017. While inquiring about the statement on Steps Alano Club's website stating that it is the current home of ". . . one of the oldest Gay Alcoholics Anonymous meetings in the nation, dating from 1974" (Steps Alano Club, n.d.), one of the leaders pointed us to a man we will refer to as Gary Smith—he agreed we could use his information as long as we refer to him by a pseudonym to protect his confidentiality. Many of the people who organized St. Louis's gay-friendly Alcoholics Anonymous (AA) meetings died in the AIDS crisis or have moved, according to Smith (personal communication, April 17, 2017). When Smith was trying to get sober in the mid-1980s, he recalled having trouble initially finding the gay-friendly AA meetings the staff at a treatment center had told him about. He would show up at a home where the meeting was supposed to occur and no one would be there—the information was apparently outdated. Eventually he found his way to the Episcopal denomination's Christ Church Cathedral in downtown St. Louis, where he was finally able to meet other members of sexual minority groups who were striving for sobriety.

Rejection by a heterosexual sponsor is what caused Smith to seek a gay-friendly meeting. In May 1984, Smith entered traditional AA (personal communication, May 2, 2017). But when he revealed his sexual orientation to his sponsor, the man abruptly walked out of Smith's house and life forever (personal communication, April 17, 2017). Even years later, a researcher hears the lingering pain of that moment.

Smith began attending the gay-friendly AA meetings in August 1984 (personal communication, May 2, 2017) and felt much more at ease when he got a gay sponsor, remarking later that he felt he could "trust him" (personal communication, April 17, 2017). Smith began holding candlelight versions of gay-friendly AA meetings, in which members speak of their struggles in near darkness, and recalled everyone hanging out afterwards and playing "gay Monopoly."

Having an LGBTQ social support group and learning to socialize without drugs or alcohol are important factors for resilience among sexual minorities (Callicott, 2012; Hicks, 2000). When one of the authors attended an LGBTQ-friendly NA meeting, a young community college student told him, without any prompting, that one of the factors keeping him sober was the new group of friends he made in the group. The young man remarked that they did simple things together like going out for pancakes (personal communication, February 17, 2017). It should be noted that this young man was seen later in the night holding hands with a young woman, so one should not make assumptions about the sexual orientation of people at these meetings. In fact, the candlelight NA meetings held late on Friday nights at Steps Alano Club is known for attracting young people who would not be considered sexual minorities. The authors hypothesize the nonjudgmental nature of these meetings may attract people outside the LGBTQ community who may feel safer sharing any details of their lives that they consider nonnormative. This is another area that would benefit from researchers inquiring into the sexual orientation of SUD clients (Flentje, Bacca, & Cochran, 2015).

Literature Review

SUD Prevalence in the Gay Community

The need for such research is great. An estimated 20 to 30 percent of gay and transgender individuals struggle with SUDs compared with 9 percent of the general population, according to researcher Jerome Hunt at the Center for American Progress (2012). The meta-analysis presented in his issue brief shows men who have sex with men (MSM) "are 9.5 times more likely to use heroin than men who do not have sex with men" (Hunt, 2012). In addition, Hunt points out, gay men are 12.2 times more likely to use amphetamines than heterosexual men. This is partly due to the "chem sex" or "party and play" phenomenon in the gay community, in which drugs like crystal methamphetamine, GHB/GBL, and mephedrone are used to enhance sexual pleasure and reduce fears of intimacy and engagement in same-sex intercourse (Bourne, Reid, Hickson, Rueda, & Weatherburn, 2014), but also has its origins in societal oppression (SAMHSA, 2012), which can result in individuals turning to substances as a coping method. SAMHSA (2012) researchers describe this societal oppression as resulting from heterosexism, which "resembles racism or sexism and denies, ignores, denigrates, or stigmatizes nonheterosexual forms of emotional and affectional expression, sexual behavior, or community." The effect on a member of the LGBTQ community can be "internalized homophobia, shame, and negative self-concept" (SAMHSA, 2012). Hicks (2000) points out that homophobia can also result in self-directed anger, suggesting an area clinicians may want to explore with LGBTQ clients struggling with sobriety.

In addition, while the Internet has provided opportunities for LGBTQ people to meet online, the central gathering places offline still tend to be gay bars and nightclubs, part of what Bourne et al. (2014) call the "gay commercial scene," describing it as the "infrastructure developed to facilitate the (socialization) of gay or bisexual men."

Experiences in SUD Treatment

Despite all the evidence about why LGBTQ individuals use substances at higher rates, there are "not enough controlled studies to demonstrate (the) effectiveness" (Hicks, 2000) of SUD treatment services designed specifically for the LGBTQ community. According to Cochran, Peavy, and Robohm (2007), a significant majority of the nation's SUD treatment agencies claim they offer them but, when prompted, less than 8 percent could identify a specific service they offer the LGBTQ community. For some LGBTQ

individuals in treatment, staff members' and peers' negative attitudes about their sexual orientation manifest as active homophobia (Matthews, Lorah, & Fenton, 2006), which creates a barrier to clients getting healthy. In a survey of 104 gay or bisexual people who had been in substance abuse treatment in the previous six years, Senreich (2009) discovered that 57 percent regarded their sexual orientation as having negatively affected them in their treatment program. In another study, Senreich (2010a) found that "being gay/bisexual in LGBT-specialized treatment were both positive predictors of current abstinence and negative predictors of leaving treatment due to 'needs not met/discharged' in comparison to being gay/bisexual in traditional treatment."

Experiences in Twelve Step Meetings

Like most SUD clients, members of the LGBTQ community are usually directed to Twelve Step meetings at some point in the treatment process. However, the perception that AA includes religious components may create a disconnect for LGBTQ individuals (Hicks, 2000). For example, five of AA's Twelve Steps directly reference "God" or "Him" (Bittle, 1982), which can present a barrier to LGBTQ folks who have rejected organized religions that denounce homosexuality (Hicks, 2000). However, Suprina (2006) found that many participants differentiated spirituality from religion. This differentiation enabled participants to develop a positive, personal relationship with a higher power that is independent of traditional religious denominations. This created a sense of belonging and served as a protective factor for the participants (Suprina, 2006).

