

The Relationship Between Posttraumatic Stress Disorder and Substance Abuse in Women With a History of Childhood Sexual Abuse Trauma

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When women are provided with an integrated treatment approach for the trauma of childhood sexual abuse (CSA), the opportunity exists to improve treatment outcomes for women that in turn improves their quality of life (Duncan, 2004). When treatment for CSA is integrated into the treatment of substance abuse/use, the outcome for women who enter substance abuse programs is decreased risk of relapse (Rowan & Foy, 1993). And, when treatment for substance abuse/use is integrated into treatment for childhood sexual abuse trauma (CSAT), the outcome for women is a decreased risk for future victimization (Duncan, 2004). The investment in treatment in terms of real dollars spent through insurance, copayments, or out of pocket direct payment has the opportunity to be of greater value to as well as improved cost-effectiveness for women when an integrated approach is provided. In general, an integrated treatment approach for the trauma of CSA and its long-term consequences improves the overall health and well-being of women—two worthwhile goals for any treatment program.

A secondary outcome for women is that their children benefit from this integrated treatment as well. Child maltreatment is one type of violence associated with substance abuse/use by mothers that occurs within families (Widom & Hiller-Sturmhofel, 2001). Childhood sexual abuse is known to be an intergenerational trauma that effects the next generation of children when it occurs within the family (Duncan, 2004). Children whose mothers were both sexually abused in childhood and who use/abuse substances are at twice the risk for maltreatment than children whose mothers were either sexually abused or who use substances only. When CSAT and substance abuse/use occur together they can increase the risk of repeated lifetime victimization to women and consequently their children.

Women sexually abused as children who use or abuse substances are a specific group of at-risk clients who require specialized treatment. Therefore, they

benefit from a certain knowledge, experience, and understanding of the complexity of their presenting problems when they come for treatment care and assistance regardless of whether they enter therapeutic treatment for CSA or substance abuse/use treatment programs. To improve the outcomes of singular (nonintegrated) treatments for women, there needs to be a concerted effort for substance abuse programs to assess women for childhood sexual abuse trauma. Equally important is that when women seek therapeutic treatment for childhood sexual abuse trauma, substance abuse/use issues need to be assessed as well. Assessment is the first step that precedes the development and implementation of integrated treatment plans that provide therapeutic strategies to address both substance abuse and CSAT for women, and therein lies both the challenge and the dilemma.

Posttraumatic Stress Disorder (PTSD)

A diagnosis of posttraumatic stress disorder (PTSD) was first developed by the American Psychiatric Association to understand and categorize the symptoms of Vietnam veterans who were returning from war and either began to exhibit or continued to experience disruptive thoughts, emotions, and behaviors reminiscent of their traumatic experience as soldiers (Rowan & Foy, 1993). Over the years, the diagnostic category of PTSD has been applied for use to all traumatic experiences without regard to whether it was accurate and valid to do so and without considering gender differences in the experience of trauma, the specific trauma that was experienced, the context in which the trauma occurred, and the age and stage of development of the person experiencing the trauma. Judith Herman (1997) was among the first to challenge PTSD as a credible and valid diagnosis for understanding the severe traumas that she described as prolonged, repeated trauma. In particular, Herman discussed both the societal and professional bias that can exist about chronic childhood traumas as well as

the knowledge and experience that is needed to understand the consequences of prolonged, repeated traumas such as sexual abuse and the witnessing of domestic violence. She explained that PTSD is a far too simple diagnosis for complex traumas and proposed that traumas such as childhood sexual and physical abuse need their own name to be understood. She put forth the term *complex posttraumatic stress disorder* and outlined seven categories that describe a more in-depth understanding of prolonged, repeated traumas.

It is estimated that 50 to 70% of women who seek mental health services report childhood sexual abuse trauma. Thus Karen Duncan (2004) challenged the American Psychiatric Association's absence of a primary diagnostic category for the female experience of childhood sexual abuse trauma. Duncan further questioned the absence of a primary diagnostic category for childhood sexual abuse based on national statistics and the reported rates of prevalence for CSAT within the general population of the United States. Given that diagnosis is the first step toward credible treatment, Duncan posed the question, "How can treatment be provided to such a significant number of women without a viable diagnosis?" Duncan proposed a specific diagnostic category for this particular trauma when experienced by women as "childhood sexual abuse, female experience." The American Psychiatric Association's singular diagnostic category of PTSD continues to be challenged as more specialized knowledge about the typology of traumas is disseminated and as research and clinical reports substantiate that not all traumas are the same nor are the individuals who experience them, that different traumas occur within different contexts, and that childhood trauma differs from that which is experienced in adulthood. CSAT as a specific childhood trauma, with long-term consequences to the developing child, raises critical questions about the application of PTSD to all traumas (Duncan, 2004; Rowan & Foy, 1993).

