

**COMPARING WOMEN IN SUBSTANCE ABUSE TREATMENT
WHO REPORT SEXUAL AND/OR PHYSICAL ABUSE WITH
WOMEN WHO DO NOT REPORT ABUSE HISTORY**

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(ABSTRACT)

This descriptive study explored whether women in substance abuse treatment who report a history of sexual and/or physical abuse have different drug use profiles than women who do not report such abuse.

The data originated from a NIDA (National Institute on Drug Abuse) study designed to evaluate the effects of different treatment modalities in inpatient substance abuse treatment for women.

The study compared the drug profiles of women in four areas: drug of choice, frequency of use, problem severity, and level of psychological problems. The following groups were compared: 1) women who did not report abuse, 2) women who reported physical abuse only, 3) women who reported sexual abuse only, and 4) women who reported physical and sexual abuse.

The study did not find significant differences in either drug choice, problem severity, or frequency of drug use. In the area of psychological problems, the study did find a significant difference in interpersonal sensitivity between participants who reported a sexual abuse history vs. the other abuse groups. This finding suggests that women with a sexual abuse history are more mistrustful in their relationships with others, and this may suggest that group treatment will be more difficult for sexually abused women than individual treatment.

Overall, the findings may also suggest abused women do not need different drug or alcohol treatment approaches than non-abused women although it does not preclude attention to the effects of their abuse.

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Chapter I: Introduction

Problem and Its Setting

Until the mid-1970's, research on substance abuse focused mostly on men. Society thought of substance abuse as a predominantly male problem. Only in the late 70's and early 80's had researchers started to focus on the gender differences in substance abuse (Greenfield, 2002; Reed 1987; Simpson & Miller, 2002). Studies found that women have a distinctive etiology, disease progression, and concomitant treatment needs (Ashley, Mardsen, & Brady, 2003). Women also have unique psychosocial characteristics associated with their substance abuse. For example, they often suffer under a variety of mental health problems. Women substance abusers generally report extreme levels of depression, anxiety, and low self-esteem. (Reed, 1987; Nelson-Zupko, Kauffman, & Dore, 1995)

As research continued to focus on the female abuser, more and more studies found a significant number of those women reporting childhood sexual and/or physical abuse. In the early 80's, sexual and/or physical abuse started to be mentioned in research as a possible link to alcoholism in women (Hurley, 1991). Since then, more studies have evaluated a possible connection between childhood abuse and substance abuse. In a study by Covington and Kohen (1984), 34% of alcoholic women in a sample of 35 had experienced incest compared to 17% of women in the matched comparison group. Miller, Downs, Gondoli, and Keil (1987) compared 45 alcoholic women with a group of 40 nonalcoholic women. They found that 67% of the alcoholic women experienced sexual abuse as compared to 28% of the non-alcoholic women. In a Swedish study (Lundgren, Gerdner, & Ludqvist, 2002), 70% of the 55 patients in an alcohol and drug rehabilitation

center reported sexual abuse accompanied by other types of childhood maltreatment. Simpson and Miller (2002) undertook a meta-study comparing 126 studies published on the co-occurrence of childhood sexual or physical abuse and substance abuse problems. The numbers reported from those studies ranged considerably. Yet, most of the differences in numbers can be explained by the studies' different definitions of sexual or physical abuse. The salient finding, however, was that the studies revealed a consistent overrepresentation of female childhood abuse victims in the population of female alcohol and drug abusers, ranging from 2-3 times the occurrence in the general population. The authors conclude: "The consistency of such convergence across widely divergent populations, cohorts, and study methods is striking and suggests that a history of childhood abuse may be an important risk factor for the development of alcohol/drug problems in women" (p. 50).

Simpson and Miller (2002) analyzed some of their studies to determine if the apparent relationship between childhood abuse and substance abuse was mediated or moderated by other conditions. They found that Post Traumatic Stress Syndrome (PTSD), Major Depression, Generalized Anxiety Disorder, and Conduct Disorder might very likely mediate, or at least moderate, the relationship between childhood abuse and substance abuse problems. "Extant data do indicate that excessive alcohol and drug use may function to help childhood abuse survivors self-medicate symptoms, such as anxiety and depression, that stem from difficult early experiences"(p. 52). The authors also conclude that more severe child abuse is most likely to be associated with disorders such as PTSD.

Briere (1998) supports this finding by looking at different levels of severity of childhood sexual abuse. Long-term abuse and more drastic forms of abuse (e.g., extended sexual abuse, multiple perpetrators, or forced sexual acts with objects/animals) resulted in higher negative impact for the victim's life such as high dissociation and suicidality.

Research has demonstrated clearly that sexual and/or physical childhood abuse is a frequent occurrence in female substance abusers' lives. The abuse poses a significant risk factor for later substance abuse (Bennett & Kemper, 1994, Simpson & Miller, 2002). However, even if research has established these facts, research has not focused on the different profile of abused substance abusers versus substance abusers without abuse history. This study aims at starting to fill this gap in research by looking for the differences between abused substance abusers and substance abusers without abuse history. This study will do this by focusing on possible differences in patterns of drug choice, problem severity, and frequency of use between these groups.

Significance

Women's substance abuse is a significant societal problem. The 1999 National Household Survey on Drug Abuse (SAMHSA, 2000b) found that 5.6 million American women use an illicit drug in any given month and during the same time period, 15.1 million women binge drink or drink heavily. Women who abuse substances experience many problems in their daily lives. They are more likely to be victims of domestic violence (Kaufman-Kantor, & Asdigian, 1997; Stuart, Ramsey, Moore, Kahler, Farrell, Recupero, & Brown, 2002); they are often socially isolated, suffer from anxiety and depression (Greenfield, 2002; Reed, 1987) and are at high risk for infertility, vaginal

infections, repeat miscarriages, and premature deliveries (Nelson-Zlupko et al., 1995). Gender-specific drug use patterns and sex-related risk behaviors make women more vulnerable to infection with HIV (Ashley et al., 2003).

Chemically addicted women are frequently dependent on the public welfare system and, while they have fewer work experiences and marketable skills than addicted men, they are much more likely to be the primary caregivers of children (Nelson-Zlupko et al., 1995). Research has established that children in homes of addicted parents suffer physically, emotionally, and socially (Billings & Moos, 1983). A recent study of children of substance abusing mothers revealed that those children are twice as likely to be exposed to risk factors such as having a poor relationship with their father, low income status, maternal mental illness, homelessness, and maternal use of alcohol and other drugs while pregnant, than children nationally (Conners, Bradley, Mansell, Liu, Roberts, Burgdorf, & Herrell, 2003).

Women are often more private about their substance abuse, and their crimes such as shoplifting and prostitution that support their use may not seem as threatening to society as men's crimes of robbery, burglary, and assault (Nelson-Zlupko et al., 1995). Society therefore might not consider female substance abuse to be a crucial societal problem. This may be a gross underestimation. Substance abuse can severely affect the woman's life, the life of her children, and her extended family. As such, women's substance abuse impacts society in a significant way. Women and their families suffer greatly and need appropriate help in restructuring their lives.

In order to help women through treatment and preventive work, it is important to understand the reasons behind their substance abuse. A significant number of women

who seek substance abuse treatment are affected by sexual and physical abuse. Those women need appropriate help to resolve their abuse histories in order to recover and to prevent them from relapse (Reed, 1987; Wallen & Berman, 1992).

It is also important to understand how drug-using women without abuse history are different from abused women. If there were to be differences in either drug choice, problem severity, and/or frequency of use, recognizing those differences would help during the assessment part of treatment. If, for example, abused women tended to use depressants instead of stimulants, a woman using depressants could be more carefully assessed for a possible history of childhood abuse. The knowledge about possible differences in drug abuse patterns could also help in directing those women to appropriate treatment, which would include addressing and resolving childhood abuse issues that relate to substance abuse.

Also, this study would underline the importance for gender-specific treatment. Mixed gender treatment programs are often hostile to women. Abused women are in danger of getting retraumatized by confrontational techniques and the requirement to share intimate information in front of male staff and clients. In mixed gender treatments, women are sometimes sexually harassed by male clients, or staff members approach clients romantically. This also leads to retraumatization and hinders the healing process (Kelly, Blacksin, & Mason, 2001). Abused women would benefit greatly from the safety of an all-female treatment group.

Theoretical Framework

This descriptive study is guided by the framework of feminism. Feminism highlights the notion of men having historically been given power and control over women. Feminism challenges this position and calls for equal rights and opportunities of both genders (Avis, 1988). The purpose of feminist research on women is to sensitize people to the reality of women's lives and to call attention to sexism and social injustice. Such research is also aimed at unmasking male bias in social sciences, and it focuses on women's concerns (Thompson, 1992).

Feminists have shown that women suffer more mental health issues than men, due to a number of sociocultural factors in their lives (Avis, 1988). Women are believed to be more vulnerable because they experience many situations in life where they have less control and less power than men. Feminists call for appropriate mental health treatment for women with a focus on "alternative, innovative, and non-oppressive ways of helping" (p. 29).

This paper highlights the needs of women in drug abuse treatment. Historically, the focus in drug rehabilitation was on men. Women were expected to fit the male treatment model (Greenfield, 2002). Following a feminist perspective, this paper focuses on women's experiences, women's voices, and women's needs in treatment. It calls for appropriate, gender-inclusive treatment options. By listening to female voices and evaluating female experiences, this paper is designed to add knowledge about women's needs in drug rehabilitation treatment. As such, this paper strives to help women gain gender-specific treatment options and help overturn the overwhelming focus that men were given in the treatment area of substance abuse.

In the early 1990's, feminists in marriage and family therapy drew attention to an especially dark side of family life: women being abused by men in instances of battering and sexual abuse (Nichols & Schwartz, 2000; Moltz, 1992). Therapists began to understand the magnitude of male abusive behavior in the family. Avis (1992) outlined the finding that men were the predominant perpetrators in both sexual and physical abuse of women and children. In order to address this issue, feminists called for mental health professionals to take a "non-neutral position, challenging male control and domination, naming the abuse and naming the abuser" (Avis, 1992).

