

Running head: THE EXPERIENCES OF MENTAL ILLNESS AND ADDICTION

The Experiences of Mental Illness and Addiction among Men and Women with  
Co-occurring Disorders

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### Abstract

The study presented used empirical phenomenological methods to gain insight into the experiences of chemical dependence and mental illness among men and women with co-occurring disorders. The literature review discussed issues concerning: gender with the self-construal, traditional gender norms, and gender as a factor in the co-occurring disorder population. The results of this study include the following themes: catalysts for change, positive and negative self-concept, substance use as a means of self-medication, and therapeutic factors. Implications for the counseling profession, and implications for further research were discussed.

## The Experiences of Mental Illness and Addiction among Men and Women with Co-occurring Disorders

The following study delves into the query of how men and women with co-occurring disorders perceive their experiences of mental illness and addiction. Six interviews have been conducted, transcribed and analyzed using an empirical phenomenological qualitative paradigm.

### Review of the Literature

For mental health and addiction practitioners, gender specific issues and themes are important to developing the best possible course of treatment for clients with co-occurring disorders. The review of the literature explores relevant issues among the co-occurring disorder population, as well as investigates studies that examine whether gender stereotypes are imbedded in an individual's self-concept, or self-construal. Studies that consider gender as an influencing factor in the presentation and existence of special concerns among the co-occurring disorder population in specific clinical areas are discussed.

No such study has been discovered regarding the perceived experience of men and women with co-occurring disorders. Research examining the perceived experiences of chemical addiction and mental illness is also deficient in the currently available literature.

### *Co-occurring Disorders*

The National Comorbidity Study (NCS) found that 51% of people diagnosed with a mental illness had been chemically dependent or abusive at some point during their lifetimes. In addition, 41-66% of people who are chemically dependent or abusive had a mental illness diagnosis at some point during their lifetimes (Kessler, McGonagle, Zhao, 1994). The presence of one or more psychiatric illness or personality disorder and dependence or abuse

of a mood altering substance is known as co-occurring disorder. Psychiatric disorders, that are non-substance use mental disorders are typically seen among people with co-occurring disorders including psychotic disorders, and mood disorders (CSAT, 2005).

The presence of a mental illness increases the risk of chemical dependence and abuse, just as being chemically dependent or abusive increase the risk of developing a mental illness (Daley, 2003). The abuse of drugs (illegal and prescription drugs) can exacerbate mental disorder symptoms and induce new symptoms (Daley). Often, the abuse of drugs and alcohol is a major factor in a person discontinuing the regular dosage of psychotropic medications (Daley). Drug and alcohol abuse also interferes with the effectiveness of psychotropic medication (Daley). People with co-occurring disorders experience higher rates of psychiatric hospitalization, social (family, occupational, relational and legal) problems, violence and incarceration, HIV and STD infection, and treatment attrition (Daley).

There is growing recognition of this issue among mental health and chemical dependency clinicians, and researchers. Researchers have examined varying aspects of the subject of co-occurring disorders. The increasing body of research has predominantly focused on the best practice for integrated services, common mental illness and substance dependence type combinations (Amodia, Eliason, 2006), program descriptions, treatment guidelines (Comtois, Ries, 1995), validity of self reported drug use (Covell, Essock, Frisman, Jackson, 2004), and treatment design in correctional facilities (Dolan, Kolthoff, Schreck, Smilanich, Todd, 2003). Researchers have also examined trauma-focused services for women with co-occurring disorders (Bjelajac, Elliot, Fallot, Markoff, Reed, 2005), motivational interviewing for people with co-occurring disorders (Carroll, Martino, Nich,

Rounsaville, 2006), and treatment outcomes for co-occurring disordered people with minority (gender, racial and sexual orientation) identifications (Amodia, Eliason, 2006).

*Gender Stereotypes in Self-Concept*

Chatard et. al. (2006) explored gender differences in the construction of self-concept and questioned whether men and women implemented learned gender roles into their self construal. Eagly and Steffen (1984) purported that gender role stereotypes are learned through the observation of men and women in social roles. Eagly and Steffen also reported that the information acquired from observing men and women in various social roles is interpreted as the innate characteristics of being male and female. For example, if an individual observed women in the role of homemaker and men as being employed in paid workforce, then the observer will assimilate the characteristics of nurturance and concern for others with being female and self-assertion and independence with being male. Josephs, Markus and Tafari (1992) and Cross and Madson (1997) assert that women's self concept emphasizes interdependence and nurturance while men's self concept emphasizes independence and personal accomplishment.

Chatard, et al. (2006) administered a questionnaire (composed of eight male stereotypes and eight female stereotypes) to men and women asking them to identify characteristics that describe and do not describe themselves and identify characteristics that describe and do not describe the typical man and woman. Chatard, et al. discovered that the study participants' self descriptions were positively associated with their corresponding gender stereotype. The participants' description of the typical man and woman also was positively associated with the corresponding gender stereotype. Thus, the results suggest that men and women incorporate learned gender stereotypes into their self-concepts.

The centrality of a gender role reflects the degree to which that role serves as a means of defining one's self-concept. Stress experienced in a social role that is exceedingly central to a self concept may be menacing to his or her self-concept and may impair psychological well-being. Brown et al., (1987) found that women who experienced a stressful life event in a social role area that was highly central to their self-concept were three times more likely to become depressed than women who experienced a stressful life event in a social role area that was not highly central (Brown et al., 1987).

### ***Traditional Gender Roles***

Chartard et. al. (2006) suggest that gendered stereotypes influence self-concept. Researchers (Brannon & Juni, 1984; Burn & Ward, 2005; Cohn & Zeichner, 2006; Cole & Zucker, 2007; Coonert-Femiano et.,al., 2005; Diemer et. al., 2003; O'Neil, 1981; Thompson & Pleck, 1986; Walker et al., 2000; & Wong et. al., 2006) have explored the qualities and characteristics that are typically stereotyped as masculine and feminine. Observations are also noted regarding the influence of gendered roles as highly central to one's self-concept or self-construal.

#### *Feminine norms*

Coonert-Femiano et.,al. (2005) examined the characteristics associated with femininity. The authors used multiple focus groups of women and men of varying ages, races and sexual orientations. After several drafts, the authors posed a draft of the Conformity to Feminine Norms Inventory to both men and women. This inventory described feminine norms in the eight-factor structure: nice in relationships, thinness, modesty, domestic, care for children, romantic relationships, sexual fidelity and investment in appearance.

Cole and Zucker (2007) assert that women who fail to successfully perform the prescribed feminine normative behaviors often face social reprimand. For example, people may respond disapprovingly to women who do not say “please” when making a neutral request, who act as assertive leaders, and who choose not to become mothers. Cole and Zucker (2007) assert that women devote extensive thought and emotion to these ideals, (whether or not they accept them) because women gain power and status through accommodation to them. Many women experience pleasure or power from behaviors associated with femininity, particularly those associated with appearance and mothering. However, such activities can simultaneously be experienced as attempts to meet a frustratingly demanding ideal (Cole, Zucker, 2007).

### ***Masculine norms***

Thompson and Pleck (1986) stated that the traditional masculine identity is founded on three main items: success-status (often determined by income), anti-femininity (avoidance of stereotypical female associations, behaviors, or occupations), and toughness (measured by physical strength, competence, ability to independently solve emotional problems and avoidance of displaying vulnerability). Diemer et. al. (2003) created the Conformity to Masculine Norms Inventory (CMNI), which describes masculine norms in the following categories: winning, emotional control, risk-taking, violence, dominance, promiscuity, self-reliance, primacy of work, power over women, disdain for homosexuals, and pursuit of status.

Burn and Ward (2005) used the CMNI along with the Relationship Assessment Scale (RAS) (Dicke, Hendrick & Hendrick, 1998) to measure how conformity to masculine norms impacts intimate relationship satisfaction by administering the CMNI and the RAS to men

and their significant others. They discovered that conformity to traditional masculine norms were negatively associated with relationship satisfaction for both men and their significant others.

