CHAPTER 7

Safety, Belonging, and Voice: Critical Clinical Practice with Girls and Women Struggling with Substance Use

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INTRODUCTION

In this chapter, we will describe the most meaningful perspectives that we have learned from working with girls and women to reduce the harm of alcohol and drugs to live full and meaningful lives with dignity. Drawing on the feminist literature, we are aware that substance use is often adaptive and a form of coping while often causing women problems. Among girls and women, the links between substance use and sexual victimization are staggering and profound (Ross, Morrison, Cukier, & Smith, 2015). We will assert that it is essential to use an intersectional and critical feminist lens to inform a trauma responsive paradigm when working with girls and women who are challenged by substance use problems. We also have found the dislocation theory of substance use problems helpful in recognizing structural and cultural interlocking forms of oppression that impact the development of substance use problems. Many girls and women who are susceptible to substance use problems experience a general feeling of inadequacy and a sense of disconnection (Ross et al., 2015). Alongside feminist approaches to substance use problems among women, dislocation theory centres the importance of relationships and meaningful connections and engagement in community life, while fully recognizing the social and political context.

As you read this chapter, ask yourself the following questions:

1. In what ways does the neoliberal conceptualization of what it means to be a successful individual discount the challenges girls and women experiencing substance use problems may face?

2. Why is the experience of safety, belonging, and having a voice central to healing from adverse childhood experience, trauma, and substance use problems?
3. What does an intersectional feminist lens reveal about the unique experiences of girls and women who are struggling with substance use problems?
4. How might a critical clinical approach incorporate biomedical advances in neuroscience in practices that empower girls and women, and what are the dangers of the dominant neoliberal focus on biomedicine?

The metaphors of "safety," "belonging," and "voice" have been a central aspect of feminist approaches to working with women and reflect the most important elements in our work with women and girls impacted by substance use problems. We suggest that these metaphors signify aspects of trauma-informed critical clinical practice and processes of healing from oppression, trauma, and substance use problems that have been refined by feminist approaches to working with women over the past 30 years (Covington, 2008; Herman, 1992; Kasl, 1992; Najavits, 2002; Schmidt, Poole, Greaves, & Hemsing, 2018). Feminist theory helps clarify the unique and frequently traumatic pathways girls and women traverse to substance use problems and their distinctly gendered and embodied experiences. It rejects postfeminist arguments that depoliticize and de-gender girls' and women's experiences to posit that a feminist lens is no longer required by recognizing historical, embodied, and daily experiences of sexism (Ahmed, 2015). Throughout this chapter, we critique neoliberalism and postfeminist theories that suggest agency is exercised by making informed and healthy individual choices to promote a gendered and politicized analysis of social contexts (Gill, 2008; O'Neill, 2015).

Safety, the first metaphor, implies not only finding a way to secure physical safety, but also embodies the search to feel at home in the world, to feel acceptance such that it is possible to trust oneself and others in one's identified family and community (Najavits, 2002). Such efforts embody critical perspectives by helping girls and women recognize the ways in which the world can be hostile, unjust, and unsafe, while clinical practices can help them improve their safety physically, emotionally, culturally, and in relationship with others. The emergence of scholarship regarding "cultural safety" implies the need for non-Indigenous practitioners to take responsibility for their own learning of Indigenous history and ways of Knowing, Being, and Doing that involves collaboration and consultation with community (Duthie, 2019). This places a

responsibility on the critical clinical practitioner to learn to practice in ways that do not retraumatize Indigenous girls and women.

The second metaphor is a sense of belonging. It is equated with obtaining psychosocial integration. This is a step toward forming connection with oneself and others to claim a meaningful and full life as a component of healing from substance use problems (Alexander, 2008; Mate, 2008). The term *psychosocial integration* describes a process of people exhibiting "a renewed stake in conventional life and in their social relationships and a new identity to go with it" (Cloud & Granfield, 2004, p. 200). Ideally, this life would include connections with those who enhance the values of an individual that is unhampered by the dictates of substance use problems. Alexander (2008, p. 161) states that those who find belonging in the social, cultural, and personal dimensions of a non-addictive life are most likely to heal and recover from substance use problems.