Callicott (2012) also raises the issue of "pride" in the gay context—that is, feeling positive about sexual orientation and having made the choice to live authentically—and how it may be viewed as a character defect in the context of a Twelve Step program. This is another issue which may be handled differently in an LGBTQ-friendly Twelve Step meeting than a meeting facilitated by a heterosexual person or attended by a majority of people outside the LGBTQ community.

At one time, gays and lesbians were even discouraged from bringing up their sexuality, as it was believed it would cause a disturbance within the group or that it was not relevant to the recovery process (Green & Faltz, 1992; Lewis & Jordan, 1989). However, we now understand the importance of LGBTQ substance users having role models who are also members of the LGBTQ community and in recovery (Matthews et al., 2006). Like Gary Smith in St. Louis, who finally felt he could trust this process when he got a gay sponsor, LGBTQ role models provide safety and comfort, allowing those in the community to be themselves. It is through LGBTQ-friendly Twelve Step meetings that they can connect with possible sponsors and role models (Matthews et al., 2006).

However, there is a dearth of research into whether LGBTQ-friendly Twelve Step meetings are any more successful in keeping their members in recovery (Callicot, 2012). When researchers choose to query participants in SUD studies about their sexual orientation, much of the time it is because the study is directly related to HIV (Flentje et al., 2015). When Senreich (2009) researched abstinence among gay and bisexual men following treatment in traditional SUD programs, he found one-third of them were still using substances, compared with one-tenth of their straight brethren, despite attending Twelve Step meetings at the time they were surveyed. Senreich (2009) hypothesizes this is explained by the majority of gay and bisexual participants in his study reporting "at least some negative experiences in treatment due to their sexual identity."

Recommendations

The SUD treatment field would benefit from more research being conducted specifically into the effectiveness of LGBTQ-friendly Twelve Step meetings. There is anecdotal evidence that participants feel as though LGBTQ-friendly meetings are an essential component to their recovery. However, much of the existing research lacks empirical evidence surrounding the impact that LGBTQ-friendly Twelve Step meetings have on sustained recovery and whether these groups prove any more effective when compared with traditional Twelve Step groups. One avenue to achieving this involves asking questions regarding sexual orientation and gender identity in federal research conducted on SUD treatment (Flentje et al., 2015).

Implications for Social Work

Through analysis of previously completed research, it is clear that the issue of substance use disorders within the LGBTQ population is multifaceted. This issue is a result of decades of systematic discrimination coupled with continuous barriers to treatment directly linked to the stigmatized status LGBTQ individuals hold. The role of social work in combatting this problem involves working towards destigmatization at the macro, mezzo, and micro levels. From advocating for LGBTQ rights and conducting research on this issue to providing culturally competent services, social workers can play a large role in gaining control over this pervasive issue.

Individuals in the LGBTQ population report that their social service providers do not always administer culturally sensitive services. This is a factor that has been shown to drive clients out of treatment, leading to increased substance use issues. In order to combat this trend, it is recommended that increased training on LGBTQ issues be provided to those in the helping professions. Many organizations encourage employees to seek such training or attend events that promote knowledge about cultural awareness, but it is rare that these types of trainings are mandated. Education is the key to improving services, especially when those in the helping profession are not always aware of what they do not know. Workshops and trainings that delve into the ethical and supportive concerns associated with working with minority group clients are essential in taking steps towards breaking down the discrimination and stigma experienced by all minority populations, including the LGBTQ population.

Research also repeatedly demonstrates that systematic discrimination, coupled with the persistent stigma tied to the LGBTQ community, directly contributes to both the high prevalence of SUDs and difficulty accessing adequate treatment experienced by this population. In order to reduce the suffering currently experienced, work must be put toward combatting the stigma at a societal level as well as at the professional level. Efforts to educate young people in school settings about cultural acceptance serve to ingrain accepting viewpoints prior to a negative bias developing. This can be achieved in the form of educational workshops in addition to the creation of an inclusive school environment through supportive ally groups, the use of inclusive language schoolwide, and intentional bullying prevention initiatives. Combatting the effects of societal stigma felt by this population at a young age is recommended in order to reduce the likelihood of individuals in the LGBTQ population resorting to substances as a coping mechanism.

SUD clients in the LGBTQ community deserve safe, comfortable, inclusive environments for their Twelve Step meetings and group therapy sessions. Social workers, along with other members of multidisciplinary treatment teams, must never forget the ethical obligation to provide them.

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Learning Objectives

After reading this article, the participant should be able to:

1. Analyze what deters people in the LGBTQ community from engaging in treatment or mutual-support groups
2. Discuss the prevalence of SUDs in among LGBTQ persons
3. Explain why traditional Twelve Step meetings may not be welcoming to members of the LGBTQ community
4. Present recommendations for treating this population

Treatment of SUDs in the US Military

Several key events and names in US military drug programs stand out in history. In the 1960s, the Vietnam War was raging, a draft was enacted, and illegal substances were widely available. As a result, marijuana and heroin were commonly used in the military community. President Richard Nixon directed that a military drug urinalysis program be implemented as drug use increased (OUSPR, 2017). This program specifically targeted those returning from the Vietnam War and Nixon's stated intent was to identify those in need of rehabilitation. According to a report released in 1973, "approximately 42 percent of US military personnel in Vietnam in 1971 had used opioids at least once, and half of these individuals were reported to be physically dependent at some time" (OUSPR, 2017). In 1981, memorandum number 62884 was issued by the Deputy Secretary of Defense Carlucci, which authorized "punitive actions including courts martial or administrative separation for drug use" (OUSPR, 2017). Over time, more requirements have been added to the military drug program, including:

- 100 percent random testing for all service members and designated civilian personnel
- Mandatory testing for individuals entering the military within seventy-two hours of arriving to training
- Mandatory separation of members who knowingly use prohibited drugs (OUSPR, 2017)

Presently, these drug testing policies remain in place, and the military continues to maintain a zero-tolerance policy for the use of illegal substances. While treatment options are available to service members for alcohol-related issues, these treatment options require the oversight of the service member's chain of command.