Cohn and Zeichner (2006) asserted that adherence to gender role norms predisposes some men to engage in behaviors viewed as consistent with traditional masculine behavior, such as being dominant, competitive, and physically strong. Brannon and Juni (1984), and Walker, et al. (2000) purport that the traditional masculine identity consists of four dimensions: competitiveness and dominance, limited emotional expression, gender role stress (pressure to maintain gender role norms and expectations), and anti-feminine attitudes. O'Neil (1981) asserts that men are socialized to fear and devalue femininity and that unexpressed emotions may result in explosions of anger and inhibit intimate exchanges with loved ones. Femininity is often associated with emotional expressiveness, thus men are having internalized cultural messages that associate masculinity with emotional inexpressiveness (Wong et al., 2006).

#### *The Influence of Gender in the Co-occurring Disorder Population*

Although the current literature does not examine the perception of experience of mental illness and chemical dependency among men and women with co-occurring disorders, the currently available literature presents offers various differences that exist between men and women with co-occurring disorders.

Comtois and Ries (1995) conducted an exploratory examination of gender differences in demographics, psychiatric diagnosis, substance use, severity of psychiatric and substance dependence symptoms, level of noncompliance, level of dysfunction and variable related to

treatment. The sample consisted of 121 women and 217 men from a rehabilitation center that combines mental health and chemical dependency treatment. The authors drew their data from the rehabilitation center's case management records, psychiatrist reviews and records, and quality assurance programs. They gathered information about client services through the center's billing records, and also applied the assessment instrument, Case Manager Rating Scale (CMRS).

The results from Comtois and Ries's (1995) study indicated that both gender groups had equal rates of legal involvement and in length of time enrolled in treatment. However, the women in this sample tended to be referred by a chemical dependency treatment center or by themselves, while the men were referred by a mental health facility or by family members. In addition, the occurrence of clients using the treatment center as a protective payee and as providing medication services is also related to gender. The men rated significantly higher in using the treatment center as a protective payee, while the women used the treatment center to provide medication services.

Comtois and Ries (1995) found no significant difference in terms of demographics, although, in terms of psychiatric diagnoses men had higher rates of schizophrenic disorders and women had higher rates of affective (depression and anxiety) disorders. This study showed a higher rate of polysubstance use, alcohol dependence, substance dependence severity and lower functioning among the men in this sample. Discrepancies within the prior results were similar to the findings of Mangrum, Spence and Steinely-Brumgarner (2006).

Mangrum, Spence and Steinely-Brumgarner (2006) examined the differences between gender groups in the domains of psychiatric diagnosis, psychiatric severity, and substance dependence type. The authors gathered a sample from six chemical dependency

treatment centers. The sample gathered by the authors consisted of 213 individuals entering chemical dependency treatment; 86 sample participants were female and 127 sample participants were male.

The authors used four assessment instruments in order to assess psychiatric diagnosis, psychological symptom severity, substance use diagnosis, and substance use patterns. Mangrum, Spence and Steinely-Brumgarner (2006) used the Mini International Neuropsychiatric Interview (MINI) to assess psychiatric diagnosis, the Brief Symptom Inventory (BSI) and the Brief Derogatis Psychiatric Rating Scale (BDPRS) to assess psychological symptom severity, and the Behavioral Health Integrated Provider System (BHIPS), which is a mandatory client-monitoring program for state-funded treatment centers in Texas. The authors were able to gather data regarding substance use diagnosis, and substance use patterns from the BHIPS.

Mangrum, Spence and Steinely-Brumgarner (2006) found that there were no significant differences between gender groups in regards to psychiatric diagnosis of depression, bipolar disorder, dysthymia, hypomania, panic disorder, obsessive compulsive disorder, generalized anxiety disorder and psychotic disorder. They did find, however, that woman had a significantly higher rate of Post Traumatic Stress Disorder (PTSD) than the men in this sample. Their results showed that differences existed in psychiatric severity between gender groups. Men rated higher on the phobic anxiety, psychosis, positive symptoms, and paranoid ideation scales of the BSI than the women in this sample. Also shown in the results is that men and women were similar in their rates of being diagnosed with affective and anxiety disorders, and no other psychiatric disorder diagnosis differences

were found between gender groups. The gender groups were similar in their rates of previous detox, inpatient/outpatient and emergency room visits.

Mangrum, Spence and Steinely-Brumgarner (2006) reported that their results indicated differences in substances type used and substance use patterns between the gender groups. Men in this sample had higher rates of alcohol as their primary substance dependence type, while women used opiates, and cocaine as their primary substance of choice. In addition, the results indicated that women had higher rates of polysubstance dependence, in contrast to the results of the study conducted by Comtois and Ries (1995).

Through their inquiry, Mangrum, Spence and Steinely-Brumgarner (2006) discovered that while men in this sample had higher rates of psychiatric symptom severity, they had a higher rates of reporting that substance use as the primary factor in problematic days, rather than reporting that psychiatric symptoms and social problems as factors in problematic days. Women in this sample had higher rates of substance dependence severity, and higher rates of reporting that psychiatric symptoms and social problems as factors in problematic days, rather than reporting that substance use as the primary factor in problematic days. The authors suggest that these findings are indicative that there is a gender differential regarding perception of psychiatric and substance dependence on life functioning; based on the demonstration that women in this sample were more willing to report psychological and social problems, and men were more willing to report substance use. DiNitto, Rubin and Webb (2002) also indicated that a gender differential existed in regards to client reports on psychological, social, and family history.

DiNitto, Rubin and Webb (2002) examined the differences between men and women with co-occurring disorders regarding problems upon inpatient chemical dependency

treatment program admission. Additionally, the authors examined outcome measures following completion of treatment. Their sample consisted of 46 men and 51 women, who had both an Axis I diagnosis and a substance use disorder. The measures used for this study consisted of the Addiction Severity Index (ASI) at the initial admission and the CMRS in addition to the ASI, at follow-up. The ASI was assessed drug and alcohol abuse and dependence, psychiatric symptoms, family and social problems. The instrument also measures medical, legal and employment problems. The CMRS was used to collect collaterals.

DiNitto, Rubin and Webb (2002) reported that the women in this sample were rated as both having more family problems, and had higher rates of request for family and social counseling than the men in this sample. Yet, the women in this sample reported having higher rates of reporting close relationships with significant others and children, than the men in this sample. The women in this sample also had higher rates of perceiving themselves as psychiatrically problematic at the follow-up interview, than did men. Compared to the women in this sample, more men in this sample reported that they were addicted to alcohol, only. The women in this sample had higher rates of drug use and drug overdose. In addition, women reported more instances of family history with addiction and mental illnesses, than the men in this sample. The authors surmise that women may have less inhibition to disclosing problematic social, familial, psychological and substance issues, than men. “Discussing family and social problems may not seem like a ‘manly’ thing to do, and many men have been socialized to cut off their feelings about these matters” (DiNitto, Rubin & Webb, 2002, p. 115). The authors suggest that a same-gender group for men with co-occurring disorders may facilitate them in identifying and socially reinforcing the expression

of their emotions. Brunette and Drake (1998) also found that the men in their sample had lower rates of social connection, than did the women in their sample.

While DiNitto, Rubin and Webb (2002) indicated that the men in their sample had a lower propensity toward social, psychological and substance dependence insight, Amodia and Eliason (2006) purported that the men in their sample were more likely to be successful in the residential treatment program for clients with co-occurring substance use disorders and mental illnesses. Amodia and Eliason examined the impact of gender, as well as race and sexual orientation on treatment outcomes within the co-occurring population.

Amodia and Eliason (2006) conducted a retrospective chart review of client records, and collected descriptive statistics. These were examined regarding personal background, substance use history, mental health diagnosis, treatment outcomes, and demographics. Treatment outcomes were measured by number of days in treatment and complete versus incomplete discharge. Examining gender specifically, 69 men and 54 women were compared. The results showed that women had lower HIV rates, less legal involvement, lower duration of drug use and fewer days in treatment than the men in this sample, though women had higher rates of attrition and incomplete discharge. Women were also more likely to have higher rates of methamphetamine addictions and higher rates of Depressive Disorder and PTSD than the men in this sample. The men in this sample, in addition to having higher successful completion rates than women, had higher rates of alcohol dependence, higher rates of schizophrenia, and higher rates of drug-induced psychosis. The authors reported that, in regards to treatment outcomes, African American and White men had the highest rate of successful completion of discharge. Gay and Bisexual men had the second highest rate of successful completion of discharge, and Lesbian and Bisexual women had the second lowest

rate of successful completion of discharge. The least successful demographic in this study consisted of the heterosexual women. Heterosexual women also had the highest rate of PTSD, and the authors surmised that there may a correlation between PTSD and resistance to treatment.