NEOLIBERALISM

Neoliberalism, a political philosophy that favours free-market capitalism, has been influential in Canada since the 1980s. It results in policies that support the wealthy and deepens the marginalization of those citizens who are already disadvantaged.

Within neoliberal frameworks, the focus is on the individual to act responsibly, drink responsibly, make rational choices, and exercise self-discipline, rather than on the social context in which people live (Gillingham, 2006; Haydock, 2014; Liebenberg, Ungar, & Ikeda, 2013; Lupton, 2005; Scourfield & Welsh, 2002; Swadener, 2010). For example, the dominant culture of alcohol normalizes the consumption of alcohol by teens and adults, while neoliberalism interprets problems with alcohol as personal and individual failures that are deeply shameful. Girls and women who are challenged with substance use issues may become silenced by a sense of stigma and shame that is particularly gendered.

Voice, the third metaphor, signifies agency and transformation from passive "object" to be acted on, to one of appreciation for agency, influence, and resistance. As a metaphor, when a person no longer has a sense of voice, they can experience a loss of humanity; a falling out of touch with meaning and the disappearance of significance. Voicelessness creates the experience of being numb, without a capacity to feel, to touch, or to be in touch (Lederach & Lederach, 2010).

This chapter highlights the ways in which a critical clinical practitioner works with girls and women to help them restore a sense of "safety," "belonging," and "voice" in the healing process. This involves the integration of feminist critical perspectives to demonstrate how they can assist girls and women to author their identity, facilitating an understanding of social factors that influence their lives. We position this within a brief discussion of theories of substance use problems and highlight the merits of the dislocation theory of substance use problems in helping to create a contextualized narrative of substance use issues. Like feminist theory, this theory describes the ways in which cultural and structural factors can sway the lives of girls and women to create a vulnerability to substance use problems that, we argue, is exploited by alcohol and pharmaceutical corporations. We then discuss the influence of childhood adversity and trauma in girls' and women's lives. The lens of neuroscience often reflects the growing neoliberal emphasis of biomedicalism, which operates to obscure social and structural inequities (Morrow & Weisser, 2012). We argue that while the dominant neuroscience focus is individualistic and decontextualized, it can also be valuable to increase girls' and women's embodied self-awareness of the effects of trauma in a critical clinical approach, while also emphasizing the ways in which social inequity impacts their lives. We then return to the guiding metaphors of safety, belonging, and voice and discuss how our work as critical clinical social workers is informed by this paradigm. Throughout, we demonstrate how a women's group can play an essential role in the recognition of social and relational factors that can contribute to these processes.

The voices of women in a film, *Women of Substance*, are highlighted, with specific attention to the challenges women encountered in re-authoring their identity (Ross, 2012). The women, who were members of a women's recovery group in Nova Scotia, chose to participate in this film to exercise their agency and "voice" to reduce stigma and influence a societal shift in attitude toward women who experience substance use issues. For example, the film begins with a description of how unsafe it feels to be a woman with substance use issues:

> As a woman you don't want people to look at you like *that* … you're a mom. You don't want to admit it. You don't want your kids to know, because you think they don't know, but they know. A woman has more shame and guilt. Shame of physical, sexual abuse. You don't have the resources. You know babysitters … you've got the schools looking at you differently. You're supposed to be the role model more so than a man.

The speaker recognizes the importance of claiming her identity and using her "voice" in healing from this gendered stigma:

> Everybody has a voice. Everyone has the ability to stand up and say, you know, I am a person. I am not that addiction. I am not the little girl that was hurt as a child or abused. You are more than that.

Another woman describes the importance of feeling safe:

> When you feel safe enough to offer yourself to others in whatever capacity you feel you have … you're a great typist, you're a painter, you're a great flower arranger, you make great pies, you make excellent soup … whatever it is when you hear the call of something in the community and you decide that what you have to offer is worth offering, you do so much more than you think you are doing. By being honest with one's self and feeling things deeply you can't help but touch others.

