2005

# Comorbid childhood sexual abuse and substance abuse among women: knowledge, training, and preparedness of graduate counselor education and social work students

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# COMORBID CHILDHOOD SEXUAL ABUSE AND SUBSTANCE ABUSE AMONG WOMEN: KNOWLEDGE, TRAINING, AND PREPAREDNESS OF GRADUATE COUNSELOR EDUCATION AND SOCIAL WORK STUDENTS

A Thesis

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Master of Social Work

in

The School of Social Work

by
Laurie Elizabeth Pennington
B.S., Louisiana State University, 2001
May 2005

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## ABSTRACT

This descriptive-correlational study examined the knowledge, training and perceived preparedness of graduate social work and counselor education students in the area of comorbid childhood sexual abuse and substance abuse among women. Participants were 71 graduate social work and approximately 12 counselor education students scheduled to graduate in the spring semester of 2005. The study was analyzed using univariate and bivariate statistics. No significant differences emerged between graduate counselor education and social work students using independent-samples *t*-tests and a Fisher's exact test on the measure of knowledge and training. Using a Mann Whitney *U* test, significant differences emerged between counselor education students on two questions on the measure of preparedness: No significant relationships emerged using a Pearson's *r* correlation coefficient to examine relationships between interval-level variables and the variable of knowledge.

The results may help determine the degree to which social work and counselor education curricula should be altered to include these issues. This research also has implications for improving practice, which begins with the professional curriculum.

## Chapter 1: Introduction

The proposed research examines the knowledge, training, and preparedness of graduate-level students in the areas of childhood sexual abuse (CSA) and substance abuse, and the interface of both of these issues among women. The knowledge in this area is of great import in diverse direct practice settings where many social work and counselor education graduate students will be employed post-graduation. Women in therapy who are abusing or dependent on substances oftentimes present with childhood sexual abuse issues that are directly related to the use of substances as the following review demonstrates.

Increasingly, research reveals a high correlation between history of sexual abuse and the manifestation of addictive behavior in women (Jarvis, Copeland, & Walton, 1998). Covington (2001) points out that early sexual abuse appears to predispose women toward alcoholism. In research done by Russell (1987) 12% to 50% of alcoholic women stated that they experienced either CSA by an immediate family member (incest) or CSA by a non-family member, and up to 75% reported incest in addition to CSA by a non-family member. A more recent study found associations between CSA and drug use other than alcohol (Freeman, Collier, & Parillo, 2002). This study was conducted with 1,478 community-recruited women to assess associations between CSA and lifetime crack use. These authors found that 64% of the sample used crack, and of those, over half (56%) had been sexually abused by the age of 18 (Freeman et al.) Results of regression analyses showed that CSA was significantly associated with lifetime crack use (Freeman et al.). The literature suggests that as many as 60% to 84% of adult women in day treatment programs are survivors of CSA (Freeman et al., 2002). The average prevalence rate of CSA in literature is around 54% (Medrano, Hatch, Zule, & Desmond, 1999). Many researchers

have also noted that CSA is more often reported by women seeking substance abuse treatment (Ellis, O'Hara, & Sowers, 2003).

The association between substance abuse and sexual abuse among women increasingly has become recognized as a problem in the field of substance abuse treatment. Social workers and counselors in a variety of capacities must therefore be well equipped to identify, diagnose, and treat survivors of childhood sexual abuse (Jones, 1996). Many times, symptoms of CSA may manifest as other types of dysfunction, (e.g., depression, suicide attempts, or drug and alcohol abuse) which may be reflections of coping on the part of the survivor (Jones). It is not clear to what extent human service professionals receive formal training in sexual abuse, despite the fact it is specialized area of practice (Jones).

The purpose of this exploratory-descriptive research is to examine the knowledge, training, and perceived preparedness of graduate-level social work and counselor education students in the area of CSA and substance abuse among women. An exploratory-descriptive approach will best ascertain what is known about the knowledge, training, and perceived preparedness of graduate social work and counselor education students in this emerging area of practice.

This proposal first reviews the literature about what is known about comorbid CSA and substance abuse among women and more specifically, the current state of knowledge of graduate social work and counselor education students in the area of CSA, substance abuse, and comorbid CSA and substance abuse among women. The methodology for the proposed research is fully described. This paper concludes with a summary of the importance of this proposed research.

## Chapter 2: Review of the Literature

It is not known how much knowledge and training graduate social work and counselor education students are getting in the area of comorbid CSA and substance abuse among women. This review focuses on what is known about CSA and substance abuse among women in general such as explanation of comorbidity, prevalence rates of substance abuse among women who have experienced CSA, other common co-occuring disorders present among women who have experienced CSA, and the treatment needs of and effective interventions for this population. This section then examines what is known about the educational materials and training graduate social work and counselor education students are currently receiving in their curriculum that would prepare them to work with women affected by comorbid CSA and substance abuse.

### The Definition of CSA

There is no universally accepted definition of what constitutes childhood sexual abuse because of differences across time and between cultures (Baker, 2002). Sanderson (1990) defined childhood sexual abuse as the involvement of dependent children and adolescents in sexual activities with an adult, or any person older or bigger, in which the child is used as a sexual object for the gratification of the older person's needs or desires. It is also considered sexual abuse when a child cannot give informed consent given the unequal power in the relationship. Activities can range from just touching and groping to forceful, penetrative sexual intercourse (The issue of the severity of the CSA is discussed below). This definition excludes consensual activity between peers (Baker, 2002; Sanderson, 1990). Prevalence rates vary for CSA. Finkelhor (1986) found populations of female CSA survivors to range from 6% to 62%. Similar prevalence rates have been replicated in many other studies (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996). Gorey and Leslie (1997) who have widely studied prevalence rates,

agree that ambiguity about childhood sexual abuse definitions and response rates account for over half of the observed variability of the reported prevalence rates (Baker).

**The Definition of Substance Abuse**

The American Psychiatric Association's APA (2000) diagnostic manual provides widely used criteria for substance abuse and dependency. A substance use disorder is used to refer to the combined category of abuse and dependency. The essence of the APA definition of substance abuse has two parts: (1) that a person uses a psychoactive substance when expected to perform significant tasks at home, work, school, or when it is physically hazardous and (2) that he or she continues to use a psychoactive substance despite awareness that such use is causing major problems in one or more aspects of life, such as financial, legal, psychological, or marital (Goldberg, 1995). Someone who is substance dependent must have three or more of the nine symptoms of dependence (Goldberg). The above symptoms constitute two. Other symptoms included are loss of control of use, inability to cut back even after trying,
substance use replacing important activities or taking up considerable time, and indications of marked psychological tolerance or withdrawal (Goldberg, 1995).

