



Substance Use and Sexual Violence

Building Prevention and Intervention Responses

A G U I D E F O R C O U N S E L O R S A N D A D V O C A T E S

PCAR
PENNSYLVANIA COALITION AGAINST RAPE



Leadership, Advocacy, Action

The Pennsylvania Coalition Against Rape is a non-profit organization working at the state and national levels to prevent sexual violence. Since its inception in 1975, PCAR has been at the forefront of the anti-sexual violence movement, utilizing its voice to advance the rights of victims and to effect critical change through its active role in public policy, education, and prevention. At the core of PCAR's success is its statewide network of 52 sexual violence centers that provide counseling, crisis intervention, referral services; hospital, court and police accompaniment; prevention education, community outreach, and more. Together, PCAR and its member programs will continue to educate society and its systems about sexual violence and to advocate for better treatment and empowerment of victims of sexual assault.

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Building Prevention and Intervention Responses

A GUIDE FOR COUNSELORS AND ADVOCATES

by Sarah Dawgert

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A G U I D E F O R C O U N S E L O R S A N D A D V O C A T E S

Introduction & Understanding Addictions

Introduction

The relationship between sexual violence and addiction is a complex and often reciprocal one. Addictions of many forms, such as addiction to food, gambling, sex and exercise may develop in response to sexual violence. This guide will focus on drug and alcohol use, abuse and addiction as it relates to sexual violence.

For example, did you know that:

- A high percentage of adult victims were intoxicated at the time of the assault and therefore unable to give consent (Abbey, Clinton-Sherrod, McAuslan, Zawacki, & Buck, 2003; Abbey, Zawacki, Buck, Clinton & McAuslan, 2001; Scalzo, 2007). This may be misunderstood as the cause of the assault. However, perpetrators often use substances such as alcohol or drugs to incapacitate their victims in order to facilitate a sexual assault (Lisak, 2005; Frost, 2002; Scalzo, 2007; United Educators, 2003).
- According to one study (Kilpatrick, Edmunds, & Seymour, 1992), when compared with non-victims, rape victims are:
 - 3.4 times more likely to use marijuana
 - 5.3 times more likely than non-survivors to use prescription drugs for non-medical purposes
 - 6.4 times more likely to use cocaine
 - 10 times more likely to use hard drugs other than cocaine
- Victims of sexual assault, including childhood sexual abuse, may use alcohol or drugs to numb or escape from painful memories or PTSD symptoms. When they attempt to stop using the drug, symptoms reappear and the likelihood of relapse increases (Caron Treatment Centers, 2004; Clark, Masson, Delucchi, Hall, & Sees, 2001; The Massachusetts MOTHERS Project, 1997; Washington Coalition of Sexual Assault Programs [WCSAP], 2005).
- Studies indicate that those working with people experiencing PTSD and drug addictions treat these conditions concurrently (Browne, Salomon, Bassuk, Dawson & Huntingdon, 2004; Caron Treatment Centers, 2004; National Center for PTSD, 2008; WCSAP, 2005).

Sexual violence can happen to anyone, regardless of age, race, income level, ethnicity, religion, sexual orientation and education level. However, certain vulnerabilities or risk factors contribute to sexual violence victimization and perpetration; consuming alcohol and drugs is among those factors (The Centers for Disease Control and Prevention [CDC], 2007). Like sexual violence, drug and alcohol abuse and addiction crosses all societal boundaries and is an issue in all communities in Pennsylvania and across the nation.

Perpetrators of sexual violence often target individuals who lack power in the larger society, such as people with addictions; women; people with disabilities; elders; children; teens; people of color; lesbian, gay, bisexual, and transgendered individuals; immigrants, migrants, and refugees; individuals who speak English as a second language; people living in poverty; people with criminal records; the homeless; sex workers; prisoners and others. Perpetrators deliberately target individuals who will be less likely to report the assault or when they do tell someone, less likely to be believed or deemed credible.

Substances may have been used by the perpetrator to facilitate a sexual assault. Someone may have been using or abusing substances before an assault occurred, or started using substances as a coping strategy following an assault. Substance abuse and sexual victimization both carry a great deal of social stigma in and of themselves, and when a victim/survivor holds both, the stigma can be especially difficult to overcome. This stigma can compound the challenges of the healing process and increase feelings of blame, shame and isolation.

The intention of this guide is to enhance the service capacity of advocates and counselors in rape crisis centers by raising awareness and providing resources about drug and alcohol abuse and addictions. Included in this guide is information about drug and alcohol use, abuse and addiction in general; the intersections of substance abuse and sexual violence; information on treatment options; considerations for rape crisis centers; and state and national resources.

Increasing knowledge, awareness and understanding of these issues will allow advocates and counselors to better fulfill a shared mission to empower all victims/survivors. Due to the reciprocal relationship between substance abuse and sexual violence, it is possible that preventing one can prevent the other. Actively working together with substance abuse providers can contribute to improved intervention and prevention efforts in both fields.

Understanding Drug and Alcohol Addiction

Many rape crisis centers do not provide specific services to victims/survivors who abuse or are addicted to drugs and alcohol. Therefore, it is important to begin the discussion in this guide with basic information on substance abuse and addiction. Trends and data can help frame and contextualize the issues that rape crisis providers must deal with when confronted with issues of sexual violence and substance use, abuse and addiction.

WHAT CAUSES ADDICTION?

The specific causes of substance abuse and addiction are unclear, though they seem to be a combination of hereditary (family history and genes), environmental, and social factors such as family, friends, peer pressure and culture (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2001; National Mental Health Association [NMHA], 2008).

Many people mistakenly view alcohol and drug addiction as strictly a social problem and may characterize those who take drugs as morally weak and lacking willpower. However, addiction has little to do with willpower. What people often underestimate is the complexity of drug and alcohol addiction—that it is a disease that impacts the brain and because of that, stopping drug abuse is not simply a matter of willpower (National Institute on Drug Abuse [NIDA], 2008).

Users are in the grip of a powerful “craving,” or uncontrollable need, for alcohol and/or drugs that overrides their ability to stop: this need can be as strong as the need for food or water (NIAAA, 2001). When users attempt to withdraw from the drug they may experience physical and psychological withdrawal symptoms.

Why do some people become addicted, while others do not?

No single factor can predict whether or not a person will become addicted to drugs (NIAA; NIDA; NMHA). Risk for addiction is influenced by a number of factors, with the presence of more risk factors increasing the chance that taking drugs can lead to addiction. Some of these factors include:

- **Biology:** the genes that people are born with—in combination with environmental influences—account for about half of their addiction vulnerability. Additionally, gender, ethnicity and the presence of other mental disorders may influence risk for drug abuse and addiction (NIDA).

Many people mistakenly view alcohol and drug addiction as strictly a social problem and may characterize those who take drugs as morally weak and lacking willpower. However, addiction has little to do with willpower.

Caroline, Age 26

In January 2006, I was sexually assaulted on my way home from the nightclub HOME in the Meat Packing District of NYC.

As I left the club, several limousines were parked outside, and one of the drivers called to me and offered to drive me home for the same cost as a taxi. I agreed and proceeded to enter the cab of the limousine. I believe I was visibly intoxicated. The driver drove to a remote street, got out of the car, entered the back of the limousine and locked the door. He offered me a joint, which I declined. He smoked part of the joint then he pulled my dress up and yanked down my underwear and proceeded to rape me.

I felt trapped and helpless; I couldn't move or scream. I panicked and froze in place while he assaulted me. I could do nothing to protect myself. While I did not protest, this was not consensual sex.

The next thing I can remember is walking back to The Four Seasons Hotel where I was staying, having been dropped off several blocks away.

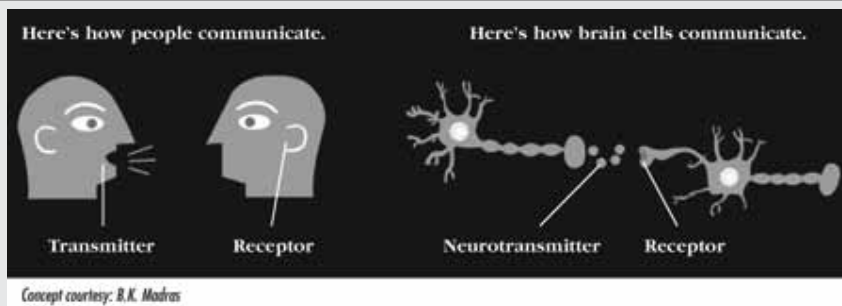
I did not report the sexual assault at the time because I was embarrassed at having been intoxicated, and I knew the police would just laugh at me like I was some young drunk girl. I also felt at the time that it was my fault for being intoxicated and making a stupid decision. But, looking back, I definitely think the driver was targeting intoxicated women coming out of the club, which is quite frankly disgusting.

Since then I've been through treatment for my drinking and have accepted that I am an alcoholic. And I've met countless women who have experienced similar acts of sexual violence. It is unfortunate that while we are in our active addictions, we cannot see that these experiences aren't our fault, that we are disproportionately targeted by perpetrators of sexual assault. But in recovery, we have the opportunity to begin to believe that it wasn't our fault and to heal.

- Environment: a person’s environment includes many different influences—from family and friends to socioeconomic status and quality of life in general. Factors such as peer pressure, physical and sexual abuse, stress and parental involvement can greatly influence the course of drug abuse and addiction in a person’s life (NIDA).
- Development: genetic and environmental factors interact with critical developmental stages in a person’s life to affect addiction vulnerability. Although taking drugs at any age can lead to addiction, the earlier that drug use begins, the more likely it is to progress to more serious abuse (NIDA).
- Adverse childhood experiences (ACEs) that have not healed with time and that are overwhelmingly concealed from awareness by shame, secrecy and social taboo (Felitti, 2004) can influence risk for drug and alcohol addiction.

What happens to your brain when you take drugs?

Drugs are chemicals that tap into the brain’s communication system and disrupt the way nerve cells normally send, receive, and process information. There are at least two ways that drugs are able to do this: (1) by imitating the brain’s natural chemical messengers, and/or (2) by over stimulating the “reward circuit” of the brain.

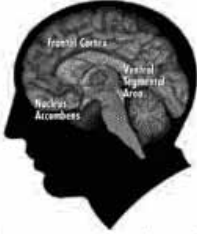


Nearly all drugs, directly or indirectly, target the brain’s reward system by flooding the circuit with dopamine. Dopamine is a neurotransmitter present in regions of the brain that control movement, emotion, motivation, and feelings of pleasure. The overstimulation of this system, which normally responds to natural behaviors that are linked to survival (eating, spending time with loved ones, etc), produces euphoric effects in response to the drugs. This reaction sets in motion a pattern that “teaches” people to repeat the behavior of abusing drugs.

Although it is true that for most people the initial decision to take drugs is voluntary, over time the changes in the brain caused by repeated drug abuse can affect a person's self control and ability to make sound decisions, and at the same time send intense impulses to take drugs (NIDA).

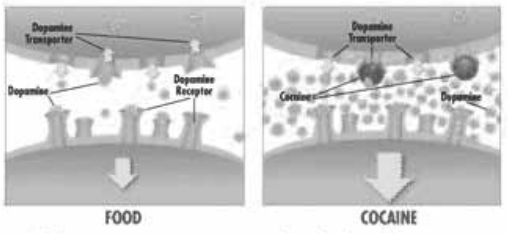
ALL DRUGS OF ABUSE TARGET THE BRAIN'S PLEASURE CENTER

Brain reward (dopamine) pathways



These brain circuits are important for natural rewards such as food, music, and art.

All drugs of abuse increase dopamine



Typically, dopamine increases in response to natural rewards such as food. When cocaine is taken, dopamine increases are exaggerated, and communication is altered.

As a person continues to abuse drugs, the brain adapts to the overwhelming surges in dopamine by producing less dopamine or by reducing the number of dopamine receptors in the reward circuit. As a result, dopamine's impact on the reward circuit is lessened, reducing the abuser's ability to enjoy the drugs and the things that previously brought pleasure. This decrease compels those addicted to drugs to keep abusing drugs in order to attempt to bring their dopamine function back to normal. And, they may now require larger amounts of the drug than they first did to achieve the dopamine high—an effect known as tolerance.

Long-term abuse causes changes in other brain chemical systems and circuits as well. Glutamate is a neurotransmitter that influences the reward circuit and the ability to learn. When the optimal concentration of glutamate is altered by drug abuse, the brain attempts to compensate, which can impair cognitive function. Drugs of abuse facilitate nonconscious (conditioned) learning, which leads the user to experience uncontrollable cravings when they see a place or person they associate with the drug experience, even when the drug itself is not available. Brain imaging studies of drug-addicted individuals show changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control. Together, these changes can drive an abuser to seek out and take drugs compulsively despite adverse consequences—in other words, to become addicted to drugs.

National Institute on Drug Abuse. (2007). Drugs, brains, and behavior: the science of addiction. Washington, D. C.: Author. Available at <http://www.drugabuse.gov/scienceofaddiction/sciofaddiction.pdf>

Addiction is a disease

Addiction is a progressive and treatable disease with signs, symptoms and complications that progress through early, mid and late stages; in its early stage, it is frequently difficult to identify (Caron Treatment Centers, 2008).

Addiction is a chronic, often relapsing brain disease that causes compulsive drug seeking and use despite harmful consequences to the individual that is addicted and to those around them. The abuse

of drugs leads to changes in the structure and function of the brain. Although it is true that for most people the initial decision to take drugs is voluntary, over time the changes in the brain caused by repeated drug abuse can affect a person's self control and ability to make sound decisions, and at the same time send intense impulses to take drugs (NIDA).

These changes in the brain make it challenging for a person who is addicted to stop abusing drugs. Fortunately, there are treatments that help people to counteract addiction's powerful disruptive effects and regain control; treatment approaches that are tailored to each patient's drug abuse patterns and any co-occurring medical, psychiatric, and social problems can lead to sustained recovery and a life without drug abuse (NIDA).

Similar to other chronic, relapsing diseases, such as diabetes, asthma, or heart disease, drug addiction can be managed successfully - although it is not uncommon for a person to relapse and begin abusing drugs again. **Relapse does not signal failure. It indicates that treatment should be reinstated or adjusted, or that alternate treatment is needed to help the individual regain control and recover (NIDA).**

WARNING SIGNS AND SYMPTOMS OF ADDICTION

There are many symptoms and warning signs of substance abuse including: using the substance on a regular basis (daily, weekends or in binges), craving, tolerance for the substance, failed attempts to stop using the substance, physical and/or psychological dependence, withdrawal symptoms (delirium tremens, trembling, hallucinations, sweating and high blood pressure), and in some cases dementia (NIAAA, 2001; NMHA).

The DSM-IV (Diagnostic Statistical Manual IV) lists seven warning signs of addiction:

Addiction (termed substance dependence by the American Psychiatric Association) is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
 - (a) A need for markedly increased amounts of the substance to achieve intoxication or the desired effect.
 - (b) Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
 - (a) The characteristic withdrawal syndrome for the substance.

Recent data show high school seniors in Pennsylvania drink, smoke, and use other drugs more than their counterparts across the country, with high rates of binge drinking reported among these students, a behavior typically highest among those in rural areas.

- (b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than intended.
 4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
 5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
 6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
 7. The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

PREVALENCE AND INCIDENCE OF SUBSTANCE ABUSE

Substance abuse affects an estimated 25 million Americans, and an additional 40 million people are affected when those who are affected indirectly, such as families of abusers and those injured or killed by intoxicated drivers, are taken into account (NMHA). Alcoholism afflicts 10 million adults and 3 million children, while an estimated 12.5 million Americans are addicted to other drugs (NMHA).

Trends in drug and alcohol use in Pennsylvania

Recent data show high school seniors in Pennsylvania drink, smoke, and use other drugs more than their counterparts across the country, with high rates of binge drinking reported among these students, a behavior typically highest among those in rural areas (Roehrich, Meil, Simansky, Davis & Dunne, 2007). Marijuana and “club drugs” such as Ecstasy have shown decreases in Pennsylvania among youth (Roehrich et al., SAMHSA, 2007). In fact, Pennsylvania showed significant decrease from 2005-2006 to 2006-2007 (at the 5 percent level of significance) in the percentage of all persons aged 12 or older who used an illicit drug in the past month and in the rates of past year illicit drug dependence or abuse among the 18 to 25 year old age group (SAMHSA, 2007).

Once viewed as urban problems, crack cocaine, cocaine, and heroin appear to be readily available across the state, although their use remains relatively low and stable. Nevertheless, these drugs are of major concern for law enforcement due to their availability and extent of use (Roehrich et al.).

Inhalant use is increasing nationally and in Pennsylvania. Inhalant use is equally high in rural and urban areas (Roehrich et al.).

Methamphetamine production is greatest in rural regions of Pennsylvania; however, it is spreading across the state. Of special

concern are its harmful effects on the user, the dangers associated with its production, and its responsibility, along with heroin, for a growing number of treatment admissions across the state (Roehrich et al.).

According to the Substance Abuse and Mental Health Services Administration [SAMHSA] (2006), for Pennsylvanians aged 12 and older:

- 849,000 or 8.14% were dependent upon or abused alcohol or illicit drugs in the past year, with 76,000 of those aged 12-17 years;
- 798,000 or 7.65% reported past month illicit drug use, with 93,000 of those aged 12-17 years;
- 5,462,000 or 52% reported alcohol use and 2,411,000 or 23% reported binge alcohol use within the past month, with 168,000 and 103,000 respectively, of those aged 12-20 years.

These numbers are significant for the sexual violence field in Pennsylvania since people who use drugs and alcohol are at greater risk for both perpetration and victimization (CDC). Additionally, many of these people will have had experiences of sexual violence prior to their abuse of drugs and alcohol.

Trends in drug and alcohol use nationally

In the United States, alcohol is one of the most commonly used substances (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2008; SAMHSA, 2007). More than 80% of Americans report having drunk alcohol at some point in their lives with use as high as 90% among young adults (NIAAA, 2008).

National surveys strongly indicate that drug use among women is increasing, often at higher rates than for men.

According to the 2007 National Survey on Drug Use and Health (NSDUH), for persons aged 12 and older in the United States:	
Alcohol	Illicit drugs
<p>51% (126.8 million people) reported being past month drinkers of alcohol (At least one drink in the past 30 days)</p> <p>23.2% (57.8 million people) participated in binge use of alcohol in the past month (Five or more drinks on the same occasion on at least 1 day in the past 30 days)</p> <p>6.9% (17.0 million people) reported heavy drinking (Five or more drinks on the same occasion on each of 5 or more days in the past 30 days)</p>	<p>8.1% (19.9 million people) had used an illicit drug in the past month</p> <p>Of those:</p> <p>5.9% used marijuana during the past month; 35.3% (5.1 million people) of these used the drug on 20 or more days in the past month) and 10.2% reported marijuana use in the past year (14.2% of these used marijuana on 300 or more days within the past 12 months)</p> <p>2.8% (6.9 million people) used psychotherapeutic drugs non-medically. In addition to the estimated 5.2 million non-medical users of pain relievers, 1.8 million used tranquilizers, 1.1 million used stimulants, and 346,000 used sedatives</p> <p>0.8% (2.1 million people) used cocaine in the past month and 2.4% used cocaine in the past year</p> <p>0.4% (1 million people) used hallucinogens in the past month, including 0.2% (503,000) who had used Ecstasy</p>
7.6% were dependent on or abused alcohol in the past year	2.8% were dependent on or abused illicit drugs in the past year

Marijuana is the most commonly used illicit drug (SAMHSA, 2007). While it is widely used, it is seen as less of a threat by law enforcement than cocaine and heroin due to their availability, extent of use and the violence associated with these drugs, especially with the crack cocaine trade.

Nationally, the use of MDMA or Ecstasy has been declining (NIDA; Roehrich et al.), as has the use of methamphetamine (Roehrich et al.). Another study found that while lifetime use of Ecstasy increased from 10.2 million persons (4.3%) in 2002 to 12.4 million (5%) in 2007, past year use of Ecstasy decreased from 3.2 million (1.3%) to 2.1 million (0.9%) over the same period (SAMHSA, 2007).

An estimated 2.7 million persons used an illicit drug for the first time within the past 12 months; this averages to more than 7,000 initiates per day (SAMHSA, 2007). Over half (56.2%) reported that their first drug was marijuana, 30.6% reported psychotherapeutic drugs, 10.7% reported inhalants, and 2.2% reported hallucinogens (SAMHSA, 2007).

Among people who used pain relievers non-medically in the past 12 months, 56.5% said they got the pain relievers they most recently used from a friend or relative for free (8.9% bought them from a friend or relative and 5.2% reported stealing them from a friend or relative); 18.1% indicated that they got the drugs from one doctor; 4.1% got pain relievers from a drug dealer or other stranger; and 0.5% said they bought them on the Internet (SAMHSA, 2007). Vicodin is one of the drugs most commonly abused by high school seniors with one in ten reporting non-medical use of Vicodin; one in twenty 12th graders reported non-medical use of OxyContin (SAMHSA, 2006).

Compulsive use of only one substance is actually uncommon (Felitti). Among heavy drinkers aged 12 or older, 32.6% were also current illicit drug users, which is higher than for non-drinkers (SAMHSA, 2006).

The rate of past year dependence on or abuse of alcohol or illicit drugs nationwide was about 9% (SAMHSA, 2007). The percentage of persons aged 12 or older needing but not receiving treatment for alcohol problems was 7.2%, which was almost 3 times larger than the 2.5% of persons needing but not receiving treatment for illicit drug problems (SAMHSA, 2007).