It was the words of these women that encouraged us to embrace the metaphors of "safety," "belonging," and "voice" for our work in the following years. A critical clinical social work approach will be demonstrated in our case study of Sally (a pseudonym representing a composite of women impacted by substance use problems). This case allows us to illustrate the themes of safety, belonging and voice in a way that is similar to how they were raised by women in the film. Other themes raised included stigma, mothering, shame, guilt, sexual and physical childhood abuse, women's inability to process alcohol as efficiently as men, opioids and pain, experiences of youth, and the need for safety and to exercise one's voice, offering one's contribution to the community and helping others. This chapter will demonstrate through Sally the ways in which a critical clinical approach informed by intersectional feminist theory and the dislocation theory of substance use problems can be helpful in linking the "personal" with the "political" to inform a gendered response.

GIRLS' AND WOMEN'S SUBSTANCE USE PROBLEMS: THE DISLOCATION THEORY OF SUBSTANCE USE PROBLEMS

The prevalence rates of girls' and women's substance use problems have steadily increased within the past few decades (Lal, Deb, & Kedia, 2015; S. C. Wilsnack,

2012; R. W. Wilsnack, S. C. Wilsnack, Gmel, & Kantor, 2018). Alcohol is the substance most commonly used by girls and women. Underage girls are drinking at ratios equivalent to boys in many high-income countries (Poole & Greaves, 2007; Thomas, 2012). Prescription drug use by girls and women has been on the rise at an alarming rate for the past two decades (Hemsing, Greaves, Poole, & Schmidt, 2016; Peteet, Mosley, Miler-Roenigk, McCuistian, & Dixon, 2019). For example, in Canada the use of opioids continues to be slightly higher for females (13.9 percent) than males (12.1 percent), women are twice as likely to use prescription sedatives (14 percent compared to 7 percent for men), and prescription stimulant use is increasing among young women (Health Canada, 2017). One study found that women were 48 percent more likely than men to use any prescription drugs and also more likely to be prescribed opioids (Simoni-Wastila, 2000). In the United States, 4.6 million adult women had problem use of prescription drugs in 2013 (Peteet et al., 2019). The application of a feminist intersectional lens reveals that among women there are differences. For example, older women are more frequently prescribed sedatives, particularly Indigenous women (Currie, 2004).

Despite these prevalence rates within the problem substance use field, 90 percent of the gender-specific research has emerged only since 1990 (Brady, Back, & Greenfield, 2009). Prior to this period, most literature related to substance use problems was largely based on men's experiences and heavily influenced by Alcoholics Anonymous 12-step programs (Kasl, 1992).

SUBSTANCE USE PROBLEMS

The term *substance use problems* refers to "a state of a person as a whole" and is an overwhelming involvement with an activity or substance (including, but not limited to, alcohol and drugs) despite the harms it causes.

Charlotte Kasl (1992) was among the first writers to critique Alcoholics Anonymous as an insufficient approach to address the complexity of women's lives. She noted that 12-step programs begin by asking people to admit they are powerless to exercise control over their substance use problems (or addictive behaviour) and that this approach was often unhelpful for women who experienced multiple oppressions. She argued that women's social context and lived realities were not accounted for within 12-step programs. For example, women are disproportionately held responsible for multiple caregiving roles, including

parenting (Poole & Greaves, 2012; Ross et al., 2015). Women experience greater levels of stigma for substance use problems. This is complicated by less access to the social determinants of health and the shorter time period, called the telescoping effect, of negative health impacts from substance use issues (Lal et al., 2015; Mancinelli, Vitali, & Ceccanti, 2009; Najavits, 2002).

The majority of women accessing substance use treatment programs have prior experiences of trauma that include childhood physical and sexual abuse (C. Brown, 2008; Covington, 2008; Najavits, 2002, 2004; Poole & Greaves, 2012). Women's experiences of substance use issues have been under-researched, including hidden and frequently related experiences of interpersonal violence (Najavits, 2002; World Health Organization, 2013). Status of Women Canada (2018) states that gender-based violence is a product of gender inequality rooted in patriarchal social structure. Gender-based violence intersects with and is intensified by other forms of systemic oppression, including colonialism, racism, ableism, heterosexism, transphobia, ageism, and poverty. Feminist theory has long asserted that experiences of interpersonal violence need to be politicized, thereby resisting tendencies to silence it (Stanley & Wise, 1993). The profound links between prior experiences of trauma and violence and women's subsequent substance use issues and mental health challenges have been witnessed in the direct (30 years combined) practice of the authors. This is also reported in research that has found women to be more likely to use substances after a traumatic experience (Collins Reed & Evans, 2009; Kendler et al., 2000).