Many women experience the harsh reality of physical and/or sexual abuse by men. Feminists raise this topic into the public awareness and discuss the political climate of violence in our culture (Nichols & Schwartz, 2000). This paper focuses on women who have suffered such abuse.

Rationale of the Study

Previous research has established that women in substance abuse treatment show a 2-3 times higher incidence of childhood sexual and/or physical abuse than women in the general population. None of the research has, however, focused on the differences between women in treatment who report abuse versus those who do not. This study looks at the possible differences in drug use between the abused versus the non-abused group.

Knowing more about any differences between abused versus non-abused female substance abusers could provide valuable information for assessment, future treatment design, and preventive work. If there is more knowledge about the implication of certain patterns of substance use with women who have experienced sexual and/or physical

abuse, therapists, physicians, and other health workers could be alerted earlier if women show a certain pattern of abusing substances. This knowledge would help professionals in further evaluating those women and referring them to appropriate services. A teenager entering a health clinic with a certain substance abuse profile, for example, might be more carefully assessed for sexual and physical abuse. She might then receive the type of help addressing the source of her problem. With this type of treatment, she might overcome her addiction and avoid future relaps.

In Root's (1989) experience, abused women often end up as "treatment failures" in substance abuse rehabilitation, since mental health workers fail to recognize the connection between symptoms of sexual abuse and the coping mechanism of drug abuse. Giving abused women appropriate help in coping with their abuse history will likely shorten the treatment career of those clients and cut down on relapsing.

The knowledge gained from this study would also further underline the importance of addressing and resolving sexual and/or physical abuse as part of the general substance abuse treatment.

Chapter II: Literature Review

Women and Substance Abuse

History of Female Substance Abuse Research in the United States

In the beginning and mid 20th century, society considered substance abuse to be mainly a male problem. Substance abuse programs were thus established with the male client in mind. Women were sharply underrepresented in those programs, but were expected to benefit in the same ways as men (Greenfield, 2002; Kelly, Blacksin, & Mason, 2001; Olenick & Chalmers, 1991, Reed 1987).

One of the reasons for the significantly smaller numbers of women entering treatment can be found in the societal shaming of female substance abuse. Past generations harbored harsh stereotypes against drug abusing women. While it was somewhat accepted that men abused alcohol and other substances, it was not acceptable for women to do so (Hurley, 1991; Kaufman-Kantor & Asdigian, 1997; Nakken, 2002). Society thought of the female substance abuser as immoral, a poor mother, an inadequate wife, weak-willed, and potentially sexually aggressive (Covington, 2002; Kane-Caviola & Rullo-Cooney, 1991). Olenick and Chalmers (1991) suggest that the greater pathology seen in alcoholic women might rather be the result of societal shaming than the characteristics of the addict. Brown (2002) writes that the stigma of moral failure associated with addiction paradoxically reinforces the denial of it.

In the mid 1970's, researchers started to focus on the female substance abuser (Greenfield, 2002; Nakken, 2002; Simpson & Miller, 2002). The National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism

(NIAA) founded a number of projects to develop and evaluate different interventions for women (Reed, 1987). However, surveys of substance abuse treatment centers in the 80's showed the new knowledge on female abuse had little impact on the existing treatment structures in the United States (Senay, 1983). The crack cocaine epidemic in the 1980's brought a new focus on female substance abuse, particularly because society was concerned about the infants of crack addicted mothers (Ashley, Mardsen, & Brady 2003).

A new body of research emphasized the particular issues surrounding the substance abuse of women and called for specialized therapeutic interventions. The 1998 Uniform Facility Data Set (UFDS) from the Substance Abuse Mental Health Services Administration surveyed facilities providing substance abuse treatments in the United States. Its findings in 1998 were that 28.4% of facilities offered special programs for women in general, and 18.5% offered special services to pregnant or postpartum women. About a third (36.2%) of the facilities offered assistance with transportation. Childcare, however, was only available in 8.6% of the facilities (SAMSHA, 2000a).

This survey shows that in the 1990's, 29.4% of treatment centers did facilitate specialized treatment for women. Still, 71.6% of treatment facilities did not offer those services. The provision of childcare, for example, an important issue for many women in treatment (Kelly et. al., 2001; McCollum & Trepper, 1995), had been largely neglected. Those numbers suggest that women's treatment needs at the end of the 20th century had not been adequately addressed in most treatment facilities.

The trend in providing women tailored treatment might actually be getting worse (Nakken, 2002). One reason is that managed health care plans often deny comprehensive treatment and do not provide anything beyond medical detoxification. This leads to a

discrimination against working and middle-class substance abusing women, who cannot afford private treatment. Financial cuts also lead to fewer trained clinicians who can handle co-occurring mental disorders common to female abusers (Ashenberg-Straussner & Attia, 2002). The “War on Drugs” has led to the troubling trend of incarceration of women. In the years from 1980 – 1992, there was a 276% increase of incarcerated women as compared to a 165% increase for men. In 1991, one in three women was incarcerated for drug use (Rosenbaum, 1997). Thus, addiction is being treated as a crime, but few inmates receive adequate treatment in prison facilities (Covington, 2002). Nakken (2002) calls for professionals to collaborate and bring forth creative solutions in order to withstand the current unsupportive social, economic, and political environment.

Prevalence of Female Substance Abuse

When discussing the numbers of women engaged in substance abuse, it is important to keep in mind that those numbers might be underrepresented. Women will often try to hide their addiction and therefore escape the stigma associated with it (Hurley, 1991). It is socially more acceptable to experience a problem with nerves, anxiety, or minor depression. Women will often choose to see their physicians for the described problems, get prescriptions for psychoactive drugs, and then become addicted to them. (Lisanksy-Gomberg, 1995; Nakken, 2002; Kane-Caviola & Rullo-Cooney, 1991). In general health care practices, addicted women are regularly misdiagnosed for psychiatric or medical problems rather than addictive disorders (Corrigan, 1985). Instead of receiving treatment for addictive behavior, women are subsequently treated for mental illness.

Studies on women's substance abuse show rising numbers of females abusing alcohol and drugs. The Epidemiologic Catchment Area Study (ECA), conducted in the early 1980's, found a lifetime prevalence of alcohol use disorders to be 23.8% in males and 4.6% in females (Helzer, Burnam, & McEvoy, 1991). This yielded a male: female ratio of about 5:1. The National Comorbidity Survey (NCS), conducted in the early 1990's found the prevalence of alcohol dependence for men to be 20.1% and for women 8.2% (Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen, & Kendler, 1994). That results in a male: female ratio of 2.45: 1. Schmidt & Weissman (1993) show in their survey that the prevalence in women's substance abuse was rising from 22% in 1982 to 28% in 1990. The rising numbers of female abusers underline the trend observed in the ECA versus NCS. Males have always outnumbered females in alcohol and drug abuse. Yet, the 1999 National Household Survey on Drug Abuse (SAMHSA) survey shows for the first time that females in the age group of 12-17 use illicit drugs in comparable numbers to males in this age group.

Why are the numbers of female abusers rising? One explanation might be found in the occurrence of societal changes during this time span. Stigma associated with women's drinking, for example, has declined in the last decades (Greenfield, 2002). Another reason might be found in the numbers of women entering the workforce and working in previously male dominated jobs. The diversification of the woman's role might provide increased opportunity for abusing substances (Wilsnack & Wilsnack, 1995). This argument finds support from a recent NIDA study stating that the lower rate of female drug abuse is largely a matter of opportunity. When girls, for example, are offered drugs they accept them at the same rate as boys. Girls, however, do not receive as

many offers as boys (NIDA, 2002). Also, since women are leaving the home in increased numbers, female alcohol consumption, for example, might also have become more visible. Additionally, women might want to copy male behavior to fit in (Hammer & Vaglum, 1989).

Recent numbers for substance abuse such as those found in the 1999 SAMHSA study show that 5.6 million American women use an illicit drug in any given month and 15.1 million women engage in binge or heavy drinking during the same period (SAMHSA, 2000b).

Health Effects of Substance Abuse

Women who abuse drugs and/or alcohol deal with more health problems than non-abusers. Those problems can include hepatitis, cirrhosis, fractures, anemia, kidney problems, bladder ailments, and breast cancer (DiNitto & Crisp, 2002). They are also at high risk for infertility, vaginal infections, repeat miscarriages, and premature deliveries (Nelson-Zlupko et al., 1995). Alcoholic women have four times the death rate of their non-alcoholic peers, the major causes being suicide, liver disease, cancer of the head, neck, and breast, circulatory disorders, respiratory disease, and the result of violence (Lisansky-Gomberg, 1993).

A major issue for women, especially women of color, is HIV-AIDS (Ashley et al., 2003). Women contract AIDS 58% of the time from infected partners who inject drugs (Centers for Disease Control and Prevention, 1998) and to a lesser extent from their own drug use. Also, some women turn to prostitution to finance their drug use, which poses another risk for contracting AIDS (Ashenberg-Straussner & Attia, 2002).

Many female patients who seek the help of health care professionals do not disclose their addiction problem, which prevents doctors from prescribing interventions that address the addiction problem (Anthony & Helzer, 1991). This leads to ineffective treatment for women and will prolong their health problems. Since drugs affect the brain chemistry, a woman who appears depressed or suffering from anxiety disorder may in fact be addicted to alcohol, sedatives, marijuana, opiates, or stimulants (O'Connor, Esherick, & Vieten, 2002). Additionally, many women addicts have coexisting psychiatric disorders (DiNitto & Crisp, 2002). In a study by Kessler, Crum, Warner, Nelson, Schulenberg, & Anthony (1997), 86% of women with a diagnosis of alcohol dependence also met lifetime criteria for another psychiatric disorder, including drug dependence.