Demographic differences

Gender

National surveys strongly indicate that drug use among women is increasing, often at higher rates than for men (Caron Treatment Centers, 2004). Of first time drug users, 54% were female (SAMHSA, 2007). Though men are more likely to become addicted to drugs and alcohol than are women, women tend to become addicted more quickly than men and to experience negative medical consequences sooner than men (Caron Treatment Centers, 2004; NIAAA, 2001).

Men are more likely than women to have used a psychedelic drug, to have ever used an illegal drug, to develop an addiction to marijuana and alcohol, and to start using drugs and alcohol at an earlier age. (Caron Treatment Centers, 2004).

The rate of current illicit drug use was higher for males than for females (10.4% vs. 5.8%, respectively) with males about twice as likely as females to be past month marijuana users (8% vs. 3.8%) (SAMHSA, 2007). However, males and females had similar rates of past month

Because adolescents' brains are still developing in the areas that govern decision-making, judgment, and self-control, they are especially prone to risk-taking behaviors, including trying drugs of abuse.

use of tranquilizers, stimulants, methamphetamine, sedatives, and OxyContin® (SAMHSA, 2007).

One study found that 56.6% of males were current drinkers, higher than the rate for females (46%). However, among youths aged 12 to 17, the percentage of males who were current drinkers (15.9%) was similar to the rate for females (16.%) (SAMHSA, 2007).

In general, fewer women than men drink (Caron Treatment Centers, 2004; NIAAA, 2008), but women become more impaired after drinking the same amount as men (NIAAA, 2008). In general, men are more likely to drink in social situations and in response to positive emotional feelings, while women are more likely to drink alcohol in isolation, when pressured by an alcoholic partner, or in response to negative emotions (Caron Treatment Centers, 2004).

Affective disorders, such as depression, may appear in women prior to substance abuse, while men are more likely to develop alcoholism first, which may lead to a secondary diagnosis of depression (Caron Treatment Centers, 2004).

Race and Ethnicity

Current illicit drug use varied by race/ethnicity in 2007 among persons aged 12 or older, with rates of 12.6% for American Indians or Alaska Natives, 11.8% for persons reporting two or more races, 9.5% for blacks, 8.2% for whites, 6.6% for Hispanics and 4.2% for Asians (SAMHSA, 2007).

Whites were more likely than other racial/ethnic groups to report current use of alcohol (56%) while the rates were 47.5% for persons reporting two or more races, 44.7% for American Indians or Alaska Natives, 42.1% for Hispanics, 39.3% for blacks, and 35.2% for Asians. The rate of binge alcohol use was 12.6% for Asians, 19.1% for blacks, 23.2% for persons reporting two or more races, 23.4% for Hispanics, 24.6% for whites, and 28.2% for American Indians or Alaska Natives.

Among youths aged 12 to 17 in 2007, whites had higher rates of current alcohol use than any other racial/ethnic group at 18.2%, while 8.1% of Asian youths, 10.1% of black youths, 12.5% of those reporting two or more races, and 15.2% of Hispanic youths used alcohol in the past month (SAMHSA, 2007).

The degree to which an ethnic group has conformed to the dominant American culture is an important predictor of women's drinking across various ethnic and racial groups; those who are more acculturated are more likely to have positive expectations about alcohol and more frequently drink in a wide range of social settings (Caron Treatment Centers, 2004).

Employment Status

Current illicit drug use differed by employment status in 2007. Among adults aged 18 or older, the rate of drug use was higher for unemployed persons (18.3%) than for those who were employed full-time (8.4%) or part-time (SAMHSA, 2007). However, while the rate of past month illicit drug use was higher among unemployed persons compared with those from other employment groups, most drug users were employed - of the estimated 17.4 million current illicit drug users aged 18 or older in 2007, 13.1 million (75.3%) were employed either full or part-time. (10.1%) (SAMHSA, 2007).

Rates of current alcohol use were 62.8% for full-time employed adults aged 18 or older in 2007, higher than the rate for unemployed adults (56.9%). However, the rate of heavy use for unemployed persons was 12.0%, which was higher than the rate of 8.8% for full-time employed persons.

Age

The overall picture of drug abuse by youth in the United States is constantly changing. Because adolescents' brains are still developing in the areas that govern decision-making, judgment, and self-control, they are especially prone to risk-taking behaviors, including trying drugs of abuse (NIDA). Three-fifths of first time drug users (60.1%) were younger than age 18 when they first used (SAMHSA, 2007).

Over half of America's teenagers have tried an illicit drug by the time they finish high school (SAMHSA, 2006). There has been an approximately 17% decline over the last three years in any illicit drug use in the past month by students in the eighth, tenth, and twelfth grades combined (NIDA). Most adolescents progress from alcohol use to marijuana use, with exception of those under age 12 who typically begin substance abuse with use of inhalants or other people's prescription drugs (Harrison, et al.). Underage drinkers were more likely than persons aged 21 or older to use illicit drugs (most commonly marijuana) within 2 hours of alcohol use on their last reported drinking occasion with 15.3% of current underage drinkers (1.6 million persons) on their last drinking occasion (SAMHSA, 2007).

In 2007, rates of past month illicit drug use varied with age: through the adolescent years from 12 to 17, the rates of current illicit drug use increased from 3.3% at ages 12 or 13 to 8.9% at ages 14 or 15 to 16% at ages 16 or 17. The highest rate was among persons aged 18 to 20 (21.6%). The rate was 18.5% among those aged 21 to 25, 12.8% among those aged 26 to 29, and 0.7% among those aged 65 or older (SAMHSA, 2007).

Although adults aged 26 or older were less likely to be current drug users than youths or young adults, there were more drug users aged 26 or older (11.0 million) than in the 12-to-17-year age group (2.4 million) and 18-to-25-year age group (6.5 million) combined (SAMHSA, 2007).

Among the female population, young women have the highest rates of alcohol consumption and alcohol related problems and tend to engage in binge drinking episodes more frequently than other age groups (Caron Treatment Centers, 2004).

Withdrawal symptoms may make someone very ill, so they may continue to use drugs or alcohol to maintain a feeling of stability, to function “normally”, or to not feel sick. Depending on the drug used, withdrawal symptoms may not only make someone physically sick but can also be fatal if withdrawal is not medically monitored.

In 2007, rates of current alcohol use were 15.9% among youth aged 12-17 (3.5% among persons aged 12 or 13, 14.7% of persons aged 14 or 15, 29.0% of 16 or 17 year olds), 50.7% of those aged 18 to 20, and 68.3% of 21 to 25 year olds. Among older age groups, the prevalence of current alcohol use decreased with increasing age, from 63.2% among 26 to 29 year olds to 47.6% among 60 to 64 year olds and 38.1% among people aged 65 or older. (SAMHSA, 2007).

The highest rates of past month alcohol use occurred in the 18 to 25 age group (SAMHSA, 2007). Rates of binge alcohol use in 2007 were 1.5% among 12 or 13 year olds, 7.8% among 14 or 15 year olds, 19.4% among 16 or 17 year olds, 35.7% among persons aged 18 to 20, and peaked among those aged 21 to 25 at 45.9%. The rate decreased beyond young adulthood from 41.8% for young adults aged 18 to 25, 35.1% of 26 to 34 year olds to 18.9% of persons aged 35 or older, 7.6% of persons aged 65 or older (SAMHSA, 2007).

The rate of heavy drinking among persons aged 65 or older was 1.4%; youth binge and heavy drinking rates were 9.7% and 2.3%, respectively. (SAMHSA, 2007).

Among adolescents, a consistent pattern exists of more frequent use of substances among males than females (Harrison, Fulkerson, & Beebe, 1997).

Among the female population, young women have the highest rates of alcohol consumption and alcohol related problems and tend to engage in binge drinking episodes more frequently than other age groups (Caron Treatment Centers, 2004).

Geography

Among persons aged 12 or older, the rate of current illicit drug use in 2007 was 9.3% in the West, 7.9% in the Midwest, 7.8% in the Northeast, and 7.4% in the South. The rates were 8.3% in large metropolitan counties, 8.2% in small metropolitan counties, and 6.7% in nonmetropolitan counties as a group. Within nonmetropolitan areas, the rate was 7.5% in urbanized counties, 6.7% in less urbanized counties, and 4.1% in completely rural counties.

The rate of past month alcohol use for people aged 12 or older in 2007 was lower in the South (46.8%) than in the Northeast (56.0%), Midwest (54.6%), or West (50.8%). Among people aged 12 or older, the rate of past month alcohol use in large metropolitan areas (53.5%) was higher than the 50.9% in small metropolitan areas and 44.0% in nonmetropolitan areas. Binge drinking was equally prevalent in small metropolitan areas (23.4%), large metropolitan areas (23.3%), and nonmetropolitan areas (23.0%). The rates of binge alcohol use among youths aged 12 to 17 were 11.6% in nonmetropolitan areas, 9.4% in small metropolitan areas, and 9.3% in large metropolitan areas.

What do all these numbers mean to rape crisis centers?

Rape crisis centers may benefit from considering the communities they serve and reflecting on the data regarding the prevalence and incidence of substance use, abuse and addiction. The prevalence and persistence of drugs and alcohol may impact the degree to which populations they serve are susceptible to sexual violence and/or may impact programming and services of centers.

COSTS TO SOCIETY AND SELF

The impact of addiction can be far reaching. Untreated substance abuse and addiction add significant costs to individuals, families and communities.

Health costs

Individuals who suffer from addiction often have one or more accompanying medical issues including: cardiovascular and lung disease; stroke; cancer; HIV/AIDS, hepatitis and other infectious diseases; respiratory, gastrointestinal, musculoskeletal, nervous system, and neurological effects; kidney and liver damage; mental health effects; hormonal effects; and mortality (NIDA).

Some of these effects occur when drugs are used at high doses or after prolonged use, however, some may occur after just one use (NIDA).

Beyond the harmful health consequences for the addicted individual, substance abuse can cause serious health problems for others including negative effects of prenatal drug exposure on infants and children, negative effects of second-hand smoke and increased spread of infectious diseases (NIDA).

Withdrawal symptoms may make someone very ill, so they may continue to use drugs or alcohol to maintain a feeling of stability, to function “normally”, or to not feel sick. Depending on the drug used, withdrawal symptoms may not only make someone physically sick but can also be fatal if withdrawal is not medically monitored. Physical symptoms can cause significant illness and death and include seizures; delirium tremens, characterized by hallucinations, mental confusion, and disorientation; cognitive impairment; cardiovascular complications; and chronic memory disorder (Trevisan, Boutros, Petrakis, and Krystal, 1998). Psychiatric problems associated with withdrawal include anxiety, depression, and sleep disturbance (Trevisan, et. al.). In addition, alterations in physiology, mood, and behavior may continue after acute withdrawal has subsided, motivating relapse.

It is estimated that for every dollar spent on addiction treatment programs, there is a \$4 to \$7 reduction in the cost of drug-related crimes (NIDA).

Economic costs

The cost to society of illicit drug abuse alone is \$181 billion annually, and when combined with alcohol and tobacco costs, they exceed \$500 billion, including those costs related to violence and property crimes, prison expenses, court and criminal costs, emergency room visits, healthcare utilization, child abuse and neglect, lost child support, foster care and welfare costs, reduced productivity, lost earnings and unemployment (NIDA).

This is an enormous burden that affects all of society - those who abuse these substances, and those who do not.

Successful drug abuse treatment can help reduce these costs in addition to reducing crime, and the spread of HIV/AIDS, hepatitis, and other infectious diseases. It is estimated that for every dollar spent on addiction treatment programs, there is a \$4 to \$7 reduction in the cost of drug-related crimes (NIDA).

Even brief outpatient treatments appear to significantly decrease costs to the individual and to society as a whole, and when compared to many other types of health care interventions, alcohol and drug abuse treatments are significantly less expensive than most medical procedures (Roehrich et al.).

Costs to Society

- **Crime:** At least half of the individuals arrested for major crimes, including homicide, theft, and assault, were under the influence of illicit drugs around the time of their arrest, and as many as 60% of adults in federal prisons are there for drug-related crimes (NIDA).
- **Drugged Driving:** The National Highway Traffic Safety Administration estimates that drugs are used by approximately 10% to 22% of drivers involved in crashes, often in combination with alcohol (NIDA).
- **Education:** Children with prenatal cocaine exposure are more likely (1.5 times) to need special education services in school, costs for which are estimated at \$23 million per year (NIDA).
- **Homelessness:** 31% of America's homeless suffer from drug abuse or alcoholism (NIDA).
- **Stress:** Exposure to stress is one of the most powerful triggers of substance abuse in vulnerable individuals and of relapse in former addicts (Bloom, 2002).
- **The Workplace:** Illicit drug users were more likely than others to have missed 2 or more days of work in the past month and to have worked for three or more employers in the past year (NIDA).

- Violence: Alcohol and drug use increase the risk of both perpetration and victimization of violence (CDC). The drug trade is a dangerous environment with high risk for violence associated especially with certain drugs.

CONCLUSION

Given the research on causes, trends, and costs of substance use, abuse and addiction, it is safe to assume that victims/survivors with whom we currently work are impacted by these issues in some way, whether directly or indirectly. The following section looks specifically at the intersections of sexual violence and substance use, abuse and addiction.



A G U I D E F O R C O U N S E L O R S A N D A D V O C A T E S

Literature Review

Literature Review

Limitations of Literature Review

A large portion of the available research focuses on women's addiction as related to the trauma of sexual violence. Much of the research on men's addiction to drugs and alcohol in relation to trauma looks at veterans. Little existing research examines the trauma of sexual violence towards men in relation to drug and alcohol addiction. This may be due to men's reluctance to come forward about sexual violence or to researchers not understanding the extent of the trauma of sexual violence in the lives of males.

Additionally, much of the current research on violence and drug and alcohol addiction looks at intimate partner violence (of which sexual violence is often a factor). Comparatively less research has been conducted specifically on sexual violence in all forms and its cyclical relationship with drug and alcohol use, abuse and addiction.

Furthermore, data on drug and alcohol use among sexual violence victims/survivors does not always include whether the substance use began prior to the assault or as a response to the assault.

Questions remain about the relationship between sexual violence and drug and alcohol addiction in certain vulnerable populations, including racial, ethnic, and linguistic minorities; people with disabilities; immigrants and refugees; the LGBT population; and those who are geographically isolated.

More research is needed to understand the complex relationships between sexual violence, and multiple oppressions such as classism, racism, able-ism, heterosexism, ageism, and sexism. It is recommended that research involve rape crisis advocates, drug and alcohol addiction counselors, as well as allied groups and individuals experiencing these "isms." Culturally appropriate, non-victimizing research must be done.

Researchers found that there are a large number of both treatment and prevention intervention methods currently in existence, which are science-based and widely considered to be effective. However, it is important to note that, to date, almost none of these interventions have been researched in rural areas, including Pennsylvania (Roehrich et al.).

In addition to the limitations stated in this guide's literature review (current research tends to focus on intimate partner violence, women, and dominant cultural groups), further research on resilience as it relates to drug and alcohol addiction and sexual violence is needed. Research and dissemination of best practices for working with victims/survivors who are currently using, as well as action steps for the prevention of both drug and alcohol addiction and sexual violence, would be beneficial.

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Jennifer, Age 42

I was sexually abused by my dad as a kid, from about age 8-12 is what I can remember, but it might have started earlier. I really try not to think about it much. It stopped when I told my mom. She didn't really believe me (she thought I was mad at my dad because he wouldn't let me go to summer camp that year), but she confronted him about it anyway. Of course he denied it, but I guess it scared him enough because he stopped doing it.

Me and my dad never had a good relationship after that. I'd get the creeps when he looked at me, and I swear he would spy on me in the bathroom and stuff, but I never caught him. I stayed out of the house as much as I could. I didn't care what I was doing. I just didn't want to be home when he was there.

At first I'd hang out at friends' houses, but the following spring one of my friends started hanging out at a neighborhood park. She was friends with the "bad kids." We'd sit under the pavilion and try to act cool. It made me feel tough to be with them. I'd always felt different, weird, like people knew there was something wrong with me. I really hated myself and wanted so bad to fit in. So when one of the older "cool boys" offered me a beer one day, I took it and drained the can like a man. That earned me lots of brownie points and all of a sudden I was the girl who could drink like a guy.

I can't even describe the way that beer made me feel. It was like magic. I didn't feel weird or dirty or ugly. I felt fantastic. That's what started it for me. I was an alcoholic with the first drink I ever took.

I can't say if I would have started drinking so young if my home life would've been better. But having a dad that made me feel like a piece of dirt sure didn't help. Was drinking an escape for me? Probably. Who wants to think about being sexually molested by your dad every day? And it was pretty damn hard not to think about it.

Barriers to further research might be how to reach victims/survivors living with drug and alcohol addiction and how to define both sexual violence and drug and alcohol addiction. Much of the research is done through treatment programs or other service programs. It is possible that large numbers of people with drug and alcohol addiction are left out of the research. Therefore, one of the challenges in future research will be finding ways to hear the stories and experiences of people living with drug and alcohol addiction who may be less visible or accessible. Legal definitions of sexual violence vary by state, and some people hold cultural or individual definitions. Some do not define what happened to them as sexual violence. Additionally, there are multiple definitions of the term drug and alcohol addiction. How researchers and participants define the terms sexual assault as well as substance use, abuse and addiction may also have implications for further research.

The following will look specifically at some research on the reciprocal relationship between sexual violence and substance use, abuse, and addiction.

INTERSECTIONS OF SEXUAL VIOLENCE AND SUBSTANCE ADDICTION

There is a range of possible connections between sexual violence and substance addictions. Substances may have been used willingly or unwillingly prior to the assault, during the assault, or as a coping strategy in response to the trauma the victim/survivor experienced – each yielding potentially different responses and reactions by the victim/survivor and by society at large.

Both substance abuse and sexual victimization carry a great deal of social stigma; when a victim/survivor experiences both, the stigma can be especially difficult to overcome. People who use or abuse drugs and alcohol or who are addicted are often either ignored or shunned by the larger society. Religious, cultural, or familial beliefs may deem alcohol and drugs inappropriate (as well as the law which does not allow those under 21 to drink alcohol). This can silence and discredit victims/survivors further, which may increase feelings of blame, shame and isolation. This in turn may compound the challenges of the healing process, especially for those experiencing other forms of oppression and isolation.

A Reciprocal Relationship

The relationship between sexual violence and addiction is complex and often reciprocal in that sexual violence may be a precursor to or consequence of substance use, abuse, or addiction.

Both substance abuse and sexual victimization carry a great deal of social stigma; when a victim/survivor experiences both, the stigma can be especially difficult to overcome.

A prior history of victimization may predispose someone to drug and alcohol use, abuse and addiction, while drug and alcohol problems may be a risk factor for victimization.

Women with substance use/abuse are more likely to have been sexually assaulted at some point in their lives, with as many as 60% of women and 20% of men undergoing substance abuse treatment reporting having survived physical, sexual or emotional abuse as a child (National Center for PTSD).

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Alcohol and drug use have been shown to increase women's vulnerability to violence through exposure to unsafe situations (Parks & Miller, 1997 as cited in Finkelstein, VandeMark, Fallot, Brown, Cadiz, & Heckman, 2004). Those who are under the influence of drugs or alcohol are even more vulnerable to attack than the general population, and less likely or able to seek help afterwards (National Health Care for the Homeless Council, 1999).

Predisposition to addiction is based on various factors such as on biology, environment, development or adverse childhood experiences. Trauma, such as sexual violence, could bring about addiction for someone who does not currently have one. For example, a social drinker may develop heavier use in response to an assault as a way to cope with the trauma.

Stress is a major contributor to the initiation and continuation of addiction to alcohol or other drugs, as well as to relapse or a return to drug use after periods of abstinence (Bloom).

Men and women reporting sexual abuse have higher rates of alcohol and drug use disorders than other men and women. In fact, 25%-75% of people who have survived abusive or violent trauma also report problems with alcohol use (National Center for PTSD, 2008).

Women with substance use/abuse are more likely to have been sexually assaulted at some point in their lives, with as many as 60% of women and 20% of men undergoing substance abuse treatment reporting having survived physical, sexual or emotional abuse as a child (National Center for PTSD). Furthermore, there is a high correlation between adverse childhood experiences (ACEs), such as sexual abuse, and a range of health, mental health, and social struggles in adulthood, including drug and alcohol abuse (Felitti, 2001).

The link between substance abuse, violence, and poverty

Sexual violence has a reciprocal relationship with substance abuse, poverty, sex work, incarceration, mental health and other health risks. People in such situations are not only at a higher risk for sexual assault given their perceived vulnerability, but also are more likely to have been sexually assaulted in the past (Greco & Dawgert, 2007).

Of those reporting sexual abuse histories in one study, homelessness, use of psychiatric medications, arrests, prostitution and earlier ages and incidences of family members with substance abuse and mental health issues were more significant than compared to those without such

histories (The Massachusetts MOTHERS Project, 1997). Certainly, there is a complex web of issues faced by victims/survivors of sexual assault.

Homelessness

Addiction and drug offending can be an outcome of street life, having to endure prostitution and economic desperation (Gilfus, 2002). Not having access to stable housing, providing safe places for their children, or being able to leave abusive relationships provided barriers for long-term recovery, contributing to relapse and recidivism rates (Hirsch, 2001).