Two prominent models of substance use problems that have been influential in shaping a narrow understanding of substance use problems are commonly referred to as the medical or disease model and the moral or skeptical model. A feminist approach to women's use of alcohol and other substances seeks to avoid these two approaches. The biomedical approach medicalizes and pathologizes women's struggles and efforts at coping without looking at the social context of their lives. The moral model view is also problematic, as it focuses on individual deficit reflected in poor choices (Alexander, 2008; Carter, Hall, & Capps, 2009; Heyman, 2009; Smith & Seymour, 2004). This position is not aligned with women-centred harm reduction approaches that work effectively with girls and women to reduce the harm they experience from substance use problems (Schmidt et al., 2018). Both of these dominant approaches to substance use problems are divested from a social analysis and aligned with the neoliberal emphasis on individual responsibility that can exacerbate the impact of stigma and criminalization of substance use for women. Therefore, treatment approaches are "grounded in neoliberal discourses of personhood and citizenship rooted

in ideologies of efficiency, individualism, and self-responsibility" (Schlosser, 2018, p. 191).

Haydock (2014) underscores common features of a neoliberal approach. Neoliberalism emphasizes market rationality located in regulatory and state structures and in the mode of the ideal citizen. For those citizens who do not perform as ideal members of society, "this approach to government focuses on 'technologies of citizenship' to shape people's behaviour" (Haydock, 2014, p. 263). Here, Haydock references Michel Foucault (1988, p. 18) to explain that these technologies focus on the individual's responsibility to make rational choices and exercise self-discipline if provided with the appropriate information, rather than on the regulatory environment in which people act. Such understandings of substance use problems preclude a wider focus on the environment and lack an intersectional feminist lens that is essential to understanding the embodied and psychosocial stress women experience that is often rooted in trauma both in childhood and adulthood.

The medical model describes substance use problems as a psychiatric disorder or disease that requires treatment (Smith & Seymour, 2004; Mate, 2008; Carter et al., 2009). Popular acceptance of this model was boosted by Alcoholics Anonymous, which, in the introductory chapter of the *Big Book of Alcoholics Anonymous*, describes the disease of alcoholism as "an allergy of the body and a compulsion of the mind" (Smith & Seymour, 2004, p. 13). The main strength of the medical or disease model is a movement away from penalizing the individual and toward the provision of therapeutic and treatment programs. Most of the criticism of this model arises from a belief that substance use problems need to be understood more broadly as a societal, political, and economic problem. For example, feminists note that medicalized programs fail to appreciate the complexity of women's lives because they do not acknowledge that many women seeking treatment for substance use problems have suffered past trauma, are single parents, and have limited access to the social determinants of health (C. Brown, 2008; Kasl, 1992; Najavits, 2002).

Consistent with a feminist approach, the dislocation theory of substance use problems differs from moral and medicalized explanations of substance use problems by focusing on social context. This theory describes "the loss of psychological, social and economic integration into family and culture [and] a sense of exclusion, isolation and powerlessness" (Mate, 2008, p. 261) as precursors to substance use problems. The first principle of this theory states, "psychosocial integration is an essential part of human well-being, and that dislocation—the sustained absence of psychosocial integration—is excruciatingly painful" (Alexander, 2008, p. 86). In advancing the dislocation theory of substance use problems, both Alexander (2008) and Mate (2008) suggest that increasing rates of substance use problems in Canada, and elsewhere, can be linked to a growing sense of alienation and disconnection that they claim is fuelled by globalization and free market economies. In his sustained critique of the neoliberal globalized agenda, Alexander (2008) describes the myriad ways in which individuals compete for employment and financial success, ways that often result in their separation from family, community, and culture. To curb growth in substance use problems, this theory points to structural and cultural change to promote psychosocial integration and a sense of belonging as the goal of human development, both personal and societal.