A special risk group in substance abuse is pregnant women. Pregnant women face increased health risks during pregnancy. They also endanger their fetuses through drug and alcohol use. The medical complications are thus carried beyond the woman's own life (Lisansky-Gomberg, 1993; Crouse, 2002; Coleman, 1987b).

Social and Economic Effects of Substance Abuse

The impact of drug addiction is devastating to many women's lives. Women lose their spouses, their children, their jobs, and their lives under the influence of drugs (O'Connor, Esherick, & Vieten, 2002).

Many women with substance abuse problems are married to husbands with substance abuse problems (Laudet, Magura, Furst, & Kumar, 1999). Often, husbands or significant others initially introduce the woman to illicit drugs (Anglin, Kao, Harlow,

Peters & Booth, 1987). Those partners can then be major obstacles to a woman's recovery, abstinence and maintenance of sobriety (Greenfield, 2002).

Addicted women are also more likely to be victims of domestic violence (Kaufman-Kantor, & Asdigian, 1997; Coleman, 1987c). Substance abuse, and especially alcohol abuse, is strongly related to marital violence (Stuart, Ramsey, Moore, Kahler, Farrell, Recupero, & Brown, 2002). Kaufman-Kantor and Asdigian report that women in general are six times more likely to require medical care for injuries stemming from family violence than men.

Chemically addicted women are frequently dependent on the public welfare system. They have fewer work-experiences and marketable skills than addicted men; however, they are much more likely to be the primary care-givers of children (Nelson-Zlupko et al., 1995). Research has well established that children in homes of addicted parents suffer emotionally and socially (Billings & Moos, 1983; Connors et al., 2003).

To finance their addictions, women are more likely to commit crimes such as shoplifting and prostitution. Those do not seem as threatening to society as men's crimes of robbery, burglary, and assault (Nelson-Zlupko et al., 1995). Women also use substances more in private, which adds to an invisibility of their problems (Reed, 1987).

Women are severely affected by their addictions. They suffer emotionally, physically, and economically. Women often have fewer economic resources than men and are apt to end up in situations where they face financial hardship and exploitative relationships.

Women and Childhood Abuse

Childhood abuse has a major impact on children (Dolan, 1991; Brabant, Forsyth, & LeBlanc, 1997; Briere, 1998; ISDH, 1991; Martin & Elmer, 1992). Feerick, Haugaard and Hien (2002) suggest that "... child maltreatment has a range of short- and long-term effects on development, including a variety of mental health, social, and cognitive consequences" (p.226). Research mentions three categories of child abuse: sexual, physical, and emotional abuse. This study looks at sexual and physical abuse, since emotional abuse is not easily substantiated, is socially very broadly defined, and is infrequently cited in the substance abuse literature.

Child sexual abuse has been shrouded in a veil of secrecy for centuries. Freud concluded in the late 1800's that most of the accounts of incestuous activities of fathers and daughters were indeed fantasies (Brabant et al., 1997, Hurley, 1991). This explains in part why researchers ignored this issue for decades. In the mid-1970's, several actions brought this topic finally into the public: in 1974 the Federal Child Abuse Prevention and Treatment Act (CAPTA) was passed, the National Center of Child Abuse and Neglect was established, and the women's movement helped to bring sexual child abuse and incest to the forefront with researchers, authors, and the public (Hurley, 1991).

The definitions for sexual abuse in research vary greatly (Wyatt, & Peters; 1986). In Boyd's (1993) study, women were asked if "a bigger or stronger person did sexual things to them that they did not want or like" (p.436). Jantzen, Ball, Leventhal, & Schottenfeld (1998) include in their definition "any kind of sexual activity, such as sexual touching or having sex" (p. 322). Miller, Downs, Gondoli, & Keil (1987) identify sexual abuse as "any unwanted sexual contact with a person at least five years older than the

respondent or with any family relative, regardless of age difference” (p. 157). They further include physical contact (e.g., fondling, intercourse) and nonphysical contact (e.g. invitations, exposure). The Child Abuse Prevention and Treatment Act (CAPTA) defines sexual abuse as follows: “Sexual abuse includes fondling a child’s genitals, intercourse, incest, rape, sodomy, exhibitionism, and commercial exploitation through prostitution or the production of pornographic materials” (ACF, 2002).

In cases of incest, Evans and Schaefer (1986) quote that legal definitions require the presence of blood-related parties and intercourse. They add, however, that the definition should be widened to include any two members of a family grouping and any type of sexual contact (such as direct and indirect touch of sexual body parts). Dolan (1991) uses the term “child incestuous sexual abuse” in her book in reference to “any sexual involvement between a child or adolescent and an individual who is in a position of power over her” (p. 2).

This variety of definitions has added to a wide discrepancy of reported incidence of sexual abuse in the literature (Hurley, 1991; Simpson & Miller, 2002). Interestingly, Simpson and Miller found in their broad analysis of childhood abuse and drug abuse that the numbers of sexual abuse reports did not increase over the last two decades: “What is striking, then, is the relative homogeneity of findings across studies that vary so widely in samples and methodology” (p. 49). The authors would have expected an increase in reports, considering the wider public disclosure of sexual abuse in the 1990’s. The National Child Abuse and Neglect Data System (NCANDS), which collects information on referrals to Child Protective Service agencies throughout the United States (ACF, 2003), reported that in 2001, 9,030 children were found to be victims of sexual abuse.

Interestingly, those numbers did not change significantly during the reports from 1996-2001. It must be understood that those numbers are only cases which have been reported and substantiated by Child Protective Services. The number of actual abuse cases is estimated to be much higher.

A large national survey in 1991 revealed about 20% of females to be victims of childhood sexual abuse (Vogeltanz, et al., 1999). The criteria for sexual abuse were: any interfamily sexual activity before the age of 18 that was unwanted (such as exhibitionism, fondling, sexual kissing, oral-genital activities, and vaginal or anal intercourse) or any unwanted sexual intercourse with non-family members occurring before the age of 18. The rates in another national survey with a slightly more inclusive definition of sexual abuse were 27% for women and 16% for men (Finkelhor, Hotaling, Lewis, & Smith, 1990).

Effects of Sexual Childhood Abuse

Sexual abuse has often long-lasting psychological consequences for the victims (Brabant, et al. 1997; Briere, 1998; Dolan, 1991; ISDH, 1991). Yvonne Dolan writes: “Sexual abuse is among the most potentially damaging traumas a person can sustain” (p. xiii). Brabant et al. cite negative consequences like feelings of increased powerlessness, betrayal, shame, guilt, and a negative self-image. The victim might experience nightmares, depression, self-mutilation, suicide attempts, sadness, withdrawal, fatigue, and symptoms of physical illness. Hurley (1991) lists possible additional symptoms in the adult survivor: sexual dysfunction, promiscuity, problems with authority figures, need for control, low self-esteem, depression, feeling of detachment, somatic complaints, anxiety,

parenting difficulties, emotional/physical abuse towards children, self-destructive behavior (including substance abuse), re-involvement in incestuous assault or tendency to become involved in repetitive abusive relationships, problems in interpersonal relationships, feelings of isolation, and poor social adjustment. People who have been sexually assaulted are also at increased risk to develop Post Traumatic Stress Disorder (Root, 1989; Gentile & Wolfe, 1989; Kramer & Green, 1991) and Dissociative Disorders (Chu & Dill, 1990). These findings are echoed by many other sources (ACF, 2002; Boyd, 1993; Coleman, 1987; Finkelhor, 1990; Wallen & Berman, 1992; Wolfe, Sas & Wekerle, 1994; Root, 1989; Vogeltanz, Wilsnack, Harris, Wilsnack, Wonderlich, & Kristjanson, 1999).

Not all survivors of childhood sexual abuse, however, experience a host of negative influences in their lives (Dolan, 1991; Briere, 1998; Finkelhor 1990). Finkelhor writes: "...asymptomatic children are mostly ones who have suffered less serious abuse and have adequate psychological and social resources to cope with the stress of abuse" (p. 327). Newenberger and De Vos (1988) talk about the child's cognition as a factor in how the abuse is interpreted. If a child labels the feelings pleasurable, and the situation is experienced within the child's psychological sense of control, the child might not feel abused. However, if the child senses a loss of control and experiences an unsupportive social environment, the impact of the abuse will be exacerbated.

Briere (1998) undertook an innovative study to examine the impact of sexual abuse on the victim. His study shows that there are different levels of trauma experienced by the victim, generally depending on duration of abuse, severity of abuse, number of perpetrators, victimization involving bizarre acts (resulting in especially high levels of

humiliation or disgust), and concomitant physical abuse. Participants of the study who scored high on those abuse categories were more likely to experience problems such as dissociation, sleep disturbance, sexual problems, anger, alcoholism, drug addiction, sexual assault, self-mutilation, and suicidality. The author concludes "...that sexual abuse is traumatic per se, becoming even more destructive in the presence of certain characteristics..." (p. 333). Bryer, Nelson, Miller, and Krol (1987) found that women who were both sexually and physically abused scored higher on scores for adult psychiatric symptoms than women who were either sexually or physically abused. The compounded abuse was most disturbing. Similarly, E. Gil (personal communication, April, 8, 2003), who works with abused children, sees in her clinical experience that sexual abuse and physical abuse can be equally disturbing to children. How much children suffer depends on the cruelty surrounding the abuse.

To explain the symptoms of the sexually abused child, Finkelhor & Browne (1985) developed a "four traumagenic dynamics model". It assumes that sexual abuse impacts four main areas of the child's development: sexuality, ability to trust in personal relationships, self esteem, and sense of their ability to affect the world. The traumagenic dynamics are: traumatic sexualization, betrayal, stigmatization, and powerlessness. Finkelhor believes that the trauma influences the child's cognitive and affective capacities and then leads to symptoms and dysfunctional behavior that characterize abuse victims.