Health and mental health risks, economic deprivation, loss of child custody, and mounting stigma have been identified as long- and short-term consequences of drug abuse for women (Browne, Salomon, Bassuk, Dawson & Huntingdon, 2004).

There is a strong correlation between physical/sexual abuse and alcohol or drug dependency among people who experience homelessness (National Health Care for the Homeless Council; US Department of Health and Human Services, 2002).

The lifetime risk for violent victimization is so high for homeless women with severe mental illness (97%) as to amount to normative experiences for this population (Goodman, Fels & Glenn, 2006). Given the high rates of violence, it is not surprising that many women who are homeless or living in extreme poverty suffer from major depression, substance abuse and post traumatic stress disorder (PTSD) (Bassuk, Melnick, & Browne, 1998; Browne & Bassuk, 1997) which then puts them at risk for sexual violence.

According to one study, 25%-30% of runaway and homeless youth experienced sexual abuse prior to leaving home; these youth demonstrated high rates of past month alcohol, marijuana, and other drug use as well as lifetime use of cocaine and other drugs (U.S. Department of Health and Human Services). Furthermore, 65% of females with runaway experiences reported ever having used an illicit drug as compared to 28% of females in the general population (U.S. Department of Health and Human Services).

Prostitution

Life on the streets is dangerous and may lead to retraumatization - the poverty that forces people, especially women and girls, onto the streets often forces them to earn money by prostitution, most often under the control of pimps where they are raped and battered again (Gilfus).

There is an intimate relationship between prostitution, substance abuse, childhood maltreatment and exposure to violence throughout the lifespan (Bloom). Women and men involved in sex work may be forced to trade sex for drugs or may use drugs in order to numb the reality and dangers of sex work. Sixty-nine percent (69%) of incarcerated women

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One study found that 90% of incarcerated women have a drug or alcohol-related history (As cited in Kurshan, 2001).

in one study disclosed working as prostitutes to supply their drug addictions (Hirsch). Homeless and runaway youth who were abused were more likely to engage in survival sex (trading sex for food, shelter, clothing, etc.) than their non-abused counterparts (38% vs. 22%) (U.S. Department of Health and Human Services).

According to one study (Falck, Wang, Carlson & Siegal, 2001) a longer duration of crack use and arrest for prostitution were significantly related to the odds of having suffered a rape. In fact, the odds of having been raped were nearly eight times greater for women with an arrest history for prostitution (Falck et al.).

Incarceration

Women at risk for incarceration— women with drug addictions, women with alcohol problems, women who work as prostitutes, and homeless women —report very high rates of child sexual abuse and adult physical and sexual abuse (as cited in Gilfus). Another study found that drug offenses committed by women were directly related to their addictions, meaning that possession was for their own usage, and that the drug abuse developed in response to overwhelming histories of sexual and physical violence as children and adults (Hirsch).

One study found that 90% of incarcerated women have a drug or alcohol-related history (As cited in Kurshan, 2001). Nearly three-fourths of women in the criminal justice system were using drugs prior to their arrest, yet only 25% of state and federal prisoners and 17% of people on probation receive any kind of drug treatment (Allard, 2002, as cited in Gilfus).

Since the introduction of crack cocaine, drug enforcement has targeted poor communities of color where visible street transactions are monitored and homes are raided. Heavier penalties and longer sentences are imposed for inexpensive crack than for higher priced forms of the drug, thus increasing convictions and imprisonment of people with low to no income (Gilfus).

Mental Health and Co-occurring Disorders

Alcohol and drug abuse and mental illness often co-exist. More than five million people in the general U.S. population have a serious mental illness and a co-occurring substance use disorder (SAMHSA & Center for Mental Health Services, 2007). In some cases, mental illness may precede addiction; in other cases, drug abuse may trigger or exacerbate mental illness (NIDA, 2008).

The onset of a diagnosable mental disorder often precedes the onset of a diagnosable substance use disorder (SAMHSA and Center for Mental Health Services). For the majority, adolescence marks the onset of primary mental health disorders, with substance use disorders occurring

some 5 to 10 years later, during late adolescence and early adulthood (Kessler, 2004 as cited in SAMHSA & Center for Mental Health Services).

Studies conducted in mental health settings found 20% to 50% of their clients had a lifetime co-occurring substance use disorder, while those conducted in substance abuse treatment agencies found 50% to 75% of their clients had a lifetime co-occurring mental disorder, however, usually not at a level that impairs a person's ability to function normally and safely (SAMHSA & Center for Mental Health Services). These findings are supported by another study that reports that 73% of persons with a drug dependence disorder in substance abuse treatment had a co-occurring mental disorder at some point during their lifetime (Compton et al., 2000, as cited in SAMHSA & Center for Mental Health Services).

The Adverse Childhood Experiences (ACE) Study found a direct link between child maltreatment—including sexual abuse—and depression, psychotropic medication use, and low mental health scores in adulthood; the higher number of ACEs, the greater risk for mental health struggles in adulthood (Chapman, Anda, Felitti, Dube, Edwards & Whitfield, 2004; Anda, Brown, Felitti, Bremner, Dube & Giles, 2007; Edwards, Holden, Anda & Felitti, 2003). Having additional traumatic life events and more severe child sexual abuse were related to greater odds of having PTSD and multiple substance use problems than having PTSD only (Ullman, et al.).

In a sample of 100 male and female subjects receiving treatment for substance abuse, more than a third was diagnosed with some form of a dissociative disorder stemming from childhood sexual or physical abuse (Ross, Kronson, Koensgen, Barkman, Clark & Rockman, 1992).

Research demonstrates that individuals with histories of sexual abuse experience high rates of:

- Drug-related problems (Bartholomew et al.; Falck et al.; Harrison et al.; U.S. Department of Health; Yuan, Koss & Stone, 2006);
- Depression (Bartholomew, Rowan-Szal, & Chatham, 2000; Greenfield, Kolodziej, Sugarman, Munez, Vagge, He & Weiss, 2002; The Massachusetts MOTHERS Project; Yuan et al.);
- Other psychological problems, including PTSD symptoms (Bartholomew et al.; Clark, Masson, Delucchi, Hall, & Sees, 2001; Greenfield et al.; Yuan et al.);
- Anxiety (Bartholomew et al.; The Massachusetts MOTHERS Project);
- Thoughts of suicide (Bartholomew et al.; Kilpatrick, Edmunds & Seymour, 1992; The Massachusetts MOTHERS Project; Yuan et al.);
- Higher sexual risk behaviors (Bartholomew et al.; Frost; U.S. Department of Health; Yuan et al.).

In some cases, mental illness may precede addiction; in other cases, drug abuse may trigger or exacerbate mental illness (NIDA, 2008).

In a study of male survivors sexually abused as children, over 80% had a history of substance abuse, 50% had suicidal thoughts, 23% attempted suicide, and almost 70% received psychological treatment (Lisak, 1994).

Untreated psychiatric problems are among the main reasons for relapse to addiction, therefore it is important for people to receive treatment for their psychiatric problems in addition to addiction treatment (Caron Treatment Centers, 2004; NIDA).

Post-Traumatic Stress Disorder (PTSD)

Women exposed to trauma such as sexual violence, even if not experiencing PTSD, have shown an increased risk for developing a substance abuse problem; furthermore, being diagnosed with PTSD increases the risk of developing a substance abuse disorder (Bloom; National Center for PTSD). Past PTSD symptoms significantly contributed to the severity of drug use (Clark, et al.).

Victims/survivors who used illicit drugs and had PTSD had more lifetime suicide attempts and more formal support seeking, suggesting that this group may be an especially high-risk group in need of intervention (Ullman, Townsend, Starzynski & Long, 2006).

According to the National Center for PTSD, as many as 10-50% of adults with alcohol use disorders and PTSD also have one or more of the following serious disorders:

- Anxiety disorders (such as panic attacks, phobias, incapacitating worry, or compulsions);
- Mood disorders (such as major depression or a dysthymic disorder);
- Disruptive behavior disorders (such as attention deficit or antisocial personality disorder);
- Addictive disorders (such as addiction to or abuse of street or prescription drugs);
- Chronic physical illness (such as diabetes, heart disease, or liver disease);
- Chronic physical pain due to physical injury/illness or due to no clear physical cause.

Victims/survivors of sexual assault may use alcohol or drugs to numb or escape from painful memories or PTSD symptoms. When they attempt to stop using the drug, symptoms reappear and the likelihood of relapse increases. Studies indicate that those working with people experiencing PTSD and drug and alcohol addictions treat these conditions concurrently (Caron Treatment Centers, 2004; National Center for PTSD; Washington Coalition of Sexual Assault Programs [WCSAP], 2005).

Relapse and treatment may be compromised if issues related to sexual abuse, its interaction with PTSD, and adult partner violence are not identified (Browne et al.).

Sexual Health Risks

Research demonstrates that for both men and women, having experienced sexual violence is strongly associated with later substance abuse, high-risk sex, and other harmful behaviors (Frost, 2002; Harrison et al.; U.S. Department of Health and Human Services).

Intoxication increases the likelihood of risky sexual behaviors, which in turn, contributes to the spread of HIV/AIDS, hepatitis B and C, and other sexually transmitted diseases (NIDA). In one study, nearly one quarter of sexually active teens and young adults aged 15-24 report having unprotected sex because they were drinking or using drugs and have worried about STDs and pregnancy because of something they did while drinking (The Henry J. Kaiser Family Foundation, 2002). Among homeless and runaway youth, those who were sexually abused were more likely to have had sex without birth control while drunk or high, were more likely to have had sex with a high-risk partner and were significantly more likely to have ever been pregnant (U.S. Department of Health and Human Services).

Sexual Violence, Intimate Partner Violence and Substance Abuse

Women who use substances are more likely to be victims of intimate partner violence than non-substance users (Bloom). Addiction can be a coping response to battering by women across class and race as battered women often experience extreme stress, symptoms of complex PTSD, anxiety, depression, sleep deprivation and physical pain and may use alcohol or drugs to self-medicate (as cited in Gilfus).

Victims of intimate partner violence are more likely to receive prescriptions for and become dependent upon tranquilizers, sedatives, stimulants, and painkillers and are more likely to abuse alcohol (Fazzone, Holton, & Reed, 1997, as cited in Bloom).

Dating violence is also associated with an increased risk for substance abuse as well as unhealthy weight control behaviors; sexual risk behaviors like first intercourse before age fifteen, pregnancy and suicidality (Bloom).

As part of the abuse, batterers may introduce their partners to drugs and alcohol, force their partner to carry, sell or buy drugs for them, encourage drug use or abuse to increase or maintain their control over their partner, prostitute their partner for drugs or money, or keep a partner from receiving the help s/he needs.

Drugs and alcohol may be used to facilitate sexual violence in intimate partner relationships. Abusers may get their partner intoxicated in order to lower her/his inhibitions so s/he will perform sexual acts that s/he typically would not - for example being videotaped or engaging in sex with multiple partners at once, prostitution, or other acts. Additionally, some victims of intimate partner violence may drink or use drugs to

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Alcohol is the most common drug used to facilitate sexual assaults. Unlike some other drugs, alcohol is legal, readily available, and socially acceptable (Scalzo) if not socially encouraged in some settings.

lower their own inhibitions or to blackout so they can try to fend off abuse that may occur if they do not go along with what the abuser is demanding sexually.

DRUGS AND ALCOHOL CONTRIBUTE TO SEXUAL ASSAULT THROUGH MULTIPLE PATHWAYS

There are a variety of ways drugs and alcohol contribute to sexual assault and vice versa. The most common pathways include:

- Drugs and alcohol used to facilitate a sexual assault
- An individual using or addicted to drugs or alcohol prior to the assault, or
- Drugs and alcohol used following an assault as a coping mechanism, which may or may not turn into addiction.

These situations may overlap, for example, someone is using drugs or alcohol to cope with a sexual assault and is then targeted and revictimized while drunk or high.

Drug and Alcohol-Facilitated Sexual Assault

The terms drug-facilitated sexual assault or alcohol-facilitated sexual assault have been coined to describe a subset of sexual assault. Some of the drugs that could be used to facilitate a sexual assault, including alcohol, can cause unconsciousness, impair the victim's memory, or limit their decision-making ability (Negrusz, Juhascik & Gaensslen, 2005; Scalzo, 2007). In some cases, the substances are given to the victims surreptitiously, which may decrease their ability to identify a dangerous situation or to physically resist the perpetrator (Negrusz et al.; Scalzo).

Alcohol is the most common drug used to facilitate sexual assaults. Unlike some other drugs, alcohol is legal, readily available, and socially acceptable (Scalzo) if not socially encouraged in some settings. Research with convicted rapists, community samples of sexual assault perpetrators and victims/survivors, and college student perpetrators and victims/survivors consistently finds that approximately half of sexual assaults are associated with alcohol use by the perpetrator, victim, or both (Abbey, Clinton-Sherrod, McAuslan, Zawacki, & Buck, 2003). Researchers consistently have found that approximately one-half of all sexual assaults are committed by men who have been drinking alcohol, with estimates ranging from 34% to 74% (Abbey, Zawacki, Buck, Clinton & McAuslan, 2001). There is widespread anecdotal evidence indicating that the majority of rape and sexual assault cases being reported to law enforcement involve alcohol use by the victim, the defendant, or both (Scalzo).

Perpetrators become extremely adept at identifying vulnerable individuals and at exploiting those vulnerabilities (Lisak, 2005).

For example, if someone was using drugs or alcohol voluntarily, a perpetrator will purposely give larger or stronger amounts to the victim, or a person who is drunk or high will be targeted because of her/his vulnerability in that situation.

Perpetrators may get drunk or high in order to justify their actions, or may deliberately get victims drunk or high to facilitate sexual assault (Frost; Lisak; United Educators, 2003). For perpetrators, being under the influence may remove both physical and psychological inhibitors of aggression (United Educators). Perpetrators may not need to be as physically forceful with an extremely intoxicated individual in order to subdue her/him (Lisak; United Educators; Scalzo). In other words, alcohol or drugs may be used as an excuse but may also be part of a plan.

For example, one study, indicated that among women raped since they began to use crack, 83% reported that they were high on crack when the rape occurred and that at least 57% of the perpetrators were high on crack when the rape was committed (Falck, et al.).

Drug and alcohol-facilitated sexual assault can be especially confusing and scary for victims/survivors: not having a clear memory of what happened, not understanding that alcohol can be used to facilitate a rape, and self-blame if they were using alcohol or drugs willingly prior to the attack. Underage victims may fear punishment for drinking or using drugs, and therefore may be reluctant to disclose what happened. This confusion, fear and uncertainty can increase feelings of self-blame and isolation following the assault.

Drug and alcohol use preceding an assault

Certain vulnerabilities or risk factors contribute to sexual violence victimization and perpetration; consuming alcohol and drugs is among those factors (CDC). Individuals who use drugs and/or alcohol are thought to be at a higher risk for sexual assault (CDC).

In some cases, victims voluntarily use substances which may impair their ability to make decisions. One study demonstrated that the subject's own drug usage was more likely a factor in facilitating a sexual assault rather than surreptitious drugging (Negrusz et al.). A high percentage of adult victims/survivors were intoxicated during their assaults and unable to give consent. Approximately one-half of all sexual assault victims report that they were drinking alcohol at the time of the assault, with estimates ranging from 30% to 79% (Abbey, et al.). Women who drink are more likely than those who do not to experience violent victimization (NIAAA, 1999). This is not to suggest that the victim is at fault but to suggest that perpetrators target victims who are perceived as vulnerable.

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This is often misconstrued as a cause of their victimization, fostering a sense of blame and shame and placing victims/survivors in a position of having to justify and defend themselves.

These issues may be of particular concern to those whose social scene often involves alcohol or drugs. For instance, the most significant predictor of alcohol use was reliance on bars as a primary social setting for individuals who identify as lesbian, gay, bisexual or transgender (LGBT), (Bloom). For individuals who identify as LGBT, bars may be the only places that feel accepting and safe. As another example, college and university campuses and military bases are often cultures of drinking, where people may feel pressure to drink or use drugs, which can lead to predatory behavior – targeting those who are drunk or high. Sex while drunk or high is considered a “normal” occurrence in these types of settings, therefore, even if the victim/survivor does not want to engage in sexual activity or cannot fully remember what happened, s/he may keep silent or not define what happened as a sexual assault.

For many teens and young adults, alcohol and drug use are closely linked to sexual decision making and risk taking, with more than a third of sexually active young people reporting that alcohol and/or drugs have influenced their decisions about sex and that they have “done more” sexually than they had planned to do while drinking or using drugs (The Henry J. Kaiser Family Foundation).

In one study, rape was reported by 32% of women since they initiated crack use (Falck et al.). The annual rate of victimization by rape is also much higher for crack users (11%) than for women in the general population (0.3%) (Falck et al.).

Blame is placed on victims/survivors by themselves and society at large when alcohol or drugs are a factor in the assault (Frost, 2002; Scalzo; U.S. Department of Justice, 2000). This is often misconstrued as a cause of their victimization, fostering a sense of blame and shame and placing victims/survivors in a position of having to justify and defend themselves.

Additionally, victims/survivors may use the fact that they were drinking or using drugs willingly to normalize what happened and not label it as a sexual assault. In our society, stereotypes say that if you are drinking, you are asking for sex. So if someone is coerced into sex, maybe not for the first time, it might be easier for a victim/survivor to say they deserved what happened than to come to terms with the fact that they were sexually assaulted. The myth acts as a coping mechanism for some people.

Drug and alcohol use and abuse as methods of coping

Coping strategies are tools someone uses to deal with stressful experiences. They can be both positive (for example, meditation, humor or exercise) and negative (for example, avoidance or denial). Higher levels of stress that are caused by fear and danger related to sexual violence can cause long-term effects to the brain and can heighten the

need for harmful coping mechanisms (for example, bulimia, anorexia, or cutting). Self-medication occurs when people use substances to cope with stressful or traumatic situations. Victims/survivors who use substances as a means of coping are often neglected by our culture and stigmatized by those who are unaware of their risk to be re-traumatized. Coping responses, including self-medication, need to be respected as adaptive and protective, not as pathologic (U.S. Department of Justice).

Reports indicate overwhelming evidence that victims/survivors of sexual violence are much more likely to use alcohol and other drugs to cope with the trauma of their victimization (WCSAP). Women with sexual abuse histories were more likely to report more drug-related problems (Bartholomew et al.). For some, substance use/abuse is a fast acting, socially accepted, and relatively accessible and inexpensive coping strategy. A vicious cycle may develop in which an already traumatized individual who uses substances to cope is at greater risk of experiencing additional trauma.

Substances may be used for many reasons following an assault, including as a way to:

- Cope with or escape from the trauma of childhood victimization and the related symptoms (Gilfus; Spatz Widom & Hiller-Sturmhofel, 2001)
- Reduce feelings of isolation and loneliness and increase self esteem (Spatz Widom & Hiller-Sturmhofel)
- Self-medicate in an attempt to gain control over the experience (Frost; Harrison et al.; Spatz Widom & Hiller-Sturmhofel)
- Function sexually, or feel comfortable sexually, even in a committed relationship
- Take back feelings of power and control, even if only temporarily (Frost).

Studies have shown a strong relationship between substance use and sexual and physical abuse (Acierno, Resnick, Flood, & Holmes, 2003; Harrison, et al.) even for those who did not use substances prior to the assault. This includes use of a greater variety of substances, earlier initiation of substance use, and more frequent attempts to self-medicate painful emotions (Harrison et al.).

Self-medication may lead to a destructive cycle. The desire for relief from trauma symptoms may lead victims/survivors to self-medicate with drugs or alcohol to invoke the numbing state; on the other hand, numbing may lead some victims/survivors to engage in risk-taking and self-injurious behaviors in order to feel alive again (Gilfus). Additionally, self-medicating to numb the triggered feelings can make trauma symptoms worsen over time, resulting in chronic PTSD (as cited in Hilsenrod & Kelley).

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Seventy-three percent (73%) of women in residential substance abuse treatment programs report they were raped; 45% were raped multiple times (Bloom).

Although substance use can provide a temporary feeling of distraction and relief, it can also:

- Reduce the ability to concentrate, enjoy life, and be productive,
- Impair one's ability to sleep restfully and to cope with trauma memories and stress,
- Put her/him at risk for revictimization,
- Impact the ability to negotiate safer sex in the future,
- Increase emotional numbing, social isolation, anger and irritability, depression, and the feeling of needing to be on guard (hyper-vigilance).

(Frost; National Center for PTSD)

Compared to women who had not been raped, rape victims are: 5.3 times more likely to have used prescription drugs non-medically; 3.4 times more likely to have used marijuana; 6 times more likely to have used cocaine; and 10.1 times more likely to have used "hard drugs" other than cocaine (Kilpatrick et al.).

Seventy-nine percent (79%) of survivors who drink alcohol became intoxicated for the first time after the assault, and 89% of survivors who use cocaine used it for the first time after the assault (Kilpatrick et al.). Those who use drugs and alcohol are at risk for developing an addiction, especially if using "street" drugs which often involves being introduced to a culture that encourages repeated use of a chemical until an addiction occurs (Wuliger).

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Various addictions may develop in response to sexual assault, and the addictions may be related. For instance, some victims/survivors may develop eating disorders as a way to regain control in their lives. In an effort to control their body, victims/survivors may use diet aid drugs or substances, even those not specifically designed for that purpose, such as cocaine. This may lead them on a path to addiction. Likewise, a victim may substitute one addiction for another. For example, s/he may give up drinking but start smoking.