In the study conducted by Mangrum, Spence and Steinely-Brumgarner (2006) the results indicated that women had higher rates of PTSD than men in their sample. Mangrum, Spence and Steinely-Brumgarner suggest that clinicians routinely assess for PTSD. They also suggest that specialized groups for women with PTSD may be useful in co-occurring disorder programs, to assist clients in identification of substance use as a means to self-medicate the symptoms related to trauma.

Grella (2003) also addressed the issue of PTSD with the co-occurring population. This body of research examined the gender differentials among the co-occurring disorder population concerning addiction and treatment histories, perceived service needs, and psychosocial functioning. The author gathered a sample of 4000 men and women (53% were male, and 47% were female). Seven assessment instruments were implemented, as well as the use of information gathered from intake interviews. The assessment instruments included: the Structured Clinical Interview (SCI) (used to assess mood, psychotic, substance use disorders, and PTSD); the Brief Symptom Inventory (BSI) (to assess psychological distress severity). Treatment motivation, initiation, and barriers were assessed using the Problem Recognition Scale (PRS), the Desire for Help Scale (DHS), and the Readiness for Treatment Scale (RTS). Additionally, the Lehman Quality of Life Scale (LQLS), and the Situational Confidence Scale (SCS) were used in assessing quality of life and self-efficacy.

The results of this study revealed a sizeable similarity between gender groups in this sample. There were no significant differences in the domains of psychiatric diagnosis, and treatment initiation, motivation, or barriers. There were also no significant differences regarding treatment history utilizations, or self-efficacy and perceived quality of life. Grella (2003) found that men had higher rates of polysubstance dependence. Which is in contrast to Mangrum, Spence and Steinely-Brumgarner (2006), whose results indicated that the men in their sample had lower rates of polysubstance dependence compared with the women in their sample. Interestingly, Grella found that the patients in this sample had begun mental health treatment approximately ten years preceding their chemical dependency treatment, and that the mean age of substance use initiation was approximately seven years prior to beginning mental health treatment.

Within this sample (Grella, 2003), 52% of the subjects were diagnosed with PTSD, women comprising approximately 65%. Of these patients, 48% reported that receiving trauma related services was important to them. Grella (2003) asserts that PTSD may exacerbate psychiatric disorders, and substance use disorders. The author also asserts that exacerbated substance and psychiatric disorders may increase the vulnerability of the individual and thus, create opportunities for re-victimization.

Brunette and Drake (1998) also found a high rate of PTSD and victimization among the women in their sample of 108 men and women who had both chemical dependence and schizophrenia or schizoaffective disorder. The participants were patients involved in treatment specifically for the homeless population. The authors interviewed their sample regarding substance use, social functioning, social support, victimization, medical illness, co-occurring disorders and legal involvement.

The results showed that women were more socially connected than men, had higher rates of sexual and physical victimization, anxiety and depressive disorders, and higher rates of medical illness than men. The researchers concluded that dually diagnosed women have distinctive treatment needs, and vulnerabilities. The authors suggested that clinicians and program coordinators implement specialized victimization education, and prevention services for women in this population.

Jerrell and Ridgely (1995) were also interested specialized interventions for women. The authors examined treatment interventions for women with co-occurring disorders. They questioned how specialized treatments would affect women in this population, if at all. The researchers sample consisted of 132 subjects, 31 of which were women from three separate sites that volunteered to offer a specialized intervention. Jerrell and Ridgely conducted a retrospective analysis focused on gender differences among people with Severe Mental Illness (SMI) and Substance Abuse Disorders in three types of therapeutic interventions: Intensive Case management (ICM), Behavioral Skills (BS), and 12 Step approach which served as the control group.

Jerrell and Ridgely's (1995) results indicated that women had higher rates of sexual abuse (Grella, 2003, Amodia & Eliason, 2006, Mangrum, Spence & Steinely-Brumgarner, 2006), higher rates of non-schizophrenia disorders, had slightly higher rates of functioning, and were more psychiatrically symptomatic than men in this sample. In addition, the women in this sample, showed to be less impaired in terms of drug and alcohol severity. Results also indicated that both genders responded equally in the attempted treatment interventions, though women tended to show higher rates of symptom and functioning change with the 12 Step model. Jerrell and Ridgely (1995) discovered in their results that the women in their

sample had more incidences of substance dependent partners, and reported having significant others who were unsupportive of treatment, than the men in this sample. Bellack, Bennett, Gearson and Nidecker (2003) found a similar trend of social networks of women in their sample as being related, and involved in substance use, in addition being a deterrent to recovery, as found by Jerrell and Ridgely (1995).

Bellack, Bennett, Gearson and Nidecker (2003) identified gender differences in access to drugs, how addictions were financed, and reasons for use in their investigation. Additionally, gender differences in physical and sexual victimization and in affective symptoms were examined. The researchers used a sample of 28 men and 24 women who were psychiatric outpatients from an inner city community mental health facility, all of which had mental illnesses and chemical dependency. The SCI – Patient Version was used to confirm diagnoses. The Positive and Negative Syndrome Scale (PNSS) was used to assess psychiatric symptoms. The ASI was used to assess chemical use and dependence. The Inventory of Drug Taking Situations (IDTS) was used to measure participants' reasons for substance use. The Access and Maintenance Questionnaire (AMQ) was used to determine how participants maintained their drug use and identified their drug use partners. Lastly, the Addiction Severity Scale Family/Social (ASS-FS) subscale was used to evaluate lifetime physical and sexual abuse as well as abuse that occurred within the past thirty days at the time of the study.

Bellack, Bennett, Gearson and Nidecker's (2003) results revealed that the women in this sample had higher lifetime rates of physical and sexual abuse than did men, which were consistent with previous research. (Amodia & Eliason, 2006; Grella, 2003; Mangrum, Spence & Steinely-Brumgarner, 2006). Women in this sample were more likely than the men

in this sample to be given drugs by significant others or to have purchased them from friends. The women interviewed were more likely than the men to have used money from family and friends to purchase drugs, and were more likely than men to have used money from prostitution to purchase drugs. The men in this sample were less likely than the women in this sample to have traded sex for drugs. Women had higher rates of cocaine and heroine dependence while men had higher rates of marijuana dependence. Men and women were equally likely to report depressive and anxiety symptoms and neither reported using drugs to ease unpleasant emotions or interpersonal conflicts.

A striking implication emerged in the literature. Men were reported to be more inhibited to disclose problematic social, familial, psychological and substance issues, than women (DiNitto, Rubin & Webb, 2002) Women were more willing to report psychological and social problems, than men. (Mangrum, Spence & Steinely-Brumgarner, 2006). Yet, women were found to have higher rates of PTSD related to physical and sexual victimization (Grella, 2003, Amodia & Eliason, 2006, Mangrum, Spence & Steinely-Brumgarner, 2006). Since the literature asserts that men are more inhibited to disclose psychosocial problems, would they also be less likely to report physical and sexual abuse?

The literature reviewed indicates that traditional gender norms are likely to be implemented into the self-concept of an individual. The literature examining gender differences among the co-occurring disorder population does not provide consistent or significant gender differences. This study purposes to explore the perceived experiences of men and women with co-occurring disorders.

## Method

### *Empirical Phenomenology*

The method utilized for this study is empirical phenomenology. Phenomenology pivots on the notion that the world is apparent through a course of consciousness as a design of meaning; that consciousness shapes what is understood of the world. The approach an individual takes in understanding his or her world is the foundation of one's body of awareness. Thus, a phenomenological methodology allows the investigator to respectfully describe the apparent experience without looking for reductive or external explanations. (Valle, 1998). Phenomenology does acknowledge the external realm of the subject in context, but does not solely focus on the 'I' or subject, or the 'external' or object. Rather, it focuses on the conscious subject and his or her external world in tandem, as inseparable parts, for, the subject is assumed to be embedded in his or her world and cannot be separated (Austin, Heins, 2001, Stanage, 1987). "This means that we explore both the manner, appearance, and form in which something is manifested and the ways in which we are thinking-of it" (Stanage, 1987, p. 51).