Most research on the effect of sexual childhood abuse has been conducted on women. Yet, research on boys shows that there are few gender differences in the reaction to sexual abuse (Finkelhor, 1990). Some of the differences include boys being less

abused at the hand of family members than girls and the abuse bringing about the stigma of homosexuality for boys.

Effects of Physical Childhood Abuse

Sexually abused children are also often victims of physical abuse, whereas a smaller percentage of physically abused children report sexual abuse (Berman & Wallen, 1992; Feerick et al., 2002). The National Child Abuse and Neglect Data System reports about 18,000 children were found to be victims of physical abuse in 2001 (ACF, 2003). These numbers are probably underestimated, since these findings only include reported incidences. Approximately 1,300 children died of abuse and neglect - a rate of 1.81 children per 100,000 children in the population. These proportions have been constant from 1996-2001. The reported cases were about equal for males and females.

The Second National Family Violence Survey (Wolfner and Gelles; 1993) took data from 6002 US households. Their sample was obtained through randomized phone calls and yielded a much higher number of abused children. This is probably due to the way the information was obtained and also due to a wider definition of physical violence. In Wolfner and Gelles' sample, 1 out of 10 children experienced severe violence (kicked, bit, hit with a fist, hit with an object, beat up, burned, scalded, threatened with a gun or a knife, or used a gun or a knife) and 6 out of 10 children experienced minor violence (pushed, grabbed, shoved, slapped, or spanked).

Most definitions of physical abuse call for physical evidence to be evident. In a recent study from Widom, Ireland, and Glynn (1995), people qualified for the category of physical abuse if they had displayed "bruises, welts, burns, abrasions, lacerations,

wounds, cuts, bone and skull fractures, and other evidence of physical injury” (p. 209). Chaffin, Kelleher, and Hollenberg (1996) included in their physical abuse category acts which resulted in bruises, bed days (needing to stay home to recover), or necessary medical care. Westermeyer, Wahmanholm, and Thuras (2001) also add “persisting, inconsistent physical punishment that was unpredictable” (p. 102). CAPTA defines physical abuse as follows: “Physical abuse is characterized by the infliction of physical injury as a result of punching, beating, kicking, biting, burning, shaking or otherwise harming a child” (p. 2), (AFC, 2002). Wolfner and Gelles (1993) defined physical abuse as an act “carried out with the intention, or perceived intention, of causing physical pain or injury to another person. The intent of the act could range from slight pain (like a slap), to homicide ... We defined abusive violence as those acts of violence that have a high probability of causing injury to the person (an act of injury does not have to occur)” (pp.199-200).

The Indiana State Department of Health trauma manual for healthcare providers (ISDH; 1991) lists the following symptoms for child victims of physical abuse:

“indiscriminate attachment, depression, low self-esteem, wary of adult contact, apprehensive when other children cry, behavioral extremes (extremely aggressive, demanding rageful; overly compliant, passive, withdrawn; self-destructive), role reversal (child parents parent, child acts inappropriately adult-like and responsible), developmental lags may fall behind in toilet training, motor skills, socialization language development), appears frightened of caretaker, wears long sleeved shirt in hot weather (to cover bruises), cringes or jumps at a sudden movement, verbally reports abuse, school absenteeism (p. 6).”

Livingston (1987) reports that physical childhood abuse interferes with cognitive, physical, social, and emotional development of the victim. Chu and Dill (1990) specify a positive correlation between childhood physical abuse and later interpersonal insensitivity, anxiety, hostility, paranoid ideation, and psychoticism in female patients.

Malinosky-Rummel and Hansen (1993) looked at childhood physical abuse and adolescent and adult aggressive behavior. They found that abused children, especially males, engaged in increased dating violence, family violence, extra-family violence, and sexual offenses. They also note a significant relationship between physical abuse and later substance abuse. Feerick et al. (2002) confirm similar results. Thus, physical abuse seems to be systemic. Chaffin, Kelleher, and Hollenberg (1996) show in their study that substance abuse and depression on the side of caretakers were the strongest risk factors for inflicting physical abuse on children.

Abused Women and Substance Abuse

Prevalence

As research started to focus on female substance abusers, it became clear that a significant number of those women reported sexual and/or physical childhood abuse. In the early 80's, sexual and/or physical abuse started to be mentioned in research as a possible link to alcoholism in women (Hurley, 1991; Wilsnack, & Wilsnack, 1995). Since then, many more studies evaluated the connection between childhood abuse and substance abuse. Vogeltanz et al.(1999) summarized findings after 20 years of research on sexually abused women as follows: "There is ... no clear consensus that sexual abuse during childhood *causes* various forms of psychopathology in adulthood, but a

relationship between childhood sexual abuse and negative long-term consequences has been firmly established” (p. 589). Many other studies also speak of physical abuse as a risk factor of substance abuse (Bennett & Kemper, 1994; Downs, Miller & Gondoli, 1987; Westermeyer, Wahlmanholm, & Thuras, 2001; Mainosky-Rummell & Hansen, 1993).

In a study by Convington and Kohen (1984), 34% of alcoholic women in a sample of 35 had experienced incest compared to 17% of women in the matched comparison group. Miller, Downs, Gondoli, and Keil (1987) compared 45 alcoholic women with a group of 40 nonalcoholic women. They found that 67% of the alcoholic women experienced sexual abuse as compared to 28% of the non-alcoholic women. Wallen and Berman (1992) screened 217 patients of 2 nonprofit inpatient substance abuse treatment centers and found that 33% of the women had been sexually abused. In a Swedish study (Lundgren, Gerdner, & Ludqvist, 2002), 70% of the 55 patients in an alcohol and drug rehabilitation center reported sexual abuse accompanied by other types of child maltreatment. In Feerick et al.’s study (2002) of cocaine abusing women, 30% of women reported childhood sexual abuse, and 22% reported a history of childhood physical abuse. In a study from Westermeyer, et al. (2001), 30.4% of a sample of 642 patients at two substance abuse facilities showed a history of childhood physical abuse.

Simpson and Miller (2002) undertook a meta-analysis using 126 studies published on the co-occurrence between childhood sexual or physical abuse and substance abuse. The abuse incidences reported from those studies ranged considerably. Yet, most of the differences in numbers can be explained by the different definitions of sexual or physical abuse. The authors compiled an average score of sexual childhood abuse for females in

substance abuse treatment. Adolescent girls scored especially high at 60.9%, whereas adult women scored at 44.5%. The physical childhood abuse score was at 46.2% for adolescent girls and at 38.7 % for adult women. The salient result of the analysis was, however, that the studies revealed a consistent overrepresentation of female childhood abuse victims in the population of female alcohol and drug abusers of 2-3 times the occurrence in the general population. The authors conclude: "The consistency of such convergence across widely divergent populations, cohorts, and study methods is striking and suggests that a history of childhood abuse may be an important risk factor for the development of alcohol/drug problems in women"(p. 50).

In contrast, Simpson and Miller's review did not find the rates of physical and sexual childhood abuse for men in substance abuse treatment elevated. They were almost identical to the national rate of 16%. Only the rates of physical abuse for adolescent males in drug rehabilitation was higher than the national average. Overall, the co-occurrence of substance abuse problems and childhood abuse were much more significant for females (Simpson & Miller, 2002).

Reasons for Female Substance Abuse

The literature suggests a variety of reasons for female substance abuse. There is no proven correlation between certain events and later substance abuse. However, a set of certain variables seems to be associated with women becoming dependent on illicit drugs. Growing up in a home where drugs are used, depression, and childhood abuse are among the more frequently cited reasons for later drug dependence (Boyd, 1993; Simpson and Miller, 2002).

Many researchers mention a link between childhood abuse and later drug use. The trauma and subsequent bad feelings stemming from the abuse seem to steer women into using drugs to elevate their moods. Miller et al. (1987) suggest that sexually abused women who cannot cope with negative feelings about themselves might initiate drinking to relieve feelings of discomfort. Wallen and Berman (1992) state that: “individuals with a sexual abuse history may learn to use alcohol or drugs to self-medicate for anxiety or depression or to combat symptoms of post-traumatic stress disorder” (p. 64). This effect is supported by Root’s (1989) studies on abused women who become increasingly agitated, anxious and fearful when decreasing their substance use. She understands the substance abuse of women as a form of coping: “Substance abuse may enable some victims to compartmentalize their internal experiences so that they are able to function as well as they do in daily life” (545). Another study supporting the self-medicating hypothesis was done by Burnam, Stein, Golding, Siegel, Sorenson, Forsythe and Telles (1988). The authors found that for women, the onset of alcohol and drug use was most concentrated in the first one to two years following a first-time sexual assault. Similarly, Kilpatrick, Acierno, Resnick, Saunders, & Best (1997), demonstrated that individuals who were newly assaulted were more than twice as likely to use and abuse substances as non-assaulted women.

Khantzian (1985) observed that many of his clients would tend to use either cocaine or opiates depending on their specific underlying psychological distress. He believes that: “Rather than simply seeking escape, euphoria, or self-destruction, addicts are attempting to medicate themselves for a range of psychiatric problems and painful emotional states” (p. 1263).

It would be tempting to reason that childhood abuse accounts for later drug use. However, the relationship between childhood abuse and substance abuse seems very intricate (Brabant et al. 1997; Jantzen et al., 1998). Lisansky-Gomberg (1993) writes: “There is, in fact, a complex of relationships between childhood sexual abuse and depressive mood, feelings of worthlessness, suicidal thoughts, use of drugs, and involvement in violent relationships” (101). Miller et al. (1987) also attribute parental substance abuse to a higher vulnerability of a child to be sexually victimized by males in her environment. Parental drug use additionally creates a family environment where addictive behaviors are modeled to the child and later substance abuse is more likely.