Command and Supervisory Involvement

In the US military, order is paramount. The conduct of service members is governed by many policies, regulations, instructions, and similar prescriptions. Unit commanders are given much discretion as to how their units are organized and governed within the limitations of military regulations. This discretion allows those who preside over service members in the chain of command, such as supervisors or commanders, to have involvement in nearly all aspects of military life. For example, branch-specific fitness standards must be maintained by each service member. While the number of formal fitness evaluations on individual service members is limited by military regulations, commanders have the discretion to require daily physical training and monitor fitness levels off the record. In this way, commanders operate within the general confines of regulation, but they are able to exercise a great deal of latitude in the administration of their respective units. The oversight of substance use treatment in the military is, in many ways, similar to this level of oversight and monitoring.

Each service—Army, Navy, Air Force, Marines, and Coast Guard—are generally governed by the US Department of Defense (DOD), and base their respective regulations on DOD policies. DOD Instruction 1010.01 (DODI 1010.01), the Military Personnel Drug Abuse Testing Program, permits ". . . commanders to use drug testing to detect drug abuse and to assess the security, military fitness, readiness, and good order and discipline of their commands" (DOD, 2012, p. 2). Furthermore, commanders are charged to, "Process all service members who knowingly misuse drugs for separation in accordance with applicable service regulations. The established drug-testing program shall enable commanders to take action, adverse or otherwise (including referral for treatment), as appropriate" (DOD, 2012, p. 2). This general

DOD policy informs how the services operates and mandates commanders to separate service members who "knowingly misuse drugs." This career-ending mandate does not apply to alcohol—alcohol use is treated much differently, and is afforded treatment and rehabilitation options, which are described in further detail in the treatment section.

Commanders and Supervisors: Advocates or Adversaries?

As referenced earlier, commanders are charged with maintaining good order and discipline, ensuring military fitness, and guaranteeing deployment readiness among those whom they preside over within the chain of command. Within the broad scope of chain of command, supervisors are appointed to serve as mentors and have more close involvement in the daily life of their subordinates than commanders do. Though commanders and supervisors are not therapists, they have much control over the careers of service members, which includes participating in decisions pertaining to SUD treatment. Due to this close involvement with the treatment process, it is vital for military service members to have strong, positive relationships with those in their chain of command. In the AA Big Book, the author describes the importance and utility of achieving an understanding relationship between individuals in care and those who are helpers in the treatment process, stating:

> *Highly competent psychiatrists who have dealt with us have found it sometimes impossible to persuade an alcoholic to discuss his situation without reserve. Strangely enough, wives, parents, and intimate friends usually find us even more unapproachable than do the psychiatrist and the doctor. But the ex-problem drinker who has found this solution, who is properly armed with facts about himself, can generally win the entire confidence of another alcoholic in a few hours. Until such an understanding is reached, little or nothing can be accomplished* (Alcoholics Anonymous, 2001, p. 18).

This is not to say that commanders and supervisors involved in the treatment process must be "ex-problem drinkers," but to underscore the sentiment of a shared experience. In many ways, the comradery of the military can conceivably serve this purpose, but only if the shared military experience is mutually positive.

DODI 1010.01, on which specific service regulations are based, is aimed directly at keeping good order and discipline, placing commanders in a position to be viewed as adversaries to those who misuse drugs. In fact, if commanders know people are misusing drugs, then they are obligated to separate those service members, per DODI 1010.01. On the other hand, commanders have the best interests of their teams in mind. In some cases, members' immediate supervisors may become adversaries if those members are unable to develop positive relationships with their supervisors.
The perception of how commanders and supervisors are viewed by service members who misuse drugs and/or alcohol are based on interactions with the chain of command. If members have a largely positive experience with the chain of command and then a negative one when caught misusing drugs or alcohol, those members may have a positive perception of the leadership. However, if members are typically in trouble related to substance use, then they may view command and supervisory relationships to be purely adversarial.

Coverage and Treatment

Coverage

For those seeking treatment in the military, the direct system of care includes providers and facilities that are directly managed by the military services. They are organized by individual service and are managed by each service's surgeon general. However, there is currently a push for reorganization, and the DOD is tasked to conduct an evaluation of the proposed shift toward a unified medical command that would oversee the medical services of all branches. Due to capacity and staffing limitations, military treatment facilities are unable to provide care to all eligible beneficiaries and they must purchase health care services from civilian providers. TRICARE sets a lifetime limit of three SUD benefit periods where each period is 365 days from the first visit (Lakind, Sericano, & Still, 2012). Chemical detoxification is covered for up to seven days, although more days may be covered if medically or psychologically necessary. SUDs rehabilitation can occur in an inpatient or partial hospitalization setting. Inpatient treatment is covered for up to twenty-one days in a TRICARE-authorized facility. Outpatient group therapy for SUDs must be provided by an approved SUD rehabilitation facility (SUDRF). This includes sixty group therapy sessions per benefit period. Family therapy is covered after the completion of rehabilitative care. Unless provided by an approved SUDRF, individual outpatient therapy is not covered for SUDs (Lakind et al., 2012).

Treatment

Comorbidity of PTSD and SUDs is a major concern in the military. Individuals with PTSD self-medicate with drugs and/or alcohol in an attempt to reduce hyperarousal. Pharmacotherapy—used to address both PTSD and alcohol use disorders—includes antidepressants, anticonvulsants, and antipsychotic medications (Back et al., 2012). A case study showed that exposure therapy combined with naltrexone was more effective in alcoholism comorbid with PTSD than either therapy alone (Back et al., 2012). Psychotherapy is the most effective treatment for those with comorbid PTSD and SUDs, especially as medications have limited effectiveness (Foa, Keane, Friedman, & Cohen, 2008). There are various psychotherapies for PTSD and SUDs, but cognitive behavioral therapy, contingency management, couples and family therapy, and a variety of other types of behavioral treatment have been shown to have the best outcomes.