DISLOCATION THEORY OF SUBSTANCE USE PROBLEMS

The dislocation theory of substance use problems suggests that rates of substance use problems increase in social contexts dominated by colonialism, patriarchy, and capitalism, resulting in mass dislocation and alienation.

Psychosocial integration, a concept originating with the work of Erikson's (1968) theory of lifespan development and developed by feminist thinkers, speaks to identity formation and the importance of choice, agency, and opportunities to define one's life (Alexander, 2008; C. Brown, 2017; Syed & McLean, 2015). This concept can be linked to our description of the importance of voice, noted in the women's decision to participate in the film *Women of Substance*. Erikson's (1968) theory and narrative therapeutic approaches emphasize relational and societal processes in which other people are crucial in constructing personally coherent identity narratives (C. Brown, 2017). Although theories of substance use problems have historically focused on individual factors as described in the medical and moral models, research continues to show that social factors play

179 continued

an important role and are involved in every stage of the development of and "recovery" from a substance use problem (Alexander, 2008; Dingle, Cruwys, & Frings, 2015; Mate, 2008; Poole & Greaves, 2012). In so doing, this research moves beyond individual explanations for the origins of substance use problems to emphasize the role of relationships, communities, and influential social and cultural factors.

In the next sections of this chapter, we argue that establishing safety, a sense of belonging, and opportunities for voice are three pillars of a woman's substance use treatment paradigm and are best informed by a critical intersectional feminist lens and the dislocation theory of substance use problems.

GIRLS' AND WOMEN'S SUBSTANCE USE PROBLEMS: AN INTERSECTIONAL CRITICAL FEMINIST LENS

Increased consumption of alcohol and prescription drug use by girls and women has been influenced by successful marketing strategies used by the alcohol and pharmaceutical industries that are referred to as "Big Alcohol" and "Big Pharma" (Chan, 2013; Ross et al., 2015). Consumption of alcohol by underage girls matches or exceeds that by underage boys in Canada (Health Canada, 2018). Heavy drinking among all age groups was higher for males (65.1 percent) than females (52.2 percent) (Health Canada, 2017). Prescription drug use has been on the rise at an alarming rate for the past two decades (Hemsing et al. 2016; Peteet et al., 2019). Canadian women are more likely to abuse prescription medications than Canadian men (Health Canada, 2017). Despite a greater burden of substance use and "relapse," prior to Peteet and colleagues (2019) systematic review, no identified studies had methodically reviewed the literature exploring prescription drug use among adult women.

The addictive nature of benzodiazepines, also known as tranquilizers or sedatives, and their profound effects on the brain and body have been known for over 40 years, yet these drugs are among the most widely prescribed in Canada and the world today. The over-prescription of benzodiazepines to women in Canada was first identified as a critical health care issue in the 1970s and yet in 2000 there were more than 15.7 million prescriptions for benzodiazepines filled by Canadian retail pharmacies (Currie, 2004). In the research that exists, it is repeatedly demonstrated that women who have prior experiences of marginalization, dislocation, and trauma are more susceptible to substance use problems (Najavits, 2002; C. Brown, 2008; Covington, 2008;

Hemsing et al., 2016; Peteet et al., 2019). There are also important differences among women and further research incorporating an intersectional and gendered lens is required. Attention to race, gender, and other identity categories help us better acknowledge and understand these differences (Crenshaw, 1991). Trans women of colour are, for example, among the most targeted victims of violence in the LGBTQIA+ community (Cox, 2014). This vulnerability also influences a susceptibility to substance use problems (Perspectives in Public Health, 2015). Colonial oppression is also a factor in a vulnerability to substance use issues among Indigenous women. However, Poole and Dell (2005) caution against making assumptions, as these can serve as a barrier to health care among poor women and women of colour who are more frequently screened for substance use when accessing perinatal care than middle-class and Caucasian women.