Boyd (1993) studied 105 female crack cocaine users and compared the following variables: age of first drug use, age of first sexual abuse, age of onset of depression, and number of family members using drugs. Boyd found a strong correlation between age of first drug use and age of first depressive episode and a moderate correlation between age of first drug use and age of first sexual abuse. Women with more drug abusing family members also had an earlier onset of illicit drug use. He suggests “women come to their substance abuse via a set of events that link family drug use, sexual trauma, and depression to their drug use” (437).

Simpson and Miller (2002) analyzed various studies to determine if the apparent relationship between childhood abuse and substance abuse was mediated or moderated by other conditions. They found that PTSD, Major Depression, Generalized Anxiety Disorder, and Conduct Disorder might very likely mediate, or at least moderate the relationship between childhood abuse and substance abuse problems. “Extant data do indicate that excessive alcohol and drug use may function to help childhood abuse

survivors self-medicate symptoms, such as anxiety and depression, that stem from difficult early experiences”(p. 52). The authors also conclude that more severe child abuse is most likely to be associated with disorders such as PTSD. The multiple pathways to substance abuse likely have special implications for treatment.

Women’s Needs in Treatment

There is growing consensus that women have different treatment needs than men, stemming from the gender-specific differences in etiology and patterns of substance abuse. For example, social and occupational impairment in men are often manifested as violence, denial about dependence problems, absence from work, loss of job, legal difficulties, impaired driving, arguments, and difficulties with family and friends (Reed, 1987). Women are more likely to admit that they are in trouble, but they often report extreme levels of depression, anxiety, and low self-esteem. Women abuse substances more often in private and end up losing crucial social connection. Women are also more likely to be married to a spouse with substance abuse problems, they are more often the victim of physical and sexual violence, and they experience more disruption to their families and receive less family support for treatment (Beckman, & Amaro, 1986; Nelson-Zupko, Kauffman, and Doe, 1995; Olenick, & Chalmers, 1991; Reed, 1987). Those issues should be addressed in multidisciplinary ways in order for women to be successful in treatment (Nakken, 2002).

To attract and retain women in substance abuse treatment, practical issues like parenting classes and vocational training are important (Ashley et al., 2003; Greenfield, 2002). Many women also depend on subsidized housing and transportation for their

treatment success (Nakken, 2002). Women often carry primary caretaking responsibilities in their family. While her children might be a motivation for a mother to complete treatment, the realities of caring for those children might undermine her treatment success. Provision of childcare is therefore enormously helpful for many women (Kelly et al., 2001; McCollum & Trepper, 1995). Reed (1987) additionally calls for access to legal services for women and financial assistance, ranging from food stamps to emergency housing.

Research demonstrates that substance abuse is rarely a single-dimension issue for women. In a review of several treatment programs for women, Ashley et al. (2003) conclude that comprehensive programs that address a wider array of women's needs are more beneficial than programs solely focusing on drug and alcohol abuse.

Covington (2002) concentrates on two main elements that addicted women share: the lack of healthy relationships and the experience of trauma. Addressing those psychological issues in a comprehensive fashion is therefore crucial for the treatment success of women.

Treating Trauma and Abuse

Addressing trauma history in substance abuse treatment is another important component for women (Brabant et al. 1997; Evans & Schaefer, 1986; Jantzen, et al., 1998; Kelly et al., 2001; Reed, 1987; Wallen & Berman, 1992). Coleman (1987a) explores the correlations between chemical dependency, child abuse, and family conflict. She concludes that children who live in abusive homes are bound to develop intimacy problems. In order to deal with the pain of family intimacy dysfunction, those children

are apt to use compulsive behavior (such as substance abuse) to compensate. Dealing with the abuse trauma, in addition to substance abuse treatment, will help the client to heal and connect in meaningful relationships. Coleman believes that many professionals in the field of chemical dependence are unaware of their clients' intimacy problems, which stem from childhood abuse and neglect. "In the meantime, many individuals are left with intimacy dysfunctions that serve as a barrier to successful rehabilitation and to greater feelings of well-being and sobriety" (p 24).

In Root's (1989) experience, abused women often end up as "treatment failures" in substance abuse rehabilitation, since there seems to be a "lack of understanding of the connection between the long-lasting sequelae of symptoms following sexual victimization and the temporary but ameliorative effects of alcohol, food, and drugs on these symptoms" (p. 543). She cautions that women's negative internal states might become more intense following cessation of substance use. Drug use can serve as an anesthesia for the abuser's memories of childhood abuse. With the anesthesia gone, the person can experience severe feelings of anxiety and suicidality which usually lead the person back to using drugs and relapse. Clients need help in developing specific coping skills to understand and deal with the psychological impact of the abuse history.

In a similar fashion, women with co-occurring disorders need special support since they are using drugs to combat symptoms of severe psychiatric illness. Those women need much support during the early withdrawal phase, use of medication, and ongoing psychotherapy (O'Connor, Esherick, & Vieten, 2002; Reed, 1987). Many women with sexual and physical abuse histories are part of this group with co-occurring disorders (Bryer, Nelson, Miller, & Krol, 1987; DiNitto & Crisp, 2002). Kessler, Nelson,

McGonagle, Edlund, Frank, & Leaf (1996) discovered by evaluating data from the National Comorbidity Survey that 59% of cases with alcohol dependence and 69% of those with drug dependence receiving treatment also had at least one 12-month episode of affective or anxiety disorder. The authors recommend treating the patients for both substance abuse and mental disorder. DiNitto and Crisp (2002) caution that dually women with co-occurring disorders might start to experience memories of traumatic events in detoxification which need to be addressed in treatment.

Successful treatment of women begins with comprehensive intake information which includes inquiring about childhood abuse. Yet, Bryer et al. (1987) caution that many sexually abused women will not disclose their sexual abuse during intake because of the extreme confusion and shame associated with the abuse. Additionally, many clinicians feel uncomfortable asking questions about childhood sexual abuse. Clinicians have to overcome their apprehension and understand that they are serving their client's best interest in particularly asking about childhood abuse. Multiple questions of a specific nature will help women to disclose more readily (Miller et al., 1987). This will lead to diagnosing patients more accurately, for example, with Post Traumatic Stress Disorder instead of character disorder or psychosis (Bryer et al., 1987) and ensure better treatment strategies for the particular patient.

Summary

In recent decades, women have received more attention in substance abuse treatment. Yet, women's needs in substance abuse treatment are still not sufficiently met. An area which has not received enough consideration is the concomitance of childhood

abuse and drug abuse. A high percentage of drug dependent women are victims of childhood sexual or physical abuse.

Women need the opportunity to address underlying issues connected to their abuse. Addicted women with childhood abuse issues should be identified at intake. Those women need the chance to resolve some of their abuse issues in order to successfully graduate from their substance abuse programs.

Clinicians need to be sensitized to this issue. This study aims at better understanding the drug use profiles of abused vs. non-abused women in substance abuse treatment. This information could help clinicians better understand the women they serve and help them better assess for childhood abuse at intake.

The study also aims at raising the topic of childhood abuse in drug dependence for women and increasing our understanding of this issue.

Chapter III: Methods

Introduction

The purpose of this study is to determine if there are differences in the drug use and psychological profiles of women who report childhood abuse versus those who do not. The comparison will focus on four criteria: drug choice, problem severity, frequency of use, and level of psychological problems. Do abused women favor particular drugs? Is there a difference in the problems the addiction creates in their lives? Are abused women using more frequently than women without abuse history? Do abused women experience different psychological problems? This study will compare information from the intake data of women in two intensive outpatient substance abuse treatment centers. The participants at those centers were treated for a wide variety of drug problems and supplied information about their history of drug use, and their current use.

Participants and Recruitment Process

The data used for this study were originally gathered for a National Institute of Drug Abuse (NIDA) research project entitled “Couple-Focused Therapy for Substance Abusing Women.” Robert A. Lewis was the principal investigator for this project. The original study followed women and their partners for a year in order to elicit the impact of couple-focused family therapy for women in drug treatment (Nelson et al., 1996).

The overall study collected data at two agencies in a large Southwestern U.S. city during a span of five years. The two different treatment agencies were selected to ensure a wide enough sample of participants and a more culturally diverse population. One of the treatment agencies provided intensive outpatient treatment. The second agency

provided outpatient methadone-maintenance. The study screened 250 women.

Participants of the study were recruited from the caseloads of both agencies and through advertisement in a variety of local media.

Demographic characteristics of the women were as follows: The ethnic background of the participants was 80.6% white, 9.7% Hispanic, 4.9% African American, and 4.5% Native American. Of the 248 women participating in the study, 89% were heterosexual and 11% homosexual or bi-sexual. The average age of the participants was 32.9, with a range of 18-48 years. The median years of absolved school years was t years. Sixty-four percent of the participants were on parole when the study began. Eighty-one percent had not undergone drug treatment before. The population consisted of a lower socio-economic group, with a median income of \$8,000 and a range from \$0-\$132,000. Forty-eight percent of the women cared for dependent children with a mean number of 1.6 children.

Admission criteria for the women were being married or being in a committed, on-going relationship for the last six months prior to the study. A woman had to want to participate in treatment and have a partner who would join her in the treatment process.

Exclusion criteria were not being in a relationship for the last six months, not wishing to participate, having a partner who did not wish to participate, and not returning to the agency following the intake assessment. Additionally, a woman was excluded if she reported on-going violence in her relationship or if a woman was diagnosed with a major mental illness. A past history of violence in the relationship did not hinder a woman from participating if she felt safe and was willing to include her partner in treatment.

Procedures

The women recruited through media and from the two treatment centers had to complete an agency standard intake interview to assess for eligibility. Should an eligible woman decide to join the research study, she had to sign a consent form (approved by the Institutional Review Board at Purdue University), informing her about the implications of the study. To participate in the study, women had to also undergo detoxification if needed. Participants would complete a pre-test and were then assigned to one of three different treatment conditions designed to test the impact of couple-focused family therapy. Two-hundred-fifty women completed an initial assessment. From this original pool, 168 women met the admission criteria and were given a pre-test assessment.