Phenomenology also purports the notion of intentionality. Mental life involves a relation of something beyond itself that has meaning to the individual. In other words, consciousness is conscious of something. Intentionality provides knowledge of the meaning of individual circumstances, and the processes that generated those meanings. A circumstance is viewed as it has been experienced, and the experiential process through how it appears to have been lived is reflectively expounded (Wertz, 2005).

The situated structural description, a method of empirical phenomenology, is employed in this study. Each transcript was read several times, in order to develop a

deepened understanding of the participant's experience. Statements relevant to the phenomenon are identified, and the non-repetitive statements are themed for meaning. The participant's experience is captured through an exhaustive description of these themes and excerpts. Then, each situated structural description was compared to identify shared themes, creating a synthetic or general structural description (Austin & Hies, 2001). General structural descriptions were created for both gender groups and then compared to identify themes with each other to create a final synthetic description. The final synthetic description was compared to the literature reviewed on the integration of gendered stereotypes into the self-concept, on traditional norms of femininity and masculinity, and findings on the dissimilarities between gender groups of people with co-occurring disorders.

A chief element of empirical phenomenology is the concept and implementation of bracketing, or phenomenological reduction. Bracketing refers to the suspension of all biases, assumptions and notions of the phenomena being explored, on the part of the researcher. The aim of the researcher is to remain as "open and receptive as possible to the participants' descriptions of their experience of the phenomena" (Austin & Ries, 2001, p. 6).

Phenomenological reduction involves bracketing the natural attitude. The natural attitude refers to the assumptive outlook that one's reality is the same as the reality of others. The aim of the researcher is to move into the transcendental attitude, which refers to the suspension of the researcher's "belief in the objective reality of the phenomenon to attend to it as it is experienced by the participant" (p. 6). The researcher centers on the phenomenon as it offers itself, eliminating the need to search for sources that cause the experience, in order to understand the structure of a phenomenon. However, true phenomenological reduction is thought to be impossible, due to the seemingly infinite layers of assumptions one may have

of reality. “We are always in the world, so we can never truly break with our way of seeing it” (p. 6). Though it may be impossible to reach a pure transcendental attitude, phenomenological reduction is a fundamental practice in increasing awareness (Austin & Heins). In this body of work, reviewed literature addressed definitions and common issues related to people with co-occurring disorders, on the integration of gendered stereotypes in to the self concept, on traditional norms of femininity and masculinity, and findings on the dissimilarities between gender groups of people with co-occurring disorders. These are prime elements of information that may become assumptions, and were suspended while the Principle Investigator analyzed the data collected.

### *Procedure*

Participants were asked to complete one semi-structured interview, lasting approximately one hour in duration. The Principle Investigator had asked the participants to describe their experiences with addiction, mental illness, and treatment. The interviews were audio-recorded and transcribed verbatim for content analysis. The transcriptions were then broken into units of meaning, coded for themes, and analyzed according to principles of empirical phenomenology. Participants were informed that non-participation in the research will have no effect on their treatment. No identifying information was recorded or included in order to assure confidentiality. Audio-recorded responses to the interviews were stored in a locked box until transcription was completed. Following transcription, the audio recordings were destroyed. Informed consent forms are included in Appendix A.

### *Subject Selection*

A purposive sample was used for this study. Participants have been diagnosed with both a Severe Mental Illness and a Substance Dependence Disorder. Men and women who

are currently in treatment at a behavioral health care facility in the Northeast United States, within a Co-Occurring Disorders (COD) program were selected on a voluntary basis, and approved by their primary therapists. The Principle Investigator targeted three men and three women. All three women were active in the second phase (of three phases) of their treatment plan. Two of the men were also active in the second phase of their treatment plan, and one man was active in the third phase of his treatment plan. Two women had been diagnosed with bipolar disorder with psychotic features. One woman was diagnosed with depressive disorder and schizophrenia. Three of three women have been diagnosed with cocaine and alcohol dependence. One of the men has been diagnosed with post traumatic stress disorder and depressive disorder. One of the men has been diagnosed with bipolar disorder. One of the men has been diagnosed with depressive disorder and generalized anxiety disorder, with psychotic features. One of the men has been diagnosed with alcohol dependence. Two of the men have been diagnosed with cocaine and alcohol dependence.

All of the participants have had prior contact with the Principle Investigator through group therapy, and group psychoeducation. Participation was on a voluntary basis only, and there was no remuneration. The participants have been given pseudonyms to protect their anonymity.

## Results

In the present study, having used the research methods of empirical phenomenology, five primary themes emerged from the data. Both men and women discussed their catalysts of seeking mental health and chemical dependency treatment, how their self-concepts have been impacted by the presence of mental illness and chemical dependency, substance use as a means of self-medication, and therapeutic factors impacting their experiences in treatment.

*Catalysts of Participating in Mental Health and Chemical Dependency Treatment**Impact on children*

The impact that addiction has upon the lives of these participants' children has shown to be a powerful vehicle for change. The participants of this study discussed how they chose to give up their addictions in order to support their children.

The children of the following participant have been affected by the financial ruin as a result of addiction, and developed the drug addiction of the parent. Racked by internal dissonance, Adrienne took action to change her life, and thus, the lives of her children.

“I kept trying to quit and I couldn't. Because I just said I didn't think it was really fair, sitting in the dark with the kids, acting like we're camping every night. It just wasn't right. And you know using, biggest thing that changed my mind was when I used with Alexis. Because Alexis had gotten into it, as well, and, she'd been like 'please mommy please please please, I'll do it with you, just get it.' So I did. And that reeeaaally made me feel bad. I called [the treatment center] on my own and said 'Look-it what do I need to do, I really need, to get help, I can't can't do this, I keep trying to quit and I just can't do it!'”

Maya described how her addiction affected her ability to recognize that she was pregnant, and jeopardized the health of her unborn child. She considered, and could have easily had an abortion and continued in active addiction, but she decided to conquer her addiction in order to have her baby. To her, this child was more important than her addiction.

“I thought that she was a miracle. Because, the first trimester of my pregnancy I used drugs....Cocaine. I was free-basin'. I was so strung out on crack cocaine it didn't make sense. I was actually four months pregnant when I decided to get

prenatal care. So I had to make a choice. And by the grace of god, at that particular time I had a midwife, that was my gynecologist. And we had a pretty good relationship. And, somehow, she could tell that something wasn't right with me. And she just simply said 'I wanna know what is going on with you and don't lie to me' and I told her, I was using drugs. And she sat down next to me with her arms around me and said you've got a few choices to make. She said you can get rid of the baby and keep using drugs and killing yourself, or you can stop using drugs, and give yourself a chance and the baby a chance. What I did was I stopped using drugs."

While Maya stopped using drugs until her baby was born, she resumed use after two months.

Compulsory participation in treatment, through the court system and social services, was the norm for Janice. She reported that she had never completed a treatment program due to denial of addiction, and absence of motivation to be sober. For her, the impact of her addiction on her own life was inconsequential.

"I was gone. My whole, outlook on life was gone. From then on, I didn't care.

'Bout nothing or nobody. Not even myself."

She did care, however, about being with her children. The drive to have custody of her children overpowered the apathy she had towards herself. Through this motivation, she was able to be internally motivated and thus, successful in maintaining sobriety for the longest period in her life.

"I've been in 12 different rehabs. I was either forced to go there, made to go there, mandated to go there, I finished one out of, all my life. And, because I chose to do it.

And stayed 18 months clean afterwards. Because I wanted my kids back. I chose to stay clean. Because I wanted my kids back.”

While the motivation to gain custody of her children was powerful enough for Janice to give up her addiction, the loss of that external motivation led her to relapse.

“I got a paper sayin’ my mother had full custody, of my kids. So that damaged my recovery and I went back to usin’, at that time I just didn’t care no more. I didn’t have nothing.”

### *Suicidal Ideation and Attempt*

Despite experiences of anxiety, depression and command audio hallucinations, these participants neither sought, nor were referred for mental health treatment until the event or repeated events of attempted suicide and suicidal ideation. While these participants had an extensive history in chemical dependency treatment programs, their psychiatric illnesses were not addressed. It was only until they came dangerously close to ending their lives that they began to receive mental health therapy.