Greenfield and Picard (2009, p. 290) write that the significant differences between men and women who are experiencing substance use problems include "risk factors, natural history, presenting problems, motivations for treatment and reasons for relapse." When compared to men, women are less likely to seek treatment and when they do it is more likely to be from a mental health practitioner (Greenfield & Picard, 2009). Girls and women are less likely to seek treatment for substance use because of the greater stigma they experience and the profound fear of losing custody of their children (Greenfield & Picard, 2009; Johnston, 2014). The impact of this stigma and fear is felt individually by the women and girls who neither seek treatment nor are adequately screened for substance use. The impact of stigma in society includes fewer allocated resources (Yang et al., 2017) meaning less research and policy initiatives. An intersectional feminist approach can help professionals who work alongside women who use substances to incorporate a women-centred and harm reduction lens to better respond to their needs. We argue that feminist theory (Ahmed, 2015; Crenshaw, 1991; Grosz, 1990; Stanley & Wise, 1993) is essential to critical practice with women in two ways. First, feminist theory assists girls and women to critique and challenge sexism existing in prevailing social, political, and theoretical relations. Second, feminist theory offers a way forward to create feminist alternatives. It can provide a sense of agency and voice.

For instance, feminist theory can help girls and women critique the ways in which they are targeted by Big Alcohol and Big Pharma. As an example, it is helpful to explore pediatrician Flegel's (2013) concern related to adolescent girls'

consumption of alcohol. He suggests that adolescents need information about the intent of alcohol advertising:

> They need to be taught that the purpose of advertising is to create a demand where there is no need. When advertising reaches a vulnerable group, such as adolescent girls, they need to understand what it means to be duped by an adult influence that does not have their interest at heart. (p. 859)

His statements offer sharp critique of government approaches that fail to limit alcohol advertising and media that target youth. Feminist theory can assist girls to be armed against these industry tactics to discern when they are duped by adult and corporate influences.

Feminist theory helps girls and women recognize how neoliberalism and globalization can influence cultural values in film, social media, and advertising in ways that can undermine their sense of self-worth. Kilbourne's (2000) huge body of work critiques the way images of women are portrayed in advertising generally and alcohol and tobacco advertising specifically. Social work researcher Brené Brown's (2012) lecture "Listening to Shame" is featured on YouTube and has been viewed by more than seven million individuals.

Many of the women featured in *Women of Substance* had also written pieces for a column published in the *Lighthouse Log*, a newspaper (with a circulation of 60,000) in Bridgewater, Nova Scotia, between 2004 and 2012. Both the newspaper column and the film evolved from the weekly women's recovery group that met in Bridgewater between 2002 and 2012. During one group meeting, we discussed what could be a title for the newspaper column and chose *Coming Home: Stories of Women in Recovery*. This title reflected aims of both the column and the women's group. The goals were to reduce stigma and silence regarding women's substance use issues and to encourage women in the community to seek help if they felt it was needed. Approximately 20 articles were published, each of which reflected the voice of a woman telling her story about what steps she had taken to rewrite the narrative of her life in "coming home."

TRAUMA AND ADVERSE CHILDHOOD EXPERIENCES

Many girls and women who access treatment for mental health and substance use problems have experienced trauma and/or adverse childhood experiences. The Adverse Childhood Experiences Study, the world's largest longitudinal health

