Research and clinical observation confirm that women seeking substance abuse treatment are more likely to be victims of childhood sexual abuse than those in the general population (Glover et al., 1995; Rohsenow et al., 1988; Wilsnack et al., 1996). Covington (1986) estimates that 38% of women and 7% of men in the general population were victims of early sexual abuse, while Finkelhor (1984) found that up to 45% of women and 22% of men entering substance abuse treatment were victims of childhood sexual abuse. Further, Briere and Runz (1989) report that among women who entered a women's crisis center, those with a history of childhood sexual victimization were ten times more likely to have been addicted to drugs and two times more likely to have been addicted to alcohol than those entering without such a history. Many authors suggest that childhood sexual abuse may in fact be a predictor of later substance abuse (Miller et al., 1987), and incest has a particularly strong association with 40-44% of chemically dependent women in one study disclosing such victimization (Hammond, 1979).

Links between substance abuse and sexual victimization

Many explanations have been given for the association between childhood sexual abuse and the development of substance abuse and dependency. There is a high degree of substance abuse in families who are sexually violent, and alcohol in particular is often used in conjunction with the commission of sex crimes. The children of chemically dependent parents have a greater than average propensity to become addicts or alcoholics themselves, whether through social modeling (Elliot & Edwards, 1991) or genetic factors (Goodwin, 1979).

Probably the strongest link between experiencing sexual trauma and developing chemical dependency, however, is the survivor's desire to regulate emotional states resulting from the victimization. The posttraumatic symptoms of autonomic arousal (anxiety, hypervigilence, nightmares, and flashbacks) are soothed through the use of alcohol and other central nervous system (CNS) depressants. The symptoms of depression (low energy, low self-esteem, sexual dysfunction, and hopelessness) are mitigated by stimulants. These tension reducing behaviors of chemical use (Briere, 1992) work quite well to control emotional pain and chronic dissociation. Because abused children tend to use drugs and alcohol earlier in life than their non-abused peers (Briere, 1992), they are likely to become dependent on these substances. Dependence, in turn, is likely to forestall the development of more sophisticated methods of managing stress. Consequently a vicious cycle emerges:

Sexual Abuse and Post Traumatic Stress Disorder

The clinical sequelae of early sexual trauma is Post Traumatic Stress Disorder (PTSD). PTSD is identified by a cyclical pattern of recurrent intrusive thoughts and images of the abuse followed by periods of avoidance of any reminders of such abuse. PTSD causes its sufferers to react behaviorally to memories of abuse with intense fear, hypervigilance, irritability, and an exaggerated startle response, or with feelings of detachment, emotional numbing, a restricted range of affect, and a sense of foreshortened future.

Drug and alcohol abuse, as defined by The American Society of Addiction, is a chronic, progressive, and often fatal illness that includes the compulsion to use despite negative consequences, loss of control over the drug, and both psychological and physiological components. Those who have symptoms of PTSD and who abuse chemicals experience a "double bind" (Trotter, 1992). Chemical abuse tends to increase the frequency and
offending behaviors, such as "Have you ever been touched in a sexual way that was uncomfortable or that you thought had to be kept a secret?" Simply asking "Have you ever been sexually abused?" may be interpreted in many different ways, or may be considered intrusive or shocking coming from a complete stranger.

Also, simply screening for the presence of a history of early victimization without providing more in-depth assessment and treatment is both clinically unhelpful and may, in fact, raise in the client such high levels of anxiety and mistrust that she drops from treatment prematurely. Therefore, assessment of sexual trauma should be an ongoing component of the recovery process. This is particularly true for substance abusers whose memories of such painful experiences may return only after long periods of sobriety. In one study of male and female substance abusers, only 4% of males and 20% of females spontaneously reported early sexual trauma (Rohsenow, 1988). After treatment staff were trained to inquire initially and throughout treatment, the percentages of disclosure quadrupled for men and rose to 75% among women. This may be due to the treatment staff offering a safe, comfortable environment for disclosure, by addressing such issues in an open, normalized fashion, and by asking at different times during treatment.

Assessment of childhood sexual abuse should address the client’s awareness of his/her childhood history and current symptoms or problems relative to his/her perceived strengths and resources (Briere, 1992). Inquiry into the client’s own awareness of early sexual trauma could consist of several descriptive questions regarding such experiences, e.g., "Have you ever been touched in a way that made you feel uncomfortable?" Other, more specific areas to address, which may add unique explanatory value to a client’s behavior and previous difficulties in recovery, include: (1) objective factors about the process and progress of the abuse, (2) the active or passive role assumed by the victimized child, (3) the idiosyncratic meaning of the abuse, (4) behavioral reactions, (5) attempts at disclose, (6) involvement of others, and (7) post-abuse adjustment (Courtois, 1988). Full interview questionnaires such as the Incest Questionnaire (Courtois, 1988) should be reserved until after initial disclosures. Other interview-type questionnaires are available but their use must be tempered by clinical judgment of the client’s possible response and its effects on treatment in general. Such detailed assessment may be better left to a time later in recovery when strong coping skills and levels of therapeutic trust have been built. Timing is a delicate and critical clinical skill. If the client’s disclosure is not likely to be believed, supported, or offered attention as part of ongoing treatment, then it may be best not to ask at all.

Assessment of Substance Abuse

There are many good standardized assessment tools for addressing an individual’s substance use. Several only ask a few simple questions. Such screening instruments as the ASI (Addiction Severity Index), CAGE, HALT, and BUMP consist of a series of questions that address degrees of alcoholism. As with trauma assessments, ongoing inquiry is likely to yield more honest and reliable disclosure about the amounts and types of substances used and the negative consequences because of the abuser’s heavy reliance on denial. It is more helpful to understand what happens when the client uses substances rather than how much or how often they use. Speaking with family members or friends can sometimes be helpful as well. When a more detailed follow-up is indicated during screening, the Substance Abuse Subtle Screening Inventory (SASSI) is a reliable tool now being used widely by substance abuse and mental health professionals to provide detailed information about a client’s substance use and abuse.

Treating Substance Abuse and PTSD

Previously considered very separately, treatment models for addressing substance abuse and PTSD are actually very similar (Trotter, 1995). Both treatment models have as primary goals the attainment of safety—through abstinence of chemicals...
and from self-destructive behavior. Both embrace behavior change and learning affect modulation skills. Addressing cognitive distortions and creating support systems are also goals in both treatment models. Additionally, both models endorse early recovery stability offered through the therapeutic relationship of individual counseling. The role of family work is as important for recovery from childhood trauma as it is for substance abuse recovery, with somewhat different goals for resolutions within the family. Both models now support the careful use of psychotropic medications. Even the most traditional substance abuse programs recognize the value of using an antidepressant in early stages of recovery. Because clients are struggling with recovery from two very strong disorders that are synergistic irritants, however, recovery must be flexible and on a continuum of care so that the client might use inpatient, outpatient and support groups as needed.

The question remains how to know when and what disorder to treat in the recovery process. In the early 1980's, survivors' accounts of the horrors of being abused sparked public and professional awareness of this issue and clinicians began offering specialized treatment for the persisting negative effects of child sexual victimization. At that time, treatment primarily focused on encouraging the recovery of memory, abreacting (acting out) aspects of those memories, and placing blame squarely on the perpetrator(s). For most survivors, this form of treatment was extraordinarily helpful due to its potential for validation from a concerned professional resulting from the revelation of long held memories. For survivors who had few coping skills, however, therapists' inquiries or insistence on the client opening up issues of child abuse was therapeutically disastrous. Many claims of abuse were met with blatant denial from those accused leading to nationally publicized law suits and a tendency for survivors to recant their histories or remain silent.

Recovery from childhood sexual abuse for substance abusers requires a rather specialized approach. Many authors have made general suggestions for a dual model approach based upon the level of current substance abuse, previous attempts at recovery, the extent and perceived negative effects of early victimization, current support systems, and financial and psychological resources (Bollarud, 1990; Glover, 1995; Wadsworth, Spampneto and Halbrook, 1995).