**The Problem of Comorbid CSA & SA: The Definition of Comorbidity**

Cross-sectional comorbidity is the occurrence at one point in time of two or more diagnosable disorders (Clarkin & Kendall, 1992). Feinstein (1970) coined the term comorbidity, which he defined as "any distinct additional clinical entity that has existed or that may occur during the clinical course of a patient who has the index disease under study" (cited in Maser & Cloninger, 1990, pp. 456-457). This, of course, was a medical definition and was applied to medical diseases at the time. In psychiatric epidemiology, the term comorbid emphasizes relative risk (Maser & Cloninger, 1990). For example, if a patient has a particular disorder, there

may be a relatively greater or lesser risk of other disorders being diagnosed or other symptoms observed (Maser & Cloniger). Clinical studies also use the concept to mean that more than one disorder can be diagnosed in the same individual. Recently, clinicians and researchers have begun to use the term, comorbidity, to include the co-occurrence of symptoms as well as co-occurrence of disorders (Maser & Cloniger).

A history of childhood sexual abuse and comorbid substance abuse among women is an area that has recently received empirical attention. One of the reasons is that more women report that they were sexually abused as children than men, and often report CSA as a reason for abusing substances. Post traumatic stress disorder (PTSD) is also comorbid with addiction, and is a diagnosis often made because of past CSA among women. The 2000 National Co-Morbidity Study found that women were twice as likely as men to develop PTSD after being exposed to traumatic stimuli (Brady, Killen, & Brewerton, 2000; Cramer, 2002). Research suggests that women begin using substances at a later age than men, but seek treatment at a younger age (Breslau, Davis, Peterson, & Edward, 1997; Cramer). Women also have significantly higher incidences of comorbid psychiatric disorders than men, with substance abuse being the second highest (Cramer). Incidence rates vary in the literature. On average, when incidence rates are self-reported in the literature by men and women in studies on comorbid substance abuse and CSA, women report higher incidence rates of CSA (Medrano, et al., 1999).

A Canadian high school found that 10.4% of young men ($n$ = 204) who abused substances were sexually abused, but the incidence rate for young women ($n$ = 88) abusing substances was 50% reflecting higher prevalence rates of CSA in women (Ballon, Courbasson, & Smith, 2001). Of those who endorsed a history of abuse, more females (64.7%, $n$ = 88) than males (37.9%, $n$ = 204) reported using substances to cope with the trauma. Whitfield's (1998)

study with psychiatric inpatient participants who were women, found that 50% to 60% had been sexually abused as children, and 40% to 70% of psychiatric outpatient participants who were women had been sexually abused as children. The number of participants was not reported in this study. According to Cramer (2002), sexual abuse can have long-term negative consequences for the victim. In addition to substance abuse and dependence, CSA has been associated with disorders such as anxiety, PTSD, attention deficit hyperactivity disorder, and conduct disorder. Cramer's research indicated that dissociative, mood, and anxiety disorders are the three most common forms of comorbidity among participants who are addicted to drugs and alcohol, and for whom CSA was a major theme. In short, short-term and long-term affects of CSA are related to a myriad of disorders.

Important clinical implications of comorbid sequelae of CSA and substance abuse problems such as long-term use, clinical course, prognosis, and treatment response have not been closely studied among adolescents, young adults, and especially among women. Ballon et al. (2001) found that women reported using substances for coping with abuse more than did males. Using substances for coping and self-medicating are issues of contention in the field of addiction but when clients report the reasons behind their use of substances, a more accurate course of treatment can be planned (Ballon et al.). That is, treatment alliance can be built better when a client lets the therapist know the motives and reasons behind substance use (Ballon et al.). There is ample evidence that realizing and understanding past CSA is crucial to addictions recovery for women (Whitfield, 1998). Moreover, Kelly, Blacksin, and Mason (2001) found that over half of a sample ($N = 70$) of outpatient and inpatient women in substance abuse treatment were survivors of CSA. Thus, the findings of these and other authors' research about alcoholism and drug abuse show that sexual abuse could be a significant factor in the genesis of addiction (Kelly

et al.). However, a causal relationship between CSA and substance abuse has not been conclusively determined, and needs to be further investigated.

**Interventions used for Treating Comorbid CSA and SA Among Women**

Few standard therapeutic interventions have been tested for women who present with comorbid CSA and substance abuse (Wadsworth & Spampneto, 1995). Because women present more often than men with issues of CSA in combination with substance abuse and dependence, Copeland and Hall (1992) argue that the first step in tackling this complex issue is to get more women into gender-based treatment groups. Copeland and Hall compared the psychosocial characteristics of women in counseling for drug and alcohol treatment who were placed in mixed-sex services with those seeking treatment in a women-only setting. Women attending the gender-sensitive service did so voluntarily, and were significantly more likely to have dependent children, to be lesbian, to have a maternal history for alcohol and drug problems, and to have suffered sexual abuse in childhood. These results suggest that the women who sought gender-sensitive services may not have sought treatment in a mixed-setting service (Copeland & Hall).

Women treated in women-only substance abuse treatment programs appear to have much higher completion rates than those in mixed-settings. Ashley, Mardsen and Brady (2003), cite a study conducted by Dahlgren and Willander in 1989, who used a randomized design to compare women in a women-only treatment unit with those in a residential ward of women treated in a traditional mixed-gender center (men and women together). Two years later, the sample was followed up, with results indicating that women placed in the women-only unit had better outcomes in terms of alcohol consumption and social adjustment. It has also been found that when given a choice, women more often seek out treatment for substance abuse issues that includes women-only treatment groups, and includes specific services for women alongside

treatment. Copeland and Hall (1992) found that 40% of women ($n$ = 80) being treated with a gender-specific program picked the program for that reason. About one-third (33%) of the same sample reportedly picked the program because it offered residential childcare (Copeland & Hall). These findings suggest that women oftentimes feel more comfortable in a setting that addresses issues related to women. They may not seek treatment at all or drop out of treatment if issues such as child-care, sexual abuse, trauma history, and sexual orientation are not addressed in conjunction with substance abuse (Copeland & Hall).