study on this subject, began in 1995 as a joint initiative of Kaiser Permanente and the Centers for Disease Control and Prevention in the United States. It aimed to better understand the relationships between adverse childhood events and the development of health and social problems as adults. This study made connections between chronic stress caused by early adversity and the profound impact on the developing brains and bodies of children that resulted in later-life health issues (Felitti et al., 1998). In the initial study, over 17,000 health maintenance organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviours. The majority of these individuals were Caucasian, middle class, and university educated. The study looked at 10 categories of childhood adversity that included physical, sexual, and emotional abuse and physical and emotional neglect, and 5 measures of household dysfunction that included domestic violence, parental mental illness and/or substance use problems, an incarcerated relative, and separation/divorce. The Adverse Childhood Experiences Study had two striking findings. First, adverse childhood experiences were incredibly common—67 percent (two out of three) of the study participants had at least one adverse childhood experience and 13 percent (one out of eight people) had four or more adverse childhood experiences. Second, there was a dose-response relationship between adverse childhood experiences and numerous health problems. This means that the more adverse childhood experiences a child has, the higher the risk of developing chronic illnesses such as heart disease, obesity, chronic obstructive pulmonary disease (COPD), depression, and cancer (Felitti et al., 1998). Today, a significant body of evidence continues to demonstrate a powerful dose-response relationship between adverse childhood experience scores and a wide array of significant health and social problems in adulthood (Anda et al., 2006; Douglas et al., 2010; Dube et al., 2003; Edwards et al., 2001; Felitti et al., 1998; Logan-Greene, Green, Nurius, & Longhi, 2014; McDonald, Kingston, Bayrampour, & Tough, 2015). Women have been found to have experienced higher rates of childhood sexual abuse in many of the adverse childhood studies and these experiences were found to increase the probability of having experienced other adverse childhood experiences (Baglivio et al., 2014; Banyard, Williams, & Siegel, 2001; Cavanaugh, Petras, & Martins, 2015). Accurate rates of childhood sexual abuse are unavailable. The studies that have been completed suggest that although both girls and boys experience childhood sexual abuse, the rate is thought to be three to five times higher for girls (Finklehor, Statluck, Turner, & Hamby, 2013; Harrison, Fulkerson & Beebe, 1997). The association of childhood sexual abuse with later

substance use problems appears to be greater for women than men (Widom, Marmorstein, & White, 2006).

Girls' and women's experiences of trauma and adverse childhood experiences are often hidden and internalized as individualized experiences that are alienating and shameful. However, adverse childhood experiences research tells a collective story that signals the need for community healing, thereby helping girls and women recognize they are not alone. Feminist theory can be influential in "clinical" approaches that are responsive to individual needs, while also highlighting the importance of advocating for social justice. In this way, the personal becomes the political. There is now considerable evidence that effective treatment approaches can help offset negative health and social consequences of adverse childhood experiences and that this framework can influence policy and legislation in efforts to reduce adverse childhood experiences (Korotana, Dobson, Pusch, & Josephson, 2016; Larkin, Felitti, & Anda, 2014). Childhood experiences of abuse and trauma often result in not feeling safe, relational injury and disconnection, and a struggle to voice the pain of these experiences (Herman, 1992, 2015). These early experiences of trauma are often dealt with in adulthood through the use of substances in order to numb the pain (C. Brown & Stewart, 2008). Through discussing Sally's experience, I will highlight the metaphors of safety, belonging, and voice.

Sally

Sally, age 38, is a white, working-class woman living in a small rural community. She has limited education and is seasonally employed. She has struggled with an alcohol problem since she was 13. Her substance use increased as she got older to include problems of opiates and benzodiazepines. She has been in both individual and group treatment at a women's substance use problems centre. She is divorced and a single parent to one child, age 11. She has described feeling powerless and a deep sense of shame regarding her substance use problems, which have resulted in some involvement with the police. Sally experienced emotional, physical, and sexual abuse during her childhood, as well as subsequent abuse in her marriage by her former partner who also struggled with substance use problems. Sally reports feeling like she is a bad mother and expresses a deep sense of isolation, insecurity, and loneliness. She believes that her child's teachers also think she is inadequate as a parent and that they do not feel the same way about the father of her child, who has limited involvement with their lives.

She has struggled with precarious employment, poverty, and feelings of anxiety and depression for as long as she can remember.

Clinical critical social work practice, with its unique focus on the individual within their social context, blends clinical approaches with a critical perspective that perceives how unjust social contexts marginalize individuals and advocates for social justice. Feminist theory can help girls and women recognize the ways in which trauma and adverse childhood experiences are both personal and political. This means it can validate girls' and women's experiences and provide guideposts to help them define a narrative in their life that makes sense of their past while pointing to steps they can take as individuals to heal. For example, Sally thought there was something personal about her that resulted in her experiences of abuse, and this thinking had contributed to internalizing a deep sense of loss and shame regarding the abuse she had experienced. When she began to realize that she was not alone in these experiences and that the abuse she had suffered was perpetrated by a man influenced by patriarchal values who had also experienced childhood trauma, she perceived her experiences of childhood abuse differently. Her feelings of shame lessened as she began to engage in a process of counterviewing her past. Catrina Brown (2017) describes this process as a way to view stories differently by unpacking what has been assumed as truth, critiquing dominant social discourse to facilitate counterstories that emphasize agency and self-compassion. A feminist clinical critical social work approach to Sally's experiences of adversity in childhood assisted her to externalize what was perceived as an intractable part of individual experience. She chose to exercise her agency to influence social change by taking this step to reduce stigma and increase recognition in her community of factors that contribute to substance use problems for women. Taking this step within her community can be described as politicizing what had been experienced as personal.