It also is helpful to consider three classifications of addicted survivors which describe the functional relationship between PTSD symptoms and strength of addiction (Trotter, 1992). A Type I client has active addiction/repressed abuse issues. This type of survivor typically has a genetic predisposition towards addiction and shows increasing tolerance and withdrawal symptoms in his/her chemical use. Type I clients may exhibit no PTSD and reveal no awareness of early sexual abuse. Along with traditional addiction treatment, these clients need to be educated about the strong link between addiction and child abuse, forewarned of the possibility of developing PTSD, and given resources for follow-up. A Type II survivor has active addiction and active PTSD. This survivor requires a dual model of treatment for PTSD symptoms and trauma-related issues as well as traditional treatment for substance abuse. A Type III survivor uses chemicals clearly as self-medication with no development of tolerance or withdrawal symptoms. This particular survivor primarily needs treatment of post-trauma symptoms along with forewarnings of addiction potential unless other coping skills are learned.

In any case, treatment of substance abusing clients who were sexually victimized must include education about both the impact of sexual victimization on subsequent behaviors, and the role chemicals have played in the clients' post-abuse adjustment. Once sobriety has been attained and the shock of abuse disclosures has waned, both substance abuse and PTSD treatment models endorse the positive role of same sex group psychotherapies.

Continued on page 18...
One of the original programs funded by the Abandoned Infants Act in October of 1990, Project Prevent is operated through the Department of Pediatrics, Emory University School of Medicine in Atlanta, Georgia. Project Prevent was designed in response to the high incidence (35%) of cocaine-positive infants admitted to the neonatal intensive care nursery at Grady Memorial Hospital, and to the large number of those infants who boarded in the hospital after they were medically readied for discharge. It was clear that in this community, many of the pregnant women who were using drugs received no prenatal care and delivered a disproportionate number of babies who were premature and had other health problems that required admission to the neonatal intensive care unit (NICU). Thus, a prime initial focus of the program was to establish a referral network that would capture this group of women, and a component based in the NICU at Grady Hospital to provide more intensive intervention and follow-up to this group of women and their infants. The program has since expanded to serve women in the metropolitan Atlanta area regardless of the site of their medical care or hospital of delivery.

**Treatment Approach**

A team approach using a Masters level social worker and an addiction counselor has been a hallmark of the program from its initiation. The teams working with the pregnant women focus on getting the women into prenatal care, attempt to get them involved with drug treatment, and work on all of the other life issues that the women bring with them. Home visiting and outreach have always been used as core components of the program.

The team functioning out of the NICU initiates involvement with the family upon the admission of the infant to that unit and identification of a positive drug history during the prenatal period or at birth. This team assists the mother in getting into treatment, stabilizing the home environment, identifying the mother or relative caregiver(s) when necessary, and preparing the appropriate caregiver to take the infant at the point of medical readiness. The team and NICU staff also coordinate services with other agencies, particularly the Division of Family and Children Service (DFCS).

Because a very large portion (over 60%) of the women served by Project Prevent have a history of a sexually transmitted disease, especially syphilis, the program secured additional funding to hire a disease prevention specialist to provide more preventive outreach and follow-up services. This specialist now works with the teams to secure and ensure adequate medical treatment for the women, educate them about their disease, and ensure that partners are brought into the process. Women who are noncompliant with medical care are particular targets for this worker, who often must transport women to the clinic. This component has provided access to a great deal of training for the entire staff on sexually transmitted diseases and helped them feel more comfortable in discussing these issues with the women. It has also linked the program closely with the health department in efforts to find and maintain contact with some of the harder-to-reach clients who are known to multiple systems.

**Assessment and Treatment of Sexual Abuse**

Upon referral to Project Prevent, the appropriate team completes thorough psycho-social and alcohol and drug assessments to learn about the woman’s health, support systems, barriers to care, sexual abuse history, housing, drug use and treatment history, education/employment, and behavioral risk. As part of the psycho-social assessment, the social worker asks each client about her family life, childhood and adolescence, and physically, sexually and emotionally violent relationships she has experienced in childhood or is currently involved in. The social worker also inquires about foster placements the women experienced as children, which often seem linked to physical or sexual abuse. In addition, the disease prevention counselor and the addiction counselor explore sexual violence with each woman as part of the alcohol and drug assessment. As recovering addicts, the addiction counselors are often able to form a bond with the clients based on their own experiences of “being there.” As a result, clients are often more willing to share with the addiction counselors some of the “secrets” they have been carrying. Once these issues have surfaced, the team can more efficiently deal with the issues at hand.

After all the assessments have been completed, the team (social worker, addiction counselor and disease prevention specialist) reviews the issues the client is currently experiencing as well as relevant influences from her past. From this point, the team develops a treatment plan in cooperation with the client, and they begin to work with the woman and all the systems with which she is involved. The addiction counselors, for instance, develop and maintain ongoing relationships with all the treatment programs in the area and facilitate their clients’ entry into treatment. Once the client is in treatment, the addiction counselor works closely with the treatment facility staff, troubleshoes any problems that arise, and makes plans for aftercare as treatment concludes.

Because many (approximately one-third) of the clients are survivors of a lifetime of sexual and physical abuse, Project Prevent has occasionally facilitated groups that deal with these issues. Additionally, all the drug and alcohol treatment facilities that are involved with Project Prevent clients offer ongoing support groups as part of the clinical process. While these groups are important, however, the entire Project...
Case in Point

RF is a 27-year-old black female, native of Alabama and the second of three children. The client has a four-year-old daughter and is presently expecting her second child. The client was four months pregnant at the time she was referred to Project Prevent by Choices, a women-only, alcohol and drug treatment center in Atlanta. After meeting the client and talking about her three prior failed attempts at treatment and her unfortunate history, the addiction counselor and RF developed a treatment plan.

History

RF's biological father began molesting her at age seven. The client shared this devastating information with both of her grandmothers and again with her uncle at age 8-1/2, but nothing was done. The client suggested that her family did not believe her and felt she made up the story because she was angry with her father after her mother had died (she committed suicide when the client was three years old). The sexual abuse from her father continued another four years until, shortly after her 12th birthday, RF killed her father with her grandmother's gun following the typical sexual "ritual."

The client was committed to a mental institution for two years in Alabama. She was released at age 14 and returned to her grandmother's house in Alabama. She stated that her grandmother and uncle constantly filled her with guilt for having killed her father. She left her grandmother's house and turned to a life of prostitution with older men and to drugs and alcohol on the streets of Alabama at the age of 14.

RF entered her first drug treatment center at the age of 26. She stated that every attempt at recovery failed because of her horrible memories. She stated being sober was much more complicated than getting high. Having sex with strangers and being high somehow felt better than being sober and having the memories of sex with her father.

Assessment and Treatment

The client’s original treatment plan was seven days of detox, followed by four months of intensive inpatient drug treatment until the time of delivery and beyond. Project Prevent suggested a different plan. It was obvious that the client could survive treatment for 30 days; but the concern was what would happen if the real work of hide and seek, truth or dare and “let’s really talk about it” occurred and the client fled.

Project Prevent staff listened to this client tell her story and realized that she needed sexual abuse counseling and substance abuse treatment in a safe environment. RF was very open with her addiction counselor about her history. Although she could easily voice what happened, however, she could not stand to feel the hurt of reality. She also had been homeless for the last six months and had an active crack habit while in Atlanta.

Project Prevent devised a plan to get her back to Alabama so that, if she did not continue her recovery long-term, at least she would be close to home. With the client’s input, a referral was made to a residential treatment program in Alabama which could provide long-term professional help. The client gave permission for Project Prevent to share information (e.g., her triggers, patterns and behaviors) that would assist her in the road to recovery. Project Prevent staff collaborated with the staff in Alabama and arranged for RF’s transportation by bus. They also continue to provide moral support and encouragement to RF by telephone, and communicate regularly with the staff in Alabama.

Conclusion

Today, after several months, RF is clean and willing to face what she calls “demons in the closet.” She states that, “My mother died of suicide; my father died of murder; and I cannot continue to make attempts at suicide one rock at a time by continuing to allow my memories to commit murder to my spirit.” Today RF chooses a life of recovery in mind, body and spirit.