After treatment completion, the participants took a post-test. At three months, six months, and twelve months after treatment completion, there were a follow-up session and a post-test. Female participants and their partners received money for completing each assessment (pre-test and all post-tests). The current study only uses the intake data and data gathered at the first pre-test of the female partners. The study looks at responses to childhood abuse, drug choice, frequency of use, problem severity of drug use, and level of psychological problems.

Trained assessors (Bachelor's-level) administered each assessment and collected all data. The assessors did not participate in any other aspect of the participant's treatment. The assessors were also not aware of the particular treatment condition of the participants.

The therapists who provided the couples-focused family therapy sessions (add-ons to the regular agency substance abuse program) were Master's level family therapists

or advanced graduate students in a local university family therapy program. Members of the Purdue University research team provided intense supervision for all therapists.

Instruments

Intake Interview—Abuse Status and Drug of Choice

As the first step of entering the treatment phase of the original project, all potential participants completed a standard, extensive intake interview. This was done at the agency where the women sought treatment. The interviewer recorded the answers to the questions from each participant. Among other questions, the participants were asked if they were ever abused as a child, specifically if they were sexually, emotionally, or physically abused. They were also asked to identify their drug of choice. Answers to these questions were used to determine participants' abuse status and drug of choice.

“Abuse” was the independent variable in this study and had four categories: 1) Childhood sexual abuse, 2) childhood physical abuse, 3) combined sexual and physical abuse, and 4) not abused. The emotional abuse category was dropped from consideration since this term is vague and very broadly defined across society, and is infrequently cited in the substance abuse literature. One dependent variable in this study was drug of choice.

Participants were asked in the intake interview to identify their primary drug of choice and were given a list of 16 substances to choose from. Some of the substances were not reported or only few people reported them. In examining the data, four clear categories emerged: “alcohol”, “downers”, “uppers”, and “other”. These categories were used in this study.

“Alcohol”	Alcohol
“Downers”	Heroin, Non-prescription Drugs, Other Opiates
“Uppers”	Amphetamines, Cocaine
“Other”	Marijuana, Hashish, PCP, Other Hallucinogens, Prescription Drugs

Addiction Severity Index

The women were given a number of measures at pre-test including the Addiction Severity Index (ASI: McLellan, Luborsky, Woody, & O’Brien, 1980). The ASI is a structured interview that lasts about 40 minutes. It measures the number, extent, and duration of problems related to substance abuse in the participant’s lifetime, and in the past 30 days. For this particular study, the data for the number, extent, and duration of problems related to substance abuse were assessed for the past 30 days only.

Problem severity on the ASI is divided into seven subscales: alcohol use, drug use, employment, family-social life, legal, medical, and psychiatric impairment. An additional measure in the ASI is the number of days the clients were using substances during the past 30 days. McLellan et al. (1980): “The design of the ASI is based upon the premise that the addiction must be considered in the context of those treatment problems which may have contributed to and/or resulted from the chemical abuse” (p. 27).

The ASI is administered by a trained technician. It uses a five-point Likert-type scale to evaluate problem severity. Clients' objective and subjective reports are used to calculate a composite score and an interviewer rating of problem severity in each of the seven areas. Test-retest studies over a three-day interval have shown very reliable results ($p > .10$), even when performed by different technicians. Technicians can estimate the severity of patients' problems with an average reliability of .89. The ASI has been compared with a battery of other previously validated tests and it has shown clear evidence of discriminant ($p < .05$ to $.01$) validity. It also showed concurrent ($p < .05$ to $.01$ across the seven subscales) and predictive validity. The ASI has been widely used in substance abuse research (McLellan, Luborsky, Cacciola, Griffith, Evans, Barr, & O'Brien, 1985).

The ASI asks the participants how many days they have used a variety of substances in the last 30 days. Since abstinence (other than for prescribed methadone) was the goal of each treatment program from which participants were drawn, drug use frequency will be calculated as the total number of times a participant reported using any substance in the past 30 days. For instance, a woman who reported using marijuana on three days, cocaine once, and alcohol on four days would be given a score of 8.

Finally, participants' scores for problem severity of alcohol use, drug use, employment, family-social life, legal, medical, and psychiatric impairment will also be used as dependent variables.

SCL-90-R

At pre-test, the women took the SCL-90-R (Derogatis, 1983). The SCL-90-R was primarily designed to reflect psychological symptom patterns of psychiatric and medical patients. It is widely used today, translated into several languages, and frequently serves as screening inventory for primary care physicians (Schmitz, Kruse, Heckrath, Alberti, & Tress, 1999).

The SCL-90-R is a brief self-report inventory asking 90 questions on a 5-point Likert scale ranging from “not at all” (0) at one pole to “extremely” (4) at the other. Test takers report how much distress they experienced in the last week. Samples questions are:

How much were you distressed by feeling that most people cannot be trusted?

How much were you distressed by feeling afraid to go out of your home alone?

How much were you distressed by nervousness or shakiness inside?

The instrument is scored and interpreted in nine primary symptom dimensions, which are:

Somatization

Obsessive-Compulsive

Interpersonal Sensitivity

Depression

Anxiety

Hostility

Phobic Anxiety

Paranoid Ideation

Psychoticism

The test also interprets three global indices of overall psychological distress:

Global Severity Index (Indicator of overall distress)

Positive Symptom Distress Index (Divides the grand total of distress scores of PST)

Positive Symptom Total (Counting number of overall positive responses)

Scoring is a simple procedure involving arithmetic addition and division to two decimal places. Forms facilitate scoring and symptom profiles.

Reliability testing for internal consistency for the nine dimensions showed a coefficient alpha range between .77 for psychoticism to .90 for depression. Construct and concurrent validity was tested by contrasting the dimension scores from the SCL-90-R with scores from the MMPI. The correlations between the SCL-90-R and the MMPI scores ranged from .40 to .68. (Derogatis, Rickels, & Rock, 1976). More recently, German researchers compared the GHQ-12 (General Health Questionnaire) and the SCL-90-R (Schmitz et al., 1999) The researchers found a linear relationship between the two tests and a correlation for total scores of .64. They declared the SCL-90-R superior to the GHQ-12 in detecting a broader range of psychological problems and symptoms of psychopathology.

Starcevic, Bogojevic, & Marinkovic (2000) find the SCL-90-R suitable to also screen for personality disorders and severe personality disturbances. Their study shows that the SCL-90-R has a 72.9% sensitivity to screen for any DSM-III-R Personality Disorders compared with the SCID-II (Structured Clinical Interview for DSM-III-R

Personality Disorders). The researchers judge the SCL-90-R to be a “well-validated self-report instrument for the assessment of distress and psychopathology” (p. 206).

In this study, the nine symptom dimensions and the three global indices of overall psychological distress were compared for abused and non-abused women.

Design

This descriptive study is designed to evaluate the differences of drug choice, frequency of use, problem severity, and level of psychological problems in substance abusing women with a sexual and/or physical abuse history vs. those who do not report such abuse. Previous research has addressed the high number of female substance abusers who experienced sexual and/or physical abuse, but research has not yet compared the possible differences in user profiles. This study looked at the answers of women who completed an intake interview and the pre-test as part of entering substance abuse treatment. It compared the answers of women who reported sexual and/or physical abuse with those who did not report such abuse. How are the answers regarding drug choice, frequency of use, problem severity, and level of psychological problems different for the two groups? Are there different patterns for abused women?

Analysis

The data for the analysis came from the answers women gave in the intake interview and the pre-test. The analysis of the data was done using analysis of variance (ANOVA) for continuous data and Chi-square tests for categorical data. Following are

the research questions and the data analysis strategies that were used to answer each question.

Research Question #1: *Do women who report sexual abuse, physical abuse, sexual and physical abuse, or no abuse report a preference for different classes of drugs?*

Data Analysis: The categories of “sexually abused”, “physically abused”, “sexually and physically abused”, and “no abuse” were cross-tabulated with the drug of choice categories “alcohol”, “downers”, “uppers”, and “other” to look for significant associations. Chi-square was used as the statistical test of a significant association.

Research Question #2: *Do women who report sexual abuse, physical abuse, sexual and physical abuse, or no abuse report different frequencies of drug use?*

Data Analysis: For “frequency of use”, the study used an analysis of variance (ANOVA) to compare the mean frequency of use during 30 days across the four abuse groups. A post-hoc analysis investigated specific group differences.

Research Questions #3 - #9

Data analysis: For the “problem severity” research questions, a one-way ANOVA was used to compare the problem severity participants in the four abuse groups experience in each of the areas measured by the ASI subscales of alcohol use, drug use, employment, family-social life, legal, medical, and psychiatric impairment. A post-hoc

analysis investigated specific group differences. The research questions for “problem severity” are:

Research Question #3: *Do women who report sexual abuse, physical abuse, sexual and physical abuse, or no abuse also report different levels of problems related to alcohol use?*

Research Question #4: *Do women who report sexual abuse, physical abuse, sexual and physical abuse, or no abuse also report different levels of problems related to drug use?*

Research Question #5: *Do women who report sexual abuse, physical abuse, sexual and physical abuse, or no abuse also report different levels of problems related to employment?*

Research Question #6: *Do women who report sexual abuse, physical abuse, sexual and physical abuse, or no abuse also report different levels of problems related to family-social life?*

Research Question #7: *Do women who report sexual abuse, physical abuse, sexual and physical abuse, or no abuse also report different levels of problems related to legal issues?*

Research Question # 8: *Do women who report sexual abuse, physical abuse, sexual and physical abuse, or no abuse also report different levels of problems related to medical issues?*

Research Question #9: *Do women who report sexual abuse, physical abuse, sexual and physical abuse, or no abuse also report different levels of problems related to psychiatric impairment?*

Research Questions #10 - #18:

Data analysis: For level of psychological problems, a one-way ANOVA was used to examine the following questions:

Research Question #10: *Do women who report sexual abuse, physical abuse, or no abuse also display different levels of somatization?*

Research Question #11: *Do women who report sexual abuse, physical abuse, or no abuse also display different levels of obsessive-compulsive behavior?*

Research Question #12: *Do women who report sexual abuse, physical abuse, or no abuse also display different levels of interpersonal sensitivity?*

Research Question #13: *Do women who report sexual abuse, physical abuse, or no abuse also display different levels of depression?*

Research Question #14: *Do women who report sexual abuse, physical abuse, or no abuse also display different levels of anxiety?*

Research Question #15: *Do women who report sexual abuse, physical abuse, or no abuse also display different levels of hostility?*

Research Question #16: *Do women who report sexual abuse, physical abuse, or no abuse also display different levels of phobia?*

Research Question #17: *Do women who report sexual abuse, physical abuse, or no abuse also display different levels of paranoid ideation?*

Research Question #18: *Do women who report sexual abuse, physical abuse, or no abuse also display different levels of psychoticism?*

Any observed differences were further explored using LSD post-hoc tests.