SALLY: SAFETY, BELONGING, AND VOICE

Table 7.1 demonstrates how centring the metaphors of safety, belonging, and voice within an intersectional and critical feminist lens is helpful to guide our work with Sally. Within a critical clinical framework, Sally's experiences are understood as influenced by community and societal influences.

While prioritizing safety for individuals who have experienced prior violence may appear self-evident, Najavits (2002) and Lederach and Lederach (2010) describe steps to feel safe as moving beyond assurances of physical security to include a search to find a way to feel at home in the world. This includes

TABLE 7.1: SALLY: SAFETY, BELONGING, AND VOICE

	SELF	COMMUNITY	SOCIAL
Safety	Are you physically safe from harm? Do you have a safe place to live? Do you have access to resources? Do you have someone to look after you if needed? Have you learned skills that help you feel safer? Do you have knowledge and skills to cope with possible physiological responses (flight, fight, or freeze) when you remember a traumatic event?	Do you have supportive people/services in your life to help you cope with your feelings of anxiety and depression? Do you feel that those around you can be trusted? Do you have places within your community where you feel safe, valued, and respected?	While recognizing factors that can contribute to social injustice do you experience cultural safety? Are you in a place where the societal and cultural values that influence your life are consistent with your own values?
Belonging	Do you feel connected to others? Do you have a friend? Do you like yourself? Can you share your experiences with others?	Are there groups of people or community organizations that foster a sense of connection to others? Do you receive and reciprocate good invitations?	Do you have cultural and/or spiritual practices that are important to you that are shared with others with whom you are connected?
Voice	Do you have a sense of agency? Can you observe and describe yourself and your situation?	Do you have groups or community organizations that will help you meet your goals? Are there safe places to meet where you can share your experiences?	Do you have opportunities to use your influence to have a voice in society to advocate for social justice in matters that are important to you? Do you know how to effectively use your influence?

Sally learning to trust herself and others. As a metaphor, safety is described as a container (Lederach & Lederach, 2010).

A sense of belonging is the antidote to disconnection, dislocation, and trauma. Sally found herself feeling connected to others as she shared her story in the group. In making the decision to participate in the film, Sally is exercising a sense of agency and voice, fuelled by a belief that sharing her story will make a difference.

SAFETY, BELONGING, AND VOICE: FOCUSING ON BOTH THE INDIVIDUAL AND SOCIAL CONTEXT

Research on adverse childhood experiences has been instrumental in helping individuals understand the ways in which the developing brain and nervous system respond to childhood adversity and trauma. Cognitive processing takes place in the neocortex. It includes functions of analyzing, strategizing, reasoning, making meaning of situations, and human language (Ogden & Fisher, 2014). When we describe in words our ideas and experiences, we use the neocortex. In other words, this is a place of "voice." When situations are outside our window of tolerance for stress, it is challenging to access cognitive functioning.

To be at our best we need to stay within our window of tolerance for stress so that we can function optimally in all three levels of information processing: sensorimotor, emotional, and cognitive. When we are playful, creative, and confident there is a coordination of brain functions (van der Kolk, 2014). Considering the prevalence of stress and trauma in the lives of women who use substances, it is not surprising that attending to the need to create a place where women can experience safety and belonging and then be given the opportunity to find and use their distinctive voice is so effective in clinical work. Understanding the brain is helpful to working with people with past traumatic experiences. For example, it helps us realize the need for safety when a woman is triggered into feeling like a traumatic event may be happening in the moment despite all evidence to the contrary.

CONCLUSION

When women decide to seek help for and safety from substance use problems, they risk more stigma than men, including receiving the label "bad mother." In some cases, women risk having their children removed from their care.