**Interventions used for Treating Substance Abuse Among Women**

A variety of treatment approaches are used with women who abuse substances: cognitive approaches, family therapy, social skills training, alcoholics anonymous and other 12-step programs, therapeutic communities, short-term residential treatment programs, and feminist-based treatment approaches. In some cases, two or more approaches are combined. There is little empirical evidence in the literature to suggest the validity of one effective model regarding positive outcomes of substance abuse treatment among women who have experienced childhood sexual abuse (Pagliaro & Pagliaro, 1999). Few of these treatment modalities have been empirically tested to include the variable of sexual abuse. There is some evidence that feminist-based approaches may work for some women who have experienced CSA, and who also abuse substances. Pagliaro and Pagliaro (1999), for example, described feminist-based treatment approaches as those "examining the realities of women's lives and attempting to better understand these realities" (pp. 209-210). These authors further state, "Central to many feminist approaches are the ideals of improving self-concept and empowering women" (pp. 209-210). Research done by Hiebert-Murphy and Richert (2000), found that solution-based therapy was associated with improved outcomes among a group of women who were mothers, who abused

substances, and who had experienced CSA. Solution-based therapy is similar to a feminist-based approach because it attempts to recognize client's strengths and normalize difficulties (Hiebert-Murphy & Richert). Further, over half (61%) of the women treated in this group ($N = 29$) reported they were "completely satisfied" with treatment while none of the women reported they were "quite dissatisfied" (Hiebert-Murphy & Richert).

Positive outcomes associated with the use of feminist-based treatment approaches have been observed among women with comorbid substance abuse and CSA, perhaps because empowerment and improved self-esteem are addressed in this approach.

**Variation of Symptomotology/Trauma in Survivors of CSA**

Before interventions are mentioned to treat CSA, it bears mentioning that the level of trauma experienced due to CSA varies from woman to woman. Some women report that they have no perceivable negative effects in relation to the childhood sexual abuse they have experienced, and some women report a vast range of symptoms perceivably related to childhood sexual abuse that they have experienced. Substance abuse is frequently one of the symptoms. The literature on the relationship between sexual abuse characteristics is inconclusive (Baker, 2002). Binder, McNeil and Goldstone (1996) carried out multivariate analyses to identify the variables that predicted psychological well-being of women who were survivors of CSA. They concluded that absence of pressure from the perpetrator, absence of family conflict, and abuse that was short in duration were good predictors of well-being in spite of the abuse. Baker cites a (1997) study conducted by Briggs and Joyce in which they examined which CSA characteristics were related to post-traumatic symptomatology. These authors found that having multiple abusive episodes that involved intercourse significantly predicted scores on hyperarousal, intrusive thoughts, and dissociation. The relationship between the perpetrator and the survivor

was not controlled for in this study. Nash, Husley, Sexton, Harralson, and Lambert (1993) found that the atmosphere in the family of origin substantially accounts for the variance of all measures of psychopathology and this has been corroborated in other studies. Moreover, Lange, De Beurs, Dolan, Lachnit, Sjollema, and Hanewald (1999) used univariate analyses with Nash et al.'s study, and found that the results held for both incest and non-incest CSA. The emotional atmosphere in the family of origin, reactions to disclosure, and self-blame were more strongly associated with pyschopathology and dysfunction than the characteristics of the abuse itself (Nash et al.). Clearly, there are many subjective factors that could be related to the abuse of substances among women who have experienced CSA. The variables that may cause long-term effects (e.g., substance abuse, PTSD) due to CSA are not fully understood. Regardless, counselors should always screen the client in order to detect trauma because there is a better understanding about how to treat women who have experienced trauma due to CSA. Trauma screens will be discussed later in this paper. The next section focuses on interventions used for treating CSA.

**Interventions Used for Treating Women who Have Experienced CSA**

The most common approaches for treating sexual abuse include behavioral exposure techniques, information processing psychotherapies (collectively called Cognitive Processing Therapy or CPT), and hypnotic techniques.

Behavioral Processing Therapy is a type of information-processing psychotherapy. In Behavioral Processing Therapy (BPT), the client re-experiences the original intense affect in the safety of therapist's office without the paired negative consequences, and with the corrective experience of reprocessing the meaning of the event and the conclusions about self through the adult's ability to comprehend (Schwartz, 1998). This is done with the therapist's structure and

input (Schwartz). Information Processing Psychotherapy (IPP) is usually paired with BPT and allows clients to learn their own "stuck points" and challenge the accuracy of them (Hall & Henderson, 1996). Homework is an essential element to IPP (Hall & Henderson). The concern with CPT techniques is that clients could be re-victimized by reliving the event (Resick & Schnicke, 1993). In a case study using Resick's techniques, Hall & Henderson found that trauma symptoms related to PTSD caused by CSA decreased significantly from a score of 3.00 at pre-test to 1.40 at post-test (Hall & Henderson). The clinical cut-off score for symptoms was 2.00 in the latter study. The client in this case had abused substances in the past, but sought treatment separately for the issues of PTSD related to CSA. Other measures such as symptom reduction, phobic anxiety, psychotiscism, and global anxiety also significantly decreased from pre-test to post-test. Although generalizability is limited, these findings indicate that Resick's techniques were associated with positive outcomes for this survivor of childhood sexual abuse. This is not strong evidence that CPT really works for the majority of women who have been sexually abused as children. There is some evidence in the literature that behavioral exposure techniques work well with women who were sexually abused in childhood, but there is no empirical evidence to suggest that hypnotic techniques work. It is not known whether CPT techniques work with clients who have experienced CSA and who are also abusing substances.