Prescription drugs also put people at risk of addiction as the abuse may be seen as part of a doctor-prescribed healing process (Wuliger).

Developing alcohol abuse problems in response to adult sexual assault was shown to be associated only for heterosexual women, however more lesbians reported experiencing adverse drinking behaviors and consequences, wondered if they might have a drinking problem, and indicated that they were in recovery more than their heterosexual counterparts (Huges, Johnson, & Wilsnack, 2001).

Substance use as a coping mechanism may have started at an early age for some victims/survivors. The challenges of adolescence include coping with issues of identity and sexuality. For sexual violence victims, getting high may be a way to feel comfortable around other people, or alternatively to avoid personal relationships or to withdraw (Harrison et al.). Ultimately, this may impede the development of healthy coping skills and interfere with personal relationships and social and academic functioning (Harrison et al.).

Physical and sexual abuse were associated with an increased likelihood of the use of alcohol, marijuana, and almost all other drugs for both male and female adolescents (Harrison et al.). Teenagers with alcohol and drug problems are 18 to 21 times more likely to have been sexually abused than those without alcohol and drug problems (Jennings, 2004). Female adolescent sexual abuse survivors are more likely to use illegal drugs – 30% compared to 13% of non-abused teenage girls (The Commonwealth Fund, 1997). Among females with runaway experiences, the prevalence of having ever used any illicit drug was higher for females who had been sexually victimized (83%) than for those who had not (59%) (U.S. Department of Health, 2002). Girls who are raped are over four times more likely to suffer from drug and alcohol abuse in adulthood (Kendler, Bulik, Silberg, Hettema, Myers & Prescott, 2000).

Coping with Child Sexual Abuse

Drug and alcohol use is often used to mask the pain and shame many child sexual abuse victims/survivors experience. Some may not directly associate their drug and alcohol use with these experiences. It may take years for memories of child sexual abuse to surface, making recovery from substance abuse difficult for many victims/survivors, especially as these memories begin to emerge.

It has been suggested that the effects of mood-altering substances are similar to the dissociative strategies many child abuse victims use to distance themselves from their traumatic experiences and that a history of trauma and dissociation may predispose victims to alcohol and drug abuse during adolescence (van der Kolk, 1987, as cited in Harrison, et al.). Abuse victims reported initiating substance use earlier than non-abused peers and gave more reasons for using including use to cope with painful emotions and to escape from problems (Harrison et al.).

Several studies have found that child sexual abuse experiences for both men and women were associated with family histories of alcoholism, suggesting that parental alcohol abuse may leave children more vulnerable to sexual abuse by others (Spatz Widom & Hiller-Sturmhofel).

Adverse Childhood Experiences (ACEs), including sexual abuse in childhood, can account for up to two-thirds of serious problems

In a study of male survivors sexually abused as children, over 80% had a history of substance abuse (Lisak, 1994).

Nearly 90% of alcoholic women were sexually abused as children or suffered severe violence at the hands of a parent.

with drug use in adulthood (Dube, Felitti, Dong, Chapman, Giles & Anda, 2003). A direct correlation between abuse and maltreatment in childhood and adult alcohol abuse was also found (Dube, Anda, Felitti, Edwards & Croft, 2002).

In a study of 100 adult patients with polytoxic drug abuse, 70% of the female and 56% of the male drug abusers had been sexually abused prior to the age of sixteen (Mueser, Rosenberg, Goodman, & Trumbetta, 2002).

Men and women who are sexually abused during childhood are at increased risk for drug abuse as adults. In a study of male survivors sexually abused as children, over 80% had a history of substance abuse (Lisak, 1994). Women who experienced any type of sexual abuse in childhood were roughly three times more likely than non-abused girls to report drug dependence as adults (Kendler et al.). Another study indicates that 33%-50% of women who abuse substances were sexually abused as children (Bloom).

Among women with histories of childhood sexual abuse, a disproportionate number also manifest high risk behaviors such as smoking and alcohol use, which may be used as coping mechanisms (Bassuk et al.) and are known to have adverse short and long term health consequences.

Nearly 90% of alcoholic women were sexually abused as children or suffered severe violence at the hands of a parent (Jennings). Childhood sexual abuse was shown to be a significant factor for developing alcohol abuse for both lesbian and heterosexual women (Huges et al.).

African American women reporting multiple victimizations of child sexual abuse were four times more likely to drink heavily than those who experienced sexual assault by one perpetrator (Jasinski, Williams, & Siegel, 2000). Women who are African American and experienced child sexual abuse at an older age were significantly more likely to engage in heavy drinking behavior (Jasinski et al.)

In a small study of lesbians in alcohol recovery, 46% unexpectedly disclosed having survived childhood sexual abuse, linking it with addiction and recovery experiences and reported multiple addictions, self-harm, isolation, sexual problems, depression, self-loathing, physical illness, and inability to work more often than did other participants (Hall, 1996, as cited in Bloom).

CHALLENGES TO COMING FORWARD

For any victim/survivor, isolation, shame, self-blame, fear, anger, lack of control, confusion, and denial are possible reactions that may deter a victim/survivor from getting help.

Individual sexual assault victims/survivors are often re-victimized when they come forward, made to feel that they did something wrong to provoke their attacker. Marginalized and traditionally oppressed groups are often further stigmatized. Additional barriers exist if the victim/survivor also has a disability, is a person of color, is male, is elderly, is a non-English speaker, identifies as LGBT, is living in poverty, or is otherwise part of a non-dominant group.

Social systems tend to respond more positively to victims/survivors who fit a constricted mold of the “good victim”—a victim who is assaulted by a stranger with a weapon resulting in injury (Campbell, 1998). Victims whose experiences deviate from this are less likely to receive desired services with outcomes consistent with their needs (Campbell) and may be blamed more frequently for the assault.

In addition to the above-mentioned challenges, victims/survivors who are also using, abusing or addicted to drugs or alcohol face numerous barriers to coming forward.

- Substance use or abuse by victims/survivors is often viewed as a reason for their victimization (Frost; U.S. Department of Justice). For example, research has demonstrated that individuals tend to view women who drink or get drunk as more sexually available or promiscuous and more likely to engage in sexual acts than women who abstain from alcohol (United Educators). Social stereotypes and myths contribute to the belief that women or men who were drunk or high when sexually assaulted put themselves at risk, and they are often blamed for the assault. Many victims/survivors, in turn, internalize these stereotypes and blame themselves for the assault.
- The media consistently reinforces the message that drinking and sex go hand in hand. These myths will likely increase others’ blame of the victim/survivor and decrease positive response from those to whom s/he discloses.
- Some people may not define what happened to them as sexual assault or rape if they were under the influence of drugs or alcohol – willingly or unwillingly - when it occurred. The stereotypical rape scenario does not involve drinking or drugs, although the reality often does.
- Depending on the drug or amount of alcohol used to facilitate a rape, the victim/survivor may not clearly remember details and therefore may be reluctant to come forward, thinking that because s/he can’t remember exactly what happened, no one will believe her/him.
- In general, society views addiction as a moral issue rather than as a disease. This means that many people blame or condemn the addict for not having the will power to stop using drugs and/or

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alcohol. People may also judge an addict for starting to use in the first place. This blame may make it difficult for someone to come forward for help, and s/he might even internalize this blame.

- Providers may hold mistaken belief systems about addiction, failure to understand triggers, unrealistic expectations, lack of knowledge about brain chemistry, liver function, relapse processes, resources and recovery options, as well as failure to understand appropriate role of accountability, consistency and structure. “Addict –phobia” makes it possible for systems to establish criteria that can limit or prohibit access to services or successful outcomes to an entire class of people (ANDVSA).
- Current use of substances may exclude victims/survivors from obtaining services at rape crisis centers or domestic violence programs. Some programs have policies specifically denying services to active users and/or individuals without a permanent address.
- If a victim/survivor is aware of using drugs or alcohol as a way to cope, s/he may be afraid or reluctant to seek treatment for fear of what memories and feelings might surface if s/he stops using.
- Withdrawal symptoms may make someone very sick, which will make attending a counseling session, court hearing, or medical appointment very challenging, if not impossible.
- If the victim/survivor is underage, s/he may be reluctant to come forward for fear of retribution or punishment for drinking or using drugs, especially if s/he was willingly using.
- Stigma is attached to certain individuals who use/abuse substances, such as pregnant women and those with young children who are seen as “morally wrong” for “doing this” to their children. Additionally, some people who are forced to live a certain lifestyle are often met with disrespect and scorn, such as sex workers or inmates.
- If someone is in an abusive relationship, the batterer may make it impossible for the victim/survivor to get help for addictions. Getting help for sexual assault may put a victim/survivor in too much danger.
- Substance abusing women tend to have fewer economic resources for obtaining treatment and are more likely to have complicating health needs. This may affect their ability to attend appointments, arrive on time, and to be able to commit to their own recovery. Operating hours of treatment facilities and client work schedules are typically the same, which may put someone in a position to choose between employment and treatment.
- Accessibility and transportation to alcohol and drug abuse services or rape crisis centers may be impediments, especially in rural areas.

- A victim/survivor may be reluctant to seek assistance or contact police for fear of arrest, deportation or having her/his children taken away, especially if s/he was willingly using drugs or alcohol, or was involved in drug trade or prostitution at the time of the assault.



A G U I D E F O R C O U N S E L O R S A N D A D V O C A T E S

Understanding Substance Abuse Treatment Options

Understanding Substance Abuse/Addiction Treatment Options

It is not necessary for advocates and counselors to determine which treatment option is “right” for a client. However, a basic awareness of options, as well as what the current research demonstrates about effective treatment, can assist rape crisis counselors and advocates in educating and empowering clients with whom they work. This is true for clients already in treatment programs and for those just starting the process of identifying their substance abuse or addiction. This may also help rape crisis centers determine which available resources might be available to victims/survivors or which might be appropriate partners for collaboration.

Drug and alcohol addiction is a complex but treatable disease. Although some people are able to recover without help, the majority need assistance of some sort (NIAA, 2001). For many people, drug abuse becomes chronic, with relapses possible even after long periods of abstinence; in fact, relapse to drug abuse occurs at rates similar to those for other well-characterized, chronic medical illnesses such as diabetes, hypertension, and asthma (NIDA).

The ultimate goal of drug addiction treatment is to enable an individual to achieve lasting abstinence (NIDA; NMHA), but the immediate goals are to reduce drug abuse, improve the patient’s ability to function, and minimize the medical and social complications of drug abuse and addiction (NIDA). Like people with diabetes or heart disease, people in treatment for drug addiction will need to change their behavior to adopt a more healthful lifestyle (NIDA).

In 2006, 4 million people aged 12 or older (1.6% of the population) received some kind of treatment for a problem related to the use of alcohol or illicit drugs (SAMHSA, 2006).

Among this group, 2.2 million persons received treatment at a self-help group, and 1.6 million received treatment at a rehabilitation facility as an outpatient. There were 1.1 million persons who received treatment at a mental health center as an outpatient, 934,000 persons who received treatment at a rehabilitation facility as an inpatient, 816,000 at a hospital as an inpatient, 610,000 at a private doctor’s office, 420,000 at a prison or jail, and 397,000 at an emergency room (SAMHSA, 2006).

Men are more likely than women to engage in addiction treatment (Caron Treatment Centers, 2004). This may be due to the fact that early addictions research was based on a male-dominated framework and did not understand that women may have different treatment and recovery needs. Additionally, women may be more likely to have factors in their lives that impede receiving treatment such as an abusive partner or childcare responsibilities.

Drug and alcohol addiction is a complex but treatable disease. Although some people are able to recover without help, the majority need assistance of some sort.

Taylor, Age 18

When I was 13 I was at a party at my friend's house. That's where I first drank alcohol, and I didn't know how much I could drink, so I got pretty drunk. While I was drunk and kind of passing in and out, two guys I knew from school had sex with me. (I didn't think it was rape at the time.) I remember some of it but not much.

The next morning I woke up, and my friend told me that two guys "ran a train on me." I laughed it off like it wasn't a big deal. When I went back to school, everyone knew. The girlfriends of the two guys both wanted to kick my ass. They harassed me for the rest of the school year, and I was the big school slut.

At first it bothered me, but I just acted like I didn't care. I also started having sex with lots of other boys. They'd call me and I knew what they wanted, but I'd go over to their houses anyway. I'm not sure why, but it's like it didn't matter, I was already the slut, nothing worse could happen.

That's when I started drinking a lot too. Like, as much as I could get my hands on. I didn't even care what it was, if it was alcohol I'd drink it. And I had to drink before I had sex with all those boys. One of the boys gave me pot and then I started smoking lots of that too. I'm embarrassed about this part, but I even had sex with boys to get pot and then coke.

By the time I was 16, I had a real problem, and so I went to rehab. I stayed for a month, then came back home and started drinking and using all over again. Now I'm 18 and back in rehab. I'm learning that one of my relapse issues is the rape when I was 13. When I think about it, or think about having sex in general, it makes me sick to my stomach, and all I want is to make those feelings go away, so I get drunk or high. But that doesn't work forever, and if I'm gonna stay clean and sober, I've got to start to work on those feelings.

Honestly, sometimes I think it's still my fault. I mean, I was dumb and drunk, and I didn't say no. I know in my head that it's still rape, but the guilt and shame in my heart takes over. I still have never told my parents. I'm afraid of what they'd think of me if they knew. But I really hope I get this soon, because I don't wanna be back here (in rehab) ever again.

In general, alcohol and drug treatment can be understood as a spectrum of treatment options representing differences in setting, types and range of services, and intensity of service use and delivery. The goal of treatment is to place the patient in the appropriate level of care; that is, to provide the specific services needed by each patient, at the appropriate level of intensity, within the appropriate setting; since the severity of the individual’s illness is likely to fluctuate over time, the level of care should change accordingly (Substance Abuse and Mental Health Services Administration and The Center for Substance Abuse Treatment [SAMHSA/CSAT], 1994).

As a chronic, recurring illness, addiction may require repeated episodes of treatment before sustained abstinence is achieved. Through treatment and support tailored to individual needs, many individuals can recover and rebuild productive lives (NIAA, 2001; NIDA).

Generally, an overall therapeutic process often begins with detoxification, followed by treatment and relapse prevention. A continuum of care that includes a customized treatment regimen, addressing all aspects of an individual’s life, including medical and mental health services, and follow-up options can be crucial to a person’s success in achieving and maintaining a drug-free lifestyle (NIDA).

Types of care may include: inpatient treatment, residential care, halfway house, partial hospitalization, intensive outpatient treatment, traditional outpatient treatment, and community-based care. Treatment modalities may include: individual, group, family, self-help, recovery, and relapse prevention/relapse management.

<p>Minors’ Rights in PA</p> <p>A minor may consent to medical care or counseling related to the diagnosis or treatment of drug and/or alcohol abuse. If the minor consents to treatment, clinicians may not disclose information about the minor’s treatment or care without the minor’s prior written consent if the facility receives any federal assistance or reimbursements (like Medicare or Medicaid) for any of its patients or services (American Civil Liberties Union [ACLU] of PA, 2005).</p> <p>If the facility does not receive any federal assistance, the question of parental notification is governed by Pennsylvania law, which permits, but does not obligate, the clinician to inform the minor’s parent or guardian about the minor’s treatment (ACLU of PA, 2005).</p>
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COMMON TREATMENT APPROACHES

Medications can be used to help with different aspects of the treatment process.

- **Withdrawal:** Medications offer help in suppressing withdrawal symptoms during detoxification. However, medically assisted withdrawal is not in itself “treatment”—it is only the first step in the treatment process. Patients who go through medically assisted withdrawal but do not receive any further treatment show drug abuse patterns similar to those who were never treated (NIDA).
- **Treatment:** Medications can be used to help re-establish normal brain function and to prevent relapse and diminish cravings throughout the treatment process. Currently, there are medications for opioid (heroin, morphine) and tobacco (nicotine) addiction. Others for treating stimulant (cocaine, methamphetamine) and cannabis (marijuana) addiction are in development. Methadone and buprenorphine are effective medications for the treatment of opiate addiction. (NIDA)

Medically Monitored Detoxification is imperative for detoxification (detox) of certain drugs (opiates such as heroin and methadone, prescription medications). Without proper medical supervision, withdrawal and detox can cause severe medical consequences, including seizures, heart attacks, violent shakiness, and dizziness. It can be fatal. This is typically done through an emergency room of a hospital or a detox facility.

Behavioral Treatments help patients engage in the treatment process, modify their attitudes and behaviors related to drug abuse, and increase healthy life skills. Behavioral treatments can also enhance the effectiveness of medications and help people stay in treatment longer (NIDA).

The American Society of Addiction Medicine (ASAM) has developed guidelines regarding levels of care to be used in treating substance abuse (SAMHSA/CSAT).

Level I: Outpatient treatment An organized nonresidential treatment service or an office practice with designated addiction professionals and clinicians providing professionally directed treatment. This treatment occurs in regularly scheduled sessions usually totaling fewer than 9 contact hours per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups like AA or NA.

Level II: Intensive outpatient treatment (including partial hospitalization) A planned and organized service in which addiction professionals and clinicians provide several treatment service components to clients. Treatment consists of regularly scheduled sessions within a structured program, with a minimum of 9 treatment hours per week. Examples include day or evening

programs in which patients attend a full spectrum of treatment programming but live at home or in special residences.

Level III: Medically monitored inpatient treatment Can be described as an organized service conducted by addiction professionals and clinicians who provide a planned regimen of around-the-clock professionally directed evaluation, care, and treatment in an inpatient setting. This level of care includes 24-hour observation, monitoring, and treatment. A multidisciplinary staff functions under medical supervision. What most people think of as a “rehab facility.”

Level IV: Medically managed intensive inpatient treatment An organized service in which addiction professionals and clinicians provide a planned regimen of 24-hour medically directed evaluation, care, and treatment in an acute care inpatient setting. Patients generally have severe withdrawal or medical, emotional, or behavioral problems that require primary medical and nursing services. An example would be a detox unit within a larger hospital.

Several treatment service models do not fit precisely within these levels of care. These service levels include halfway houses, sober houses, and extended residential programs such as therapeutic communities. These programs are designed for people who do not have housing, who experience housing instability, or who lack an organized support system. These programs are often used in conjunction with outpatient or intensive outpatient treatment.

Treatment Within the Criminal Justice System can succeed in preventing an offender’s return to criminal behavior, particularly when treatment continues as the person transitions back into the community. Studies show that treatment does not need to be voluntary to be effective. Research suggests that treatment can cut drug abuse in half, drastically decrease criminal activity, and significantly reduce arrests (NIDA).

Psychotherapy aids patients in understanding behavior and motivations and in developing self-esteem and coping with stress (NMHA).

Self-Help or 12 step Programs can complement and extend the effects of professional treatment. Self-help groups are very effective in helping the patient establish a support network (NMHA). The most prominent self-help groups are those affiliated with Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA), all of which are based on the 12 step model, and Smart Recovery®. Most drug addiction treatment programs encourage patients to participate in a self-help group during and after formal treatment. It is important to note that 12

step programs are spiritually based, although not directly affiliated with any particular religious denomination.

Basis for Effective Addictions Treatment (NIDA)

According to NIDA, scientific research since the mid-1970s shows that treatment can help many people change destructive behaviors, avoid relapse, and successfully remove themselves from a life of substance abuse and addiction. Based on this research, key principles have been identified that should form the basis of any effective treatment program:

- No single treatment is appropriate for all individuals.
- Treatment needs to be readily available.
- Effective treatment attends to multiple needs of the individual, not just his or her drug addiction.
- An individual's treatment and services plan must be assessed often and modified to meet the person's changing needs.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
- Counseling and other behavioral therapies are critical components of virtually all effective treatments for addiction.
- For certain types of disorders, medications are an important element of treatment, especially when combined with counseling and other behavioral therapies.
- Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
- Medical management of withdrawal syndrome is only the first stage of addiction treatment and by itself does little to change long-term drug use.
- Treatment does not need to be voluntary to be effective.
- Possible drug use during treatment must be monitored continuously.
- Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, and should provide counseling to help patients modify or change behaviors that place themselves or others at risk of infection.
- As is the case with other chronic, relapsing diseases, recovery from drug addiction can be a long-term process and typically requires multiple episodes of treatment, including "booster" sessions and other forms of continuing care.

Other Models of Addictions Treatment

The following list was compiled by the Texas Association Against Sexual Assault (TAASA) and reprinted with permission.

16 Steps of Discovery and Empowerment

This model was developed by Charlotte Kasl, Ph.D. in her book, “Many Roads, One Journey: Moving Beyond the 12 Steps,” which states that the 12 Steps, while helpful, are also anachronistic, sexist and mired in fundamentalist Christian dogma. She feels that AA’s message of ego deflation is not the only path to recovery and that most women have very little ego strength; that many are battered, in bad relationships, are incest survivors and the 12 Steps has them constantly focusing on their faults and accepting the blame for their actions. The 16 Steps encourages addicts and people with dependency issues to “take charge of their lives and examine beliefs, addictions and dependent behavior in the context of living in a hierarchical, patriarchal culture.” The 16 Steps offers support for a wide variety of quality of life issues, such as addiction, abuse, codependency, self-esteem and personal empowerment. The 16 Steps encourage the celebration of personal strengths, choices, standing up for oneself, healing the physical body, and seeing people as a holistic community, not just the recovery community. Some men may feel less comfortable with this model. www.charlottekasl.com/16steps.html.