RF and many of the other 2,500 clients in Project Prevent’s first seven years demonstrate that the team approach can be effective at assisting addicted women who are sexual abuse survivors to address their complex issues. This requires that all the components (the social worker, addiction counselor and ancillary services) are functional. Providing drug treatment alone is insufficient if unresolved or ongoing abuse, housing, legal and medical issues are unstable or not addressed. The approach must be holistic if women are to truly have the best chance of success.

— Donna Carson, MSW, M.Ed., Director, and Demetria Walls, Addiction Counselor, Project Prevent
An Innovative Program to Serve Low Income Women with Histories of Chemical Dependency and Childhood Sexual Abuse

The high incidence of childhood sexual abuse among women who misuse or abuse alcohol and/or other drugs has been well documented in recent years (Benward & Densen-Gerber, 1998; Briere & Runtz, 1998; Miller et al., 1987; Paone et al., 1992). The long-term effects of childhood sexual abuse, including repeated adult victimization, are seen as contributing factors to drug and alcohol relapse. Despite this recognition in many substance abuse programs and in other arenas such as mental health and medicine, there remains a lack of specific treatment and coordinated services for chemically addicted survivors of childhood sexual abuse.

In her clinical report of a treatment model for addressing trauma related syndromes in chemically dependent women, Bollerud (1990) states:

Traditionally, alcoholics and addicts are encouraged to deal with intrapsychic issues after sobriety has been established. Consequently, traumatic events that may impact on the patient’s ability to use AA or to achieve sobriety are overlooked in early treatment. Frequently female substance abusers are locked in cycles of victimization and intoxication. Because similar defenses are used to cope with addiction and abuse, they may be unable to break the cycle and to achieve sobriety without education and treatment for both problems. (p. 87)

The failure of alcohol and drug treatment programs to identify and treat underlying childhood trauma and its effects, or to address current adult abuse, has contributed to the failure of women from all walks of life to complete treatment, maintain long-lasting sobriety, or break patterns of victimization and interpersonal dysfunction. In fact, “relapse may be indicative of the overwhelming pain experienced by the client in coming to terms with the trauma and not an indication of an unwillingness to abstain from mood-altering substances or harmful behavior ... Addressing and working with sexual abuse issues in women who are substance abusers is fundamental to the process of obtaining quality recovery” (Wadsworth, Spampeto & Halbrook, 1995).

With growing awareness of the long-term effects of childhood abuse and the effects of substance abuse, community agencies, treatment programs and funding sources need to collaborate on strategies that address these problems effectively. A multimodal treatment strategy, using interventions for addiction and unresolved trauma, will help to diminish relapse and reduce revictimization of women who are more vulnerable to abuse when under the influence and more vulnerable to relapse when they are traumatized or threatened with abuse. Training about effective ways to assess and treat this population also needs to be available for professionals who work in various settings with women who have histories of relapse, childhood abuse and adult victimization.

Program Description

In 1995, Treatment Alternatives to Street Crime (TASC) of King County in Washington State developed the Women’s Recovery Groups (WRG) program to address the needs of low income, culturally diverse women who have histories of chemical dependency and childhood sexual abuse. The goals of WRG were to meet the growing treatment needs of this population, and to address the long-term effects of childhood sexual abuse and its impact on adult functioning. WRG was housed at TASC, which provides case management, alcohol/drug evaluations, and monitoring for the courts and related criminal justice programs. Although WRG was developed external to alcohol and drug treatment programs, it addressed chemical dependency treatment aftercare needs specific to the targeted population. WRG also collaborated with other community programs in order to provide previously unmet services for this population.

Identified as a mid-stage component for treating combined childhood sexual abuse and substance abuse, WRG employed a supportive, psycho-educational group model designed with the recognition that women with these histories commonly have complex and long-term treatment needs. Women who had completed outpatient and/or inpatient chemical dependency treatment, and/or used 12 step or other self-help recovery groups to achieve sobriety, were accepted into WRG. At the time of admission to the program, women needed to be clean and sober and have at least six months experience of abstinence during adulthood.

This requirement was to ensure that women had learned skills for achieving sobriety even though they had difficulty maintaining long-lasting sobriety.

Group Treatment

WRG treatment focused on the inter-relationships between the use of alcohol and other drugs and the long term effects of childhood sexual abuse. With ongoing revisions to the original WRG model, the clinical program provided two types of
therapy groups. Women were placed in Group I after an initial screening interview. In Group I, participants addressed current life issues including ongoing alcohol and drug recovery, became familiar with the program and other participants, and prepared for Group II—the next phase of the program.

Through the use of a psycho-educational format, Group II focused on the specific problems related to the long term effects of childhood sexual abuse and its connections to alcohol and other drug abuse and relapse. The groups, which were centered on the women’s need for safety, trust building and staying clean and sober, addressed issues such as “how the past affects the present” and “what to do so that we will not get abused again.” At the end of the 16-week program, each participant received a certificate and a referral to continue their long-term recovery process through Alcoholics Anonymous (AA) or other self-help groups along with either on-going group therapy or individual psychotherapy. Referrals were also made to other related resources such as drug free housing, medical care, and job training.

WRG Staff

As a pilot program, WRG began with a small staff consisting of an administrator, a clinical project director, a counselor, and a clinical consultant. All four staff members were trained in group treatment with women who have histories of childhood sexual abuse, substance abuse and adult revictimization. Each group was co-facilitated by one staff member and one trainee who was either a graduate student or a counselor trained either as a chemical dependency counselor or as a treatment provider in domestic violence or sexual assault. Recognizing that staff who work with individuals who have experienced trauma and its long-term effects also experience stress and other reactions, WRG provided weekly supervision that included regular outside consultation. Also, in order to provide specialized training for all types and levels of staff who may have contact with substance abusing women who have histories of childhood abuse, WRG developed a training module for each level of TASC staff—from receptionist to case manager.

Community Outreach, Training & Consultation

WRG staff also recognized the need for a supportive referral process in order to help women overcome obstacles in seeking treatment and following up on recommendations for further treatment. Therefore, WRG staff developed and carried out a community outreach module to: inform potential referral sources about the effects of childhood sexual abuse and substance abuse and the benefits of providing multimodal treatment; provide suggestions for assessing and acknowledging issues related to sexual abuse and substance abuse with clients; and provide information and support to encourage referrals to WRG and other similar programs. WRG staff also maintained ongoing contact with potential referral sources and offered follow-up with each client they referred to another program.

Additionally, after gaining experience from running several groups and learning from the program participants, WRG staff offered a six week training program to multi-disciplinary professionals including chemical dependency counselors, sexual assault and trauma counselors, domestic violence shelter staff and group counselors, homeless shelter staff, and mental health clinicians. Each week the training focused on specific topics relevant to identifying and addressing treatment and program issues for culturally diverse women with histories of multi-abuse.

From the beginning of the program, WRG also initiated a Multi-Abuse Professional Peer Consultation group for any interested staff throughout the community to participate in monthly clinical consultation held at TASC. Although the project ended in December 1997, the peer consultation group has continued. During the three years that it has been active, participants have included staff from many types of programs such as: substance abuse treatment and housing staff, domestic violence shelter and group counseling staff, homeless shelter staff, sexual assault and trauma counselors and therapists, Child Protective Services staff, and outreach staff from many other programs. This group has developed a strong network that facilitates referrals to all programs serving women with multi-abuse.

They also have developed a successful and supportive model of presenting treatment and ethical issues and providing feedback to one another across many disciplines. The need for regular feedback and ongoing support for the professionals who work with women with such complex issues cannot be underestimated for the health of the staff and for continued provision of effective treatment.

Tools for Assessing Chemically Dependent Trauma Survivors

All the women in the WRG program presented with histories of chemical dependency and relapse along with multiple childhood and adult problems that appeared to be associated with their histories of childhood sexual abuse. Most of them had numerous encounters with social services, medical facilities and the legal system, and they all had experienced concerns and fears about seeking help that were related to their histories of abuse. As a result, the primary goal of the initial interview was to build an alliance between the client and the therapist. It was not uncommon to contact a potential participant several times on the phone before she felt safe enough to come for a face-to-face assessment. On a number of occasions, women also arrived for an appointment too late or found reasons to leave before an interview could be carried out.