After struggling with alcoholism, depression and anxiety for most of his life, Neil was ready to end his life. Fortunately, he reached out and sought help in saving his life. It was after this event that Neil, and his treatment providers were able to address his psychiatric illnesses.

“I went to [Hospital], felt like killing myself. I felt so, like a worthless piece of nothing. What’s the sense? If I’m going to drink myself to death I might as well, I left [Hospital] Emergency and to the psych ward for a few days, and that’s when everything started getting more geared towards mental recovery, cuz something, something was missing.”

Jackson made several attempts to end his life. He, also, had experienced psychiatric illnesses for most of his life, yet was only being treated for his addiction to cocaine and alcohol. Jackson described how his suicide attempts finally induced his treatment providers to place him in a program for people with mental illness and chemical addiction (MICA). This program proved to be the key for him in addressing the psychiatric illnesses that motivated him to end his life.

“As time progressed, I had a lot of suicide attempts and what they decided to do finally was they put me in a MICA group. And, going to the MICA group and getting the education, I started relating to some things. I was no longer in denial, or I was willing to take a look at some things. That’s when I finally realized that I really did have a mental illness and I started seeing someone.”

Jackson also described how he assumed that cocaine intoxication was mimicking psychotic symptoms, but that it was his overlooked psychiatric illnesses that were the cause of his suicide attempts.

“I remember being somewhere and being on a balcony. And hearing something say ‘JUMP’. Walk across the bridge and something says ‘JUMP’. That’s why I acted on it when I was under the influence, because I remember always hearing that voice. And I never wanted to admit, and I really didn’t know that, I have the voices. I used to think that that was going on cause of the drugs that I used and for how long I used them and, that if I stayed clean for a certain amount of time than, that they would go away. But, I’ve had just about nine months clean three times and they don’t go away. And I also from being in group, learned about that and said, well, you know, I have that problem too.”

### *Values of Self-Concept*

The experience of mental illness and addiction has been an influential factor on the value of these participants' self-concepts. These include both positive and negative self-concepts.

#### *Negative Self-concepts*

It has been expressed through this research that the symptoms of psychiatric illness can be perceived as innate character defects, and thus be internalized as negative self-concept. A negative self-concept is also manifested by the presence of a psychiatric illness. The feeling of worthlessness is a diagnostic criterion for Major Depressive Disorder (DSM), and in lieu of being viewed as a symptom of one's psychiatric illness, this feeling is internalized as being true to the individual's actual self worth.

The experience of addiction has also shown to have a marked affect on an individual's self-concept. The substance that one is addicted to is often the paramount focus in the individual's life. In this way, an individual interprets his or her drive to obtain and ingest the substance, while neglecting loved ones and responsibilities as being a selfish or uncaring person, rather than as a symptom of the disease of addiction. While an individual may appear to be taking responsibility for his or her behaviors, the individual has actually created a negative self-concept that inhibits the motivation for change.

Jackson described how he experienced internalizing his Depressive Disorder symptoms as innate character defects.

“I didn't know I was depressed, I thought I was just lazy. [Though] I'm not a lazy person. I get up I get things done, people count on me for stuff. When I get

depressed, it's the end of the world I don't want to do nothing. I consider myself lazy, I have crazy thoughts.”

Jackson also described how the experience of audio hallucinations affected his self-concept in a negative way.

“And that used to make me feel like a bad person. I would be around people and I would be hearing the voices. And I didn't know that was the voices, I just thought that was my thoughts. And it was terrible, especially being around people that I loved and have helped me through so much, to be around them and to hear all that negativity, I started to not go around family as much. Say for instance, say it's my first time meeting you, you seem like a very nice person and, you were talking, and like, in my head they would say ‘why don't this ugly B shut up?!’ I would think, ‘Wow, where is that coming from?’ and, it made me feel like a bad person.”

Jackson feared to such a degree that his audio hallucinations were reflective of his innate character, that he interpreted the probing of a treatment provider as validation of his fear, that indeed, these grotesque commands were his own thoughts and wishes. This, in turn, caused him to feel unsupported and ultimately, alone. Thus, Jackson abandoned the pursuit of therapy.

“...the first time I made an effort to talk about that with a psychiatrist, she said, ‘is that really voices? Or is that your thoughts?’ And immediately I shut down and I didn't want to deal with it anymore. Because I know that's not my thought. To harm my grandmother. I said, ‘Well, I know it's not my thought, I don't know what it is, but I'll just deal with it [by myself]’. And, for another couple years, I didn't go back to get help with that. There was a big part of me saying, that's not you! That's

not what you think. And then there was another part saying ‘well, yeah, that is you that's how you are. You're a bad person’.”

Nick, who has been struggling with Major Depressive Disorder, described how very faint the line is between his symptomatic experience of worthlessness and his belief that he is worthless. Nick also expressed his difficulty in acknowledging the positive factors of his personality, and that this creates a sense of stagnation in his life.

“I’ve never been a good person, I’ve never been very good to myself. My mind’s been telling me ‘you ain’t going nowhere just throw in the towel’, and it’s been a serious battle. I’ve made it to the point that I can get down on my knees and pray to God for help, but sometimes I don’t think even he don’t care that much about me. I got a lot of good things, assets about me...but the good things don’t overpower the bad things. The bad things always seem to outweigh the good.”

Janice described how her experience of addiction has caused her to view herself as being sub-human. She reported that her significant other has no experienced addiction and is a positive role model for how she wants to perceive herself. Janice emphasized the importance of perceiving herself as having the choice to give her energy to others and to herself, instead of perceiving herself as enslaved to serving her addiction.

“He knows how to be a human being! That’s what I want to be. I know I always been a human being but I wanna be a good human being. there’s a difference...Being an addict you don’t care about nobody. you don’t care about kids, old people, you don’t care about yourself, you don’t care what happens to you, you don’t care about your appearance. I always felt like a robot. All my life it was like

something was I was bein' controlled. I was the robot havin' to do this, havin' to do that!"

*Positive Self-concepts*

A person who experiences psychiatric illness and addiction may also develop a positive self-concept through therapeutic intervention, or retain a positive self-concept that pre-existed the presence of mental illness and addiction. A positive self-concept has been reported to provide hope, resiliency and the self-efficacy to make choices that will allow the individual to heal.

Neil reported that his sense of identity is fundamentally benevolent. He expressed that this positive self-concept has withstood both the devastating results of his addiction and the depths of despair caused by his experience with depression. Neil stated that while he continues to search for himself, he retains a basic tenant of his self-identity that is based in his spiritual belief.

"I know who I am, somewhat. I know I'm not a bad person. I know I'm not evil. And, I'm just tryin' to do the best I can. To be god's child. I believed that all my life."

Jackson reported that he has been able to create a positive self-concept through education of his psychiatric illness. He reported utilizing therapeutic techniques to assist him in countering his previous negative self-concept. Most importantly for this participant is the awareness, and acceptance that his audio hallucinations were separate from his basic nature. Through this belief, Jackson has been able to accept himself enough to continue pursuing the work of therapy, and recovery.

“I can kind of deal with the voices. Before I used to say, 'Oh god I'm such a bad person' and they used to make it worse. Now I just say, 'Well, that's the illness, not the way I think. I like people'. I have to use positive self-talk, I have to realize I'm not a bad person, this is a chemical imbalance. I am a good person and I like people. Those thoughts, that's not me.”

Maya described how her positive self-concept has bolstered her sense of self-love and thus, self-protection. Her positive self-concept acts as an armor that strengthens her ability to prevent relapse and destructive emotional involvement with others. It is because she values herself and loves herself, despite her weaknesses and shortcomings, she is able to devote her attention to therapeutic work on herself.

“I love me, today to a greater degree that I don't want to do anything to hurt me. Like, drug addiction. Or, being in an unhealthy relationship. Whether the relationship is with a family member, or in a relationship with a male, or in a friendship with a female. I refuse to hurt myself or refuse to allow myself to deal with anyone else, that is going to hurt me. I must not disrespect myself by committing a slow suicide, by indulging in drugs, alcohol. Because that hinders my ability to, first of all be in tune with myself and then second of all to be in tune with you. As an individual, then I'm more able to see and comprehend, what are your intentions. That way I don't make myself available to you for you to dictate an outcome for me, that could end up hurting me, later on. The focal point is me, on a mental, physical, spiritual and emotional level.”