SMART Recovery (Self Management And Recovery Training)

This method helps people recover from all types of addictive behaviors and is an alternative to 12 Step programs. SMART believes that addictions/compulsions are complex maladaptive behaviors with possible physiological factors. This model shows the client how to change self-defeating thinking, emotions and actions and emphasizes working toward long-term satisfaction and quality of life through self-empowerment and self-reliance. www.smartrecovery.org.

White Bison, Inc

White Bison offers sobriety, recovery, addictions prevention and wellness (wellbriety) learning resources to Native American communities nationwide. Many non-Native people also use White Bison’s healing resource products and attend its learning circles. “Wellbriety” means to be sober and well. The “well” part of wellbriety is the inspiration to go beyond sobriety and recovery, committing to a life of wellness and healing every day. www.whitebison.org.

Women for Sobriety

This New Life program is designed to help achieve sobriety and sustain ongoing recovery by focusing on 13 positive statements that encourage emotional and spiritual growth. The program has been effective in helping women overcome their addictions and learn a new lifestyle. This program can be used as a stand-alone program

or with other programs. It is also used in hospitals, clinics, treatment facilities, women's centers and wherever addictions are treated. This program may feel like a safe alternative for female survivors who have trust issues with self-disclosing in front of men in groups. www.womenforsobriety.org.

Secular Organizations for Sobriety (Save Our Selves; SOS)

SOS takes a self-empowerment approach to recovery and maintains that sobriety is a separate issue from all other life issues. It credits the individual for achieving and maintaining his or her own sobriety. SOS respects recovery in any form, regardless of the path by which it is achieved. SOS also respects diversity, welcomes healthy skepticism, and encourages rational thinking as well as the expression of feelings. SOS chooses to make sobriety a separate issue from spirituality and religion. www.health.groups.yahoo.com/groups/SOS.

Rational Recovery (RR)

This ideology identifies the self-recovered individuals as the experts on their addiction recovery. They are the inspiration and the mentors of Rational Recovery. RR is a source of counseling, guidance and direct instruction on self-recovery from addiction, alcohol and other drugs through planned, permanent abstinence. RR is a for-profit organization, offered via the Internet, books, videos and lectures. Based on recognizing negative internal self-talk, RR does not regard alcoholism as a disease but as a voluntary behavior and discourages adoption of the chronic recovering drunk persona. Great emphasis is placed on self-efficacy, and there are no discrete steps, no consideration of religious matters, and no recovery groups. This program is self-paced and self-structured. www.rational.org.

Moderation Management (MM)

This model is an early intervention/harm reduction behavioral change program and support group for people concerned about their drinking. The program empowers individuals to accept personal responsibility for choosing and maintaining their own path, whether it's moderation or abstinence. MM is based on nine steps to help a person find balance and moderation in their lives. If this program proves to be an ineffective solution, the individual is encouraged to find another program that work better for them. www.moderation.org.

Dual Recovery Anonymous (DRA)

This is a fellowship of men and women who meet to support each other in their common recovery from two no-fault conditions. They believe that emotional or psychiatric illness and chemical dependency

are not the fault of the addict. DRA members are encouraged to build a strong personal support network, including support from chemical dependency or mental health treatment facilities, medical or social service professionals, and spiritual or religious assistance, in addition to other 12-Step or self-help groups. DRA has no opinion on the way the other groups address dual disorders or dual recovery. DRA does not offer advice regarding specific forms of treatment for the various types of emotional or psychiatric conditions. Members of DRA share their personal experiences regarding the ways they cope with their symptoms by applying the 12 Steps in their daily lives. draws@draonline.org.

ADDICTIONS TREATMENT FOR VICTIMS/ SURVIVORS OF SEXUAL VIOLENCE

Research shows that treatment can help many people change destructive behaviors, avoid relapse, and successfully remove themselves from a life of substance abuse and addiction (NIDA). Recovery from drug and alcohol addiction is a long-term process and frequently requires multiple episodes of treatment.

However, victims/survivors of sexual violence are less successful in completing substance abuse treatment (Briere & Elliott, 1994; Corbin, Bernat, Calhoun, McNair & Seals, 2001) and are less likely to remain abstinent from substances and more likely to relapse (Greenfield et al.).

Victims/survivors may use drugs and alcohol as a coping mechanism to mask and numb painful traumatic memories, PTSD symptoms, and flashbacks. Because someone may have used this particular coping mechanism for some time, if a history of sexual violence is not addressed in substance abuse treatment, the memories of the trauma may come flooding back when the person stops using alcohol or drugs. Consequently, this will increase the likelihood of relapse (Clark et al.; The Massachusetts MOTHERS Project; WCSAP).

Misidentified or misdiagnosed trauma-related symptoms interfere with help-seeking, hamper engagement in treatment, lead to early drop-out and make relapse more likely (Brown, 2000; Finkelstein et al.). Symptoms such as difficulty concentrating, hypervigilance or being constantly “on guard”, avoiding thoughts, feelings, or conversations associated with the trauma, loss of interest in activities and life in general, a sense of isolation, feeling emotionally numb, feelings of intense distress when reminded of the trauma, physiological stress response to reminders of the event – any of these trauma-related symptoms, or others not mentioned here, might make going to and sticking with treatment difficult, if not impossible, for some people.

The pattern of addiction will continue in various forms unless the root of the addiction and the link between the addiction and the root problem(s) are explored, and new coping skills are learned. As victims/

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Victims/survivors may need to have their experiences heard and validated early on in recovery, although not necessarily therapeutically treated, to minimize the potential for relapse (Finkelstein et al.; WCSAP).

survivors end their dependence on one addiction, others may develop. This is referred to as cross-addiction or transferring addiction. For instance, if someone stops using drugs or alcohol but has not addressed the sexual violence, s/he may develop an addiction to something else, such as gambling, work, smoking, shopping, exercise, sex or food.

Therefore, it is critical to address trauma as part of substance abuse treatment - and vice versa - in a safe and supportive environment (Bartholomew et al.; Caron Treatment Centers, 2004; Felitti; Falck et al.; Finkelstein et al.; Greenfield et al.; Harrison et al.; Huges et al.; WCSAP).

For victims/survivors with active substance use, the focus of trauma work should be on stabilization, safety, and understanding the links between trauma and substance use/abuse, not on telling the traumatic story (Finkelstein et al.). Victims/survivors may need to have their experiences heard and validated early on in recovery, although not necessarily therapeutically treated, to minimize the potential for relapse (Finkelstein et al.; WCSAP). Communicating that being a victim/survivor is not shameful may encourage someone to discuss his or her experiences. This enables the client to be strengthened, supported, and helped to learn new coping strategies before moving on to later stages (Finkelstein et al.).

Early treatment models were based on male-dominated models and did not take into account the role that trauma and sexual abuse play in chemical dependency until more recently (The Caron Institute, 2004; WCSAP).

Addressing trauma in substance abuse treatment involves both “trauma-informed” and “trauma-specific” approaches (Finkelstein et al.). Trauma-informed systems and services incorporate knowledge about trauma into all aspects of service delivery, including trauma’s impact, interpersonal dynamics, and paths to recovery (Finkelstein et al.). Trauma-specific services are focused on directly addressing the impact of trauma on people’s lives and facilitating trauma recovery and healing (Finkelstein et al.). Ideally, substance abuse treatment programs will create trauma-informed environments, provide services that are sensitive and responsive to the unique needs of victims/survivors and offer trauma-specific interventions (Finkelstein et al.).

Post Acute Withdrawal Syndrome (PAWS)

When people think about addiction, they usually think about the drug-based symptoms rather than the sobriety-based symptoms which can make sobriety a challenge.

Recovery causes a great deal of stress. Many addicts have not learned to manage stress without the use of chemicals. Research indicates the presence of brain dysfunction in 75%-95% of the recovering alcoholics/addicts tested (Gorski, 1994) that disappear over time. The stress of recovery can aggravate the brain dysfunction and makes the symptoms worse.

Helping the client to understand the sobriety-based symptoms of Post Acute Withdrawal Syndrome (PAWS) may go a long way in preventing relapse. Recovery from the damage caused by substance abuse requires abstinence. The damage caused by the substance abuse interferes with the ability to abstain. This is the paradox of recovery. For this reason, it is necessary to do everything possible to reduce the symptoms of PAWS. PAWS occurs after the acute withdrawal phase. PAWS is a biopsychosocial syndrome resulting from the combination of damage to the nervous system caused by the drugs and psycho-social stress of coping with life. PAWS symptoms usually peak in intensity over a three-3 month to two-2 year period after withdrawal. Depending on the severity of the client's brain dysfunction and the psychosocial stress the client experiences in recovery, the nervous system requires anywhere from six to 24 twenty-four months to readjust.

Symptoms of PAWS

- Inability to think clearly
- Memory problems
- Emotional overreaction or numbness
- Sleep problems
- Physical coordination problems
- Stress sensitivity

PAWS symptoms are not the same in everyone. They vary in how severe they are, how often they occur, and how long they last. Some people experience certain symptoms, some people have other symptoms, some people have none at all.

Over a period of time PAWS may get better (regenerative), it may get worse (degenerative), it may stay the same (stable), or it may come and go (intermittent). Traditional treatment usually does not address these symptoms because, until recently, they were unrecognized. The most common pattern of PAWS is regenerative, and over time it becomes intermittent. It gradually gets better until the symptoms disappear and then it comes and goes.

Managing PAWS Symptoms

The less a client does to prepare for a PAWS episode, the higher the risk of relapse. Conditions that put the client in a high risk situations are usually lack of self-care. R – recovering without a relapse means being aware of the stressful situations in the client's life and how to handle those situations when they occur. It is not the situation that makes the client vulnerable; it is the client's reaction. Because stress can trigger and intensify the symptoms of PAWS, learning to manage stress by identifying its source early is important. Proper diet, exercise, regular habits, and positive attitudes play important roles in controlling PAWS.

Relaxation can be used as a tool to retrain the brain to function properly and to reduce stress.

When the client experiences PAWS symptoms, it is important to bring them under control as soon as possible. Here are some suggestions that have helped others:

- Verbalization. Talk about the experience to people who are not going to accuse, criticize or minimize. This can help the client look at the situation more realistically. It can help bring internal symptoms to conscious awareness.
- Venting. Expressing as much as the client can, even if it seems irrational and unfounded.
- Reality Testing. The client's perception of what is happening may be very different from reality. Learning to ask someone if the client is making sense (the client's words and behavior) can become an invaluable skill.
- Problem Solving and Goal Setting. What can the client do right now about the situation? Is this a situation the client can change? If it is, what actions can the client choose?
- Backtracking. Thinking over what happened; can the client identify how the episode started? Can the client think of other times they experienced symptoms of PAWS? What turned it on? What turned it off? Are there other options that might have worked better or sooner?

Education and Retraining: Learning about addiction, recovery and PAWS symptoms can help the client relieve anxiety, guilt, and confusion that tends to create stress by "normalizing" the symptoms. As the client learns to use skills and tools that interrupt and control the stress and the symptoms when they occur, the client improves his/her ability to remember, to concentrate and to think clearly. This retraining involves practicing these tools and skills in a safe environment where the client can build confidence. Part of the retraining includes doing things one step at a time, doing only one thing at a time, writing down or making a list of what is important or needs to be remembered, and asking questions when clarification is needed.

Self-Protective Behavior: In the end, the client is responsible for their behaviors, sobriety and understanding their triggers. This is both daunting and liberating. Learning coping skills that reduce stress may help the client by not allowing other people, places or things to push the client into reactions that are not in their best interest. Once clients have identified what situations may bring about an overreaction, they can learn to avoid them, or learn to interrupt the situation before it gets out of control.

One of the ways to diminish a trigger is to connect it in the here and now with something positive, comforting and nurturing. Remind the client that they are sitting next to you and they are safe. Ask them to tell you about their favorite memory or favorite color or something that makes them smile or sing their favorite song. Traumatic memories will resurface as negative reactions at unexpected times in unexpected places. To minimize the affects of the trigger, linking the negative to the positive, is a great help. The bad reaction surfaces first and then the next thought is a comforting one. This is a tool a person can learn to use in order to catch their breath and to help keep them from reacting. Like all tools, it needs to be practiced until it becomes second nature.

Exercise: Exercise helps rebuild the body and keeps it functioning properly, reduces stress and produces endorphins that make the client feel good. Different types of exercise are helpful for different reasons. Consistency and regularity are the key words for the recovering person. Whatever exercise the client chooses, remind them not over-do it! If it hurts don't do it. The old adage "no pain, no gain" is not true for recovering people.

Relaxation: Deep relaxation rebalances the body and reduces the production of stress hormones. It is the opposite of the "fight or flight" reaction. A muscle cannot relax and tense at the same time. It is impossible to maintain tension while physically relaxing. The distress resulting from thought process impairments, emotional process impairments, memory impairments, and stress sensitivity can be reduced or relieved through proper use of relaxation.

Finding a method that the client finds relaxing and will use can help in reducing stress.

Cravings

Drug craving is linked with drug abuse and withdrawal, and occurs for physiological, psychological and social reasons. When the client is craving their drug, they may sweat and also have the physical sensation of smelling and tasting the drug. Craving triggers can come from: situations, events, thoughts about the fun role of the drug, cruising old neighborhoods, talking with using buddies, going to a bar or other places where the client used in the past, watching T.V, or even listening to certain songs.

The craving cycle is marked by obsession (out-of-control thinking about use), which quickly turns to compulsion (an overwhelming urge to use though the client knows it is not in their best interest to do so), which becomes a craving (obsession and compulsion merged into a full-blown physical craving), which leads to drug-seeking behaviors.

Psychological Cravings

- Euphoric Recall. This romanticizes the high - remembers only the good/fun of using, and exaggerates it.
- Awful-izing Abstinence. Only the negative aspects of recovery are noted and exaggerated. This can make the client feel deprived, which can lead to the thought that being sober is about not having any fun.
- being sober is not about not having any fun.
- Magical Thinking. This is the thought distortion that using will solve all problems. Magical thinking is a response to euphoric recall and awful-izing sobriety.
- Empowering the Compulsion. Exaggerates the power of the compulsion by believing that the craving is irresistible.
- Denial and Evasion. Addiction is a disease of denial which does not go away because the client stopped using. Because denial is usually an unconscious process, most clients believe they are doing the best they can when they are not.

(Gorski, 1990)

Social Cravings

- Lack of Communication. The client stops talking about feelings and experiences and resorts to superficial communication and isolates from the new people in their his or her life.
- Social Conflict. Argument and disagreement because of the lack of communication. This further isolates the client who ends up spending more time alone.
- Socializing with Other Drug-Using Friends. Out of loneliness the client seeks others who they feel understand them. This usually means people who the client associated with while using. (Gorski, 1990)

Preventing Cravings

- Structure. This puts the client in daily contact with other healthy people.
- Awareness of triggers. Prepare a safety plan on how to cope with them.
- Set-up behaviors. These self-sabotaging patterns can easily be blamed on others without awareness.
- Unintended Consequences. What were the negative unintended consequences for the drug use? Debunk euphoric recall. This also applies to magical thinking and awfulizing sobriety.

Craving Intervention

Cravings are a natural symptom of recovery. Though they occur most frequent in early recovery, they can also happen throughout the client's life. Instead of feeling doomed, the client can learn and practice a number of healthy choices, including:

1. Recognize the craving. Do not deny the feeling.
2. Accept cravings as a natural part of recovery, and the client can take positive action.
3. Talk about the craving instead of acting on the craving with trusted people.
4. Balance diet to nourish the brain. Talking with a dietician is a wonderful way to promote self-care.
5. Reducing stress. Life stressors are unavoidable. Finding ways to relax can reduce the intensity of a craving.
6. Exercise to stimulate brain chemistry to and reduce the physiological effects of a craving.
7. Go somewhere else, especially if the craving is triggered by the environment.
8. Productive distraction, such as (like a hobby,) to divert attention away from the craving.
9. Cravings are feelings! Feelings come and go. They do not last forever.

(Gorski, 1990.)

Hilsenrod, W. & Kelley, E. (n.d.). Working with Addicted Survivors of Sexual Assault. Texas Association Against Sexual Assault (TAASA).

Research suggests a need for gender-specific substance abuse treatment

Research clearly points to the need for gender-specific treatment programs that address both sexual assault victimization and substance abuse concurrently in order to decrease relapse (Caron Treatment Centers, 2004). Although men and women suffer from the same disease of addiction, gender does play a significant role in the development of addiction, for instance, women tend to become medically compromised more quickly and differently than male addicts and alcoholics (Caron Treatment Centers, 2004).

Evaluations of gender-specific programs tend to show that females in gender-specific programs stayed in treatment longer and were more than twice as likely to complete treatment (Caron Treatment Centers, 2004; WCSAP).

Some women prefer an all-female environment for many reasons, including:

- A majority of patients in addictions treatment are male, therefore women may feel in the minority (Caron Treatment Centers, 2004; WCSAP)
- Group dynamics in which males typically dominate conversations in mixed-gender groups (Caron Treatment Centers, 2004; WCSAP)
- Issues of sexual harassment (Caron Treatment Centers, 2004; WCSAP)
- Women tend to express themselves more frequently in female-only groups (Caron Treatment Centers, 2004; WCSAP)
- Techniques emphasizing the confrontation of denial and anger that is typical of mainstay treatment for men who are substance abusers do not work for women but only serve to reinforce the shame and guilt that women are already feeling (Bloom).

Areas of gender-specific enhanced services for women include medical and health care issues, emotional and psychological issues, life skills, partner and parenting skills, and services directed to culturally specific populations. These may be part of one comprehensive program or provided in conjunction with community-based organizations (Caron Treatment Centers, 2004).

Men have different treatment needs than women so may also benefit from gender-specific treatment, including a continuum of care to help men address those issues in a safe and supportive environment. This may include: skill building to prevent compartmentalizing feelings, learning how to ask for help, gaining insight into compulsive behavior, looking at resentments, anger, difficulty letting go of control, isolation issues and developing healthy relationships (Caron Treatment Centers, 2008).

WORKING THROUGH THE TENSION: PROVIDERS COMING TOGETHER

Working Together

While the underlying elements and philosophies of recovery in the fields of sexual violence and substance abuse may differ, both models are beneficial. Integrating the two - while potentially challenging - is critical for long-term recovery. **Research points to the need for simultaneous and cohesive treatment of both substance abuse and the trauma of sexual violence** (Caron Treatment Centers, 2004; Finkelstein et al.; Greenfield et al.; NIDA; WCSAP).

Early findings on the effectiveness of integrated models of treatment in reducing substance abuse and related problems, general mental health problems, and PTSD symptoms are promising (as cited in Finkelstein, et al.).

Opportunities exist for substance abuse programs and services to work with sexual violence agencies on cross-training and simultaneous integrated support.

Starting points:

- It may help to find areas of agreement first, then work on addressing differences. Try to get past differences of terms and listen for the content of what the other person is saying.
- Advocates and other providers need cross-training to recognize co-occurring issues and make appropriate referrals.
- Develop a multidisciplinary team with people from rape crisis centers, substance abuse/addictions programs, as well as professionals from other backgrounds, for example, medical, education, mental health and criminal justice professionals.
- Provide groups or individual counseling at drug and alcohol programs. Drug and alcohol programs provide education or groups at rape crisis centers.
- Arrange to provide space at your center for AA or NA meetings by contacting the local chapter.
- Apply for new funding to develop new programs in conjunction with substance abuse providers.
- Conduct public awareness and prevention programs in the community together.
- Support each other's policies and legislation.

Potential Tension Between the Empowerment Model and Traditional Addictions Treatment

Challenges to integrated treatment of both sexual assault and substance abuse abound, especially in the competing frameworks of both fields of study. The empowerment model for counseling victims/survivors is quite different from most drug and alcohol addiction treatment models.

Addictions Treatment Model	Sexual Assault Field/ Empowerment Model
Based heavily on a medical model, which tends to be more patriarchal in nature	Based heavily in viewing sexual assault from a sociopolitical, feminist-based perspective which stresses the concept of empowerment
Addicts may need direct confrontation to break through the often entrenched system of denial that prevents them from recognizing that they have a substance abuse problem	Victims/survivors need support and validation, not confrontation, to help regain a sense of control in their lives
Addicts must first recognize that they are powerless in the face of their addiction in order to begin recovery	Victims/survivors work to regain feelings of power and control as part of recovery
Addicts need to take responsibility for their substance abuse	Victims/survivors realize that they had no control over the assault, let go of personal responsibility for the sexual violence and place it on the perpetrator
Structured environment	Structure based on what works for the individual victim/survivor
Drug and alcohol treatment does not have to be voluntary to be effective	Emphasizes victim/survivor choices about help-seeking and meeting a client where s/he is at
Priority or goal is sobriety	Priority or goal is whatever the victim/survivor needs it to be at that moment



A G U I D E F O R C O U N S E L O R S A N D A D V O C A T E S

Considerations for Rape Crisis Centers

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Rape Crisis Centers

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No one who has been sexually assaulted should have to face unnecessary obstacles to getting help. Some victims/survivors may be re-victimized by those they turn to for help. Rape crisis centers can be more effective by increasing their knowledge about addictions issues. Whether they know it or not, they likely already serve clients who are currently using or have abused drugs and alcohol in the past. Additionally, agencies will be better able to serve clients if they consider the varying contexts in which clients reside, such as ethnic, religious, and economic factors and/or rural, urban or suburban areas.