The initial interview consisted of: (1) introductions and orientation to the program; (2) signing of a release of information form when appropriate, and completing a consent to participate in treatment; (3) a brief interview to obtain personal history, history of substance abuse, acknowledgment of a history of sexual abuse (full disclosure is discouraged during this initial and brief contact) and discussion of program fit; and (4) administration of the Revised Symptom Checklist, SCL-90-R (a self-report symptom inventory designed to reflect the psychological symptoms associated with trauma), and the Dissociative Events Scale (DES), which evaluates the level of dissociation presented by the client.

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Initial Interview Data

Of the 70 women who were interviewed during the two-year project, most reported onset of alcohol and/or drug use between the ages of 12 and 18 years. Although many of these women began using alcohol or other drugs with their friends, over one-third of the women in the WRG program indicated that they began using alcohol or drugs with their family of origin. The most commonly reported substances used were alcohol and cocaine followed by marijuana and heroin.

Most women reported numerous treatment episodes—ranging from 0 to 10—not including AA or other self-help groups. Reported months of sobriety was usually around 10, with a range from 0 to 36. The number of substance abuse treatment programs attended seemed to be proportional to the number of years the client had been using and the variety of substances used.

At the time of the initial interview, over half of the women were involved with Child Protective Services, and approximately one-third had other ongoing legal involvement, such as probation, often for prostitution or possession of drugs. Childcare issues also were predominant among participants, which is consistent with problems reported by women seeking substance abuse treatment in general (Golding et al., 1988; Koss, Koss, & Woodruff, 1991).

During the initial interview, many women did not disclose or had difficulty disclosing information about their sexual abuse. We believe this is largely due to the stigma and realistic fear of retraumatization that often surrounds these disclosures. Many women disclosed that they had felt “cornered” into disclosing while in substance abuse treatment.

All the women involved in the WRG program showed a high level of stress on the SCL-90-R, and a high level of dissociation on the DES. These responses are most consistent with post-traumatic stress disorder and dissociative identity disorder scores and, for most of these women, they reflect the high level of distress under which they operate daily.

Outcomes of WRG Treatment Model

WRG staff (and most group participants) emphatically agree that this program was an essential component to participants’ ongoing recovery and willingness to continue with needed treatment. Of those who completed the program, most reported changes in some or most of the following ways:

- Greater awareness of behaviors that increase potential for relapse and revictimization;
- Increased acknowledgment of the impact substance abuse has on self-esteem, self-confidence, and difficulties in interpersonal relationships including potential for being abused or abusing others;
- Increased acknowledgment of the long-lasting effects of childhood abuse and influence on their current life including relapse;
- Increased ability to talk with other women about “real” feelings and their reactions to others;
- Increased ability to participate regularly in group counseling and address self-identified problems; and
- Increased belief in themselves and their ability to survive and succeed.

As a pilot project, WRG also was able to identify the following issues that affected participation in and effectiveness of treatment.

- Difficulty for women to participate regularly due to lack of resources (e.g., childcare, transportation and housing, and demands placed on participants by other agencies and the legal system);
- Difficulties for women to participate in screening interviews, as well as groups, due to overwhelming fears and anxieties about “telling the truth” about their lives, about identifying and letting go of defenses such as denial and isolation, and about trying one more time to trust authority figures and their peers;
- Difficulties for staff to create a safe environment while attending to participants’ overt and covert expressions of volatile emotions, a common result of childhood abuse and substance abuse;
- Difficulties for staff to maintain a safe environment while allowing and encouraging participants to express and take ownership of thoughts and feelings that are painful, frightening, and overwhelming; and
- Overall difficulties in running an effective program in an environment that is unresponsive to the needs of this population and with a lack of stable funding.

Conclusions and Recommendations

The WRG participants’ involvement in substance abuse and relapse seemed to correlate highly with their abuse experiences in childhood. This finding has strong implications for the types and direction of treatment these women need. The WRG staff recognized that women need treatment that addresses their life experiences including substance abuse and relapse, as well as the long-term effects of substance abuse and other trauma. When and how these issues are addressed is key to the effectiveness of any treatment for this population.

Based on the information and experience gained in the WRG program, the following recommendations for treatment and collaboration with other service providers are offered to improve treatment outcomes.

Treatment Recommendations:

- Within a supportive treatment environment, assess at entry and throughout chemical dependency treatment for history of childhood sexual abuse and other abuse;
- Provide continuity of care through aftercare and supportive referrals to mental health clinicians and other service providers trained to work with this population;
- Address substance abuse relapse in a realistic and supportive manner to facilitate women’s efforts to return to their community with an understanding of the connection between substance abuse, relapse and victimization; and
Provide these women with skills to reduce relapse and eliminate revictimization.

**Recommendations for Collaboration with Other Service Providers:**

- Develop a collaborative model to provide assessment and supportive referrals into and out of substance abuse treatment that includes other primary service providers (i.e., substance abuse programs, mental health providers, medical and public health agencies, child protective services, homeless and domestic violence shelters and other programs for low income women);

- Develop a program of systematic outreach and training of other service providers that will increase and maintain interdisciplinary collaboration; and

- Provide ongoing multi-abuse supervision and monthly community consultation groups that will increase networking, interagency collaboration, identification of common recovery issues and collaborative problem-solving.

Unfortunately, the WRG program ended in December 1997 due to lack of funding. With the recommendations listed above, however, the model offers promise in the treatment of chemically addicted victims of sexual abuse.

— Nancy Slater, Ph.D., A.T.R.
Marie-France C. Minton, M.C., N.C.C.

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**REFERENCES**


(See box on page 12 for list of other suggested readings.)
Numerous studies have demonstrated a link between experiences of sexual abuse and an array of physical and mental health problems among adolescent and adult women (Bachman and Saltzman, 1995; Bagley and Ramsay, 1986; Finkelhor, Hotaling, Lewis and Smith, 1990; Greenfeld, 1997; Mullen, Romans-Clarkson, Walton and Herbison, 1998; Schoen et al., 1997, 1995; U.S. DHHS, 1997). The evidence of a relationship between sexual abuse and adult chemical dependency supports the need for adolescent health and social service providers to routinely screen patients for histories of sexual victimization as a way of preventing subsequent chemical dependency. This article explores the magnitude of the problem of childhood sexual abuse and presents strategies for assessment and intervention with adolescent girls.

Prevalence and Impact of Childhood Sexual Abuse

The challenges of adolescence include coping with issues of identity and sexuality. Experimenting with substances is a normal part of adolescent development for most people. For sexual abuse victims, getting high may be a way to feel comfortable around other people or, alternatively, to withdraw and avoid personal relationships (Harrison, Fulkerson & Beebe, 1997). The first national study on the prevalence of childhood sexual abuse found that 27% of the women and 16% of the men studied had experienced some form of child sexual victimization (NRCCSA, 1992). A 1997 Commonwealth Fund study found that while 50% of girls surveyed stated they would appreciate being asked questions about abuse, only 10% of girls had actually been asked such questions (Schoen et al., 1997).

The Role of Adolescent Providers

Health promoting efforts for adolescents, access to clinic services, and care and attention from trusted adults have been identified as protective factors for adolescents who report physical or sexual abuse (Chandy, 1996). Adolescent providers clearly have an opportunity to intervene with sexual abuse victims before patterns of chemical addiction and other adverse consequences emerge in response to the trauma of abuse (Wilsnack, 1997). Unfortunately, while screening and intervention for domestic violence among adults has become commonplace in many health care settings, few adolescent health and social service providers regularly investigate the abuse histories of their young clients (Bassuk, 1998). Explicit questions about familial sexual and physical abuse are not included in the vast majority of youth health surveys because of political opposition to questions that critics believe impinge on family privacy (Harrison, Fulkerson & Beebe, 1997).