Integrative models of therapy, where both disorders are simultaneously addressed, show significant improvement in substance use severity, PTSD symptomatology, and overall function. Studies show that patients who improve PTSD symptomatology are significantly more likely to show subsequent improvement in substance use, whereas there is only minimal evidence that improvement in substance use yields improvement in PTSD (Back et al., 2012). These findings express the critical need to address PTSD in order to provide the most effective treatment for co-occurring PTSD and SUD patients.

Research supports cognitive behavioral therapy that addresses PTSD and SUDs concurrently. COPE—Concurrent treatment of PTSD and SUDs using prolonged exposure—consists of twelve individual, ninety-minute sessions that integrate relapse prevention for substance use with prolonged exposure for PTSD (Back et al., 2012). The SUD portion of treatment is designed to help patients identify environmental and emotional triggers as well as high-risk situations for substance use, and also effectively managing cravings through a variety of cognitive behavioral techniques. A unique addition to COPE is that it teaches patients to manage anger, a symptom of PTSD and a common trigger for SUD relapse.

The PTSD portion of treatment is designed to normalize common reactions to trauma and reduce PTSD symptoms via in-vivo (i.e., occurring in the real world) and imaginal (i.e., occurring in the imagination) exposure (Back et al., 2012). The prolonged exposure program includes education about reactions related to trauma, breathing retraining, and in-vivo exposure to situations that people avoid because they are reminded of their traumatic event and become anxious, and repeated imaginal exposure to the memories associated with the traumatic event. The treatment aims for patients to stop avoidance and confront trauma to help organize their memories, gain new perspectives, decrease emotional reactivity to memories, and enhance self-competence. In patients with PTSD and SUDs, the combined use of COPE plus usual treatment, compared with usual treatment alone, resulted in improvement in PTSD symptom severity without an increase in severity of substance dependence (Back et al., 2012).

Department of Veterans Affairs and DOD Joint Guideline

The US Department of Veterans Affairs (VA) and the DOD jointly published revised guidelines for treatment options using evidence-based practices, most recently in 2015 called the "VA/DOD Clinical Practice Guideline for Management of Substance Use Disorders (SUDs)" (2015). The Management of Substance Use Disorders Work Group (MSUDWG), which is a joint work group between the VA and DoD, make clear that the guidelines are only guidelines and not a rigid prescription for treatment modalities. This is important to remember for clinicians, as clients may respond differently to different treatment modalities. However, the guidelines contain evidence-based practices shown to be effective in significant numbers. The treatment guidelines cover a range of interventions for alcohol, opioid, cannabis, and stimulant use disorders and contain both pharmacotherapy and psychosocial interventions.

As referenced previously, DODI 1010.01 mandates separation for service members who misuse drugs other than alcohol. However, in addition to the separation process, the same instruction affords commanders the ability to refer members to treatment. As such, active duty practitioners may use the VA/DoD Guideline for treatment of substances other than alcohol, but should inform members about the possibilities of continued treatment at the VA when actual separation is imminent.

<u>Treatment Modalities Recommended by DoD and VA</u>

With a wide array of treatment options available and emerging interventions being discovered, it is important for practitioners to be aware of treatment options which will help clients to the greatest extent. However, as with all social work, it is important to consult evidence-based practices when selecting treatment modalities. That is where the VA/DOD Guideline offers guidance for practitioners. The recommendations mentioned in the Guideline relate to the severity of the addiction, medication-assisted treatment (MAT) or other pharmacotherapy options, and psychosocial treatment. An overall recommendation for patients with SUDs are peer linkage, network support, and Twelve Step facilitation.

Alcohol Use Disorder

The VA/DoD suggests acamprosate, disulfiram, naltrexone, and topiramate for MAT and states that "These medications should be offered in conjunction with a psychosocial intervention and considering the preferences of appropriately informed patients" (MSUDWG, 2015, p. 33). The psychosocial

interventions suggested for alcohol use disorder among active duty service members are behavioral couples therapy, cognitive behavioral therapy, community reinforcement approach, motivational enhancement therapy, and Twelve Step facilitation.

Opioid Use Disorder

The MAT recommended for opioid use disorder among active duty service members is buprenorphine/naloxone and methadone. The Guideline notes that, "For patients in office-based buprenorphine treatment, there is insufficient evidence to recommend for or against any specific psychosocial interventions in addition to addiction-focused medical management. Choice of psychosocial intervention should be made considering patient preferences and provider training/competence" (MSUDWG, 2015, p. 45). The Guideline goes on to discuss the benefits of urine testing to ensure medication regimen compliance, brief counseling with a physician, and participation in Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) as well as a possibility for contingency management.

Cannabis Use Disorder and Stimulant Use Disorder

There currently is no MAT recommendation for either cannabis or stimulant use disorder. No MAT is recommended for cannabis use disorder as no medication has been shown to be effective in its treatment. However, the psychosocial interventions recommended are cognitive behavioral therapy, motivational enhancement therapy, or a combination of the two. For stimulant use disorder, there are no recommendations due to a lack of evidence to suggest any MAT is effective in treating this disorder. The recommended psychosocial interventions for stimulant use disorder include cognitive behavioral therapy, recovery-focused behavioral therapy, or a combination of these two interventions with contingency management.

Issues and Recommendations

Commander notification and the lack of confidentiality in treatment of substance abuse discourage many service members from seeking treatment for fear of disciplinary actions. The result is that many service members suffering from SUDs are likely not receiving treatment (DOD, 2011). In 2010, the "Comprehensive Plan" was developed, which includes recommendations for SUD prevention, training for health care professionals treating SUDs, SUD services for military dependents, and the dissemination of SUD prevention materials (DOD, 2011). The Plan was enacted by US Senator Claire McCaskill (D-MO), who introduced legislation to overhaul the alcohol and drug abuse treatment programs throughout the armed forces. This plan provides detailed information on treating active duty military and includes the key aims of addressing the issue of confidentiality and disciplinary versus treatment issues in substance abuse programs (DOD, 2011).