Collaboration with substance abuse programs is key to success. Collaboration adds resources and ideas as well as knowledge and credibility. While your agency may be a great source of knowledge and experience on sexual assault services, a substance abuse program will be a great source of information and experience on addictions and substance abuse. Both rape crisis centers and substance abuse programs face a shortage of resources including funding. Working together creatively through collaboration can help your agency successfully serve victims/survivors who also abuse drugs and alcohol.

Ideally, victims/survivors of sexual violence who are abusing substances would receive concurrent treatment for both the sexual trauma as well as the substance abuse from specialized providers. In reality, this may not be possible for numerous reasons, including a lack of specialized services in a given geographic area, insufficient resources for attending drug and alcohol treatment, or the victim/survivor not being ready to address both issues at once. At the very least, a rape crisis advocate or counselor can provide a meaningful referral to a credible drug and alcohol provider or help a client attend one session of a 12 step program.

To enhance service capacity, some suggestions are provided to assist rape crisis centers in providing services to victims/survivors who are using, abusing or addicted to drugs or alcohol. The following suggestions require an integrated approach. There is no one correct method, and rape crisis center staff must work closely with individual victims/survivors, members of the community and key community leaders to determine which efforts will yield the best results.

The information that follows is organized along job categories, however, there is a great deal of overlap across these areas and ideally, staff will work individually and collectively across multiple levels in advocating for victims/survivors who are using, abusing or addicted to drugs or alcohol.

Collaboration with substance abuse programs is key to success. Collaboration adds resources and ideas as well as knowledge and credibility.

Working together creatively through collaboration can help your agency successfully serve victims/survivors who also abuse drugs and alcohol.

My name is Alan and I'm an alcoholic/addict. I'm really used to saying that by now, this is my third time in rehab. But I still can't say out loud in front of other people that I'm a victim of sexual abuse.

When I was about 11 years old a family friend would babysit me and my little brother when my parents went out. They went out a lot, both alcoholics themselves. So this guy would come over to our house and we'd play video games and eat pizza and do other "guy stuff," like throwing around a football.

This guy was about 19, my parents knew him since he was a little kid, and thought he was great. He worked part-time at a movie rental store and went to community college.

Anyway, one time he was watching just me because my little brother was at a friend's house and he had brought over some movies for us to watch. He always brought movies because he got them for free from the store where he worked at. One of them was a porno. He told me this is what guys watched, so I watched it. I'm not going to go into detail, but then some stuff happened. I didn't know what to do and didn't want to get in trouble, so I just went along with it. I remember feeling really gross after.

It started happening regularly after that first time whenever my little brother wasn't around. He even started making my little brother go to bed earlier than me so he could do stuff. It went on for 2 years, until my parents thought I was old enough to stay home by myself with my little brother, and I never said anything to anybody about it. But it didn't take long for me to find alcohol and drugs.

Beer, vodka, pot, pills, all that stuff made me forget about what happened. It also made me feel kinda normal. When I wasn't drunk or high, I felt real guilty and gross.

In 9th grade some of my friends started joking around, calling each other gay, and I punched my best friend in the face when he said it to me. Cause I really didn't want to be gay, but the things that happened with that guy were definitely gay, so I didn't know if that stuff might have "made me gay."

Anyway, the drug and alcohol use continued, obviously, because I'm here. Now I'm 25 and I'm still not sure if I'm gay. In my active addiction I had sexual relationships with men and women, so I'm confused. But I think as long as I stay clean and sober I'll be able to figure it out by getting to know the real me.

KEY CONSIDERATIONS FOR RAPE CRISIS CENTERS

1. Addiction is a disease, not a moral issue.
2. There is no one “right” way to serve victims/survivors who are using, abusing or addicted to drugs or alcohol. This will be determined by each agency, community and victim/survivor.
3. Include the voices of community leaders and victims/survivors across all levels of agency planning.
4. Ethically, rape crisis services should serve all victims/survivors, regardless of their current or past drug and alcohol use, abuse or addiction.

ADMINISTRATION

Foster an inclusive, supportive environment

- Be a role model. Be willing to take the risks that leadership calls for by demonstrating that you respect and value the diversity of all people.
- The physical environment can say a lot to a victim/survivor. Clients will sense if they can expect respect and compassion before they ever talk with you. For instance, display flyers from substance abuse treatment programs.
- Provide information specific to substance abuse issues, such as drug-facilitated sexual assault or drugs and alcohol as coping methods. This can help normalize reactions and educate victims/survivors.
- Provide a confidential meeting space; this may be at your agency or off-site, such as a local library or community center. This will help victims/survivors feel comfortable, safe and therefore more likely to access services from your agency.
- Consider doing an “environmental scan” of your agency. If you will be promoting services for drug and alcohol-addicted victims/survivors through education, outreach and prevention efforts, you want to be sure that they will feel welcome and supported at your agency.

Provide empowering services that meet the needs of your community

- Conduct both internal and external assessments of the agency’s strengths and gaps in responding to victims/survivors who are using, abusing or addicted to drugs and alcohol. For example, conduct focus groups or a survey with drug and alcohol treatment programs to understand the perception of the agency within this community.

Addiction is a disease, not a moral issue.

- Develop a standard assessment for drug and alcohol use as part of the intake process and throughout the counseling process.
- Reconsider agency policies and requirements around clients who are actively using alcohol and drugs. As clients work through their trauma, their use of substances may increase, unless new skills are learned.
- Make certain that referrals to substance abuse programs used by staff and volunteers are aware of and sensitive to the specific needs of sexual violence victims/survivors. You have an ethical obligation to make proper referrals if the client's needs are out of your scope of service. Referring a client to an inappropriate program or service may not only diminish her/his trust in your agency's ability to help but also further traumatize the client.
- Offer some specific support groups for victims/survivors who are struggling with drugs and alcohol. Consider a group for parents or partners of drug and alcohol using victims/survivors.
- Collaborate with substance abuse service providers to provide comprehensive services for victims/survivors and their loved ones.
- Consider collaborating with other providers who also have connections to this population (even is not expressly mentioned in their purpose). Given the research about populations especially at risk, other providers might be those who work with youth, college students, individuals with disabilities, people who are homeless, people who are sex workers, those involved in the criminal justice system, or individuals who have co-occurring disorders.
- Based on feedback from clients or other service providers, consider alternative ways of providing services to those whose needs are not met. For example, sending a staff member to a treatment program to provide group or one-on-one counseling, pairing with an addictions treatment counselor to co-facilitate a group at your center or in a different location, and providing phone counseling to those who cannot come into the office due to their drug or alcohol addiction and/or recovery.

Educate, train and support staff and volunteers

- Encourage staff and volunteers to examine their own comfort level when working with victims/survivors who are using, abusing or addicted to drugs and alcohol.
- Assist staff in dealing with their own beliefs, feelings and prejudices about substance abuse and addiction.
- Provide ongoing training to enable staff to recognize the characteristics of substance abuse and to make appropriate referrals.

- Provide training for existing and new staff and volunteers on drug and alcohol-facilitated sexual assault as well as working with victims/survivors who are currently using. Make the connections between all forms of oppression, substance use and sexual violence.
- Provide training on how to empower victims/survivors who are drunk or high when they come to the hospital, call the hotline, or arrive for a scheduled or drop-in appointment. Be clear about appropriate procedures in these crisis situations, which should be empowering, non-discriminatory and non-judgmental.
- Contact local substance abuse programs to provide training for staff and volunteers. Training should address dealing with conflict stemming from philosophical differences among multiple helping systems and emphasize the importance of working together for the benefit of victims/survivors.
- Invite community speakers or victims/survivors of sexual assault who are in recovery or were victims of drug-facilitated sexual assault to present a workshop at your agency. Invite them as guest speakers at your sexual assault crisis training for staff and volunteers.
- Encourage staff and volunteers to attend an Alcoholics Anonymous (AA), Narcotics Anonymous (NA) or related meetings, which are open to anyone, so they can see what they are like. Unless attending for their own personal addiction, they should only observe. This allows staff to inform clients of what they can expect at these meetings.
- If staff or volunteers have struggled with substance abuse or addiction, encourage self care around these issues. Remind staff that their personal stories and experiences should remain outside of advocacy and counseling work with clients. Offer a time and place to discuss personal issues.

Encourage staff and volunteers to attend an Alcoholics Anonymous (AA), Narcotics Anonymous (NA) or related meetings, which are open to anyone, so they can see what they are like.

Collaborate

- Contact your local or regional substance abuse program for more information and opportunities to begin a collaborative relationship. Familiarize yourself on current issues and policies that may affect this population.
- Provide prevention programs in collaboration, highlighting the intersections of multiple oppressions, substance abuse, and sexual violence
- Provide counseling or psychoeducational groups in partnership with a substance abuse program, addressing the intersection of issues in the lives of victims/survivors. For instance, rape crisis center staff could provide individual or group counseling on site of a treatment program. Services can be available by phone to

those in residential treatment facilities. Drug and alcohol programs provide educational or support groups at rape crisis centers.

- When working with other providers, always discuss confidentiality issues with both the provider and the client.
- Identify and apply for new funding to bridge gaps and address the intersections of substance use, abuse and addiction and sexual violence
- Build support for legislative change, lending support to bills related to substance abuse issues, highlighting the impact on sexual violence victims and survivors.
- Collaborate with SANE nurses on how to best serve victims/survivors who arrive at the hospital while drunk or high.
- Advocates and other providers need cross-training to recognize co-occurring issues and make appropriate referrals.
- Develop a multidisciplinary team with people from rape crisis centers, substance abuse/addictions programs, as well as professionals from other backgrounds, for example, medical, education, mental health and criminal justice professionals.
- Arrange to provide space at your center for AA or NA meetings by contacting the local chapter.

Provide Concurrent Treatment

As previously discussed in this guide, research points to the critical need for concurrent treatment of substance abuse and sexual trauma.

- Research programs that have successfully set up working relationships with substance abuse treatment programs.
- Explore funding opportunities for this type of collaboration.
- Consider the implications on client confidentiality.

DIRECT SERVICES

Be nonjudgmental when working with victims/survivors who are actively using.

- Addiction is a disease, not a choice. It is not a moral issue. It is a disease that they will have for life but one that can be managed like any other chronic disease.
- Clients may miss appointments and phone calls which may be related directly to their addiction. However, it may also be related to other factors in her/his life, such as not having access to transportation, lack of consistent child care or not being ready for counseling. Work with clients to meet their needs while considering their life circumstances.

It is a disease that they will have for life but one that can be managed like any other chronic disease.

- Both sexual violence and substance abuse are mired in shame and self blame. Try to avoid further blame for relapse for continued substance use or abuse.

Empower All Victims/Survivors

- Validate a victim/survivor for coming forward for help and point out the strength it must have taken to do so. Those who are currently using or are in recovery face many barriers to coming forward in addition to the barriers already in place as a victim/survivor of sexual assault.
- No matter what, assure victims/survivors that they did not deserve the assault and are not to blame for it. Victims/survivors often believe they (or their substance use) have somehow caused the assault. Remind them that there is no acceptable “reason” for anyone to assault her/him and it is not her/his fault.
- Educate survivors on the risks and links between substance use/abuse and sexual violence.
- Acknowledge that recovery is a difficult process.
- Reassure victims/survivors that all information will be kept in strict confidence and will not be released to anybody without their permission. If there are situations where confidentiality must be breached, inform victims/survivors of this early on in the process.
- Discuss safety, coping mechanisms, support systems, and options for care, including health, emotional and legal services.
- Normalize reactions to the assault, including use/abuse of drugs or alcohol.
- If the victim/survivor expresses concern over her/his use of drugs or alcohol, ask if s/he would like information on a treatment program or other substance abuse services.
- If after providing options and resources to a victim/survivor, s/he decides not to go to the hospital, work with law enforcement or see a counselor, respect that decision as the best one for him/her at this moment—just as you would with any victim/survivor.
- Choices made by a victim/survivor may or may not be related to their addictions. Remember to let the client decide what she or he needs right now. For some victims/survivors their substance use or abuse may not be the most pressing issue for them.
- If someone has called the hotline and is drunk or high, keep them focused on talking about the sexual assault. It might be necessary to ask them to call back when they are not under the influence so you can help them in a more meaningful way.
- Learn what drug use and the implications of coming forward might look like in various communities.

Victims/survivors often believe they (or their substance use) have somehow caused the assault. Remind them that there is no acceptable “reason” for anyone to assault her/him and it is not her/his fault.

Recognize that substance abuse may be related to coping with the assault.

- In order for her/him to maintain recovery, alternative coping skills need to be developed. Assist victims/survivors by helping them find an alternate means of empowerment as replacement for the sense of power produced by substance use.

Engage with victims/survivors where they are.

- The goal is to focus on what the client wants to achieve, not necessarily to get her/him into treatment.
- Use language that works for the victim/survivor and is familiar to her/him. Mirror their language.
- If a certain addiction treatment method is working for someone, explore how you can use aspects of it in counseling sessions. For instance, if something about the 12 Steps resonates with someone, explore what works for them and determine if there are aspects that can be adapted to sexual assault counseling for this client.
- Recognize that a client may be unable to attend sessions in person if experiencing withdrawal symptoms. Determine if other options for support are available through the center or otherwise.
- Just as you would not tell a victim to leave an abuser, you cannot tell or demand the victim/survivor to stop using. Just as there are many reasons why a victim may stay in an abusive relationship, there are many reasons why someone may use/abuse drugs/alcohol.

Have open conversations about how substance abuse might affect the healing process from a sexual assault.

- Ask questions. Sensitively and thoroughly identify patterns of past and current alcohol and drug use. When asking about their drug and alcohol use, do so in a non-judgmental way: “Has your drug (or alcohol) use increased since this happened?” “How do you feel about your drug/alcohol use?”
- Even if initial encounters with a victim/survivor show no signs of substance use/abuse, it may develop in the future. Discussion of healthy coping skills for all victims/survivors is important.
- Help the victim/survivor sort out how to let go of the self-blame and sense of responsibility for the sexual assault while taking responsibility for their recovery process and any problems their addiction may have created.
- Help the victim/survivor prepare for possible setbacks to recovery. It is common for people to relapse as memories of the assault

return and the related reactions to this emerge. Relapse is not failure but a step in a very difficult process.

- Ask clients openly about their use/abuse of drugs and alcohol. Using may be part of their “normal” existence and coping patterns. This does not mean it is healthy. They may not wish to discuss it in detail and that is ok. Be aware that some people may minimize their substance use, as they may have learned to do in various parts of their lives.
- Talk about addiction and how it impacts recovery. What triggers her/him to use? How does this relate to the sexual assault?
- Victims/survivors who are actively using often feel judged or like they cannot talk about their addiction on top of the sexual assault. Communicate that you will not judge them for using, and that you want to focus on whatever would be most helpful to them.
- Do not need to use the word “addiction” or label someone as an “addict”. Use the terms that they use.

Discuss safety issues.

- The essence of being a drug user is dangerous. Addicts may enter risky situations in order to get their drug of choice. Safety planning may look more like risk reduction.

Be informed about treatment options/ providers available in your community.

- Know what to refer out to other providers regarding substance abuse while providing empowering supportive rape crisis services.
- Ideally, victims should be referred to a treatment provider sensitive to the issues of sexual violence.
- If a client expresses that she/he is ready to quit using/abusing drugs or alcohol, call a drug and alcohol program for information on what next steps might be appropriate.
- Parents or partners of victims/survivors may benefit from referrals to support for family members of addicts, if appropriate.
- Educate yourself on various available services including what the hospital emergency room can offer as well as specific drug and alcohol treatment programs. Cost, location, experience with sexual assault issues are all relevant pieces of information of which to be aware.
- Be informed about various addiction treatment principles. For instance, some victims/survivors have difficulty integrating the 12 Step concept of powerlessness with the work of healing from sexual violence through empowerment and regaining a sense of personal power.

Talk about addiction and how it impacts recovery. What triggers her/him to use? How does this relate to the sexual assault?

- Have updated schedules of local AA and NA meetings available to distribute to clients. Even if someone is still using, they can attend meetings. Provide as much information as possible, such as times, days, locations, relevant web site or phone number. Additionally, have substance abuse hotline numbers available for distribution to victims/survivors and/or posted in your center.

PUBLIC POLICY

- Educate yourself on areas of unique concern in your state or region to victims/survivors who use or abuse drugs and alcohol or who are victims/survivors of drug/alcohol-facilitated sexual assault.
- Evaluate policies and identify their effects, intended or unintended, along racial, gender, sexual orientation, ethnic, age, class, ability, and other social lines.
- Build support for legislative change, lending support to bills related to substance abuse issues, highlighting the impact on sexual violence victims/survivors.
- Meet with substance abuse programs to identify areas of overlap between sexual assault issues and substance abuse issues. Partner on how to effectively lobby for certain legislation or policies.
- Attend rallies, speak outs, and press conferences to show your support and lend your voice to issues surrounding substance abuse and addictions. Ask substance abuse programs to do the same for sexual assault issues.
- Learn about the broad spectrum of what is considered public policy. Public policy includes federal, state, and local laws that impact victims and survivors of sexual violence and address: prevention strategies; the configuration and operation of agencies and systems that respond to and prevent sexual violence; policies and protocols; and funding for the provision of services to victims and survivors.

EDUCATION/OUTREACH

- Partner with drug and alcohol outreach workers. Collaboratively go into communities to talk about the intersections between substance abuse and sexual violence.
- Student Assistance Programs (SAP) funded by substance abuse programs may be a good entry into schools.
- Provide training for other professionals with facilitators from both the substance abuse and sexual assault fields.

PREVENTION

Drug and alcohol addiction is a preventable disease. Research has shown that prevention programs that involve the family, schools, communities, and the media are effective in reducing drug abuse (NIDA). Likewise, the Spectrum of Violence Prevention involves a multi-faceted approach: strengthening individual knowledge and skills; promoting community education; educating providers; fostering coalitions and networks; changing organizational practices; influencing policies and legislation (Davis, Fujie Parks, & Cohen, 2006).

Until recently, the predominant approach in the field of health promotion sought to motivate behavior change by highlighting risk. However, the social norms approach uses a variety of methods to correct negative misperceptions (usually overestimations of use), and to identify, model, and promote the healthy, protective behaviors that are the actual norm in a given population (National Social Norms Institute, 2008). In other words, rather than focusing on the problems and deficits of particular populations, promote the attitudinal and behavioral solutions and assets that are the actual norms in various populations (National Social Norms Institute). This approach has proven effective.

For example, college students often believe that their fellow classmates are drinking and using drugs at much higher rates than the reality. Awareness of the reality changes their behavior.

Because of the reciprocal relationship between substance use, abuse and addiction and sexual violence perpetration and victimization, it can be assumed that prevention of substance abuse will lead to a reduction of sexual violence and, conversely, the prevention of sexual violence will lead to a reduction in substance abuse. Effective preventive programs address sexual assault and substance abuse as a linked problem. These programs may start in the early years of dating so young people can develop realistic views of drugs, alcohol, and sex (United Educators).

Resources

PENNSYLVANIA RESOURCES

Bureau of Drug and Alcohol Programs, PA Department of Health.

(877) PA-HEALTH (877-724-3258)

www.dsf.health.state.pa.us

Offers information on treatment, prevention, and more, including drug and alcohol publications, policy bulletins, information bulletins, provider directories, and web link resources.

Co-occurring Resource and Information Center

www.pa-co-occurring.org

Resources and information related to mental health and substance use disorders.

NATIONAL RESOURCES

GENERAL INFORMATION

Al-Anon Family Group Headquarters

<http://www.al-anon.alateen.org>

Makes referrals to local Al-Anon groups, which are support groups for spouses and other significant adults in an alcoholic person's life. Also makes referrals to Alateen groups, which offer support to children of alcoholics.

Locations of Al-Anon or Alateen meetings worldwide can be obtained by calling (888) 4AL-ANON (425-2666). Free informational materials can be obtained by calling (757) 563-1600.

Alcoholics Anonymous (AA) World Services

(212) 870-3400

<http://www.aa.org>

Makes referrals to local AA groups and provides informational materials on the AA program. Many cities and towns also have a local AA office listed in the telephone book.

Deaf and Hard of Hearing 12-Step Recovery Resources

<http://www.dhh12s.com/>

Provides information on AA groups and activities that offer American Sign Language services for the deaf and hard of hearing. It links to online meetings, offers information on how to construct a meeting for deaf and hard of hearing persons, provides an information packet, and suggests guidelines and literature on people with alcohol and other drug problems with special needs.

Faces and Voices of Recovery

<http://www.facesandvoicesofrecovery.org>

Faces & Voices of Recovery is a national organization of individuals and organizations joining together to support local, state, regional and national recovery advocacy by increasing access to research, policy, organizing and technical support; facilitating relationships among local and regional groups; improving access to policymakers and the media; and providing a national rallying point for recovery advocates.

National Association for Children of Alcoholics (NACoA)

(888) 554-COAS or (301) 468-0985

<http://www.nacoa.net>

Works on behalf of children of alcohol- and drug-dependent parents.

National Clearinghouse for Alcohol and Drug Information

(800) 729-6686 (English)

(877) 767-8432 (Spanish)

<http://ncadi.samhsa.gov>

One-stop resource for the most current and comprehensive information about substance abuse prevention and treatment and prevention.

National Council on Alcoholism and Drug Dependence (NCADD)

(800) 622-2255

<http://www.ncadd.org>

Provides telephone numbers of local NCADD affiliates (who can provide information on local treatment resources) and educational materials on alcoholism.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

(301) 443-3860

<http://www.niaaa.nih.gov>

Free publications on all aspects of alcohol abuse and alcoholism. Many are available in Spanish. Call, write, or search the NIAAA Web site for a list of publications and ordering information.