In addition, Maya's positive self-concept has allowed her to nurture her capacity to be authentic with others with others without seeking external completion, and to engage in

altruism, in lieu of giving to others in order to receive the nurturing she needs. She expressed that it is she, because of her positive self-concept, who nurtures herself. In light of that, she is able to have egalitarian relationships with others.

“It’s precious in that the value of who and what I am is not by the materialistic things that I have, it’s about the depth of the woman inside of me. How I communicate, how honest am I with you, um, when I give or do, am I giving or doing to get something in return, or is that just genuine from my heart.”

#### *Substance Use as a Means of Self-Medication*

Five of six participants expressed using drugs and alcohol to numb the pain of childhood trauma, to cope with grief and loss, to manage uncomfortable emotions, and to dull the symptoms of psychiatric illness.

Janice described how she used drugs to escape the pain of childhood rape, and homelessness.

“[ I ] went to live with my father at 11. Then my father raped me. I couldn’t really tell you from 11 to 14 what I did. Cuz I don’t even remember. But I know it wasn’t good. I know it was stayin’ wherever I could and doin’ whatever I had to, takin’ all kinds of drugs. To numb myself.”

Maya poignantly illustrated her experience of using drugs and alcohol to cope with the pain of childhood sexual trauma. She also described how that trauma continued to hunt her into adulthood, and fueled the need to medicate herself with drugs and alcohol.

“There was deep rooted, pain, before I even knew what pain was. Being molested as a child. I’ve come to understand that pain is a part of life. It’s a part of our development. But, there are some pains we are not to receive and if you receive

them then you have to go through a process of healing, but if you never communicate what took place that caused the pain, you never truly heal inside, so there is a festering wound that, doesn't heal. And as you grow and develop, in life, either the sore gets bigger, until it becomes unbearable and you don't want to feel it or you learn to medicate at a young age, to numb out so that you don't feel, that pain. But you don't have true knowledge of why you're medicating. You just know that you've got this overwhelming feeling inside, and you don't want to feel that."

Jackson revealed how he used drugs and alcohol to escape the sense of alienation he experienced due to his psychiatric illness.

"I latched onto drugs to make me feel different, to make me feel better, to make me feel not a bad person, When I started drinking, I skipped being a social drinker. I would drink till I threw up, blacked out. And I did that with whatever drug, the next was marijuana. I'd just smoke, smoke, smoke. One time I was at a party and I thought I was just going to die. It was the same thing with crack. I was doing stuff cause I was feeling strange [ and ] real different. And I had these issues that, I didn't know what they were, and I just felt strange."

Nick expressed how he uses drugs to cope with difficult emotions.

"I set my expectations way to high all the time, and then I get disappointed, and I get hurt, and I get angry, and then I start considering using."

Neil reported that he began drinking when he was a child, after the loss of his father. In addition to the loss of his father, he also grieved the loss of his childhood, due the cultural assumption that, since Neil was the only male of his household, that he was responsible for taking the role of his father.

“My dad died when I was eleven, I don’t remember a lot about him. When he died we moved back to the city. ‘I’m the man of the house now.’ I had four women to take care of: my mom, three sisters. And me, I’m eleven years old. That’s when I started drinking. I liked it. Made me feel good.... I was the father. I played the role.”

### *Therapeutic Factors*

The participants in this study identified five major therapeutic factors: living in the moment, self-responsibility, honesty, connection with others, and patience in the therapeutic process. Once internalized and implemented in their daily lives, these factors contribute to their progress, and fruition in their personal journeys of recovery from psychiatric illnesses and addiction. The power of these therapeutic factors may reside in the notion that they are attitudes and coping skills that are contrary to those utilized in active addiction.

### *Living in the Moment*

Since most of the participants reported using drugs and alcohol as a means of self-medication, and self-medication is indicative of intolerance of painful feelings, to stay in the moment requires both discipline and bravery in staying with painful feelings. Living in the moment is therapeutic for these contributors in two ways. They have are able to both focus on the feelings that arise in the moment, rather than undertake all of the issues that have compounded throughout their lives.

Maya described how she stays in the moment rather than self-medicating.

“I have been blessed by looking at life on life’s terms without being so quick to jump even when the situation seems so grim, so dim, just to remain still, and feel. Without inducing something because it don’t feel comfortable. Because I feel nervous, because I’m unsure, because I don’t know if I can do this.”

Jackson stated that by focusing on his thoughts and actions in the moment, he is able to deter himself from becoming overwhelmed, and thus unable to manage his feelings.

“I beat myself up so much...so, now I’m just taking it a day at time, I’m doing something positive, and things are looking better.”

Janice stated that by living in the moment she has a sense of control of her choices. Though, she may want to focus upon the optimistic possibilities of her future, she remains grounded and stable by staying in the moment.

“I choose not to go back to where I was, I’m gonna stay where I am. My future’s looking pretty good. But right now I take it one day at a time. I take it minute by minute.”

### *Self-Responsibility*

Self-responsibility as a therapeutic factor is demonstrated by the participants through the abandonment of the role of powerless victim. Each participant described events in their lives that were painful, traumatizing, and ultimately out of their control. While many of the participants used drugs and alcohol to cope with the pain, many of them made statements that expressed determination to take responsibility for their lives, their behaviors, and their choices. With this mentality, these participants can make healthy choices regarding their actions. For the contributors, self-responsibility means acceptance of one’s own personal power.

Maya expressed self-responsibility in terms of her interactive choices. She reported that unhealthy relationships are a key element in her story, and are closely related to her relationship with her addiction. In this excerpt, she illustrates how she chooses to interact, in order to honor and protect herself, while respecting others.

“Am I trying to manipulate you, deceive you, play games with you? No. Because I do not do to someone what I do not want done to me. If I see that that is what you are doing, then, I need to make a choice. That choice need to be based on what is right and what is best for me. But that the value of me doing what I feel is right, in a manner in what I feel is right, isn’t liable to anyone but me. And I need to make sure that I do it in the right way.”

Janice articulated her acceptance that her journey on the road to recovery will be difficult, but that it is she who is in charge of her choices.

“There’s gonna be times where everything bothers me. It’s just how I deal with it that’s gonna be the best way to go.”

In this excerpt, Janice expressed that despite external discouragement, she acknowledges that her chemical dependency recovery, and her mental health therapy is her responsibility.

“There’s gonna be people in my life that’s gonna put it down. Like to think that I’m working on it. But that don’t mean I have to keep dwellin’ on it. I can go through it an’ work on it.”

Further, Jackson discussed being responsible for his way of thinking. He reported struggling with his treatment recommendations to live at a community residential half-way house. Jackson developed an outlook that showed he has the power to change his thinking and thus, his feelings about a situation. By changing his outlook, he can gain more from the process, and thus work on becoming healthy.

“I ’m grateful for the [Community residence]. When I first came that was my main thing was ‘I hate the [Community residence]. I kept comparing it to where I was at instead of looking at it for what it is. It’s a stepping-stone for me to get to the next

step in my process. It's because of being there that I have that opportunity. I have to look at all that stuff. Looking at things in other ways. I just look at it one way and that's the way it is. But, it's always another way and I can change my thoughts.”

### *Honesty*

The contributors discussed the impact being honest has on their healing, and recovery. Being honest with others, and with one's self has shown to be a powerful factor. Like living in the moment and self-responsibility, honesty is described to be an internal drive to behave openly. This is the direct opposite mentality of active addiction, in which people lie to others and deny to themselves in order to maintain the addictive behavior. In this way, being honest with one's self and with others is therapeutic because the participants are creating drastically contradictory behaviors, and mentalities.

Adrienne describes how feeling obligated to be honest with the members of her therapy group motivate her to remain sober.

“When I when I think about wanting to use, [I think] ‘I can't do that, because I wanna go in there honestly and say ‘this is still my clean date’. It's the honesty part of it that works too because I don't wanna come in here and be dishonest.”

Maya was affected by the honesty demonstrated by a speaker at a self-help meeting. She portrays how honesty she perceived allowed her to face many painful truths in her own life and thus, learn to healthfully cope with them and heal.