**Issues Surrounding the Treatment of Comorbid SA and CSA**

There are several issues surrounding treatment of comorbid substance abuse and childhood sexual abuse among women. One being that traditional approaches to substance abuse treatment (e.g., Alcoholics Anonymous) which use powerlessness as a core concept in treatment may create more problems and exacerbate symptoms among women who abuse substances, and who have a history of childhood sexual abuse (Wadsworth & Spampneto, 1995). Another issue

that is common in substance abuse treatment for women who have experienced CSA is that trauma is treated as a secondary issue by many of those who treat substance abuse, with abstinence from chemical use being a priority in treatment (Wadsworth & Spampneto). Yet another issue involves how important a role the inquiry about CSA plays in treatment of women addicted to or abusing substances. Research conducted by Rosenhow, Corbett, & Devine (1988) indicated that direct, routine, and repeated, inquiry into the sexual abuse history of women in treatment for substance abuse facilitates their awareness of the abuse. They also found that the disclosure rates of sexual trauma among women with chemical dependency tripled as a result of proactively inquiring about abuse history. Many clients who relapsed chronically had never disclosed a history of sexual abuse simply because no one ever asked (Rosenhow et al.)

It is unclear which treatment works best for women who abuse substances and who have experienced CSA. In early recovery, a focus on staying sober rather than on CSA issues is suggested (Underhill, 1986). One major concern is that women in early recovery may not have the proper coping skills to deal with the overwhelming pain and fear that comes with CSA disclosure (Underhill). Many women who have been sexually abused acknowledge that unresolved issues around the sexual abuse is the reason for returning to substance use (Wadsworth & Spampneto, 1995). Substance abuse literature recommends addressing the issue of sexual trauma directly and being proactive in the discovery of sexual trauma (Rosenhow et al., 1988). In addition to facilitating disclosure, Bass and Davis (1988) and Briere and Runtz (1987) recommended educating clients about the possible effects of addressing the sexual abuse so that they are somewhat prepared when and if negative feelings associated with the abuse occurs. This may enable the client to avoid relapse more easily (Wadsworth & Spampneto). Counselors working with women with comorbid substance abuse and childhood sexual abuse should be

skilled in counseling approaches that emphasize the importance of the therapeutic relationship. Empowering the clients is also important (Wadsworth & Spampneto). It helps the client learn new ways to address environmental obstacles that may be getting in the way of self-actualization. Empowerment also involves helping women identify social constructs such as racism, sexism, discrimination, and interpersonal violence which can all be triggers for substance use (Nelson-Zlupko & Kauffman, 1995). Nelson-Zlupko and Kauffman also recommend that social workers empower *themselves* with knowledge about the special needs of women who are chemically dependent, and focus on the strengths of these women. Further research is needed on how to best serve this population.

**Importance of Treatment Alliance When Working With CSA Survivors**

When treating women with comorbid childhood sexual abuse and substance abuse, a strong treatment alliance is essential to the process. Women who have survived trauma in childhood and who are abusing substances to alleviate unbearable feelings such as shame, guilt, anger, disgust, fear, and depression are likely to engage in more high-risk behaviors (Cramer, 2002). Some of these high-risk behaviors include self mutilation, unsafe sexual practices, driving while under the influence of substances, and mixing more than one drug together (Cramer 2002; Mullings, 1998). It is commonly stated in the literature about comorbid childhood sexual abuse and substance abuse among women that if a client discloses CSA in chemical dependency treatment, then it should almost always be discussed, and strategies to address the issue of CSA should be integrated into the treatment plan. Coutrios (1997) suggested that assessment should be considered ongoing throughout the course of treatment for women who disclose CSA. She also stated that the degree to which the CSA affected the client should be

explored. This is where the relationship between the abuse of substances and the CSA becomes very important.

Ellason, Ross, and Sainton (1996) found that a history of childhood sexual trauma among women who were also abusing substances was associated with more severe psychopathology. Dissociative disorders were present in over half the sample ($N = 69$, 56.9%), with 18.6% of these meeting criteria for dissociative identity disorder. About half (47%) of Ellason et al.'s sample met criteria for a mood disorder. These authors concluded that while these individuals are aware of their addictions, they are often unaware of other psychological disturbances. According to Cramer (2002), women affected by comorbid CSA and substance abuse also tend to progress through treatment more slowly, are hospitalized more frequently, and suffer more severe regressions of both illnesses than patients experiencing either one alone. Though it has not been empirically tested, it is hypothesized that due to diagnostic confusion and the high levels of psychopathology, clinicians treating such patients may be vulnerable to feelings of shame, rage, and despair that mimic the patient's core experience and threaten the treatment alliance (Cramer, 2002).

Baker (2002), who has worked with sexual abuse survivors for many years, explained that listening to survivors is the best way to become engaged in therapy. In addition to listening, validating their disclosures is critical. Not only is it important to validate clients' disclosures, but it is important to do so in a manner that can begin to provide necessary safety within which to break the silence. Breaking the silence then facilitates the progress of therapy. Therefore, listening to clients, engaging clients, validating clients, and ensuring safety to clients constitutes the primary concerns of the therapeutic alliance for survivors and their therapist (Baker). When working with survivors, trust is the most important issue. Without trust, survivors typically will

not open up with the therapist, thereby bringing therapy to a "screeching halt" (Baker). However, Baker provides no empirical data to support these statements.

In sum, available evidence suggests that women who have experienced CSA and who also abuse substances could be more difficult to treat than women who are only abusing substances because of their slower progression through treatment, more frequent hospitalizations, and more severe regressions of both illnesses (Cramer, 2002). In addition, literature has shown there to be more severe psychopathology and vulnerability to dissociative and mood disorders among women who are experiencing comorbid CSA and substance abuse (Ellason et al., 1996).

Moreover, trust is an important issue concerning the therapeutic alliance between CSA survivors and the therapist. The limited research on treating comorbid CSA and substance abuse among women suggests that neglecting to address issues related to CSA, and failing to build trust when working with CSA survivors, could threaten the treatment alliance (Baker, 2002).

It is possible that there is not one best approach that should be implemented when women disclose CSA in substance abuse treatment. It is likely that different women will need different levels of addressing the CSA, intervention, and assessment with regard to this complex issue. As suggested earlier, this is an area that needs further exploration.

**Detection and Assessment**

The prevalence rates of comorbid CSA and substance abuse among women suggest that graduate social work and counselor education students should acquire, throughout their graduate program of study, the knowledge, training, and skills to identify, assess, and intervene with these women. Such clients will present in a variety of settings including schools, substance abuse treatment centers, hospitals, private practices, and prisons, which are the settings in which many social workers and counselors are employed. For simplicity's sake, the issues of childhood

sexual abuse and substance abuse will be discussed separately in this section. Detection skills and assessment tools will be discussed for each issue (CSA and substance abuse).