Additional provider barriers to sexual abuse screening and intervention include lack of education and training on sexual abuse, confusion about reporting requirements, and a reluctance to raise difficult issues when few services for teen victims of violence exist. This failure to address sexual victimization represents a grave disservice to adolescent girls, who are generally receptive to health provider inquiry and intervention. In fact, the previously-mentioned Commonwealth Fund study found that while 50% of girls questioned on sensitive topics (Teare & English, 1998). The provider should also explain to the client the likely response to

Confidentiality

Given these issues, what should adolescent providers do? A critical starting point is establishing a safe client-provider relationship. Providers have long understood that confidentiality is an important element of such a relationship and thus often feel uncomfortable informing their minor patients about the limits of confidentiality in relation to disclosures of abuse. While there is no stated legal requirement to discuss with clients the requirements of child abuse reporting laws, ethical standards do require that clients be told the limits of confidentiality before they are questioned on sensitive topics (Teare & English, 1998). The provider should also explain to the client the likely response to
Assessment and Intervention

Past and more recent experiences of sexual abuse can be a difficult topic for providers and clients alike. Although few protocols have been developed specifically for use with adolescents, many of the approaches to domestic violence screening and referral apply to childhood sexual abuse as well. As a general rule, the role of the provider is to be supportive in a nonjudgmental way and provide referrals based upon the client's stated needs. The specific approach will differ depending on whether the abuse is past or current. In any case, the provider should be careful not to pressure the client into pursuing a particular course of treatment or action, but rather should try to respect the client's decisions and focus on helping the client take steps to protect her safety. This is consistent with a harm reduction approach to youth services and sexual health, which emphasizes the need to treat clients as individuals and to focus on risk reduction.

Youth providers should keep in mind that violence assessment is an ongoing process. While some clients will be unwilling or unable to connect current problems to past sexual abuse, they may be able to take steps to ensure healthier behaviors, such as reducing substance use or unsafe sex. Following are suggested strategies for questioning adolescents about abuse and responding to disclosure. For additional resources, please contact the Community Wellness & Prevention Program's Violence Prevention Project (510-313-6808) and request the Health Provider Guidelines for Addressing and Preventing Adolescent Abuse.

Provider Recommendations

- Introduce questions about abuse by initiating a relationship/family history: “Do you have a girlfriend/boyfriend?

- Are you sexually active? How do you get along with your family? What happens when conflicts occur?

- Ask simple and direct questions to assess past or current physical, sexual, or emotional violence: “Has anyone ever hurt or threatened you, physically or sexually? Who hurt you? Can you tell me about the last time this happened?”

- Validate the experience: “What happened to you is against the law. Violence against women is a big problem in our society. The abuse is not your fault, and help is available.”

- Assess coping mechanisms: “How do you think the abuse affects you? Have you told others in your life? What happened?”

- If abuse is current, assess the client’s level of safety: “Are you afraid to go home? Are you being followed or threatened? Who can you call if the abuse persists or escalates?” Follow your facility’s procedures for safety planning.

- Ask your client what you can do to help: “How can I help you cope with this experience? Would you like to talk more to someone about this experience?”

- Tailor referrals to clients’ expressed needs. If the client is not ready to seek assistance related to the sexual abuse, provide her with the referrals she does want, as well as a list of local resources for sexual abuse survivors, and schedule a follow up visit. If the client is interested in pursuing assistance, offer to help her make the call.

Program and Policy-Level Recommendations

- Work with your agency to develop policies and training programs focused on adolescent abuse. Providers can benefit from in-depth training on abuse assessment, intervention, and legal concerns. Local programs should have policies in place which require regular screening of clients and training for staff.

- Stay current on appropriate referrals. Work with other providers in your area to assess services for teen victims of physical and sexual abuse. If none exists, encourage rape crisis or battered women’s agencies to develop programs focused on adolescents and expand their therapy referral networks to include professionals skilled in working with adolescents.

- Advocate locally for effective police and child welfare response. Because responses to reports of childhood sexual abuse vary considerably from jurisdiction to jurisdiction, consult with your local child welfare agency or police department for specific information on how they are handled in your area. If you have concerns about the way victims are treated, work with child welfare and police agencies to improve existing policies.

- Break the silence about sexual abuse. Domestic violence has become an acceptable topic of conversation among health and social service providers and the general public. Sexual abuse of girls and adolescents should likewise be exposed as a key risk factor for an array of adult physical and mental health issues.

- Raise awareness among your colleagues and community by supporting comprehensive efforts to prevent violence against women and girls, from childhood sexual abuse to date rape to domestic violence.

Conclusion

In order to eliminate sexual abuse and associated health risks to adolescent and adult women, it is ultimately necessary to focus on both individual behaviors as well as the larger social context in which violence against women occurs. Policy makers, funders, and providers alike need to advocate for social and economic justice for girls and women, in concert with similar efforts on behalf of communities of color and low-income communities.

In the meantime, early intervention and

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treatment for childhood sexual abuse can help prevent adolescent survivors from becoming chemically addicted adults.

— Amy Hill, MA, Violence Prevention Coordinator, Community Wellness & Prevention Program, Contra Costa County Health Services Department

The author would like to thank Priya Kandaswamy for her invaluable assistance with the preparation of this article.

REFERENCES


Suggested Further Readings on Serving Women with Histories of Chemical Dependency & Childhood Sexual Abuse


Compiled by Nancy Slater and Marie-France C. Minton
Treatment for Sexually Abused Children

The incidence in our society of child sexual abuse, particularly incest, is disturbingly high. Due to the magnitude of this problem and the serious impact of abuse on victims and their families, it is important that medical, mental health and social service professionals acquire specific knowledge and understanding of this problem, its impact, and the treatment process for victims of child sexual abuse.

Consequences of Sexual Abuse

The impact of sexual abuse on a child victim can vary depending on myriad factors such as:
- Age
- Specific type of abuse
- Number of incidents of abuse
- Child's relationship with the abuser
- Number of abusers
- Manner of discovery or disclosure
- Response of others after disclosure
- Availability of protection and treatment
- Personal resources (e.g., intellectual, emotional)
- Family and social support
- Legal consequences

Psychological and behavioral consequences for the child may include:
- Sleeping difficulties
- Enuresis
- Nightmares
- Fear of the dark
- Withdrawal
- Eating disorders
- Running away
- Learning difficulties
- Behavioral problems in school
- Truancy
- Depression
- Substance abuse
- Anxiety
- Fears of being alone
- Guilt
- Shame
- Low self-esteem
- Anger
- Promiscuity
- Aggressive sexual behavior

No child will exhibit all these symptoms, and any of these symptoms may be experienced by non-abused children. However, most sexually abused children will exhibit several, if not many, of these symptoms in the months and years following an experience of sexual abuse. If treatment is not provided, additional long-term consequences may be experienced years later. These may include:
- Poorly developed identity
- Poor self image
- Limited capacity for basic trust
- Suppressed anger
- Intense feeling of inferiority
- Low self-esteem
- Difficulties with intimacy and sexual functioning
- Vulnerability to subsequent exploitation and victimization
- Impaired body image
- Social withdrawal
- Impaired peer relations
- Flashbacks
- Sleep disorder
- Chronic depression
- Dissociative experiences
- Substance abuse

Evaluation of Treatment Needs

The overall goals of treatment are the alleviation of current symptoms and the prevention of long-term problems. The initial task is a therapeutic evaluation to identify problem areas, as well as strengths and coping styles of the child. This evaluation is separate and different from a forensic assessment (conducted for legal purposes) or any other evaluation used to validate the abuse report.

The therapeutic evaluation should be a multi-modal assessment including child interview, observation, family evaluation, caretaker report and teacher report. The interview with and clinical observation of the child will reveal much information regarding the abuse, problems, and strengths, and may be supplemented by psychological tests to obtain more information regarding symptoms, underlying dynamics, and coping styles. The family evaluation helps determine the extent to which the family will be an asset or a deterrent to the child's recovery, but the victim and perpetrator should not be included in the same session at this phase of treatment. The family's level of willingness and ability to support the treatment process provides critical information affecting not only the child's responsiveness to and progress in treatment, but the practical aspects such as treatment length and regularity of attendance. Caretaker and teacher reports provide additional information regarding the child's symptomatic reaction to the abuse.