“His honesty, set the pace for the kind of honesty you gotta have with yourself about your recovery and who you are. If you don't, you're doomed. You don't deal with your pain from the past or your pain from the present, it's like a festering sore. It will never heal. And every time you encounter a disappointment, someone that

abuses you, a person that disrespects you, doesn't honor you, doesn't care about you, if they see you don't care about you, they're gonna do what they do, and you're gonna end up hurt. And as sure as you're gonna hurt, that's gonna connect to the sore and that sore is gonna pump and pulsate and you're gonna feel it and when you feel it, it's gonna be unbearable, and you gonna wanna medicate. And that medication is poison. And you'll never heal that way.

Lastly, Neil revealed how being honest with himself about his powerlessness of his addiction was a catalyst in his accepting help, and making changes. While being honest with others and with one's past has been shown to be therapeutic, Neil illustrated the power of being honest with one's self in the moment. In this excerpt, he describes his experience being in a Chemical Dependency inpatient program, after his third DWI.

“First two weeks of struggling and fightin’, [I] finally wound up waking up an sayin’, ‘Wow I have a problem’. It’s not anyone else, it’s not their fault. I had to look inside, a spiritual awakening, if you will. In my last two weeks I was there, I really worked on it.”

### *Connecting with Others*

Connecting with others has been reported to be a difficult, and risky behavior for these contributors. They expressed that their trust in others has been violated by family, and peers repeatedly. However, they express that taking risks revealing themselves, and being vulnerable with others can be profoundly therapeutic.

Nick described his unwillingness to share his experiences with others, despite his longing to engage others.

“Out in the real world, I don’t have anybody that I can really talk about my issues. Because it’s been my experience that trusting people with delicate information sometimes can come back to bite you. It makes me kind of not willing to share myself and my feelings with anybody else. So it’s kind of like I’m damned if you do and damned if you don’t.”

Trauma in relationships with men showed to be a prominent theme in Janice’s story. In this way, she is faced with the challenge of trusting, and accepting the support of her current significant other, who has been described as being in tune with her mental health symptoms, as well as being willing to support her. Accepting him into her sphere of trust may prove to be therapeutic for her.

“But he noticed it. And it was longer than three weeks. And he, he just couldn’t take it no more, ‘come on, you gotta get out of this, let’s go (snaps fingers) cuz if you don’t you know where you’re goin, and I’ll call the police myself and make you go, to the hospital’. I was getting that low. And he knew it. He knows me better than I know myself. Okay, cuz I didn’t notice it. I knew, physically I was getting drained but not mentally. And emotionally. I didn’t know I was getting drained. But everything was getting ready to go. And he knew it.”

Maya illustrated how she was able to lower her defenses at a self-help meeting, and come into contact with the feelings, and experiences of others. She expressed being highly affected, due to her willingness to open her heart to others.

“...there was this one particular meeting that I went to an I was so surprised with, the warmth, the greetings, something that I wasn’t accustomed to. And I’m feeling so uncomfortable, cuz I’m saying ‘these people don’t know me. I don’t know them.

I don't trust them. I ain't never been here before. It can't be this real. It can't be'. In actuality, it was what it was. And that there were times when I heard things in there that cut right through me. And I immediately started to cry. Because it was so real, because it hit home. Very deeply.”

Jackson described how he recognizes his need to connect with other. He describes his fear of rejection as being a primary deterrent to revealing himself, and how he believes his struggle with depression may be assisted by allowing others to see what he is experiencing.

“I'm realizing now, I have to take some chances, become vulnerable, trust people you know, cause, cause, the depression is like a big thing for me now... And, what I'm learning now, the acceptance of it, and I wasn't sharing stuff that would let me become vulnerable, you know, I didn't get to close to people cause I figured if they knew who I really was, they wouldn't like me.”

In this excerpt, Jackson discussed his previous resistance to engage others. Becoming open enough to extend his experience of another person, and to accept the extension of another person allowed him to feel noticed, and connected.

“...if I can relate to what they've been through, you know, that helped me. As to before, where, I was just like, 'I don't care to help or not. I'm not going to say anything'. You know, and. As someone did mention, like, I saw progress in someone else, someone else mentioned they saw progress in me, and that made me feel good, but see, they didn't have to tell me that, I know, I can feel it because I feel different.”

Janice discussed her struggle with experiencing emotions. She had stated that sobriety has allowed her feel emotions that had been anesthetized while she was in active addiction.

In this excerpt, Janice described that sharing her experiences with others is helpful in managing her emotions. Janice also described that her barriers to isolate herself are beginning to crumble, and that this is affecting her in a positive way.

“...and I have to deal with them, but I can’t deal with them, no, I shouldn’t say I can’t, it’s hard to deal with them when people are not around. So when I get to group or get around people, I tell them how I’m feelin’. And that’s part of what I never did. Cuz my adult addiction didn’t care. The old part of me had the wall up. The new person’s got a wall but not...a wall. My wall has got holes in it. The other one has a solid wall. But I got a hole in my wall which is ok, too. And I like it.”

#### *Patience in the Therapeutic Process*

Mental health and addiction therapy has been reported to be long, and difficult process. It has been expressed that when one begins the therapeutic process, one may be compelled to rush through it in order to see the end result. These participants expressed the need to be cognizant of being patient in the therapeutic process. The contributors have described their active addiction as a means to escape the pain they have held within themselves. Therapy has been uncomfortable, and often frightening, but the contributors stress the need not to hasten the process. To do so, they warn, may jeopardize the recovery they have worked so hard to achieve.

Jackson asserted his awareness of focusing on one thing at a time, despite his desire to work on many aspects of himself at once. He expressed that to follow his impulses and hasten the process; he will not accomplish anything in completion.

“I think there is so much I want to take care of but what I’m realizing now, is that as long as I stay on my medication, and stay clean, I’ll get things achieved. Sometimes,

when I'm in the middle of being anxious, I'll want to do everything all at once. But, I realize to really do things and do them right I have to take my time and, to do them right. Because, if I just half do things, it just comes back."

Maya illustrated her decision to take her time in the therapeutic process. She tells herself that her emotions may feel overwhelming, but that she will survive that sensation and grow from it.

"Am I gonna continue this path and experience it? Yes, I am, yes, I can and it doesn't make me any less of a woman. It makes me more of a woman, more in tune with myself, more able to deal with life on life's terms. And don't fall part and don't crumble and don't run into a glass pipe. Or look for some alcohol to numb the feeling. No, it is what it is. And I needed to go through this process just the way I'm going through it. Exactly the way I'm goin' through it and you're not gonna die! It's not gonna kill you. You can handle it! If you allow yourself to handle it and all the feelings that come with it are natural to have those feelings."

Janice echoed this message by describing her fear of facing her pain. She also emphasized that she explores her issues slowly and carefully, rather than expecting herself to examine all of her problems at one time.

"I never thought I could survive the pain. The agony, the sad, oo-oo! I never thought I could feel them pains! And go through it, that's my new thing today. It's working out that the feeling that I'm goin' through, cuz there's a lot of feelings inside of me! That I never knew I had. They're scary, real scary, but for me today...there's a lot of things I like to hide still! But eventually I will work on them, eventually I will deal with them...but I'm working on most of them that I need to work on."

Adrienne described her therapeutic process as emerging over time. She stated that for her, the therapeutic experience needs to germinate within her psyche. In time, she is able to internalize, and apply the experiences to her life.

“I think it works on my unconscious. When I’m sitting here [ at the treatment center ]I don’t feel like it’s working, I feel like I’m wasting my time. But then, when I’m at home and I’m just sitting there quietly, it comes forward more and I hear the things that people had said, I do try to use the stuff as I get it, as it comes back to me. That’s why, I think it works. Subconsciously.”

In her perspective, patience in the therapeutic process allows other therapeutic factors to emerge. If she were to expect instant progression, she may remain in a state of stagnation, and perhaps rely on her previous and singular coping skill: substance use.

## Discussion

### *Substance Use as a Means of Self-Medication*

Bellack, Bennett, Gearson and Nidecker (2003) reported that neither men nor women reported using drugs to ease unpleasant emotions or interpersonal conflicts. This is contradictory to the findings in this study. Five of six participants described their use of drugs and alcohol as a coping mechanism to deal with trauma, disappointment, and stress.