Chapter IV: Results

The purpose of this study was to determine if there are differences in the drug use profiles of women entering a drug rehabilitation program who report childhood abuse versus those who do not. The level of analysis is the individual. The data were analyzed to investigate differences in drug choice, problem severity associated with substance abuse, frequency of use, and level of psychological problems.

Participants

This study used two subsets of participants from the NIDA study. The first sample consists of women who completed the intake data. Two hundred fifty women were screened for the study and went through an intake interview. Demographic characteristics of those women were as follows: The ethnic background of the participants was 80.6% white, 9.7% Hispanic, 4.9% African American, and 4.5% Native American. Of the 248 women who provided complete intake data, 89% were heterosexual and 11% homosexual or bi-sexual. The average age of the participants was 32.9, with a range of 18-48 years. The median years of education were twelve years. Sixty-four percent of the participants were on probation when the study began. Eighty-one percent had not undergone drug treatment before. The population consisted of a lower socio-economic group with a median income of \$8,000 with a range from \$0-\$132,000. Forty-eight percent of the women cared for dependent children with a mean of 1.6 children.

When asked about their child abuse history, 51% of the women reported no abuse and 49% reported abuse (12% reported physical abuse only, 15% reported sexual abuse only, and 22% reported having been physically and sexually abused).

The second sample used for this study consists of 168 women entering the first stage of treatment. Those women and their partners all had agreed to participate in treatment and they were all eligible for the study. The data were gathered through a pre-test. There were only slight differences in ethnicity compared with the first sample: 80.7% White, 9% Hispanic, 4.2% African American, and 5.4% Native American. Sexual orientation and years of education were the same. The mean age dropped slightly to 32.6 within the same age range. The mean income rose to \$11,281 with the same range of income. The median number of children was 2.

In the second sample, 54% of the women reported no abuse, while 46% reported abuse (10% reported physical abuse only, 15% reported sexual abuse only, and 20% reported having been physically and sexually abused).

Research Question One

Research Question #1: Do women who report sexual abuse, physical abuse, physical and sexual abuse, or no abuse report a preference for different classes of drugs?

Data from the intake interview were analyzed to answer this question. The reported drug choices were combined into four groups: “alcohol”, “downers”, “uppers”, and “other”. “Alcohol” included alcohol only. “Downers” included heroin, non-prescription methadone, other opiates, barbiturates, and tranquilizers. “Uppers” included amphetamines and cocaine. “Other” included marijuana, hashish, PCP, other hallucinogens, and prescription drugs. There were two reasons for combining the different drugs into groups. First, to have fewer categories for the analysis, since the Chi-square analysis is negatively affected by cells with no scores. In the questionnaire, there

were 17 original categories, many of them with no one reporting or few people reporting them. Second, this study did not just arbitrarily combine groups, but used standard classes of drugs as described in the literature (Blum, 1984).

The four abuse groups were cross-tabulated with the four drug choices. Chi square was used as the statistical test of a significant association. There were no significant associations. The drugs of choice were similarly distributed across the four comparison groups.

Table 1

Drug Choice by Abuse Group

Abuse Categories	Alcohol	Downers	Uppers	Other	Total
No Abuse	20 (16.7%)	69 (57.5%)	26 (21.7%)	5 (4.2%)	120 (100%)
Physical Only	7 (25.0%)	13 (46.4%)	8 (28.6%)	0 (0. %)	28 (100%)
Sexual Only	7 (20.0%)	14 (40.0%)	9 (25.7%)	5 (14.3%)	35 (100%)
Phys. & Sexual	9 (17.6%)	29 (56.9%)	9 (17.6%)	4 (7.8%)	51 (100%)
Total	43 (18.4%)	125 (53.4%)	52 (22.2%)	14 (6.0%)	234 (100%)

$\chi^2 = 10.71$, $df = 9$ $p = .296$

Research Question Two

Research Question #2: Do women who report sexual abuse, physical abuse, physical and sexual abuse, or no abuse report different frequencies of drug use?

Data from the intake interview were analyzed to answer this question. Frequency of use was defined in four time periods: “none”, “once a week”, “several times a week”, and “1-3 times daily”. Those time periods were collapsed from a more detailed time line to have fewer categories for analysis, again to create categories without empty cells. The original questionnaire had 7 time categories (1. no use, 2. less than once a day, 3. once a week, 4. several times per week, 5. once a day, 6. 2-3 times per day, 7. more than 3 times a day). A cross-tabulation was done and Chi square was used to measure any associations between the time periods and the abuse groups. No association was found for any of the abuse groups.

Table 2

30 Day Frequency of Use at Intake

Abuse Categories	None	1 time a week	Several times a week	1-3 x daily
No Abuse	9 (7.7%)	28 (23.9%)	18 (15.4%)	32 (27.4%)
Physical Only	3 (10.7%)	5 (17.9%)	6 (21.4%)	10 (35.7%)
Sexual Only	5 (14.3%)	6 (17.1%)	6 (17.1%)	9 (25.7%)
Both	4 (8.0%)	6 (12.0%)	9 (18.0%)	19 (38.0%)
Total	21 (9.1%)	45 (19.6%)	39 (17.0%)	70 (30.4%)

$\chi^2 = 13.82$, $df = 18$ $p = .74$

Research Questions Three through Nine

Research Questions #3-#9: Do women who report sexual abuse, physical abuse, sexual and physical abuse, or no abuse report different levels of problems related to alcohol use/ drug use/ employment/ family-social life/ legal issues/ medical issues/ and/or psychiatric impairment?

Data from the ASI, the Addiction Severity Index, were analyzed to answer research questions #3 - #9. The data were gathered at the pre-test. For each question, a one-way ANOVA was used to compare mean scores between groups for each subscale of problem severity across the four abuse groups. No significant differences were found on any of the subscales.

Research Questions Ten through Eighteen

Research Questions #10 - #18: Do women who report sexual abuse, physical abuse, or no abuse display different levels of somatization/ obsessive-compulsive behavior/ interpersonal sensitivity/ depression/ anxiety/ hostility/ phobia/ paranoid ideation and/or psychoticism?

A one-way ANOVA was used to examine differences on each of the nine subscales of the SCL-90-R. The only subscale on which significant differences were found was the SCL Interpersonal Sensitivity Scale. This subscale asked the following questions to evaluate the participants' interpersonal sensitivity:

How much were you distressed by

Feeling critical of others

Feeling shy or uneasy with the opposite sex

Your feelings being easily hurt

Feeling others do not understand you or are unsympathetic

Feeling that people are unfriendly or dislike you

Feeling inferior to others

Feeling uneasy when people are watching or talking about you

Feeling very self-conscious with others

Feeling uncomfortable about eating or drinking in public

Table 3

ANOVA for SCL Interpersonal Sensitivity

	Sum of Squares	df	Mean Square	F	Significance
Between Groups	6.93	3	2.31	3.24	.024
Within Groups	111.15	156	.71		
Total	118.08	159			

The overall ANOVA was significant and a post-hoc analysis revealed 2 significant group differences. It showed that “sexual abuse only” is significantly different than “no abuse” ($p = .005$) and “physical abuse only” ($p = .017$). “Physical and sexual abuse” was not significantly different than any of the groups.

The mean scores on the Interpersonal Sensitivity Scale using ANOVA were as follows:

Table 4

Mean Scores on Interpersonal Sensitivity

No Abuse	Phys. Abuse Only	Sexual Abuse Only	Phys. & Sex. Abuse
.90	.64	1.35	1.03

Chapter V: Discussion

The purpose of this study was to determine if there are differences in the drug use profiles of women who report sexual and/or physical abuse versus those who do not. The study focused on four areas: drug choice, problem severity, frequency of use, and level of psychological problems. The study analyzed data using two subsets of participants from a NIDA study. One subset consisted of the intake data taken from 248 women; the other subset consisted of 168 of the larger group of women who extended the first stage of treatment. The study compared data for four abuse groups: not abused, sexually abused, physically abused, and sexually & physically abused. The data were analyzed to see if there were any significant differences between the abuse groups.

Discussion for Results for Research Question One

Research Question #1: Do women who report sexual abuse, physical abuse, physical and sexual abuse, or no abuse report a preference for different classes of drugs?

There were no significant differences for preferences of drugs for any of the abuse groups. It is actually striking how closely the groups correspond in their pattern of drug choices. For all groups, the biggest percentage of women reported preferring “downers” with a range of 40-57%. Considering that many women might self-medicate for a variety of psychological reasons (Brabant, et al. 1997; Jantzen et al., 1998, Lisansky-Gomberg 1993), the primary choice of “downers” is not surprising. Khantzian (1985) reports in a study on the self-medication hypothesis that individuals who choose opiates (downers) as their drug of choice report: “opiates helped them to feel normal, calm, mellow, soothed,

and relaxed” (p. 1262). Given the relatively equal proportion of women using the various groups of drugs, it appears that reported abuse does not influence drug of choice.