The therapeutic function of the child evaluation is essential. In order to insure a therapeutic experience, adequate time (usually two or more sessions) must be allocated. During these sessions, the therapist must establish rapport with the child and develop a sense of safety for the child in the treatment situation. These therapeutic steps seem obvious, yet they are tremendously challenging with a child who has been traumatized by abuse. An important aspect of the development of safety and rapport is the avoidance of intrusion. It is important to empower the child with some choice and sense of control regarding decisions about when and how to discuss the abuse with the therapist. This caution to avoid intrusion must be balanced with the clear message that the sexual abuse can and should be talked about openly in therapy.

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Goals of Treatment

Several general treatment goals apply to almost all child victims of sexual abuse (Tyndall, 1997). The more specific aspects of each, as well as any additional goals, are determined on an individual basis during the evaluation phase and throughout treatment. General goals, listed in Table 1, often are addressed simultaneously and through various treatment modalities.

Alleviation of presenting symptoms is central to therapy with all populations. In the case of child sexual abuse victims, these symptoms include the general behavior problems and specific sexual behavior problems as discussed above. Many victims present with a distorted or confused understanding of the abusive experience due to a lack of information, misinformation they received (directly or subtly) from the perpetrator, reactions of others, and/or the use of defense or coping mechanisms involving cognitive distortion (e.g., dissociation, magical thinking). The clarification of reality is an important goal of treatment. However, in cases of long-term repeated abuse, total memory retrieval of each incident may not be necessary. Memories need only be recalled in a quantity and specificity sufficient to clarify reality, overcome denial, understand behavior, minimize risk of further abuse, and otherwise recover.

A serious consequence of child sexual abuse involves boundary problems due to the severe physical and psychological intrusion inherent in the abusive act, as well as the more subtle but constant absence of appropriate boundaries in incestuous families. Treatment must facilitate the development or re-establishment of healthy physical, psychological and interpersonal boundaries.

The development of a sense of physical and emotional safety is essential. This safety is violated by the abusive experience and must be reclaimed. However, encouraging a child to develop a non-discriminating trust could predispose the child to further victimization in the future. Thus, a sensitive and difficult therapeutic task involves helping the child achieve a healthy balance between feeling safe and still remaining aware of potential danger.

Most children experience an assault to their self esteem during sexual abuse, and treatment should address this problem, directly and indirectly, to increase self esteem and self efficacy. Therapeutic interactions, often nonverbal, in various modalities, are powerful in addressing this issue. For example, carefully attending to the child’s verbalizations, reinforcing positive self-statements, and challenging of irrational negative beliefs in a timely manner are interventions which may improve self esteem.

Accurate information about healthy sexuality should be provided during treatment. This can be accomplished directly with the child and/or indirectly through educating and coaching parents in providing sex education to their child.

Although most victims of child sexual abuse do not become perpetrators, victims may be at higher risk to perpetrate than non-victims. Further, many older children are aware of this information, and experience anxiety about their risk for becoming a perpetrator (Ivens, 1989). Treatment should directly address these issues by helping the child to develop a realistic understanding of the risk and the reasons for it, and to resolve the associate problems, e.g., confused boundary issues, unhealthy sexual information, inappropriate expression of emotion, decreased self-awareness, and poor self-esteem.

<table>
<thead>
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<th>TABLE 1</th>
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<tr>
<td><strong>Treatment Goals for Child Sexual Abuse Victims</strong></td>
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<tr>
<td>1. Ameliorate presenting symptoms.</td>
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<tr>
<td>2. Develop a realistic and factual understanding of the abusive experience.</td>
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<td>3. Ventilation of feelings associated with the abuse.</td>
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<tr>
<td>4. Develop healthy physical, psychological and interpersonal boundaries.</td>
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<td>5. Accomplish an appropriate balance between a sense of personal safety and a self protective awareness.</td>
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<tr>
<td>6. Increase self esteem.</td>
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<td>7. Learn about healthy sexuality.</td>
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<td>8. Prevent perpetration by victim.</td>
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Reprinted from Tyndall, 1997

Effective treatment of a child sexual abuse victim is likely to involve some combination of individual, family and group psychotherapy modalities. Individual psychotherapy will constitute the primary or only treatment available or appropriate for many of these children. The technique of individual psychotherapy with this population is similar to that with a general child population with variations based primarily on the developmental level of the child.

The first task of individual psychotherapy with sexually abused children is to establish a trusting therapeutic relationship, a task which can be slow and difficult due to the intrusion and violation of trust these children experienced during the abuse. **This initial task is so important to the process that it should not be viewed as a prerequisite to the therapeutic work, but as a primary, integral and ongoing part of the work.** To facilitate progress in this area, consistency of the therapist is essential, and consistency of the therapeutic setting (e.g., time, room, furnishing) should be maximized. As noted above, a careful balance is necessary between avoiding intrusion and openly discussing the abuse. After establishing a trusting relationship, each of the goals of treatment listed in Table 1 can be addressed in individual psychotherapy.

Group psychotherapy, usually in conjunction with other modalities, is frequently a treatment of choice for victims of sexual abuse (Friedrich, 1990; Ivens, 1989; Porter, Blick & Sgroi, 1982; Tyndall, 1997). However, children whose allegations of abuse are questionable should be excluded from group therapy until the reports have been validated. This
is because, in the rare event that the child has fabricated the allegation, the social pressure of a group would greatly increase the child's difficulty in retracting a false allegation (Tyndall, 1997). Therapy groups may be time limited or ongoing, open or closed, structured or unstructured, and with various levels of homogeneity of members in terms of gender and abuse experience (e.g., incest vs. extrafamilial abuse). Short-term and structured groups are primarily educative and/or issue-focused. Unstructured therapy groups, are typically ongoing, with the expectation of moderate to long-term (four to eighteen months) participation of each member. The organization of each unstructured group session alternates between active and quiet, between task-oriented and playful, and between therapist-focused and peer-focused interactions or activities. The therapist remains aware of specific goals for each child during each session and capitalizes on specific discussions and activities, which develop spontaneously. The ideas and reactions of the children are used and shaped into therapeutic activities. For example, the commonly arising topic of “boys” in girls’ groups can be directed by the skilled therapist into a productive examination and discussion of the impact of the abuse upon heterosexual relationships.

Family psychotherapy is usually appropriate in the later phase of treatment, after all family members have participated in individual or group psychotherapy and have demonstrated some degree of therapeutic progress (Friedrich, 1990; Ivens, 1989; Porter et al., 1982). Family psychotherapy including the child incest victim is recommended only when the adults included in the family sessions take total responsibility for the abuse. This criterion, of course, requires significant therapeutic progress by the parents prior to the family sessions and sometimes is not achieved. The primary tasks of family psychotherapy include an apology of the perpetrator to the victim, an explanation by the perpetrator which absolves the child victim of any responsibility for the abuse, clarification of physical and interpersonal boundaries in the family, and problem solving to assure physical and psychological protection of the child. Additional issues also involve the role of the non-offending parent, reactions of siblings, and issues of parental authority and control by the perpetrator.

The therapist’s balanced approach in the family psychotherapy sessions is essential to treatment success. The victim must be actively supported and protected, while the family system simultaneously is valued and respected. As Mrazek (1981) asserts, the therapist must achieve a balance of compassion and control. This includes compassion for each family member including the perpetrator—a task that can be difficult. Understanding the child victim’s ambivalent feelings of loyalty and rage toward the perpetrator can help the therapist to maintain a therapeutic balance.

It is important to note before concluding this section, that the model recommended above is the ideal, and reality may create dilemmas for the therapist. For example, when courts have mandated contact between a victim and perpetrator despite the perpetrator’s continued denial or other inability to meet the criteria described above, the therapist may be forced to choose between providing no potentially therapeutic contact between victim and perpetrator, and proceeding with family sessions despite obvious severe limitations in appropriateness and therapeutic effectiveness. When faced with this dilemma, the therapist should consider updated assessments of the child’s resources and vulnerabilities, the potential risks to the child (e.g., emotional traumatization, confusion, guilt), the potential benefits of the “less than ideal” sessions (e.g., helping the child with the anxiety common with initial contact with the perpetrator), and the degree to which the perpetrator is capable of cooperating with the therapeutic goals. The cautious evaluation of these risks and benefit factors will guide, on an case-by-case basis, the difficult therapeutic decision of how to proceed.