National Institute on Drug Abuse (NIDA)

<http://www.nida.nih.gov>

SUPPORT AND REFERRALS

Alcohol Abuse and Crisis Intervention

(800) 234-0246

Alcohol and Drug Abuse Helpline and Treatment

(800) 234-0420

Alcohol and Drug Referral Hotline

(800) 252-6465 (24 hours)

Al-Anon, Alateen Family Group Hotline

(800) 344-2666

The Al-Anon Family Groups include relatives and friends of alcoholics who share their experience, strength and hope in order to solve their common problems. Al-Anon is not allied with any sect, denomination, political entity, organization or institution. There are no dues for membership.

Alcoholics Anonymous (AA)

www.aa.org

Through the web site you can learn more about AA as well as find times and places of local AA meetings or events. The primary purpose is to stay sober and help other alcoholics to achieve sobriety. There are no dues or fees; AA is not allied with any sect, denomination, politics or organization.

Cocaine Anonymous

(800) 347-8998

www.ca.org

Crystal Meth Anonymous

www.crystalmeth.org

DrugRehabs.org

(866) 845-8975 (24-hour)

www.drug-rehabs.org

Provide assistance in finding a rehabilitation program for specific drug and alcohol problems.

Focus on Recovery Helpline

(800) 234-1253

Heroin Anonymous

www.heroin-anonymous.org

Marijuana Anonymous

(800) 766-6779

www.marijuana-anonymous.org

Narcotics Anonymous

(818) 773-9999

National Cocaine Hotline

(800) COCAINE (262-2463)

National Drug Information Treatment and Referral Hotline

800-662-HELP (4357)

Information, support, treatment options and referrals to local rehab centers for any drug or alcohol problem. Operates 24 hours, seven days a week.

TECHNICAL ASSISTANCE

Getting Safe and Sober: Real Tools You Can Use, An Advocacy Teaching Kit for Working with Women Coping with Substance Abuse, Interpersonal Violence and Trauma, 2nd edition

Alaska Network on Domestic Violence and Sexual Assault, 2008.
Available through <http://www.andvsa.org/pubs/pubs.htm>

Guide to States: Treatment Standards for Women with Substance Use Disorders

National Association of State Alcohol and Drug Abuse Directors with assistance from Women's Services Network. August 2008.

Principles of Drug Addiction Treatment: A Research Based Guide

NIH Publication No. 00-4180. Printed October 1999, Reprinted July 2000.
Available through www.nida.nih.gov.

The Relationship Between Alcohol Consumption and Sexual Violence

Jeanette Norris, PhD. December, 2008.

A VAWnet Applied Research Paper. VAWnet is a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence. Available through <http://www.vawnet.org>

Responding to Physical and Sexual Abuse in Women with Alcohol and Other Drug and Mental Disorders: Program Building

Bonita Veysey, PhD, Colleen Clark, PhD Editors. Hawthorn Press, Inc., 2004.

Substance Abuse in Brief Fact Sheet: An Introduction to Mutual Support Groups for Alcohol and Drug Abuse. Spring 2008, Volume 5, Issue 1.

Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration and U.S. Department of Health and Human Services.

Available through SAMHSA's Health Information Network
1-877-SAMHSA-7 (1-877-726-4727) or www.samhsa.gov/shin or www.kap.samhsa.gov/products/brochures/pdfs/saib_spring08_v5i1.pdf

Trauma Informed Addictions Treatment: A 20 Session Psycho-Educational Group Intervention Designed To Address Substance Abuse Issues Within a Trauma Informed Perspective

M. Harris, R. Fallot, A. Holzapfel, C. Mitchell, K. Singleton, R. Wolfson, Community Connections, Inc. Washington, DC, Copyright Winter, 2001.

A Woman's Way Through the Twelve Steps

Stephanie Covington, PhD. Hazelden, 1994.

This illuminating view of how women understand and process the Twelve Steps of Alcoholics Anonymous explores such essential topics as spirituality, powerlessness, and the emergence of a woman's sense

of feminine soul. “A Woman’s Way Through the Twelve Steps” remains true to the underlying spiritual truths of the Twelve Step program of Alcoholics Anonymous while triumphantly overcoming the traditional male orientation of Alcoholics Anonymous.

Women & Addiction: Gender Issues in Abuse and Treatment

Caron Treatment Centers, 2004

Women With Co-Occurring Disorders and Violence Study

G . McHugo , N . Kammerer , E . Jackson , L . Markoff , M . Gatz , M . Larson , R . Mazelis , K . Hennigan. Journal of Substance Abuse Treatment, Volume 28, Issue 2.

SAMHSA funded study investigating promising models for treating women with substance abuse problems and trauma histories, symptoms, or post traumatic stress disorder. Focuses on the first stage of treatment: establishing safety and stabilization.

Working with Addicted Survivors of Sexual Assault

Texas Association Against Sexual Assault (TAASA). Available through http://www.taasa.org/member/pdfs/wassa_manual.pdf

FILMS AND VIDEOS

Numbing the Pain: Substance Abuse and Psychological Trauma

Explores the functions of substance abuse in trauma survivors’ lives and the difficulties faced in therapy. Two men who experienced combat trauma and two women who are adult survivors of child abuse discuss their work in overcoming these effects.

Available through: <http://www.cavalcadeproductions.com/adult-survivors.html>

Spin the Bottle

This 45-minute video explores the role that alcohol plays in college life. Award-winning media critics Jean Kilbourne and Jackson Katz examine the relationship between media, gender, and alcohol, while campus health professionals speak about the impact of heavy drinking on the lives of students. Throughout the video, young adults give voice to the complexity of the issues. It offers concrete strategies for countering the ubiquitous presence of alcohol propaganda and challenges young people to make conscious decisions about their own lives. Available through: Media Education Foundation, (800) 897-0089, <http://www.mediaed.org>

Trauma and Substance Abuse: Therapeutic Approaches and Special Treatment Issues

This video series describes the special trauma and substance abuse treatment issues that this dual diagnosis presents. For survivors of child

abuse and/or combat relate how trauma and substance abuse have impacted their lives.

Available through: <http://www.cavalcadeproductions.com/adult-survivors.html>

Undetected Rapist

This video is a reenactment of an interview with a fraternity member conducted by Dr. David Lisak as part of his research on undetected rapists which illustrates key characteristics of serial and acquaintance rapists and the tactics they use to target unsuspecting women and carry out an assault. The reenactment in this video is excerpted from a video/workbook curriculum titled Understanding Sexual Violence: The Judge's Role in Stranger and Nonstranger Rape and Sexual Assault Cases.

Available through: National Judicial Education Program, (212) 925-6635 or <http://www.nowldef.org/html/njep/video.shtml#undetected>

Wounds That Won't Heal: The Adverse Childhood Experiences Study

Three men and five women, adult survivors of adverse childhood experiences, describe the effects of these experiences in their lives.

Available through: <http://www.cavalcadeproductions.com/adult-survivors.html>

Appendix

GLOSSARY OF TERMS

People who have experienced sexual violence and addiction do not necessarily consider themselves “victims” or “addicts.” Even with the best intentions, as soon as a frame or definition is placed around an issue, there is risk of losing sight of the whole person and only seeing “the problem” or “condition” (Pennsylvania Coalition Against Rape [PCAR], 2008).

The following terms are listed in order to help understand and define the terms used throughout this guide. These terms may be defined differently by certain groups and are by no means meant to place anyone into rigid “boxes”. When working with victims/survivors, what is important is how individuals define their own experiences and that counselors reflect their language back to them.

Please note that it is not an advocate or counselor’s job to determine if a victim/survivor is abusing drugs or alcohol, addicted or dependent. This is best determined by a treatment provider.

Adapted from:

1. Substance Abuse and Mental Health Services Administration [SAMHSA]
2. World Health Organization [WHO]
3. Alaska Network on Domestic Violence and Sexual Assault [ANDVSA]

Abstinence: Refraining from drug use or from drinking alcoholic beverages, whether as a matter of principle or for other reasons. 2

Addict: Refers to a person who is addicted to drugs and/or alcohol.

Addict-phobia: Includes fear of people with substance use problems, disorders or dependence and addiction, holding negative stereotypes pertaining to people suffering from substance use problems; refraining from offering services, support or respect. Addict-phobia creates barriers for those who are afraid of getting labeled and fearful about seeking help, negatively impacts people struggling to recover daily and is a form of oppression in our society. 3

Addiction, drug or alcohol: Repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means. Typically, tolerance is prominent and a withdrawal syndrome frequently occurs when substance use is interrupted. The life of the addict may be

dominated by substance use to the virtual exclusion of all other activities and responsibilities. 2

The DSM-IV (Diagnostic Statistical Manual IV) lists seven warning signs of addiction:

- 1) Tolerance
- 2) Withdrawal
- 3) Drinking alcohol in larger amounts or over a longer period of time than intended
- 4) Persistent desire to cut down
- 5) Great deal of time spent in activities necessary to obtain alcohol
- 6) Interfered functioning, either social, academic or recreational
- 7) Continued use despite knowledge of having persistent or recurrent physical or psychological problems

Alcoholic: An individual who suffers from alcoholism. Note that this noun has a different meaning from the adjective in alcoholic beverage. 2

Alcoholism: A term of long-standing use and variable meaning, generally taken to refer to chronic continual drinking or periodic consumption of alcohol, which is characterized by impaired control over drinking, frequent episodes of intoxication, and preoccupation with alcohol and the use of alcohol despite adverse consequences. 2

Binge: Using large amounts of alcohol or other drugs in a short period of time. Binge drinking for women may be defined as four or more drinks in one drinking session at least once every two weeks but being abstinent in between those times. 3

Co-Occurring Disorder: Clinical terms referring specifically to patients who meet the diagnostic criteria for a substance use disorder as well as the diagnostic criteria for:

- 1.) An organic mental or developmental disorder
- 2.) A major psychiatric disorder with or without current symptomology
- 3.) A personality disorder or
- 4.) A compulsive disorder such as an eating or pathological gambling disorder. 3

Detoxification (Detox): The process of providing medical care during the removal of dependence-producing substances from the body so that withdrawal symptoms are minimized and physiological function is safely restored. Treatment includes medication, rest, diet, fluids and nursing care. 3

Recovery: Maintenance of abstinence from alcohol and/or other drug use by any means. The term is particularly associated with mutual help groups, and in Alcoholics Anonymous (AA) and other twelve-

step groups refers to the process of attaining and maintaining sobriety. Since recovery is viewed as a lifelong process, an AA member is always viewed internally as a “recovering” alcoholic, although “recovered” alcoholic may be used as a description to the outside world. 2

Relapse: A return to drinking or other drug use after a period of abstinence, often accompanied by reinstatement of dependence symptoms. Some writers distinguish between relapse and lapse (“slip”), with the latter denoting an isolated occasion of alcohol or drug use. 2

Self-help group: A group in which participants support each other in recovering or maintaining recovery from alcohol or other drug dependence or problems, or from the effects of another’s dependence, without professional therapy or guidance. Prominent groups in the alcohol and other drug field include Alcoholics Anonymous, Narcotics Anonymous, and Al-Anon (for members of alcoholics’ families), which are among a wide range of twelve-step groups based on a non-denominational, spiritual approach. It also refers to groups that teach cognitive behavioral and other techniques of self-management. 2

Sexual violence: Occurs whenever a person is forced, coerced, and/or manipulated into any unwanted sexual activity, including when she/he is unable to consent due to age, illness, disability, or the influence of alcohol or other drugs. Sexual violence includes rape, incest, child sexual assault, ritual abuse, non-stranger rape, statutory rape, marital or partner rape, sexual exploitation and trafficking, sexual contact, sexual harassment, exposure, and voyeurism. Sexual violence is a crime not typically motivated by sexual desire but by the desire to control, humiliate, dominate and/or harm. It is often interconnected with other forms of violence and oppression.

Substance: Drug (alcohol, or other legal or illegal drug) that affects the body or mind. 1

Substance Abuse: Excessive, chronic use of a drug resulting in impairment of daily living.

According to the DSM-IV Symptoms of Abuse, abuse is manifested by one of the following in a 12-month period due to substance use:

- Recurrent failure to fulfill role obligations
- Recurrent use in physically hazardous situations
- Recurrent legal problems
- Recurrent social and interpersonal problems

Substance Dependence: Considered to be a more severe substance use problem than abuse because it involves the psychological and physiological effects of tolerance and withdrawal. Although individuals may meet the criteria specified for both dependence and abuse, persons meeting the criteria for both are classified as having dependence, but not abuse. 1

According to the DSM-IV Symptoms of Dependence, dependence is manifested by three or more of the following in a 12-month period due to substance use:

- Tolerance
- Withdrawal
- Taken in larger amounts or longer periods of time than intended
- Unsuccessful attempts to cut down or control
- Great deal of time to obtain, use, or recover
- Social, occupational, or recreational activities reduced or stopped
- Continued use despite medical, legal, job, or relational problems

Tolerance: The need for significantly larger amounts of substance to achieve intoxication. Drug effects decrease if the usual amount is taken.

3

Treatment: Programs designed to help an individual overcome alcohol and /or drug abuse or addiction. Abstinence is typically the primary goal. There are various forms of treatment which may be used in conjunction with one another or individually. Examples include medication, self-help, or psychotherapy. Please see the “Treatment Options” section in this guide for more information.

Withdrawal: Adverse reaction after a reduction of substance. 3

Victim/survivor: Refers to those who have experienced sexual violence at some point in their lifetime. Some people prefer the word survivor while others prefer the word victim. Some prefer to use person-first language, i.e., “a person who was sexually assaulted.” Still others prefer no label at all. For the purposes of this guide, the term “victim/survivor” is used.

COMMONLY ABUSED DRUGS

STIMULANTS	DEPRESSANTS
<p>AMPHETIMINES Include Adderall and Ritalin</p>	<p>OPIATES Include Morphine, Opium, Heroin</p> <p>As well as pain killers such as Percodan, Oxycontin/Oxycodone, Vicodin, Lortab, Darvon, Fentanyl, etc.</p>
<p>METHAMPHETAMINES</p>	
<p>COCAINE/CRACK</p>	<p>BARBITUATES Including Tuinal, Seconal, Amytal, and Phenobarbital</p> <p>BENZODIAZEPINES Include Ativan, Valium, Xanax, Tranxene, Halcion, Klonopin, Librium, and Serax</p>
<p>PRESCRIPTION DIET PILLS</p> <p>✓ Didrex</p> <p>✓ Plegrine</p>	

<p>CLUB DRUGS</p> <ul style="list-style-type: none"> ✓ Ecstasy ✓ Ketamine (Special K) 	<p>HALLUCINOGENS</p> <p>Including PCP, LSD, Mescaline, Peyote, Mushrooms, Marijuana, Salvia</p>
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Why People Use These Drugs...

Amphetamines

Decreases appetite to lose weight or to keep weight off. Increase focus and concentration, more energy, produces feelings of competence and that you can get things done. Decreased need for sleep. Commonly used by college students to “pull all-nighters”.

Methamphetamines

Same benefits of amphetamines but more intense. Also may produce a longer lasting high, dependent upon the quality of the drug.

Cocaine (Coke) and Crack

(Coke) Produces euphoria, increased energy. Many users report increased confidence and social ability. Also can cause weight loss and decrease in appetite, which attracts some users.

(Crack) Crack is similar but produces more intense euphoria than powder cocaine. However, the high is shorter, leading the user to use more and more to stay feeling high.

Prescription Diet Pills

Primary benefit is decreased appetite and increased energy.

Opiates

Produces euphoria and sleepiness, also numbing sensations, kills pain.

Heroin and opium produce the most intense euphoria of all the opiates. Some users describe the feeling as having “an entire body orgasm”. A heroin user will use opiate pills if they cannot get heroin.

Barbituates

Commonly used as sleeping aids. Some people may use them to “come down” from a stimulant drug like cocaine. Phenobarbital is also used to control seizures.

Benzodiazepines (Benzos)

Alleviates anxiety and stress. Produces a sense of relaxation and calm. Also used to control panic attacks.

Hallucinogens

Produces intense feelings and vivid hallucinations. Many users believe these drugs help them to “expand their minds” and reach higher levels of spirituality. These drugs are also sometimes used in religious/spiritual rituals.

Inhalants

Commonly used by adolescents because they are more easily accessible than harder drugs. Produces quick, intense high. Nitrous oxide is sometimes called “hippie crack” because the high is similar (short and intense) but not as strong as crack.

Club Drugs

Ecstasy is popularly used in clubs for its effects of increased tactile sensitivity, feelings of sexual arousal, and affectionate urges. It also elevates one’s mood and increases energy so users can “dance all night long”.

Ketamine produces euphoria and an “out of body” type of high.

GENERAL GUIDELINES FOR IDENTIFYING PEOPLE WHO MAY BE AFFECTED BY ALCOHOL OR OTHER DRUG USE

1. LOOK FOR CHANGE IN BEHAVIOR, ATTITUDE OR APPEARANCE
2. IDENTIFY BEHAVIOR WHICH DOESN’T SEEM RIGHT
 - Individual cannot stay awake
 - Is unable to sit still
 - Is disoriented or confused for no apparent reason
 - Laughs or cries at inappropriate times
 - Displays rapid shifts in mood
 - Slurs speech
 - Speech is rapid and loud, and it is difficult to follow person’s train of thought
3. DO NOT AUTOMATICALLY ASSUME BEHAVIOR IS CAUSED BY ALCOHOL OR OTHER DRUG USE. RULE OUT OTHER CAUSES FIRST.
 - Individual is physically ill (e.g., flu)
 - Is upset about some obvious problem (e.g., has been victimized by sexual partner or other person; is concerned about son’s gang involvement)
 - Person’s physician has recently prescribed new medication, particularly for psychiatric reasons
4. DO NOT ARGUE WITH PEOPLE YOU PROVIDE SERVICES FOR REGARDING THEIR USE OF ALCOHOL OR OTHER DRUGS

Adapted from: Domestic Violence/Substance Abuse Interdisciplinary Task Force, IL DHS (7/2000). As cited in Getting Safe and Sober:

CARON FOUNDATION SUBSTANCE ABUSE SCALE FOR WOMEN: 25 QUESTIONS ABOUT YOUR ALCOHOL AND SUBSTANCE USE

Eileen Beyer, Ph.D., Susan Gordon, Ph.D., Marianne Henninger, B.A., C.A.C.

Answer Yes or No to the following questions as honestly as you can, thinking specifically of the last six months. Drug use in these questions refers to any chemical substance that has a mood-altering effect. This includes prescription and over-the-counter medications.

- Y N** Do you like the feeling that alcohol or drugs give you?
- Y N** Do you look forward to times when you can drink or use drugs without interference, perhaps when your responsibilities are less than usual?
- Y N** Do you feel that you deserve to have a drink or use drugs to help you unwind in the evening after your work, parenting or other home responsibilities are complete for the night?
- Y N** Does drinking or drug use make it easier for you to cope with competing demands?
- Y N** Does drinking or drug use temporarily lessen your loneliness and/or emptiness?
- Y N** Do you believe drinking or using drugs helps you to fit in socially?
- Y N** Do you believe drinking or using drugs helps you to cope with a difficult relationship?
- Y N** Do you have fewer arguments when you are drinking or using drugs?
- Y N** Does drinking or drug use allow you to more easily express your anger?
- Y N** Does drinking or drug use soften bad memories and the distress associated with them?
- Y N** Do you use alcohol or drugs to numb feelings of grief or loss?
- Y N** Do you drink or use drugs to control your weight?
- Y N** Do you drink or use drugs to lessen distress about your appearance?
- Y N** Do you drink or use drugs to numb uncomfortable feelings in sexual encounters?

- Y N** Do you drink or use drugs to enhance sexual interest or responsiveness?
- Y N** Does drinking or drug use help you get to sleep more easily?
- Y N** Does drinking or drug use prevent you from getting restful sleep?
- Y N** Does alcohol or drug use help take away anxious thoughts and feelings?
- Y N** Do you believe that alcohol or drug use enhances your intellectual ability or creativity?
- Y N** Do you drink or use drugs to enhance your work or school performance?
- Y N** Have you experienced more physical complaints such as chronic pain, gastrointestinal, or gynecological problems since your drinking or drug use has become more regular?
- Y N** Do you sometimes drink or use more drugs than the limits you set for yourself?
- Y N** Have you noticed that it takes more alcohol or drugs to achieve the same feeling than it did when you first began your use?
- Y N** Do you have trouble cutting back on your drinking or drug use?
- Y N** Do you feel more disconnected from your spiritual self and experience less satisfaction with life?

A YES answer to four or more questions suggests that you may have problems with drug or alcohol use. Also, if any of these questions made you feel uncomfortable or question your drug or alcohol use, it is important for you to consider seeking a professional evaluation of your substance use.

This is not a standardized diagnostic instrument and is intended only to provide an initial screening to suggest need for professional evaluation of substance use.

ANNOTATED BIBLIOGRAPHY SEXUAL VIOLENCE AND SUBSTANCE ABUSE

Resources compiled by Angeline Binick.