Recommendations

One recommendation is to consider the benefits of abolishing immediate separation for drugs other than alcohol. The fundamental question posed in this recommendation is, "Can service members on active duty recover from drug abuse?" For alcohol use disorder, there are options for treatment and return to duty, but for other drugs, the finality of separation is the first option. Current policy grants

those with alcohol use disorder the opportunity to recover. While other drugs have the potential to be highly addictive and problematic, the viability of granting further recovery periods to those struggling with other drug use disorders to recovery while on active duty should be researched. A test run could be conducted with assigning active duty personnel to an active guard reserve (AGR) position while in recovery after inpatient or during intensive outpatient recovery. Regardless, further research is warranted to find out of such a recommendation is viable for active duty military members.

Another recommendation is to provide appropriate levels of confidentiality to those seeking treatment. There is currently no confidentiality for service members who seek care, which is a major barrier to seeking treatment. Substance abuse is a medical problem, and must be treated in a manner that protects those seeking treatment. Service members should not be discouraged to seek treatment for fear of punishment or negative consequences. Incorporating a nondisclosure statement may protect a service member's confidentiality while seeking treatment. Further evaluation of confidentiality concerns would benefit current standards of substance use treatment, particularly in researching the efficacy of having the chain of command involved in treatment. The benefit to this research is twofold:

1. Findings may uphold the involvement of commanders and supervisors, which could inform treatment protocols outside of the military to include civilian equivalents through bodies like employment assistance programs
2. Findings may show that involvement of the chain of command is a dangerous barrier to treatment, discouraging the disclosure of substance use issues and further endangering the military mission

Whether the zero-tolerance measures can be changed or confidentiality issues addressed through research, military members will inevitably continue being discharged from the military due to substance use issues. In doing so, it is vital to give our nation's veterans every opportunity to succeed in this transition. Unfortunately, little to no research exists on the current discharge process for members exiting the military due to substance use issues. Therefore, the final recommendation is to evaluate these exit procedures and ensure the discharges provide not only the best footing for members to move forward in their own lives, but for the military to ensure these discharges are truly ensuring the readiness of our military. Discharging members from the military is expensive, and others must be recruited and trained in their place. Additionally, those new recruits may just as well follow the same path out.

If these recommendations can be thoroughly analyzed and researched, more recovery will be seen within the ranks of our military. When military members have the opportunity to recover, not only are they able to preserve their own careers, but they will have the understanding to help others in the military who find themselves struggling with addiction.

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Learning Objectives

After reading this article, the participant should be able to:

1. Describe how substance use in the military is treated
2. Explain the role of commanders and supervisors in relation to substance use in armed forces
3. Evaluate some of the requirements of military drug programs
4. List psychotherapies that are effective for PTSD and co-occurring SUDs

Using Storytelling, Role Play, and Film with Incarcerated Women

Helping incarcerated women overcome addiction is one of the most challenging feats for addiction counselors and behavioral health professionals. Incarcerated women report a history of trauma and abuse at a much higher rate than the general population (O'Brien, 2002). As a result, increased numbers of female offenders in the criminal justice system (Sydney, 2005) suffer from addiction and have experienced trauma. To assist incarcerated women who have experienced trauma, addiction counselors and behavioral health professionals employ a number of trauma-informed interventions and other techniques to ameliorate the problem.

Unfortunately, women prisoners experience trauma at the hands of domestic partners and sexual assault behind bars. Traumatic events experienced in and out of incarceration make women more susceptible to substance dependence, relapse, and other mental health issues (Nowotny, Belknap, Lynch, & DeHart, 2014). Although traditional therapeutic interventions are adequate, the need for gender-responsive interventions and flexible behavioral strategies is essential. Policymakers are rethinking how to address the growing population of incarcerated women, while researchers address the most effective interventions. Storytelling can be a manageable way to package information in a way that gives meaning to these women's individual stories and provides easy retrieval from memory (Miller, 2015). Storytelling may be just as effective as traditional approaches to address trauma, substance abuse, and criminal behaviors in incarcerated women.

Changing Behavior

The role of storytelling, role play, and film as therapeutic interventions are prominently highlighted in narrative psychology, which focuses on the way people integrate and internalize specific details and events to make sense of the world (Leeder & Wimmer, 2007). Historically, addiction counselors have used storytelling to help incarcerated women connect with their peers in therapeutic groups, but most importantly as a vehicle to access buried emotions. Specifically, storytelling has been an integral part of the recovery journey in therapeutic communities (TC), residential facilities, and outpatient programs. Conversely, role play is often used as an adjunct to storytelling. Role play affords clients opportunities to process their stories in the safety of groups.

Formulating the Problem

Women represent the fastest growing segment of incarcerated individuals in the criminal justice system (Frost, Green, & Pranis, 2006). As a population, incarcerated women lack gender-responsive interventions and learning strategies to deal with substance abuse and criminal behaviors (Frost et al., 2006). Sydney (2005) highlighted a sharp increase of female offenders in the criminal justice system, positing this segment of the prison population doubled from 1990 to 2003. The Bureau of Justice Statistics reported "women make up 23 percent of persons on probation and 12 percent of those on parole" (van Wormer, 2010, p. 3). The increase of incarcerated women and limited learning strategies to support desired behaviors may pose a potential risk of recidivism among this segment of the population.

Using storytelling and film as a learning strategy in other contexts has been successful (Blasco, Moreto, Blasco, Levites, & Janaudis, 2015; Vázquez, 2014; Delamarter, 2015). This strategy could be considered to address substance abuse and criminal behavior in incarcerated women as a flexible alternative that

engages the emotional and intellectual nature of women dealing with traumatic memories. How people construct and tell their stories reflects and shapes who they are (Miller, 2015). Storytelling, as a learning strategy, can be a powerful tool for self-assertion that allows storytellers to reframe responses to trauma such as survival, resilience, and coping through reflection (Miller, 2015). Findings from this study may be of interest to counselors, social workers, and corrections officers who work with incarcerated women to prepare them for transition into the community.