**Detection of CSA**

Mennen and Pearlmutter (1993) noted that all therapists need better skills to detect CSA. The long-term effects of childhood sexual abuse among women include low self-esteem, reduced self-efficacy, depression, anxiety, sexual/interpersonal problems, and negative self-attributions (Baker, 2002; Jehu, 1991). Mennen and Pearlmutter suggest that a constellation of symptoms presents with anxiety, depression, low self-esteem, past or present history of self-destructive or self-mutilating behavior, substance abuse, and/or eating disorders on one psychosocial assessment is more likely to have experienced CSA than a woman who presents with only one or two of these symptoms or behaviors on the psychosocial assessment (Mennen and Pearlmutter, 1993). Similar to women who present with both CSA and a substance use disorder (and not CSA alone), Mennen and Pearlmutter also found that borderline personality disorder, physical complaints, PTSD, dissociation, lack of trust, and recurrent patterns of victimization can all be indicators of previous CSA. Research shows that most women are not properly screened at the outset, and usually are referred to the improper resources when CSA is at the root of the problem (Pagliaro & Pagliaro, 1999). For example, women who are experiencing sexual problems in their relationship may not be optimally helped by a counselor whose expertise is in marriage and the family (Pagliaro & Pagliaro). It could be that the woman is having sexual problems because of CSA and is afraid to disclose that information (Mennen & Pearlmutter). Knowing how to screen and properly assess for CSA will ultimately help counselors facilitate proper referrals. The subsection below describes instruments used to detect CSA.

**Instruments for Assessing for CSA or Trauma**

The Trauma History Screen is a 14-item questionnaire developed by Allen and Huntoon (1999) to screen for potentially traumatic events among women admitted for specialized treatment of trauma-related disorders. Because there is a subscale for sexual trauma, the authors recommend using the questionnaire to alert clinicians to trauma that should be explored more fully in the context of the clinical relationship (Allen & Huntoon). Other assessment tools for trauma include, The Childhood Trauma Questionnaire which includes 34 items that assess for childhood trauma (Bernstein & Putman, 1986), The Impact of Event Scale (IES), which includes 22 items to assess for distress due to specific life events (Weiss & Marmar, 1997), the Dissociative Experiences Scale (DES), a 28-item self-report instrument (Bernstein & Putnam), and the Structured Trauma Interview (Draijer, 1989) which includes questions that examine the effect the effect of physical and sexual abuse on adults.

Social workers and counselors may find the Childhood Trauma Questionnaire and the Structured Trauma Interview useful in a variety of practice settings for detecting CSA, although other instruments (e.g., DES, IES) could be optimal in some cases.

The Childhood Trauma Questionnaire is practitioner-friendly because it has been widely used in a range of practice settings, has high test-retest reliability (.88), has subtypes associated with it (e.g., a short version and a Swedish version), and is the most comprehensive of any of the other versions (Lundgren, Gerdner, & Lundqvist, 2002).

Lundgren et al. (2002) administered The Childhood Trauma Questionnaire (Swedish version) to female addicts and found high consistency and homogeneity on the subscale for sexual abuse. The Childhood Trauma Questionnaire was also used by Medrano et al. (1999) to estimate the prevalence of positive trauma histories among a community sample of 181

intravenous drug using women, with results indicating that 60.2% ($n$ = 100) of the sample had been sexually abused.

The Structured Trauma Interview is a measure that could be easily used in practice settings in which social workers and counselors are employed. It involves a semi-structured interview with questions about traumatic experiences during childhood (Van Den Bosch, Verheul, Langeland, & Van Den Brink, 2003), and it has also been used in studies investigating women and substance abuse issues. So far, no data on its validity or reliability have been published yet.

**Detection and Assessment of Substance Abuse**

Lehman (1991) reported estimates published by the Alcohol, Drug Abuse, and Mental Health Administration in the 1990's, which found approximately five % of American women abuse or are dependent on alcohol alone, and 1.5% abuse or are dependent on other illicit psychoactive drugs. This information is consistent across class and socioeconomic status, though heavy drinking is more prevalent among Caucasian women than among African American women (Goldberg, 1995). However, Native American women have the highest prevalence rates of drinking (Goldberg; Wilsnack & Wilsnack, 1991).

The cornerstone of appropriate therapeutic intervention is proper assessment and diagnosis (Pagliaro, & Pagliaro, 1999). Detection of alcohol and substance abuse goes hand in hand with assessment tools that are used to determine the extent of substance use and whether it constitutes abuse, dependence, or neither. There are a number of psychometric instruments appropriate for substance use disorders among clients who are women. According to Pagliaro and Pagliaro: "Health and social care professionals must also be familiar with the basic assumptions, concepts, and principles that govern the use of these instruments" (pp.180). The

instruments which can be easily used by social workers and counselors to assess for drug and alcohol problems among women include: The Addiction Severity Index; a comprehensive interview schedule including several sections with approximately 200 items used to assess for addiction to a particular substance (Davis, Carpenter, Malte, Carney, Chambers, & Saxon, 2002); Alcohol Use Disorders Identification Test, which includes 10 items about the amount and frequency of drinking (Barbor, Biddle-Higgins, Saunders, & Monteiro, 2001); the Michigan Alcohol Screening Test, which is a 25-question interview used to detect alcoholism (Swett & Halpert, 1994); the Rapid Alcohol Problems Screen, a 4-item instrument that provides high sensitivity across gender and ethnic groups for alcohol dependence (Borges & Cherpitel, 2001); the T-ACE (Tolerance, Annoyance, Cut-Down, Eye, Opener) which is a measurement tool consisting of four questions that identify risk drinking, specifically, among pregnant women (Sokol, Martier, & Ager, 1989); and the TWEAK (Tolerance, Worried, Eye-opener, Amnesia, K=Cut-Down) which consists of 5 questions used to detect high risk drug and alcohol use among women (Pagliaro & Pagliaro, 1999).

The Addiction Severity Index has been used to examine women's comorbid issues and women's perceived treatment needs (Davis, et al., 2002). Davis et al. found when using the ASI, that women in treatment for substance use disorders endorsed high rates of previous CSA as well as high rates of psychiatric and medical comorbidity.