Discussion of Results for Research Question Two

Research Question #2: Do women who report sexual abuse, physical abuse, physical and sexual abuse, or no abuse report different frequencies of drug use?

No association was found between the abuse groups and frequency of drug use. Several women in each group (7.7%-14.3%) reported no use for the last 30 days. This is a curious fact, since the women were interested in going through a drug rehabilitation program and one could assume that every participant had used substances at least once during the last month. One could also wonder if the participants felt comfortable enough telling the truth at intake and if the data were truly representative. Some of the women were court-ordered for treatment. Those women could have already stopped using drugs in anticipation of treatment, but were still required to participate. However, what is again striking in research question two is that the four abuse groups report similar frequencies of use. This might mean that the type of trauma experienced does not correlate with the frequency of drug use. This data cannot show, however, whether the intensity of trauma correlates with the frequency of drug use. This would be an interesting question to explore in a further study. Jantzen et al. (1998), for example, discovered in his study on pregnant women and cocaine use that “rates of lifetime and perinatal cocaine use were not related to the frequency of abuse, but were related to a measure of severity of physical and sexual abuse” (322).

Discussion of Results for Research Questions Three through Nine:

Research Questions #3-#9: Do women who report sexual abuse, physical abuse, sexual and physical abuse, or no abuse report different levels of problems related to alcohol use/ drug use/ employment/ family-social life/ legal issues/ medical issues/ and/or psychiatric impairment?

Again, there were no significant differences found for any of the research questions three through nine. The non-abuse group seems to fare similarly in problem severity as did the three abuse groups. This finding would suggest that clients who report no abuse have as many problems related to areas of alcohol use, drug use, employment, family-social life, legal issues, medical issues, and psychiatric impairment as do clients who report abuse. This would indicate that non-abused clients are as problem-laden as abused clients. Positively expressed, one could say abused clients are as resilient in the seven problem areas as are non-abused clients.

Discussion of Results for Research Questions Ten through Eighteen

Research Questions #10 - #18: Do women who report sexual abuse, physical abuse, or no abuse display different levels of somatization/ obsessive- compulsive behavior/ interpersonal sensitivity/ depression/ anxiety/ hostility/ phobia/ paranoid ideation and/or psychoticism?

For research questions #10 - #18, there was only one subscale on which significant differences were found. Research question #12, which analyzed interpersonal sensitivity, showed significant differences between sexual abuse only and no abuse/physical abuse only. Sexually abused clients answered the following questions on

the interpersonal sensitivity scale of the SLC-90 with significantly higher average scores than the other groups.

How much were you distressed by

Feeling critical of others

Feeling shy or uneasy with the opposite sex

Your feelings being easily hurt

Feeling others do not understand you or are unsympathetic

Feeling that people are unfriendly or dislike you

Feeling inferior to others

Feeling uneasy when people are watching or talking about you

Feeling very self-conscious with others

Feeling uncomfortable about eating or drinking in public

This group obviously felt uncomfortable about how other people perceive them. Clients felt easily judged and worried about others having a negative impression of them. One can assume that those clients feel more easily intimidated in social situations and might become stressed and anxious when encountering social situations. Brabant et al. (1997) describe the psychological consequences for victims of sexual assault as feelings of increased powerlessness, betrayal, shame, guilt, and negative self-image. Those feelings would certainly fit clients scoring high in the Interpersonal Sensitivity Scale.

It is interesting that the sexual abuse group differs from the physical and no abuse group. In this data set, physically and non-abused clients scored significantly lower on problems in interpersonal sensitivity than did sexually abused clients. This data would suggest that sexually abused clients who have not been physically abused are more

insecure about their relationships with others than physically or non-abused clients. Expressed differently, non-abused and physically abused clients would not feel as anxious about interpersonal contacts as sexually abused clients.

One could expect that the physically and sexually abused clients would have at least the same amount of difficulties as the sexually abused only clients, since physical abuse is considered a psychological stressor in the literature (Livingston, 1987; Chu and Dill, 1990). It is curious that the physically and sexually abused clients score lower than the sexually abused only group. One explanation could be that women in the sexual abuse only group experienced more severe trauma than clients in the other groups.

Limitations

The study did not find many differences between clients who report an abuse history and those who do not. It might be that there are in fact no major differences between the drug use profiles of women who report abuse and those who do not. It might also be that the lack of differences could be due to a limitation in the way the data were gathered. The original data set was designed to evaluate a couple's component in treatment, not abuse. The assessment for abuse thus only consisted of one question set in the intake interview asking if the interviewee had experienced abuse, and if so, whether the abuse was physical, sexual, or both.

The literature in childhood sexual abuse clearly points to the need for a more thorough questioning technique to gather reliable information about abuse, since fear of rejection, shame, and lack of trust may hinder individuals from disclosing a history of childhood abuse (Jantzen et al., 1998). By simply asking several times about childhood

abuse during substance abuse treatment, Rohsenhow et al. (1988) saw reports of childhood sexual abuse increase from 20% to 77% for females. Miller et al. (1987) also stressed asking multiple questions about abuse to get a more accurate response about childhood abuse. One of the reasons clients start reporting abuse more freely after repeated questioning might be that they feel more trusting and comfortable with the assessment and the assessor. Boyd (1993) also stresses the importance of timing and trusting rapport between the assessor and the client: “for instance, *who* – and *when* they ask (the sexual abuse questions) – may determine what will be reported” (434).

For this study, one might assume that the percentages of childhood abuse reported would be higher if the assessor had inquired about it at different times during treatment. However, the percentages of abuse in this study (12% physical abuse only, 15% sexual abuse only, and 22% physical and sexual abuse in first sample; 10% physical abuse only, 15% sexual abuse only, and 20% physical and sexual abuse in second sample) are consistent with reported percentages in other substance abuse studies (Simpson & Miller, 2002).

Clinical Implications

The overall finding of this study is that women who report sexual and/or physical abuse in substance abuse treatment might be largely indistinguishable from each other in terms of drug of choice, frequency of drug use, and problem severity of drug use. The drugs of choice, the frequency of use, and the problems in daily life associated with drug use might not serve as hints for counselors to suspect an abuse history. The data suggests that the drug and alcohol component of women’s treatment may be useful to women

regardless of their abuse status. It does not preclude, however, specific treatment for PTSD or other sequelae of abuse.

The data in this study further suggest that women who report having been sexually abused might be more anxious and mistrusting about their interpersonal relationships than other clients. In order to uncover abuse, counselors would have to carefully screen women and ask them repeatedly throughout treatment about past abuse (Rohsenow et al., 1988; Miller et al., 1987), keeping in mind that abused clients might take a long time to build trust in the counseling relationship. Another implication for treatment might be that sexually abused clients would be apt to feel nervous and insecure when being treated in group settings, since the number of interpersonal relationships would be much higher than in a therapist–client-only relationship. Most substance abuse treatment centers rely heavily on group treatment settings. Kelly et al. (2001) mentioned the stress on abused women having to participate in mixed-gender treatment settings. This study would go one step further and suggest that abused women, particularly sexually abused women, might even benefit from a one-to-one counseling setting, especially in the beginning stages of treatment.

The data also suggest for therapists to be especially aware of their abused clients' difficulties in relationship issues. Therapists must be patient and understanding about their clients' trust issues and see them in light of their abuse history.

In this study 49% of women reported at intake that they had either experienced sexual or physical childhood abuse or both. This might be an under-representation of the true number of abuse victims. However, this study reports that at least one in two of the interviewed women see themselves as survivors of childhood abuse. This study supports

earlier findings (Simpson & Miller, 2002) in pointing to the large number of female childhood abuse survivors among women seeking substance abuse treatment. Counselors should be aware of the likelihood that their female substance abuse clients might also very well deal with issues of childhood abuse. Counselors need training to be able to assess for and treat issues related to childhood abuse.

Future Research

It would be interesting to test the hypothesis about sexually abused women benefiting from one-to-one therapy. A qualitative study could inquire about the experiences of women in substance abuse treatment who reported a sexual abuse history. Did they go through group and individual therapy? How did they experience group treatment? Would they have felt safer in a therapist-client-only relationship? What were their negative and positive experiences in treatment? Was their abuse history addressed in treatment? If yes, how valuable was this to the client? If a qualitative study supports the hypothesis, a wider quantitative study could be used to get more data on this subject.

It would also be interesting to repeat the study in designing a quantitative study to retest the profiles of women who report abuse vs. those who do not. It would be important to carefully interview women about their history of abuse to collect reliable data on the frequency of abuse. Women should have a chance to build a trusting relationship with the interviewer over time. Questions about childhood abuse should be asked repeatedly throughout treatment. It would also be helpful to ask women if they experienced certain types of sexual behavior (e.g. having ever been unwantedly touched, having ever had unwanted intercourse). This would define sexual abuse for the study and

not leave the definition up to individual interpretation. With a better certainty of the abuse history of the participants, there might be more significant differences between non-abused and abused participants. It would also be interesting to examine any non-abuse-related difference between the abuse and non-abuse groups. Were they, for example, different in socioeconomic background? Would those differences between the groups account for any differences in drug use or psychological functioning? Part of the abuse assessment could also entail severity of childhood abuse. Several researchers found that severity of abuse negatively impacted the coping mechanism of abuse survivors (Briere, 1998; Jantzen et al., 1998; Finkelhor, 1990). In looking at the drug abuse profile, one could compare more severely abused clients vs. those who report milder forms of abuse.

Summary

This study looked at a variety of variables to compare the profiles of women in substance abuse treatment who reported sexual or physical abuse versus those who did not. The study did not find significant differences in either drug choice, problem severity, or frequency of drug use. In the area of psychological problems, the study did confirm a significant difference in interpersonal sensitivity between participants who reported a sexual abuse history versus the other abuse groups. This finding suggests that women with a sexual abuse history are more mistrusting in their relationships with others. Sexually abused clients might benefit from participating mainly in a therapist-client-only relationship.

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