As explained by the participants, when psychological pain intensifies, the drug or the drink is there to be smoked, sniffed or swallowed, and the painful feelings are diminished, and are quieted. The painful feelings have been reported to be not only symptoms of mental illnesses, or haunting from trauma in the past, or from uncomfortable, disappointing events in life, but from the absence of the drug, itself. Intoxication becomes the baseline feeling; sobriety is initially painful.

After listening to the participants shared their perceptions and experiences with drugs and alcohol, a metaphor emerged that illustrates the pain of sobriety. One has worn earmuffs and sunglasses for decades, and the removal of the earmuffs and sunglasses reveals blaring light and jarring sounds. One's emotional reception is highly sensitized, and feelings and sensations are intensified. Yet, the only skill one had in dealing with stress, and pain was to chemically alter one's perception. In chemical dependency recovery treatment, this is no longer an option. Thus, these participants have reported that they are developing the coping skills of living in the moment, and patience in the therapeutic process.

*Patience in the Therapeutic Process and Living in the Moment*

The participants in this study have learned expressed that they have learned to tolerate the feelings that they once thought would overwhelm and destroy them. They have learned to live in the moment: taking baby-step-by-baby-step, one day at a time, minute by minute. This appears to be an essential element to their therapeutic process, not only in the management of intense feelings but also, as a skill that is absolutely contrary to the coping skill of instant gratification that has been honed for most of the participants' lives.

*Catalysts for Change: Internal and External Motivation*

By nature, addiction is overpowering and often health risks, financial ruin, the damage to significant relationships, and legal consequences are not motivation enough for an individual to change his or her life. In this study, the participants identified two catalysts for change: the impact of addiction on children, and suicide as a means to seek mental health therapy. The impact of addiction on children appears to be an external motivation for change. The participants who identified this factor as the motivation to seek sobriety did so not out of a desire to salvage their own lives, but rather to salvage the lives of their children. Two of three

participants who identified an external motivation for change, relapsed shortly after the strength of the external motivation had subsided. For Maya, she returned to using cocaine after her daughter was born, and proved to be healthy. For Janice, she returned to using drugs and alcohol after she realized she would not receive custody of her children. Adrienne has not yet returned to using drugs and alcohol, though her motivation continues to be the health and well-being of her children.

Neil and Jackson identified suicide as the catalyst that brought them to seek and work on psychiatric therapy. Suicide could be viewed as an internal motivation. They both were motivated by the desire to salvage their own lives. The impact of their mental illnesses on the lives of others did not have the motivating power that impending death had. Both Jackson and Neil continue to be dedicated to mental health therapy.

Based on the lasting effect of change as motivated by external versus internal catalysts, it can be surmised that one who is internally motivated to change will have a greater likelihood of being committed to the process of change.

*The Influence of Gender as Impacting on the Perception of Experience with Addiction and Mental Illness*

The male and female participants discussed the areas of their experiences that were most important to them regarding addiction and mental illness. Each gender was represented in each theme, excluding the impact of children as a catalyst for change. Not one of the male participants, and all of the female participants reported that the impact their addictions were having on the lives of their children was the sole motivation for them to seek change, to seek sobriety. The other themes presented here are present across genders.

### *Considering Feminine Norms*

As Coonert-Femiano et.,al. (2005) identified feminine norms within an eight- factor structure. Within the themes presented here, “care for children” was the only feminine norm factor has been represented in this study. Perhaps, adherence to traditional gender norms becomes a lesser priority when faced with the challenge of changing one’s value of self-concept, coping skills, and connection with others; as well as facing the tribulation of managing psychiatric symptoms and addictive behaviors and urges. Perhaps, when a woman is recovering from addiction and psychiatric illness, being nice in relationships, thinness, modesty, being domestic, having romantic relationships, sexual fidelity and investing in appearance (Coonert-Femiano et.,al., 2005) seems less important, at this stage in their recovery process. The women in this study reported that the romantic relationships they have had with men have been addictive and destructive. Part of their healing experience is learning to prioritize themselves, rather than pouring their energy into a romantic partner.

### *Considering Masculine Norms*

Burn and Ward (2005) identified twelve masculine norms in their Conformity to Masculine Norms Inventory: winning, emotional control, risk-taking, violence, dominance, promiscuity, self-reliance, primacy of work, power over women, disdain for homosexuals, and pursuit of status. The men in this study described themselves as currently focusing on emotional expressiveness, wanting to connect with others as a therapeutic factor, and being patient in the therapeutic process.

### *Emotional expression*

DiNitto, Rubin and Webb (2002) reported that the men in their study were emotionally restrained. Wong et. al., (2006) and O’Neil (1981) purport that emotional

expressiveness has been equivocated with femininity. They assert that men have internalized social messages that associate masculinity with emotional inexpressiveness, and that unexpressed emotions may result in explosions of anger, and inhibit intimate exchanges.

While the men in this study are developing their propensity toward emotional expression, they also report that it has been through the therapeutic process that such emotional express has occurred. Jackson reported being emotionally restrained, but realized that he needed to be open and vulnerable in order to heal. Neil reported that he experienced storing his feelings until he lashed out on others. He reported that he now is able to express his feelings as they arise, and that this has prevented unproductive flare-up of anger.

### *Implications for Counseling*

#### *Men's Inhibition to Reveal Victimization*

DiNitto, Rubin and Webb, 2002, and Mangrum, Spence and Steinely-Brumgarner, 2006 reported that men were reported to be more inhibited to disclose problematic social, familial, psychological and substance issues, than women. Grella (2003), Amodia and Eliason (2006), Mangrum, Spence and Steinely-Brumgarner (2006) reported that women were found to have higher rates of PTSD related to physical and sexual victimization. These results imply that men are more inhibited to disclose psychosocial problems, thus are less likely to report physical and sexual abuse.

Thompson and Pleck's (1986) cited the factor of toughness (measured by physical strength, competence, ability to independently solve emotional problems and avoidance of displaying vulnerability) as a key component in the traditional masculine identity. Disclosing physical and sexual abuse, and asking for help in healing these traumas appears to counter

Thompson and Pleck's (1986) notion of toughness. It seems to be imperative that counselors recognize that men may be secretly suffering the same victimization, and trauma that women are suffering.

### *Mental Health and Addiction Education Impacting Self Concept*

Some of the participants in this study have reported that their attitudes, and behaviors in active addiction molded a negative self-concept. Likewise, mental health symptoms (such as command audio-hallucinations, and depression) have been confused as being an innate part of the individual's character. Jackson has described how powerful mental health education has been on his ability to decipher the difference between his symptoms and his personality. In addition, education on chemical dependency has facilitated participants to recognize that the power of addiction has influenced the choices they would not have made, had they been sober.

Counselors and program designers need to be cognizant of the impact mental health symptoms and addictive behaviors have on the individual's value of his or her self-concept, and that educating clients is a powerful tool in creating positive self-concepts and thus, self-efficacy.

### *Implications for Future Research*

Future qualitative studies examining the experiences of gender among the co-occurring population would be helpful in understanding what it means to be a man or woman to an individual with co-occurring disorders. Also needed is qualitative research on the experience of how the social microcosm of the therapy group translates to the macrocosm of the client's outside social structure. In this study, Janice reported that while she is taking

risks in connecting with others within her therapy group, she is also taking risks to trust her significant other.

Quantitative research in the domain of gender and co-occurring disorders is heavily laden with attention on women's issues and concerns. Much attention has been given to the victimization of women within this population. Future research on issues related to men, and men's experiences of trauma and victimization could help counselors and program designers to facilitate the therapeutic progress of men.

In addition, research on how men and women perceive each other and themselves could prove to be a powerful reflective tool in gaining insight into gender conceptualizing.

### Conclusions

This study reflects the secondary nature of gender socialization compared with the genderless therapeutic factors, impact of mental illness and addiction on the value of self-concept, and substance use as a mean of self-medication. What is important to the men and women in this study regarding their experiences of mental illness and addiction is analogous. Research regarding the victimization of men and the socialization of emotional restrictiveness would be a useful tool for the practice of counseling, to inspire ideas for further research, and to create social change. Still, more research regarding the experiences of men and women with co-occurring disorders is needed to continue the exploration.

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