The Michigan Alcohol Screening Test is often used in psychiatric inpatient settings that routinely employ social workers and counselors. Swett and Halpert (1994) found that women scoring higher on the Michigan Alcohol Screening Test, (with high scores indicating a more severe history of alcohol problems) also reported a history of physical or sexual abuse, whereas lower scores were not associated with self-reported physical and sexual abuse histories.

The TWEAK (Tolerance, Worry, Eye-Opener, Amnesia, Cut Down) and the Alcohol Use Disorders Identification Test were more sensitive for detecting substance abuse among women that the CAGE (Cut Down, Annoyed, Guilty, and Eye-Opener) and the Brief Michigan Alcohol Screening Test (a truncated version of the Michigan Alcohol Screening Test) (Cherpitel, 1997). The T-ACE (Tolerance, Annoyance, Cut-Down, Eye-opener) has been used specifically for pregnant women to identify high risk drinking, (e.g., drinking while pregnant), and has been determined to have high criterion validity (Sokol et al., 1989).

**Detection and Assessment of CSA and Substance Abuse: State of Knowledge**

A variety of screening instruments can be used to detect trauma and substance use disorders. Graduate social work and counselor education students may find it easiest to use the Childhood Trauma Questionnaire and the Structured Trauma Interview for detecting CSA. Both have been administered to women who abuse substances, were found to have high test-retest reliability (Davis et al., 2002; Swett & Halpert, 1994), are easy for social workers and counselors to administer, and have been used in conjunction with women experiencing substance abuse (Swett & Halpert).

The instruments used for detecting substance abuse among women that social workers and counselors may find most useful are: The Addiction Severity Index, the Rapid Alcohol Problems Screen, the Michigan Alcohol Screening Test, the Alcohol Use Disorders Identification Test, the T-ACE, (Tolerance, Annoyance, Cut-Down, Eye Opener), and the TWEAK (Tolerance, Worry, Eye-Opener, Amnesia, Cut Down) (Barbor et al., 2001; Borges & Cherpitel, 2001; Cherpitel, 1997; Davis et al., 2001; Pagliaro & Pagliaro, 1999; Sokol et al.,1989; Swett & Halpert, 1994). Some of these instruments have been used in studies

investigating comorbid CSA and substance abuse issues among women (e.g., ASI, MAST) and some (e.g., T-ACE, TWEAK) were designed specifically for women and substance abuse issues.

It is important to note that there is not an instrument in existence at the present time that screens for both CSA and substance abuse simultaneously. A practitioner's best option if he or she suspects a client is experiencing comorbid CSA and substance abuse is to administer two (one for trauma and one for substance abuse) of the aforementioned screening tools.

**Education and Training for Counselor Education Students: Substance Abuse**

Substance abuse problems emerge frequently in a variety of counseling, social service, and health settings (Lenhardt, 1994). Since the 1980s, many educators have focused on a need to incorporate alcohol and drug abuse training programs into the curricula of counselor education programs (Buckalew & Daley, 1986). Substance abuse training in counselor education curricula appears to be somewhat limited, with few programs offering specialized training (Lendhardt). The programs that do cover substance abuse content focus mainly on short-term training for counselors interested in obtaining certification (Lendhardt).

Instruction in substance abuse counseling is not identified as an important criterion for determining program effectiveness of counselor education degree programs (Carroll, 2000). In this same vein, The Council for Accreditation of Counseling and Related Educational Programs (CACREP) (1988) does not require instruction in substance abuse counseling for accreditation of counselor education programs.

In 1991, seven accredited counselor education programs reportedly offered opportunities for students to specialize in substance abuse counseling by requiring six or more semester hours of instruction in this area (Carroll; Cowger, Hinkle, DeRidder, & Erk). Carroll (2000) found thatcounselor education students who received at least three hours of instruction in substance

abuse counseling were more likely than students who have received less instruction to appropriately treat or refer a client presenting with dependence. Conversely, students with little or no instruction in substance abuse counseling were more likely to first treat or refer a client who was dependent on substances for a problem other than substance dependence (Carroll, 2000).

The Canisius Youth Connection (CYC), a program put into place with the help of grants from the U.S. Department of Education in 1991, provided a school-based training model for counselor education students in two different addiction settings. Results indicated that students found the program beneficial with regard to assessment, designing, and implementing prevention and intervention programs in the school setting (Lenhardt, 1994).

In 1997, Morgan and Tolczko surveyed counselor education programs about counselor education in the addictions and found that 97% of the respondents indicated that addiction-related training and education were needed in the respective programs.

The type and amount of instruction counselor education students are receiving in the area of substance abuse is unclear. Although recent data have not been published, there is some evidence to indicate that counselor education students are receiving curricular content on substance abuse. However, because many counselor education students may not be taught in a consistent and uniform manner about the etiology and progression of substance dependence, they may lack skills that enable them to properly screen and assess for substance abuse (Carroll, 2000). In turn, this would make it difficult for counselor education students to determine appropriate levels of professional treatment to which to refer clients in need of substance abuse services and self-help support groups (Carroll). Skills needed to counsel and educate persons with substance abuse problems may also be lacking (Carroll).

## Education and Training of Graduate Social Work Students: Substance Abuse

Many scholars and practitioners believe that all social work students should have a basic understanding of substance abuse disorders including biochemistry, pharmacology, etiology, signs and symptoms, and social effects (Lemieux & Schroeder, 2002) as well as receive training in differential assessment, intervention, and relapse prevention skills. Upon graduating, social workers will likely be expected to assess, diagnose, refer, and intervene with individuals with drug and alcohol problems, in all practice settings (Gassman, Demone, & Abigail, 2001).

In 1992, Alaszweski and Harrison found that graduate social work students in the U.S. were not exposed to course work that focused on substance abuse issues in a systematic manner. Moreover, when graduate social work students do receive instruction pertaining to substance abuse, it usually focuses on the disease model (Burke & Clapp, 1997).

Approximately two-thirds of graduate social work programs offer concentrations in mental health, family services, child welfare, and health (Lennon, 1998; Gassman et al., 2001), but do not offer specialized training in the area of substance abuse. However, the findings of studies that have implemented and tested specialized curricular content suggest that offering specialized alcohol and other drug courses and core courses with drug and alcohol content are beneficial and useful (Gassman et al.). Integrating these types of courses into the curriculum was found to improve students' assessment for substance abuse, and improve assessment of clients' clinical needs (Gassman et al.). Further, students who minored in the alcohol and other drug courses reported a greater knowledge and skill level for general assessment of alcohol and drug problems than did students who did not enroll in alcohol and other drug courses (Gassman et al.)