Purpose and Research Question

The purpose of the qualitative narrative inquiry was to provide counselors who work with incarcerated women the opportunity to share narrative insights as to how film, documentaries, or other avenues of storytelling provided therapeutic support for incarcerated women. Storytelling had been used previously for therapeutic purposes (Blasco et al., 2015; Miller, 2015); however, less is known about using film with this population. The narrative analysis research design allowed researchers to gather firsthand accounts of the experiences of participants. Counselors who work with incarcerated women and have used film as a therapeutic approach were able to observe and assist their clients to reflect on themes presented in the film. Findings of the exploratory research addressed gaps in the literature and provided insights that could be used to support practice-based innovations and further research. In addition, the findings—while not generalizable—may be transferred to women who were on parole in community settings as a point of comparison or for further testing. The geographic location of the research study was southern California, and the research population for the study were counselors who worked with incarcerated women serving time in the southern California penal system. As researchers, we sought to explore the experiences and observations of drug and alcohol counselors and how storytelling, role play, and film were used as strategies to affect positive behavioral change in incarcerated women. The intent led us to the following research question: How do counselors who work with incarcerated women describe their experience using storytelling, role play, and film as a therapeutic strategy to drive behavioral change in this population?

Method and Design

Narrative analysis was used in the current qualitative study to accurately capture the storytelling of research participants. Narrative analysis provided researchers the ability to assemble and understand participants' narrative and construct meaning from the experiences within specific populations based on the environment in which those participants live, work, and interact (Clandinin & Connelly, 2004; Gudmundsdóttir, 2001). Freeman (1997) described the role of narrative analysis as a means to develop a deeper understanding of the value of people's life experiences, which other qualitative methodologies are not able to construe. Thus, storytelling can be seen as a powerful means to convey the insights and experiences of participants' thoughts, emotions, and interpretations of life events (Chase, 2005).

In the context of storytelling, the role of the narrative analyst is to observe "the telling or retelling of an experience [that] entails a complex combination of description, explanation, analysis, interpretation, and construal of one's private reality as it is brought into the public sphere" (Johnson & Golombek, 2011, p. 490). Traditionally in storytelling, a series of occurrences as shared by participants scaffold as a sequence of events and experiences. The construct of the stories shared by participants in this study may not be described in the exact order in which the events occurred. Narrative analysis is a collaborative enterprise, over a period of time, in which researchers and participants fully develop

experiences into profound and personal stories (Clandinin & Connelly, 2000). In qualitative research, researchers become instruments of the study that gather and interpret data (Glesne, 2011). Therefore, the role of researchers when employing narrative analysis is to give meaning and interpret the sequence of participants' stories logically and succinctly. Using narrative analysis allows researchers to acquire and further illustrate the stories, as revealed by participants, to promote a deeper understanding of the role of counselors' use of film during therapeutic support sessions when working with incarcerated women who are serving sentences in the southern California state prisons.

Participants

The population selected for this study was comprised of counselors who worked with incarcerated women in southern California and who used film to support behavioral change. The sample was drawn from a professional site constituting counselors who worked for the state prison systems where storytelling, role play, and film had been used in a therapeutic context. Participants in the study were certified or registered drug and alcohol counselors who had worked with incarcerated women for a minimum of six months. Participants ranged in age from eighteen to sixty years old—generally, drug and alcohol counselors retire or leave the field by the age of sixty. Participants' average number of years as a counselor in the addiction field was ten years.

The population and sample were purposively selected following guidelines established by Twining (2009), where the goal was to draw data from individuals best positioned to observe and comment on the research phenomenon of interest. Accordingly, the sample of interest were counselors who had experience using film as a therapeutic support for behavioral change. Counselors self-selected as participants in the study by responding to various announcements posted electronically at the principal writer's LinkedIn website. Interested individuals returned the signed consent form to the lead researcher. The next step involved confirming that each potential participant met the criteria for inclusion in the study. The intention was to interview between five to ten addiction counselors who worked with incarcerated women in the California penal system. Ultimately, ten addiction counselors were interviewed.

Data Collection

Telephone, face to face, and open-ended survey interviews were conducted with individuals who had self-selected by responding to a notice posted at a professional social media site, signed the informed consent, returned it electronically, and who were confirmed as meeting the criteria to participate in the study. Following the confirmation, each participant was contacted to set up a telephone or face-to-face interview. Six participants completed extensive interviews either in person or by telephone. Additionally, several participants provided data through an online survey that featured open-ended questions. Each of the researchers participated in the interview. Every participant was identified by alphanumeric code throughout the entire process. Transcripts and related notes were all labeled with the code.

Participants received an advance copy of the interview questions for the interview, which lasted about an hour. While all interviewers took notes, one researcher was the primary transcriber. Following the interview, the transcript was reviewed by all team members who checked against their notes for any

omissions or details. The transcript was sent to the participants for member checks within two weeks of the interview date.

Data Analysis

Analysis began once participants verified the accuracy of the transcript. The inductive analysis followed participant verification and each researcher read all narratives following validation of the transcripts by the participants. Each researcher wrote an abbreviated narrative that captured key points of the stories gathered from participants. Shared narratives were considered separately and collectively by all three researchers. The narratives were used as an introduction to the thematic analysis developed using the transcripts. Extensive memoing—that is, notes on what researchers are learning—about the transcripts was shared among the researchers, who reached consensus on emerging themes. A summary of themes was presented at the end of the analysis.

Results of Analysis

Ten drug and alcohol counselors who worked in the California Department of Corrections and Rehabilitation (CDCR) participated in the study. Each participant reported a minimum of two years and a maximum of eighteen years of experience working with incarcerated women with a primary substance abuse or dependence diagnosis. Drug and alcohol counselors referred to incarcerated women who participated in their sessions as "clients." This nomenclature was used in context to humanely address the women as members of a collective group who were seeking the skills and means of personal betterment and fulfillment. An additional term used during the study to identify the incarcerated women was "students," and this nomenclature highlighted the women's position as learners in the program. The narrative analysis began with a description of the use of storytelling, role play, and film as viable tools to encourage incarcerated women to discuss connections to self, others, and their crimes. Subsequently, the discussion centered on an overview of dominant themes and subthemes, which were key to understanding each counselor's experience when working with their clients.