- I. General
- II. Substance Abuse and Perpetration
- III. Substance Abuse and Adult Victimization
- IV. Substance Abuse and Childhood Victimization
- V. Diverse Populations
 - LGBT
 - African Americans
 - Native Americans / First Nations

- Latinas
 - Survivors Involved in the Criminal Justice System
- VI. Treatment and Services
- VII. Societal Attitudes

I. GENERAL

Clark, H. Westley, Carmen L. Masson, Kevin L. Delucchi, Sharon M. Hall, and Karen L. Sees. 2001. "Violent Traumatic Events and Drug Use Severity." *Journal of Substance Abuse Treatment*. 20(2): pp. 121-127.

This article explores the correlation between violent traumatic life events, post-traumatic stress disorder (PTSD), and substance abuse. In a study of 150 opioid-dependent substance abusers, Clark et al. uncovered a high rate of PTSD among respondents and observed that PTSD-related symptoms were associated with greater drug abuse severity.

Miranda, Robert Jr., Lori A. Meyerson, Patricia J. Long, Brian P. Marx, and Sharon M. Simpson. 2002. "Sexual Assault and Alcohol Use: Exploring the Self-Medication Hypothesis." *Violence and Victims*. 17(2): pp. 205-217.

In a study of 318 undergraduate female victims of sexual assault, Miranda et al. found that a history of sexual assault was associated with increased psychological distress, which in turn was correlated with increased alcohol consumption. The authors argue that these results are consistent with the hypothesis that some sexual assault victims consume alcohol to self-medicate their emotional distress. However, the authors encourage further research on the role of other functions of alcohol use (i.e., recreation) and other psychological and social variables on post-rape alcohol consumption.

Sexual Violence and Substance Abuse. Madison, WI: Wisconsin Coalition Against Sexual Assault, 2000. <http://www.prandicenter.org/Resources/sexual%20assault%20and%20substance.pdf>. Accessed 6 March 2009

This fact sheet looks at the relationship between sexual violence and substance abuse, with attention to the role of alcohol and drugs in sexual violence perpetration, victimization, and post-victimization coping.

Washington Coalition of Sexual Assault Programs. 2005. Sexual Assault and Substance Abuse Issue. *Research & Advocacy Digest*. 8(1): pp. 1-15. <http://www.wcsap.org/pdf/DigestOct05.pdf>. Accessed 6 March 2009.

This issue of WCASP's *Research & Advocacy Digest* discusses correlations between substance abuse and sexual violence. This publication features an interview with Lindsay Palmer, director of education for the King County Sexual Assault Resource Center, who discusses trauma, treatment issues, and the role of specific drugs (i.e.,

alcohol, methamphetamines) in sexual assault. Finally, this digest reviews of various research articles on sexual violence and substance abuse, with attention to diverse populations.

II. SUBSTANCE ABUSE AND PERPETRATION

Abbey, Antonia, A. Monique Clinton-Sherrod, Pam McAuslan, Tina Zawacki, and Philip O. Buck. 2003. "The Relationship Between the Quantity of Alcohol Consumed and the Severity of Sexual Assaults Committed by College Men." *Journal of Interpersonal Violence*. 18(7): pp. 813-833.

Abbey et al. gathered data from 113 undergraduate men who reported that they had committed a sexual assault since the age of 14. The authors found that higher quantities of alcohol consumed by sexual assault perpetrators were correlated with greater degrees of aggression against victims.

Abracen, Jeffrey, Jan Looman, and Dana Anderson. 2000. "Alcohol and Drug Abuse in Sexual and Nonsexual Violent Offenders." *Sexual Abuse: A Journal of Research and Treatment*. 12(4), pp. 263-274.

In a study of 106 sexual offenders and 24 nonsexual violent offenders, Abracen et al. found that sexual offenders were more likely to abuse alcohol than nonsexual violent offenders. Nonsexual violent offenders, on the other hand, were more likely to have reported a history of other forms of substance abuse.

Baltieri, Danilo Antonio and Arthur Guerra de Andrade. 2008. "Drug Consumption Among Sexual Offenders Against Females." *International Journal of Offender Therapy and Comparative Criminology*. 52(1): pp. 62-80.

This study looked at drug consumption among 133 sexual offenders who had committed offenses against women and girls. Baltieri and Guerra de Andrade found that sexual offenders against women were more likely to have substance abuse problems and higher impulsivity levels than sexual offenders against female children and adolescent girls. The authors conclude that the combination of drug abuse and higher levels of impulsivity may contribute to sexual aggression against women.

Brecklin, Leanne R. and Sarah E. Ullman. 2001. "The Role of Offender Alcohol Use in Rape Attacks: An Analysis of National Crime Victimization Survey Data." *Journal of Interpersonal Violence*. 16(1) pp. 3-21.

Brecklin and Ullman discuss perpetrator alcohol use prior to sexual assault. Drawing data from the 1992-1996 National Crime Victimization Survey, the authors observe that offender alcohol use was associated

with stranger sexual assaults, night assaults, outdoor locations for assaults, and greater victim resistance. Additionally, perpetrator alcohol use was associated with a decreased likelihood of rape completion.

III. SUBSTANCE ABUSE AND ADULT VICTIMIZATION

Messman-Moore, Terri L. and Patricia J. Long. 2002. "Alcohol and Substance Use Disorders as Predictors of Child to Adult Sexual Revictimization in a Sample of Community Women." *Violence and Victims*. 17(3): pp. 319-340.

In a study of 300 adult women, Messman-Moore and Long found that rates of adult sexual victimization were higher among childhood sexual abuse (CSA) survivors than non-victims. Adult rape victims were more likely to report alcohol and substance abuse disorders than women who had not experienced rape as adults. The authors conclude that CSA and substance abuse disorders increase women's risk for sexual victimization as adults.

Mohler-Kuo, Meichun, George W. Dowdall, Mary P. Koss, and Henry Wechsler. 2004. "Correlates of Rape While Intoxicated in a National Sample of College Women." *Journal of Studies on Alcohol*. January 2004, pp. 37-45. <http://www.hsph.harvard.edu/cas/Documents/rapeintox/037-Mohler-Kuo.sep1.pdf>. Accessed 9 March 2009.

Mohler-Kuo et al. draw upon data from 119 colleges and universities participating in three Harvard School of Public Health College Alcohol Study surveys. The authors found that 4.7% of female respondents reported being raped, and 72% of those victims experienced rape while intoxicated. Women under the age of 21 who were white, resided in sorority houses, drank heavily in high school, used illegal drugs, and attended colleges with high rates of drinking were at a higher risk of experiencing rape while intoxicated. The authors highlight the need for campus alcohol prevention programs that address sexual violence.

IV. SUBSTANCE ABUSE AND CHILDHOOD VICTIMIZATION

Boles, Sharon M., Vandana Joshi, Christine Grella, and Jean Wellisch. 2005. "Childhood Sexual Abuse Patterns, Psychosocial Correlates, and Treatment Outcomes Among Adults in Drug Abuse Treatment." *Journal of Child Sexual Abuse*. 14(1): pp. 39-55.

In a national sample of 2,434 adult substance abusers in drug treatment programs, Boles et al. found that 27.2% of female respondents and 9.2% of male respondents reported childhood sexual abuse (CSA). Compared to respondents who did not report CSA, substance abusers who reported CSA were more likely to be cocaine or alcohol dependent, suffer from a co morbid mental disorder, have higher levels of criminal

activity, exhibit higher levels of problem recognition, and have more negative peer influence. Additionally, a history of CSA was correlated with a lower likelihood of post-treatment abstinence from drugs and alcohol.

Felitti, Vincent J. 2004. *The Origins of Addiction: Evidence from the Adverse Childhood Experiences Study*. San Diego, CA: Kaiser Permanente Medical Care Program, Department of Preventive Medicine. <http://www.acestudy.org/files/OriginsofAddiction.pdf>. Accessed 9 March 2009.

Felitti, who in collaboration with Robert Anda, developed the Adverse Childhood Experiences (ACE) Study, discusses correlations between adverse childhood experiences and substance abuse later in life. Felitti observes that higher ACE scores (indicating multiple categories of childhood maltreatment and household dysfunction) are correlated with higher rates of smoking, alcoholism, and injected drug use. More information on the study is available at <http://www.acestudy.org/>

Felitti, Vincent J. 2002. "The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead." *The Permanente Journal*. 6(1). <http://xnet.kp.org/permanentejournal/winter02/goldtolead.html>. Accessed 9 March 2009.

Felitti provides an overview of the Adverse Childhood Experiences (ACE) Study, a large-scale research study of 17,421 adults at Kaiser Permanente's Department of Preventive Medicine. The ACE Study revealed correlations between eight types of adverse childhood events and household dysfunctions (physical abuse, sexual abuse, emotional abuse, witnessing violence against one's mother, growing up in a household with an alcohol or drug abuser, growing up in a household with a mentally ill member, growing up in a household with a member in prison, or growing up in a household in which both biological parents are absent) with illness later in life (i.e., depression, diabetes, obesity, substance abuse).

Harrison, P.A., J. A. Fulkerson, and T. J. Beebe. 1997. *Multiple Substance Abuse Among Adolescent Physical and Sexual Abuse Victims*. Rockville, MD: U.S. Department of Health and Human Services.

This report draws upon a 1995 study of 122,824 Minnesota public school students in grades 6, 9 and 12. Researchers found that a history of physical and/or sexual abuse was correlated with increased likelihood of alcohol and drug use. Additionally, abuse victims were more likely to use multiple substances, with the highest rates among students who reported both physical and sexual abuse.

V. DIVERSE POPULATIONS

LGBT

Hughes, Tonda L., Timothy Johnson, and Sharon C. Wilsnack. 2001. Sexual Assault and Alcohol Abuse: A Comparison of Lesbians and Heterosexual Women. *Journal of Substance Abuse*. 13(4): pp. 515-532.

This article explores the relationship between sexual victimization and alcohol abuse among heterosexual and lesbian women. In a study of 57 heterosexual women and 63 lesbians, the authors found childhood sexual abuse was associated with lifetime alcohol abuse among both groups. However, adult sexual assault was associated with alcohol abuse among heterosexual respondents only.

Kalichman, Seth C., Cheryl Gore-Felton, Eric Benotsch, Marjorie Cage, and David Rompa. 2004. "Trauma Symptoms, Sexual Behaviors, and Substance Abuse: Correlated of Childhood Sexual Abuse and HIV Risks Among Men Who Have Sex with Men." *Journal of Child Sexual Abuse*. 13(1), pp. 1-15.

Kalichman et al. explores the relationship between childhood sexual abuse and HIV-related risk behavior among men who have sex with men (MSM). In a study of 647 MSM, researchers found that men with a history of childhood sexual abuse are more likely to barter sex for drugs or money, engage in high-risk sexual behavior, experience intimate partner violence, and report being HIV-positive.

AFRICAN AMERICANS

Jasinski, J. L., L. M. Williams, and K. Siegel. 2000. "Childhood Physical and Sexual Abuse as Risk Factors for Heavy Drinking Among African-American Women: A Prospective Study." *Child Abuse and Neglect*. 24(8), pp. 1061-1071.

This study draws upon interviews with 113 African American adults who were child victims of sexual and/or physical abuse in the 1970s. The authors found that multiple incidents of child sexual abuse are a predictor of later alcohol abuse as an adult, even after controlling for the effects of parental drinking behavior.

NATIVE AMERICANS / FIRST NATIONS

Jacobs, Kaha:wi J. and Kathryn J. Gill. 2002. "Substance Abuse Among Urban Aboriginals: Association with a History of Physical/Sexual Abuse." *Journal of Ethnicity in Substance Abuse*. 1(2), pp. 19-39.

In a study of thirty First Nations individuals in urban Canada, Jacobs and Gill found correlations between physical and/or sexual abuse and substance abuse, family dysfunction, and difficulties in interpersonal relationships. Although rates of family history of substance abuse were high among respondents, those who had experienced physical and/

or sexual abuse were more likely to exhibit current substance abuse problems.

Libby, Anne M., Heather D. Orton, Douglas K. Novins, Paul Spicer, Dedra Buchwald, Janette Beals, Spero M. Manson, the AI-SUPERPPF Team. 2004. "Childhood Physical and Sexual Abuse and Subsequent Alcohol and Drug Use Disorders in Two American-Indian Tribes." *Journal of Studies on Alcohol and Drugs*. 65(1): pp. 74-83.

This study of 3,084 Native Americans from Southwest and Northern Plains tribal populations examines the relationship between childhood physical and sexual abuse and lifetime substance abuse disorders. Libby et al. found that 7% of respondents reported childhood physical abuse, and 4-5% reported childhood sexual abuse. The authors observed that childhood sexual abuse was associated with lifetime substance abuse, and that while female respondents were more likely to report childhood abuse, they were less likely than male respondents to develop substance abuse disorders later in life.

Yuan, Nicole, Mary P. Koss, Mona Polacca, and David Goldman. 2006. "Risk Factors for Physical Assault and Rape Among Six Native American Tribes." *Journal of Interpersonal Violence*. 21(12), pp. 1566-1590.

This article on physical and sexual assault of Native Americans draws upon a study of 1,368 adult respondents from six Native American tribes. The authors found that lifetime alcohol dependence, childhood maltreatment, and marital status were predictors of sexual assault among Native American woman. The same factors, as well as having an alcoholic parent, were also predictors of physical assault against Native American women. Only lifetime alcohol dependence and childhood maltreatment were predictors of physical assault against Native American men.

LATINAS

Cuellar, Jeanette and Theodore R. Curry. 2007. "The Prevalence and Comorbidity Between Delinquency, Drug Abuse, Suicide Attempts, Physical and Sexual Abuse, and Self-Mutilation Among Delinquent Hispanic Females." *Hispanic Journal of Behavioral Sciences*. 29(1), pp. 68-82.

This article evaluates data from pre-sentence investigations on 141 Hispanic adolescent girls sentenced to probation. The authors observed very high rates of violent delinquency, suicide attempts, self-injury, and marijuana use among the sample. Additionally, the authors uncovered extensive comorbidity between physical and sexual abuse, suicide attempts, self-injury, and drug abuse. This study highlights problems facing delinquent Hispanic adolescent females and notes correlations between various traumas and pathologies.

Finlinson, H. Ann, Denise Oliver-Vélez, Sherry Deren, John G. H. Cant, Héctor M. Colón, Rafaela R. Robles, and Jonny F. Andía. 2003. "Puerto Rican Drug Users' Experiences of Physical and Sexual Abuse: Comparisons Based on Gender and Developmental Stage." *Violence Against Women*. 9(7): pp. 839-858.

In a study of 1181 Puerto Rican drug injector and crack smokers from New York and Puerto Rico, Finlinson et al. found that female respondents were significantly more likely than male respondents to report histories of sexual violence and physical abuse. Many incidents of sexual and physical violence related directly to respondents' involvement in the illegal drug trade or prostitution, and perpetrators often included law enforcement officials, johns and other people involved in the drug trade.

Vera, Mildred, Margarita Alegria, Angela M. Pattatucci-Aragon, and Marisol Pena. 2005. "Childhood Sexual Abuse and Drug Use Among Low-Income Urban Puerto Rican Women." From De La Rosa, Mario and Lori Holleran, eds. 2005. *Substance Abusing Latinos: Current Research On Epidemiology, Prevention, and Treatment*. Binghamton, NY: The Haworth Social Work Practice Press, pp. 45-68.

This article discusses the relationship between substance abuse and childhood sexual abuse among low-income urban Puerto Rican women. In a study of 718 substance-abusing, low-income Puerto Rican women, the authors found strong correlations between childhood sexual abuse and adult drug use. These correlations were not mediated by family background variables or other childhood maltreatment variables. The authors offer recommendations for treatment, prevention and sexual abuse screening for Puerto Rican women.

SURVIVORS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM

Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide. Bethesda, MD: National Institute on Drug Abuse, 2006. http://www.drugabuse.gov/PDF/PODAT_CJ/PODAT_CJ.pdf. Accessed 6 March 2009.

This guide discusses assessment and treatment for substance abusers involved in the criminal justice system, with emphasis on unified principles for treating this distinct population. NIDA devotes attention to treatment of substance-abusing offenders with co-occurring conditions (i.e., mental health disorders, HIV/AIDS), as well as special populations such as women and juveniles.

Zlotnick, Caron. 2002. Treatment of Incarcerated Women with Substance Abuse and Post Traumatic Stress Disorder, Final Report. Providence, RI: Brown University, Department of Psychiatry and Human Behavior. <http://www.ncjrs.gov/pdffiles1/nij/grants/195165.pdf>. Accessed 6 March 2009.

This report explores the effectiveness of using “Seeking Safety” treatment with incarcerated women with comorbid substance abuse disorders and post traumatic stress disorder (PTSD). In a study of six incarcerated women who received “Seeking Safety” treatment and 22 who received standard treatment, Zlotnik found no significant differences in PTSD symptom improvement and substance use between the two samples. Extending “Seeking Safety” treatment to post-release women may improve its long-term impact.

VI. TREATMENT AND SERVICES

Acierno, Ron, Heidi S. Resnick, Amanda Flood, and Melisa Holmes. 2003. “An Acute Post-Rape Intervention to Prevent Substance Use and Abuse.” *Addictive Behaviors*. 28: pp. 1701-1715.

Post-rape anxiety and distress increases victims’ risk of alcohol and drug use. To address this problem, a video-based intervention program was developed for rape victims and intended for use immediately after their forensic exam. In a study of 226 rape victims over the age of 15, Acierno et al. found that victims who watched the intervention video were less likely to use marijuana after six weeks but only slightly less likely to consume alcohol.

Daley, M. and M. Argeriou. 1997. Characteristics and Treatment Needs of Sexually Abused Pregnant Women in Drug Rehabilitation: The Massachusetts MOTHERS Project.” *Journal of Substance Abuse Treatment*. 14(2), pp. 191-196.

Daley and Argeriou conducted a study of 447 pregnant, chemically-dependent women undergoing treatment at a Massachusetts detoxification center and found that 41% reported sexual victimization during their lifetime. The authors discuss the unique psychological, social and medical concerns of sexually victimized, substance abusing women, highlighting their special treatment needs.

Davies, Jill. 2007. Helping Sexual Assault Survivors with Multiple Victimization and Needs: A Guide for Agencies Serving Sexual Assault Survivors. Hartford, CT: Greater Hartford Legal Aid. <http://www.uiowa.edu/~socialwk/publications/Sexual%20Assault%20Guide.pdf>. Accessed 6 March 2009.

This guide book discusses advocacy issues and approaches relevant to sexual assault survivors who have experienced multiple victimizations and/or have multiple needs. Davies provides advocates and service providers with strategies for assessing and expanding services to this distinct population. The guide devotes attention to sexual assault survivors who specifically struggle with mental health issues, substance abuse, poverty, and involvement in the criminal justice system.

Herz, Denise C, Meghan Stroshine, and Kristen Houser. 2005. "Exploring Agreement on Appropriate Responses to Domestic Violence and Sexual Trauma Across Victim Advocates, Mental Health Services Providers, and Substance Abuse Treatment Providers." *Women & Criminal Justice*. 16(4), pp. 119-144.

This study looks at the extent of domestic violence (DV) and sexual assault (SA) training provided to three categories of service providers (mental health service providers, victim advocates, and substance abuse professionals), as well as the extent to which they agree on how to serve DV and SA victims. The authors found that victim advocates receive the most extensive training on domestic violence and sexual assault, while substance abuse treatment providers received the least training. Herz et al. offer recommendations for implementing and assessing DV and SA training for service providers, as well as for facilitating cross-disciplinary collaboration.

Hiebert-Murphy, Diane and Lee Woytkiw. 2000. "A Model for Working with Women Dealing with Child Sexual Abuse and Addictions: The Laurel Centre, Winnipeg, Manitoba, Canada." *Journal of Substance Abuse Treatment*. 18(4): pp. 387-394.

This article discusses a feminist clinical model that integrates substance abuse and trauma treatment at the Laurel Centre in Winnipeg, Manitoba.

Knauer, Sandra. 2002. *Recovering from Sexual Abuse, Addictions, and Compulsive Behavior: "Numb" Survivors*. New York: Haworth Press, Inc.

This book explores the psychological impact of sexual abuse and why some survivors develop addictions and compulsive behaviors as coping mechanisms. Knauer offers suggestions for therapists who counsel this population on establishing health boundaries, addressing the spiritual concerns of survivors, and developing practical approaches to counseling.

Moses, Dawn Jahn, Beth Glover Reed, Ruta Mazelis, and Brandy D'Ambrosio. 2003. *Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse, and Mental Health Disorders Who Have Histories of Violence Study*. Rockville, MD: SAMHSA.

This guide offers recommendations for program development, outreach, and advocacy for women with alcohol, drug abuse, or mental health disorders who have survived violence (specifically intimate partner violence and sexual violence).

VII. SOCIETAL ATTITUDES

Finch, Emily and Vanessa E. Munro. 2007. "The Demon Drink and the Demonized Woman: Socio-Sexual Stereotypes and Responsibility Attributions in Rape Trials Involving Intoxicants." *Social & Legal Studies*. 16(4): pp. 591-614.

This article discusses the societal double standard in the attribution of responsibilities in sexual assaults involving alcohol or drugs, particularly as it relates to jury decisions. Finch and Munro observe that jurors tend to view perpetrators as less accountable if intoxicated during a sexual assault, and victims as more accountable if intoxicated. The article explores how jurors' views on intoxication shaped their conclusions on responsibility for sexual assaults. Additionally, the article explores how the social acceptability of some intoxicants (i.e., alcohol) and the social unacceptability of others (i.e., Rohypnol) lead to assumptions about drug-facilitated rape versus alcohol-facilitated rape.

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