Terminating Treatment

Termination is the final, and one of the most important, phases of treatment. When treatment goals have been accomplished, or when continued progress toward these goals can continue without further treatment, the child and the family should be carefully prepared for termination. During the termination phase of treatment, it is essential that the child and the parents receive permission and encouragement to return for further treatment if or when needed. This recommendation should be very specific, explaining that while treatment has been successful, the child may need to return to treatment to rework the abuse and sexual issues as she or he reaches a higher developmental level, especially physically and psychologically significant phases such as puberty. The need for further treatment should not be viewed as a failure. When premature termination is necessary due to variables beyond the therapist’s or child’s control, every effort should be made to address termination issues. In cases of premature termination, the therapist needs to consolidate the progress that has been made in order to increase the likelihood that the child will be open to therapeutic experiences should they become available in the future. Regardless of the circumstances, the termination phase should provide a positive springboard for the child to continue progress toward a healthy and satisfying life.

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Resource Psychological Consultants

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A high incidence of childhood sexual abuse has been reported for adults in addiction treatment. Estimates as high as 90% have been reported for alcohol-dependent women (Ladwig & Andersen, 1992) and from 28% to 61% for drug-dependent women (Boyd, 1993; Mondaino, Wedenoja, Densen-Gerber, Elahi, Mason, & Redmond, 1982). The wide range of prevalence rates reported in the literature is due primarily to methodological differences in identifying survivors of abuse (Wyatt & Peters, 1986) and the presumed high rate of false negatives (Chiavaroli, 1992; Finkelhor, Hotaling, Lewis & Smith, 1990; Hurley, 1991). Consequently, researchers and clinicians are emphasizing the need to identify those who have been victims and to address sexual abuse issues in the addiction treatment setting.

The Center for Perinatal Addiction

The Center for Perinatal Addiction (CPA) in Richmond, Virginia is an intensive outpatient substance abuse program for pregnant or recently postpartum women. This program was originally designed as a Treatment Research Unit funded by the National Institute on Drug Abuse and is currently funded by the Center for Substance Abuse Treatment. The CPA offers several structured (substance abuse education, household management, nutrition, prenatal education, and parenting classes), semi-structured (community meeting, skills building, prepared childbirth, mother-infant group, relapse prevention, career planning and development), and unstructured (therapeutic milieu, spirituality, psychodrama, AA/NA, and individual, group, and family therapy) treatment components. Child care, transitional housing, and medical care services are also available. See Haller, Knisely, Dawson, & Schnoll (1993) for a detailed program description.

In the first phase of evaluating this program, a substantial number of participants reported that they had been victims of some type of abuse. The percentage of women who reported childhood physical and sexual abuse as part of an intake psychosocial history were 33% and 21%, respectively. Since various issues regarding abuse arose during multi-disciplinary team meetings, prevalence rates were again assessed for women discharged during a 12-month period. In the discharge assessments, rates of physical and sexual abuse were reported at a much higher rate (49% and 57%, respectively), suggesting that there was a need to address abuse issues as women progressed in the recovery program. In order to assist with the identification of abuse issues and develop treatment plans for the identified issues, CPA developed a Survivors Group.

The Survivors Group

The Survivors Group Unit is designed for adult women in recovery who are new parents or will soon be parents. The unit is a 12-hour, semi-structured group consisting of eight hours of didactic material and four hours of written assignments to assist the participants in self-identification issues. The group meets twice a week for three weeks in two-hour sessions. The overall goals of the Survivors Group include both education and the development of skills for managing abuse issues. Each topic addressed in this group has specific objectives, and the content and activities associated with each objective are standardized. A description of each topic is presented below.

Loss and Grief

This topic focuses on defining grief, identifying unresolved grief as a possible relapse trigger, identifying types of loss (death, separation, abortion, pregnancy, abstinence from alcohol and drugs, loss of childhood, and loss of virginity), identifying personal reasons to deal with childhood abuse issues, and to identify feelings about the abuse. Participants also develop a plan of action to further address the identified abuse issues.

Childhood Abuse Issues

This topic identifies the most common types of childhood abuse (physical, sexual, and emotional). An opportunity is provided for participants to assess their own history of childhood abuse, to identify personal reasons to deal with childhood abuse issues, and to identify feelings about the abuse. Participants also develop a plan of action to further address the identified abuse issues.

Adult Symptoms of Childhood Abuse

The objective of this topic is to identify present-day ramifications of childhood abuse. Discussion is directed towards trust issues, addictive behaviors, co-dependent behaviors, offender behaviors, craving for acceptance, intimacy problems, sexual problems, discipline problems, and abandonment issues. Participants develop an action plan to begin to change the maladaptive behaviors identified.

Boundary Issues

This topic defines personal boundaries as either "internal" (taking responsibility for one's own thoughts, feelings, and behaviors and allowing others to take responsibility for their thoughts, feelings, and behaviors, thus removing the victim/blame dynamic) or "external" (choosing physical/sexual distance from
The objectives of this session are to distinguish between healthy and unhealthy boundary systems, assist participants with identifying their boundary issues, and develop a plan of action to address boundary issues.

**Presentation of Action Plans**

These two sessions are devoted to allowing participants to share their identified issues and their plans to further address the issues. Obviously, identified issues cannot be resolved in this short-term group. Instead, in these last two sessions, the participants are encouraged to select the most appropriate ongoing group (relapse prevention, psychotherapy, spirituality, or psychodrama) to further address their identified issues. This insures ongoing peer support and encouragement to work toward resolution of survivor issues beyond the 12-hour intervention.

**Case Reports**

The following two case reports exemplify some impacts of the intervention when employed as part of a substance abuse program.

**CASE 1**

This 30-year-old single mother of two was pregnant with her third child. She had a history of marijuana and cocaine dependence beginning at age 17. She had one failed outpatient and two failed inpatient substance abuse treatment attempts prior to her admission to the CPA. During her first week in treatment at the CPA, she disclosed a history of sexual abuse by her uncle when she was 11. Further disclosures made in Survivors Group revealed that she told her mother about the abuse but her mother did not believe her. No action was taken to protect her and the abuse continued until she was 14 or 15. At that time, she disclosed the abuse to her minister who also sexually abused her.

She demonstrated serious problems with trust, rage, relationships with peers, and relationships with perceived authority figures, all of which were acted out in the course of her treatment at the CPA. The treatment staff, aware of her trauma history, were able to minimize her self-sabotaging behaviors by enforcing limits on her behavior, helping her to understand the connection between the behavior and her trauma history, and supporting her in developing new coping skills. She was able to systematically work on portions of her abuse history in group psychotherapy, relapse prevention, psychodrama, and spirituality group. She was discharged prior to completion of the program, but at last report, one year following discharge, she was still drug-free and working in an outreach program for abused women.

**CASE 2**

This 26-year-old single mother of one was pregnant with her second child. She came to CPA with a 10-year history of alcohol, marijuana, and cocaine dependence. She had one failed inpatient substance abuse treatment experience prior to her admission to the CPA. At intake, she vividly described a history of physical abuse (severe beatings for unknown reasons and a near death experience when her mother attempted to drown her) but denied sexual abuse.

In Survivors Group, she readily worked on her physical abuse issues but had some dissociative avoidance behaviors during the sexual abuse segments of the group. She related that her alcoholic mother frequently accused her alcoholic father of sexually abusing her. She remembered sleeping with her father at age 7 but had no recollection beyond that. She did, however, identify with many of the symptoms and behaviors typically associated with sexual abuse survivors. Even though she never did recall a specific sexual trauma, she had recurrent distressing dreams of being sexually abused and experienced dissociative episodes where she regressed to a child-like state (sucking her thumb and engaging in self-stimulating behaviors). She met all criteria and was diagnosed with Post Traumatic Stress Disorder. Treatment staff, aware of the known physical abuse and sensitive to the possibility of childhood sexual abuse, were able to work with her in relapse prevention group, group psychotherapy and skills building group to reduce the negative impact of her childhood abuse. She maintained abstinence from alcohol and other drugs for the duration of treatment. She transitioned out of the CPA residential facility to an independent living situation and successfully completed the program while living off-site. At last report, she was attending GED classes and planning to attend training to be an EKG technician.