Using a narrative analysis to capture the lived experiences of counselors who worked in the CDCR aptly summarized participants' understanding of the use of movies, role play, and storytelling as important strategies to affect behavioral change in incarcerated women. The use of film as a behavioral strategy in corrections is not readily embraced as a mainstream counseling intervention. Although, storytelling and role play have been efficaciously used in other contexts (Blasco et al., 2015; Vázquez, 2014; Delamarter, 2015), this study highlights drug and alcohol counselors' positive views of these strategies as effective tools in changing behavior in incarcerated women who suffer from drug and alcohol abuse and/or dependence.

Building Bridges: Awareness, Connections, Relationships, and Empowerment

The overarching theme of the study was "Building Bridges: Looking Back, Looking Forward" which represented the participating counselors' view that the use of storytelling, role play, and film afforded incarcerated women the opportunity to connect current behaviors to past trauma. This view was reiterated in each participant's story through key themes such as awareness, connections, relationships, and empowerment. Each theme was supported by several situation-specific subthemes distributed unevenly across stories that highlighted empathy, compassion, and healthy relationships. Subthemes

were embedded in counselors' observations and supported the broader themes of awareness, connections, relationships, and empowerment. Each theme is discussed in further detail below. Pseudonyms were identified for each counselor—Amy, David, Joan, Sue, Walter, and Yannick—and will be used throughout this section.

Awareness

The theme of awareness laid the foundation for progressive scaffolding of the concepts of connections, relationships, and empowerment. Each of the themes built upon one another to demonstrate a direct correlation of how the therapeutic strategies of storytelling, role play, and film were symbiotic in nurturing the behavioral changes evoked within the incarcerated women. Participants were reflective and insightful, recalling specific instances in which one or more of the behavioral strategies employed resonated with their clients. Working with their clients caused participants to pause and examine the process and overall effect the use of storytelling, role play, and film had on instilling an immediacy in the development of awareness. Furthermore, participants became aware of the prominent role they played when working with clients. Counselors' shared life experiences, which in many instances were similar to their clients, helped clients realize they were not alone. The power of sharing personal stories or "walking the walk" gained counselors the respect of their clients. This connection highlighted the similarities in experiences and lifestyles between participants and their clients; thus, it increased participants' awareness of their clients' struggles with addiction.

The theme of awareness emerged as a result of observing client behaviors, their personal growth, and counselor/client interactions. Furthermore, empathy, as a subtheme of awareness, became clearer as Joan's clients became more cognizant of the similarities between themselves and other group members. Joan reported that her clients often walked around the room, after listening to music, to appreciate the similarities in expression among their peers. This became the clients' first opportunity to observe others and learn to decipher facial and emotional differences and similarities in expression. Clients' ability to detect similarities in emotional expression between themselves and others may elicit empathy and deepen interpersonal connections. The documentary, *Children of the Camps* (Ina & Holsapple, 1999), enabled these connections and greater awareness.

According to Amy, the theme of awareness was salient in the movie *Collateral Beauty* (Dorros et al., 2016). Although the movie's primary theme centered on relationships, clients were able to connect other themes in the movie to their own feelings of grief and loss; thus, making them more responsive to the film's characters. Sensitivity to the storyline and the problems highlighted in the movie allowed clients to empathize with the characters. This was evident in their ability to identify with characters in the film.

The process of storytelling is significant because it helps clients gain personal awareness and empathy by listening to the stories of fellow inmates. Amy reported that a client's disclosure of newly acquired insight caused a domino effect in the group. Clients garnered increased awareness of their environment and of each other, "connect more to their pain and personal story and therefore demonstrate growth." For example, one of Amy's clients became notably softer, more polite, and respectful after seeing those behaviors modeled in film. The client even renounced previous behaviors, stating that she dreamt of becoming a drug and alcohol counselor instead. Amy further noted the following: "Change happens,

awareness happens, and empathy is cultivated naturally." Her saying symbolizes the connections between change, awareness, and the ability to empathize with others.

Connections

Results from this study showed a natural flow from the theme of connections to that of awareness; which was further supported by the subtheme of compassion. Reflecting on the stories highlighted and the connections between themes, the counselors began their work with a fragile population by connecting their personal past experiences through similar stories. By employing this strategy, incarcerated women reexperienced their own stories in the safety of the group, knowing they were not alone on the journey to recovery. Openly communicating via storytelling, role play, and film facilitated discussion about clients' trauma, which was shared in a safe environment with other group members. The connections formed extended from clients' ability to show empathy to another's plight.

Sue's clients experienced change though what she referred to as "a light bulb moment"; for example, clients realized that they were not alone on the journey ("Oh, I'm not the only one"). The use of storytelling, role play, and film can be seen as a bridge that connects clients to each other and the therapeutic process; this connection highlights what counselors refer to as "the theory of universality." Sue believes there are different types of bridges just as there are different types of clients. A bridge can be used to go back to the past, through reflection, or to move forward through forgiveness. The bridge symbolizes connections to the past, present, and future.

Although Walter did not express a direct connection to his clients, mostly because of gender differences, he noted that he could relate to their experiences as addicts. He reflected on his work with incarcerated women, referring to it as interesting; "the connection between women is not necessarily present between incarcerated men." Walter's use of storytelling and role play focused on connecting with female clients from the standpoint of a safe role model. He described these strategies as a bridge that connected clients in a safe milieu.

Walter used role play as an effective therapeutic strategy; for example, his clients listened to the song *Rolling in the Deep* by Adele (Adkins & Epworth, 2010), as a way to connect to traumatic events that reminded them of being in deep dark waters. Walter and other counselors are cognizant that role play and similar strategies (e.g., listening to songs) evoke memories that can cause transference and countertransference. He explained that "the women connected to the 'deep' as their personal darkness"—for example, they rolled into the criminal lifestyle but were unable to roll out of it. Listening to songs can be a powerful medium that touches clients on a deep emotional level, especially, when the song has a "personal connection to specific events in the client's life." Walter reported that his clients shared specific parts of their lives with one another after listening to the song and that these connections transcended the actual role play. He encouraged his clients to reenact movie scenes, the lyrics from a song, or group processes (e.g., "being prostituted or assaulted by a spouse or partner"). Consequently, clients shared lived experiences and commonalities with each other, thus connecting on a deeper level.