In 2002, Lemieux and Schroeder reviewed the literature on social work curriculum and instruction and found no descriptions of substance abuse instructional education strategies in social work that were empirically-based. In their pilot study, they reported training, work experience, and coursework preparation in the area of substance abuse with first-year (foundation) and advanced year social work students. Approximately, two-thirds of the foundation ($n$ = 28, 62.2%) and advanced-year students ($n$ = 35, 60.3%) reported fewer than 10 hours of substance abuse training (Lemieux & Schroeder, 2002).

The social work curriculum has made some strides in the area of substance abuse education. Even despite the problem of fragmented substance abuse training of graduate social work students, schools of social work have come a long way with regard to providing training programs in the area of substance abuse since the 1980's (Lemieux & Schroeder, 2002). For example, many schools of social work now offer substance abuse training programs that meet many mental health providers state certification qualifications (e.g., Boston University, Adelphi University, University of Wisconsin-Madison) (Lemieux & Schroeder). Schools such as the University of North Carolina, the University of Northern Michigan, and the University of West Virginia have made available concentrations in the area of substance abuse to students, and awards have been given by the National Institute on Drug Abuse to schools of social work at major universities around the country (e.g., Columbia University, University of Texas-Austin, Washington University-St. Louis) (Lemieux & Schroeder) to encourage these universities to carry out substance abuse research and training. These kinds of awards provide a catalyst to continue substance abuse research and training (Lemieux & Schroeder).

There are some limitations in the studies examining alcohol and drug education and training among graduate social work students and counselor education students. Much of the data

were self-reported data. Only one study looked at whether students' knowledge increased using standardized, empirical measures (Lemieux & Schroeder, 2002). In addition to measurement problems and the use of self-reported data, it is unclear to what extent students received content on gender differences regarding treatment of substance use disorders.

Although there is some evidence in the literature that graduate social work and counselor education students are receiving some substance abuse training and education, it is not known whether graduate social work and counselor education students are receiving training and education in the area of comorbid substance abuse and CSA among women. It is unclear to what extent students are knowledgeable about, trained, and prepared to work with women who present with comorbid CSA and substance abuse. This author's review of the literature yielded no studies investigating specialized training in the area of CSA or comorbid CSA and substance abuse among women.

**Review of the Literature: Summary and Implications**

Social work and counselor education practitioners are likely to encounter women who have experienced childhood sexual abuse among those who abuse substances because of the notable prevalence of CSA reported by women with substance abuse problems.

Substance abuse is prevalent among women who report childhood sexual abuse. Well over half (at least 60%) of women in treatment programs at any given time report that they experienced sexual abuse as children (Freeman, Collier, & Parillo, 2002).

There are traditional and non-traditional treatments for both substance abuse and childhood sexual abuse. The most effective treatment for comorbid childhood sexual abuse and substance abuse has not been empirically established, but gender-specific treatment appears to be

promising (Copeland & Hall, 1992). It is clear that specialized skills are needed when intervening with women with comorbid childhood sexual abuse and substance abuse.

Students should be familiar with the most reliable and valid screening instruments to detect CSA and substance abuse issues among women, and be familiar with how to administer CSA and substance abuse screening instruments. Additionally, sequalae related to comorbid CSA and substance abuse among women is something that students should be familiar with. Students should also be familiar with the common symptoms women present with when CSA and substance abuse are present.

There is evidence to suggest that counselor education and social work graduate students are receiving some curricular content on substance abuse, but not on comorbid substance abuse and childhood sexual abuse. In order to keep pace with practice, it is important to understand the knowledge, training, and perceived preparedness of incumbent social work graduate students and counselor education students.

## Chapter 3: Purpose of Proposed Research

The purpose of the present study was to examine the knowledge, training, and perceived preparedness of graduate level students in the area of comorbid childhood sexual abuse and substance abuse among women. Since it is not known whether graduate social work students or counselor education students are receiving education in these areas, the objectives were accomplished by administering a questionnaire developed by the author. The questionnaire was designed to measure students' knowledge, training, and perceived preparedness in the area of comorbid childhood sexual abuse and substance abuse among women, and gathered relevant demographic data and information on individual and educational program characteristics.

### Hypotheses

Based on literature reviewed about graduate social work and counselor education students' knowledge of comorbid childhood sexual abuse and substance abuse among women, the following hypothesis was formulated: There is no difference between social work graduate students and counselor education graduate students on measures of knowledge, training, and perceived preparedness for assessing comorbid childhood sexual abuse and substance abuse among women. With respect to findings, we expected some students would have specialized knowledge and training in the area of substance abuse, but the majority would not. Even fewer students would have knowledge and training in the area of childhood sexual abuse, and the fewest of all would have knowledge of and training in the area of comorbid childhood sexual abuse and substance abuse among women. Thus, we expected very few students to feel prepared to work with women experiencing comorbid childhood sexual abuse and substance abuse. We expected there would be a significant positive relationship between test scores and training and perceived preparedness.

Additional related research questions have been formulated:

1) How knowledgeable are graduate social work and counselor education students in the areas of childhood sexual abuse, substance abuse, and comorbid childhood sexual abuse and substance abuse among women?
2) What level of training have graduate social work and counselor education students received in the areas of childhood sexual abuse, substance abuse, and comorbid childhood sexual abuse and substance abuse among women in their curriculum?
3) Do graduate social work and counselor education students feel prepared to work in the areas of childhood sexual abuse, substance abuse, and comorbid childhood sexual abuse among women?

## Chapter 4: Method

### Participants

The participant pool was made up of 83 graduate level counselor education ($n$ =12) and social work students ($n$ = 71) expected to graduate in May 2005 who voluntarily participated in the proposed research. There were 78 women and 5 men in the participant pool. Among the participants, 67 identified themselves as Caucasian, 12 as African American, 2 did not identify an ethnic status, 1 identified as biracial, and 1 identified as an ethnic status other than those listed. The mean age of the counselor education students was 32.2 years ($SD$ = 12.0) and the mean age of the social work students was 27.7 years, ($SD$ = 7.1). The mean age of the entire sample was 28.8 years, ($SD$ = 8.0) Participants did not receive compensation for participating, and all participants were treated in accordance with Louisiana State University policies governing the protection of human subjects. This research met the criteria for exemption from IRB oversight.