However limited it may be, PTSD as the current diagnostic category for trauma symptoms it is often the focus of research investigating the relationship between CSAT and its long-term consequences to the lives of women. Studies have shown that screening women for PTSD symptoms when they enter substance abuse programs is one way of identifying women presenting with this childhood trauma (Fullilove et al., 1993, Kofoed, Friedman, & Peck, 1993). One of the problems with these studies is that most do not qualify the specific PTSD symptoms (versus the meeting of diagnostic criteria for PTSD) relevant to the screening of women for CSAT. Another problem is that the measures used in studies for PTSD determination are not consistent from study to study. Other studies have indicated that

even screening women for depressive or anxiety disorders along with substance abuse can also identify CSAT since depression and anxiety frequently coexist with CSAT and with PTSD (Bifulco, Brown, & Adler, 1990; Grice, Brady, Dustan, Malcolm, & Kilpatrick, 1995). Also, women report childhood sexual abuse trauma and substance abuse/use without PTSD symptoms so if CSAT has occurred to women who are not reporting PTSD symptoms, then this group of women are not identified even if they may be experiencing other traumatic consequences of CSA along with substance abuse/use (Fullilove et al., 1993). These conclusions indicate that PTSD screening alone may not be effective for consistent identification of this trauma in women and may be limited in identifying its link to substance abuse/use in women within the general population who do not meet the criteria for PTSD, but who have experienced the trauma of childhood sexual abuse.

One can easily see the dilemma: What is an accurate and consistent means of assessing for CSAT with women who come to substance abuse/use treatment programs regardless of PTSD symptoms? Direct questioning of women at the time of an intake interview has been indicated clinically and through research studies to be both an accurate, consistent, and simple screening tool with women when assessing for CSAT (Briere & Zaidi, 1989; Duncan, 2004). However, initial screening for this trauma is not the same as asking for in-depth disclosure nor should it be. Identification of the need for childhood sexual abuse trauma treatment (CSATT) is proposed as possible for integration into substance abuse/use programs for women with the goal to provide initial individual screening and assessment, along with the beginning of a first stage of treatment delivered in a group format.

Integration of CSATT With Substance Abuse Treatment Programs

Substance abuse/use (SA/U) programs are often brief inpatient programs lasting for up to 3 to 5 days with a focus on detoxification, addiction education, acclimating women to the Twelve-Step programs, and planning for discharge with a strategy for maintaining sobriety. Depending on the specific focus of assessment within the SA/U treatment program, an initial psychiatric assessment by a psychiatrist may or may not be provided to women upon entering SA/U programs. However, even when psychiatric assessment is provided, the psychiatrist may be more interested in determining if the individual presents with active psychotic or severe personality disorder that would prevent admission to the SA/U program rather than

necessarily assessing for underlying CSAT or how SA/U mediates the traumatic consequences for women. Therefore, psychiatric assessment, while worthwhile, is also limiting the assessment of CSAT for women in SA/U treatment programs and consequently their treatment outcomes.

Another factor is the psychiatrist working with a SA/U program may not have the necessary education and training to assess for CSAT accurately. Given the professional bias that can still exist about believing CSAT when it is reported by women and the lack of both undergraduate and graduate training about CSAT across professional degree programs in the United States and other countries, it is understandable that a psychiatrist, qualified to assess for psychiatric disorders, may not be qualified to assess for CSAT. Therefore, accurate CSAT screening, assessment, and treatment for women are not necessarily within the majority of protocols for SA/U treatment programs even though substantial research exists supporting the benefit to women when a process of identifying CSAT is made available to women (Gil-Rivas, Fiorentine, Anglin, & Taylor, 1997; Najavits et al., 1998).

Since most substance abuse/use treatment programs are provided within a therapeutic group protocol rather than an individual therapeutic protocol, which is often the case for CSAT treatment, the focus of discussion here is on how to integrate CSAT screening, assessment, and treatment into SA/U programs and how CSAT can utilize SA/U programs to refer women for assessment and treatment with the goal of returning to or cotreating CSAT as an integrated approach for women. The outcomes of relapse prevention, a decrease of lifetime victimization, and overall improvement in the quality of life for women is presented as well.

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