**Conclusion**

As is evident from these case reports, the objectives of this intervention were realized upon implementation. Participants had an opportunity to identify abuse issues in a safe environment and participate in the development of action plans for these issues. The Survivors Group Unit successfully accomplished the following objectives: (1) distinguishing between unresolved loss and normal, healthy grief; (2) providing an understanding of childhood abuse issues; (3) presenting the connections between childhood abuse and adult survivor symptoms; (4) assisting participants with developing skills in setting boundaries; and (5) assisting participants with developing skills in grief and trauma resolution.

Survivors’ issues, whether known to the patient or repressed, can pose a significant barrier to ongoing recovery and can be a major contributing factor to relapse. The Survivors Group model developed by Center for Perinatal Addiction is thought to be effective at early screening and intervention. Formal evaluation is needed to determine the efficacy of this group’s ability to help chemically addicted survivors achieve long-term sobriety.

— Janet S. Knisely, Ph.D., Departments of Psychiatry and Internal Medicine, Medical College of Virginia of Virginia Commonwealth University, and Jan Dawson, LPC, C.S.A.C., District 19 Community Services Board

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Addiction staff for their dedicated work in the addictions field and participants of the CPA who had the courage to face their addictions. In addition to the second author of this article (J. Dawson), Rodney Boudreaux, M.A., C.S.A.C. made invaluable contributions to the development of the Survivors Group Unit. For more information regarding the Survivors Group Unit, contact the CPA at 804-828-BABE. Correspondence concerning this article should be addressed to: Janet S. Knisely, Ph.D., Division of Substance Abuse Medicine, Box 980109, Medical College of Virginia of Virginia Commonwealth University, Richmond, VA 23298-0109. Telephone: (804) 828-3522; FAX: (804) 828-9906.

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Rockville, MD: National Institute on Drug Abuse.


One dual model approach for treating trauma-related syndromes among chemically dependent women appears to blend many necessary treatment goals (Bollerud, 1990). The model was implemented in an inpatient addiction treatment facility with parallel tracks for men and women. All entering clients were queried about prior physical or sexual abuse during the intake evaluation. Those who disclosed abuse were referred for a more in-depth assessment. Those women survivors who showed difficulty in attaining or maintaining sobriety were offered one or two individual counseling sessions per week in conjunction with the regular substance abuse program. The psychotherapy was problem-focused on the alleviation of PTSD symptoms and the development of a therapeutic alliance so the client might more fully participate in AA and traditional 12-Step work groups. Individual treatment was supported by specialized weekly groups that were gender specific. Sharing traumatic material with others who had undergone similar trials decreased shame and encouraged a re-evaluation of abuse-related behaviors once perceived as "deserving" of abuse. When inpatient treatment was completed, clients were encouraged to continue in aftercare groups for substance abuse, attendance in AA, and individual psychotherapy which addressed trauma-related issues. Using community support groups for related problems such as domestic violence or parenting was also encouraged.

This multimodal continuum of care that used interventions for addictions and unresolved trauma appears to be a promising model. Focusing on the client's natural progression through a developmental process of learning new skills, trying out new behaviors, leveling out, then reaching for even more challenging growth while offering support during inevitable relapses seems to offer a sound clinical alternative to current single model treatments.

Relapse

Many substance abusers who drop from treatment sincerely want to break free from their chemical dependency. However, as survivors decrease their reliance on chemicals, memories of traumatic material may surface with accompanying feelings of anxiety, fear, and depression. Periods of abstinence may be followed by relapses as these survivors lack the skills to cope with overwhelming negative feelings and memories. Literature on relapse indicates that much can be attributed to the inability to cope with negative feelings and lack of skills in dealing with high risk situations (Daley, 1989). Trauma-related memories can create powerful emotional "triggers" leading to a relapse to the very substances that mitigated symptoms initially. Root (1989) suggests that survivors slowly decrease their use of substances (alcohol, drugs, and food) while learning new skills to deal with the negative affect, images, and cognitions that accompany unresolved sexual trauma. Insistence on abstinence without necessary skills building is likely to lead to chemical relapse and a sense of demoralization by the client and treatment provider. Survivors may also be in very real situations which hinder or prohibit abstinence from substances. Women who live in sexually or physically abusive households may not be able to give up chemicals until they are safe from further harm and influence.

Recommendations for Caregivers

It is very exciting to see the professional fields of substance abuse and mental health begin to value each other's clinical contributions in treating chemically dependent survivors of childhood sexual abuse. There is an ever-growing need for a multidisciplinary effort to improve the quality of identification, diagnosis, and treatment of this dual disorder. Strides must be made for early detection and even earlier prevention. Mental health and substance abuse professionals are encouraged to find common denominators in their treatment approaches.

Yet mental health and substance abuse services have different cultures and practices. Evans and Sullivan (1995) indicate several conflicts between philosophies and approaches to treatment that
require resolution. Three of these are particularly relevant to developing an effective treatment model for dually diagnosed survivors. First, there has been a persistent argument that substance abuse is not a true medical condition, but merely self-medication of emotional pain. Nevertheless, the need for safety through abstinence, however gradual, is generally the best clinical decision even if the origin of the chemical dependency is never understood. Second, substance abuse counseling has traditionally held a bias against the use of psychotropic medication. However, survivors debilitated by depression or panic attacks are not likely to respond favorably to suggestions to just go to a meeting or call a sponsor. Careful diagnosis and prescription of nonaddictive medications can significantly enhance the probability of treatment success. Third, substance abuse and mental health counselors have disagreed about whether a client's psychiatric symptoms are true or merely the result of drug and alcohol use and will diminish once sobriety is attained. In this case, the issue of a functional versus differential diagnosis becomes critical in regard to the most appropriate level or mode of treatment.

Treatment professionals must recognize that developing a therapeutic relationship with a survivor may be difficult, as these clients will often vacillate between being overly dependent and outright aloof. Due to the trauma of victimization, survivors view interpersonal relationships with great trepidation. As a result, they are likely to feel the need to manipulate and control all relationships, including those with treatment professionals. Positive therapeutic gains may transform into periods of relapse and noncompliance due to the survivor's predictions of failure and ultimate fear of rejection. Recognizing these abuse-related emotions and behaviors can go a long way towards understanding and effectively treating the client.

Conclusion

Addressing early on sexual trauma issues with chemically dependent survivors is basic in the process of attaining sobriety and accomplishing successful recovery. Assessment for, and treatment of, PTSD needs to be an integral part of substance abuse treatment. Providing a therapeutic atmosphere in which to accomplish this dual treatment needs to be carefully planned, and traditional male bias in some treatment programs must be challenged.

Blended programs continue to offer the greatest hope for dually diagnosed survivors. Following are several important strategies for integrating substance abuse and mental health approaches to treating this population:

- Develop and implement programs for educators and health care professionals to identify high-risk youth and offer education and counseling about their vulnerability to substance abuse.
- Develop and implement clinical training for substance abuse and mental health professionals that will aid in understanding comorbidity of addiction and PTSD, identifying dual disorders, and treating trauma-related syndromes.
- Develop and implement academic curricula that train medical personnel, social workers, and mental health professionals to include an understanding of substance abuse and PTSD.
- Develop and implement specialized programs in inpatient and outpatient substance abuse facilities that offer direct treatment to sexual trauma survivors.

As greater numbers of health care providers are trained in the assessment and treatment of trauma related issues, survivors will attain sobriety sooner, relapse less often with less impact, and stand a much greater chance for successful recovery. A multimodal model provided by well trained professionals using interventions specific to unresolved trauma, as well as specialized aftercare planning, holds a promising future for a chemical-free and less painful lifestyle for afflicted survivors.

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