Relationships

The transition between the themes of connections and relationships was seamless. These links were forged as clients saw their experiences play out in film and were able to connect to the characters in the film and other members of the group. Yannick added her perspective regarding relationships in prison, stating that inmates often try to form homogenous relationships based on race. The prison system promotes racial segregation, which keeps clients from establishing relationships with people who are different. Yannick indicated that the basis of her work with film, such as the movie *Beaches* (Bruckheimer-Martell, Midler, & Jeuth, 1988), provided a catalyst "to help clients understand that they can be friends with women from different cultures and racial backgrounds." Developing relationships with diverse racial and ethnic groups encouraged a greater understanding of culture and ethnic differences and helped clients highlight shared similarities and life experiences. Discussions following the film often transitioned to role play, reinforcing what clients learned from the film. For example, the movie *Beaches* highlighted the lesson of friendship. Participants used lessons learned to asked questions such as "In your own life, what would you have done differently?"

The topic of relationships and healing led David and Walter to share the importance of discussing the difference between a bad relationship and a healthy relationship. David challenged his clients to describe one type of healthy relationship and what made the relationship healthy. Films such as *Hidden Figures* (Gigliotti, Chernin, Topping, Williams, & Melfi, 2016), allows women to visualize what a healthy relationship with other women might look like. David and Walter believed they played a significant role in the recovery community; both men realized that many female inmates had never experienced healthy interactions with men.

Empowerment

The fourth and final theme, not surprisingly, is empowerment. The role of empowerment was cultivated through building the foundations of awareness and connections, which led to healthy and meaningful relationships that transcended culture, ethnicity, and race. Each theme became the basis for an emotional bridge that led to new behaviors, forgiveness, and hope for a brighter future.
Sue often shares her recovery journey with her clients and advises them that sobriety is a journey, not a destination. She has been clean and sober for fifteen years, but continues to attend Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings. Sue proudly displayed her certificates of achievement to demonstrate that in spite battling demons related to substance dependence, there is still hope. Displaying these certificates was Sue's way of motivating her clients and eliciting conversations about their goals. Information garnered from discussions are sometimes used to develop the treatment plan. Sue's role as a counselor was to empower and guide her clients, help them build self-confidence, and encourage them to develop self-esteem.

Each participant reported observing their clients' transformations and an increased sense of empowerment following the use of film, role play, or storytelling. For example, Yannick had observed clients heal, take ownership of past behaviors, and forgive others. Yannick's goals for her clients were to become better communicators, develop positive relationships, and voice their pain, thus building a positive future and healthy families. Empowerment for Joan's clients took the form of "I statements." The film *Gimme Shelter* (Krauss & Rice, 2013) allowed Joan's clients to better relate to the difficult tasks of making choices, moving forward, and forgiving. Each step in the healing process encouraged change, resulting in personal fulfillment. Walter's clients also experienced personal growth; they allowed themselves to explore options and reflect on past experiences. Clients appreciated Amy's story because

it gave them hope that they too could lead a fulfilling life. Amy was confident that her clients could change once they knew it was possible.

Summary

Drug and alcohol counselors who used film as a therapeutic strategy with incarcerated women confirmed that people are primarily social learners and gain new knowledge through observation, imitation, and modeling (Bandura, 1971). Counselors reported that the use of film had been an effective tool in supporting behavioral change. Thus, this study sought to reveal how storytelling, role play, and film are used as learning strategies to change behavior in incarcerated women in the CDCR. The insights into this form of behavioral intervention may support incarcerated women who are able to incorporate newly acquired behaviors by participating in reenactments of their stories. The theme of awareness emerged early in the analysis with counselors based on their clients' awareness of feeling that they were not alone—hence the theory of universality. Moreover, clients developed empathy as a result of the awareness that others share in their suffering and struggle.

Conclusions and Recommendations

Female offenders are a growing population in the American justice system and are more vulnerable to trauma and abuse (O'Brien, 2002). Moreover, this population is susceptible to mental illness and substance dependency, thereby increasing the need for therapeutic and behavioral strategies that address their unique needs. Developing gender-responsive treatments and understanding women's pathways into criminality has been a priority for researchers and clinicians alike (Kauffman, Dore, & Nelson-Zlupko, 1995). The effects of using gender-responsive interventions cannot be understated; however, this study found that utilizing storytelling, role play, and film as adjuncts to treatment can provide positive outcomes for incarcerated women.

The current findings may provide drug and alcohol counselors, social workers, and prison officials with a deeper understanding of the importance of developing alternative therapeutic strategies to help prepare incarcerated women for a successful reintegration into society. Therefore, providing a flexible alternative that help incarcerated women make the connections between past trauma and the pathway to criminal behavior is essential to effective treatment. Incarcerated women find commonality with the characters in stories and are able to tell their personal stories through these characters. Additionally, film provides a way for them to make sense of lived experience (Eisner, 1999; Eisner, 2004) and does so by providing a safe platform to tell their story.

Inmates are able to reflect on past trauma in the context of storytelling, role play, and film. Blasco et al. (2015) proposed that cinema engages the heart and mind; thus, the arts allow clients to address traumatic events in a cognitive way. Behavioral health professionals and addiction counselors can take advantage of the use of storytelling, role play, and film to promote transformative learning when combined with structured reflection (Delamarter, 2015). For example, this study highlights the need for learning environments in which healthy relationships are cultivated.

Some clients garnered new skills necessary for healthy interpersonal relationships in a diverse environment. Incorporating the arts as an adjunct to other therapeutic interventions can enable greater client engagement in the therapeutic process. Additionally, the strategies employed by drug and alcohol

counselors in this study provided an opportunity for clients to gain insight, self-worth, and a sense of empowerment that promoted more empathy. This knowledge could only have been revealed through the narrative stories of dedicated drug and alcohol counselors who participated in the study. Results of the study may also add to the body of knowledge on therapeutic strategies, behavioral studies, innovative prison counseling programs, and prison reform.

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Learning Objectives

After reading this article, the participant should be able to:

1. Clarify how storytelling, role play, and film may be used as learning strategies in treatment
2. Describe the narrative analysis research method
3. Define each of the subthemes in the theme of the study
4. Explain some of the issues incarcerated women might be struggling with