### Materials

A 59-item written questionnaire developed by the author was used to gather demographic data and to measure respondents' knowledge, training, and perceived preparedness for working with women with comorbid childhood sexual abuse and substance use disorders.

The questionnaire consisted of four sections. The first section of the questionnaire (questions 1-20) was a test consisting of 20 items in multiple choice and true-false format designed to measure students' knowledge about childhood sexual abuse, substance abuse, and comorbid childhood sexual abuse and substance abuse among women. Two additional sections (sections 2 and 3) of the questionnaire included self-report questions designed to

measure training and perceived preparedness of students in the areas of childhood sexual abuse, substance abuse, and comorbid childhood sexual abuse among women.

The second section of the questionnaire (questions 21-37) consisted of 17 Likert-scale (Marlow, 2000) questions with response options that ranged from one through five; with one being "strongly agree" and five being "strongly disagree."

The third section of the questionnaire (questions 38-52) consisted of 15 open-ended questions about students' professional experiences in the areas of comorbid childhood sexual abuse and substance abuse among women. There was one question which allowed students to report personal experience with this issue if they chose to do so. Four questions in section three of the questionnaire (questions 53-56) inquired about degree programs, GPA, and date of graduation. The fourth and final section of the questionnaire (questions 57-59) consisted of three questions that gathered demographic data.

**Variables**

a) Knowledge was measured using students' scores on the 20 questions in first section of the questionnaire. The percentage of answers correct was the interval- level measure of knowledge of comorbid childhood sexual abuse and substance abuse among women.

b) Training and perceived preparedness were measured using the questions in sections two and three of the questionnaire (questions 21-56) that followed the test portion. The questions regarding perceived preparedness were included in section two (questions 21-37) and the questions regarding training were included in section three (questions 38-52). Seventeen Likert-scale (Marlow, 2000) questions pertained to self-perceived abilities, application, and competency. The fifteen open-ended questions in section three pertained to graduate school experience and non-graduate school experience

in the areas of childhood sexual abuse, substance abuse, and comorbid childhood sexual abuse, and substance abuse among women. The questions in sections two and three of the questionnaire yielded nominal-level, ordinal-level, as well as ratio-level data about the training and perceived preparedness of graduate social work and counselor education students. Many responses to these questions yielded qualitative data.

## Design and Procedure

This exploratory research was descriptive-correlational. The questionnaire was pre-tested with first-year students in a foundation class to assess reliability and face validity (Marlow, 2000). First-year students were asked to comment on which questions were unclear, areas they felt were not captured, and any additional comments they wished to add. The pre-testing resulted in one question in the first section being discarded because it was similar to a question already asked in a subsequent section. The majority of the foundation-year students found the wording of a few questions unclear, and those questions were re-worded in a way that was though to more clearly convey the question. One question was changed completely because the majority of the foundation-year students stated they were unable to answer it.

All advanced-year counselor education and social work students were administered questionnaires during a required course in their respective curricula on four separate days. Students were provided with a brief explanation about the research and subsequently asked to fill out the questionnaire completely and return it to the author during class.

## Data Analysis

Participants' knowledge was assessed with a 20-item test instrument developed by the author. Descriptive statistics were used to summarize data. A Pearson's product moment correlation coefficient was used to examine relationships among variables measured at the

interval level. Differences between counselor education students' and social work students' knowledge scores were examined using an independent samples *t*-test (Pyrczak, 2003). Differences in students' preparedness were measured using the Mann Whitney *U* test, which is a non-parametric statistic appropriate for analyzing ordinal-level data (Weinbach & Grinnell, 1995). Students' differences in training were examined using Fisher's Exact test (for nominal level data) (Weinbach & Grinnell), and independent-samples *t*-tests.

According to Rubin and Babbie (1997), a sample of at least 80 is required to obtain sufficient level of power (.80), at the .05 level of significance, to detect a medium effect size ($r = .30$). The total sample size in this study was 83, therefore, this study appears to have a sufficient level of power to correctly reject the null hypothesis as the designated alpha level.

## Chapter 5: Results

This research examined the knowledge, training, and perceived preparedness of graduate social work ($n$ = 71) and counselor education students ($n$ = 12) in the areas of comorbid childhood sexual abuse and substance abuse among women. There were 83 participants in this study.

### Knowledge

The mean score of the overall sample ($n$ = 83) on the test of knowledge was 44.5%, ($SD$ = 10.3) As seen in Table 1, the mean score for social work students ($n$ = 71) on the test of knowledge was 43.8% ($SD$ = 10.7), and counselor education students ($n$ = 12) had a mean score of 48.3% ($SD$ = 6.9). No significant differences emerged between graduate social work and counselor education students on the measure of knowledge.

### Training

Table 1 summarizes information regarding coursework, practice experience, training, and GPA of the social work students, counselor education students, and the overall sample. No significant differences emerged between the two groups in terms of years of experience, extent of coursework and training, and GPA.

As seen in Table 1, counselor education and social work students had a similar number of courses with content on substance abuse, childhood sexual abuse, and comorbid childhood sexual abuse and substance abuse among women. Despite social work students having more paid experience and hours of substance abuse training, a Fisher's Exact Test used to analyze these data showed no significant difference between social work and counselor education students in terms of years of experience, and their internship and counseling experiences. Table 2

summarizes information about the proportion of participants who reported various professional experiences and counseling experiences around sexual abuse and substance abuse issues.

**Table 1: Different Aspects of Training Among Counselor Education ($n$ = 12) and Social Work ($n$ = 71) Students ($N$ = 83)**

| Aspects of Training, score on test, and age | Counselor Education Mean and *SD* | Social Work Mean and *SD* | Overall Mean and *SD* |
|---|---|---|---|
| Number of Courses | $M$ = 2.3, $SD$ = 1.3 | $M$ = 2.4, $SD$ = 1.4 | $M$ = 2.4, $SD$ =1.4 |
| Years of Experience | $M$ =.3, $SD$ = 1.2 | $M$ = 2.3, $SD$ =5.3 | $M$ = 2.0, $SD$ = 4.9 |
| Hours of Sexual Abuse Training | $M$ = .8, $SD$ = 1.4 | $M$ = 9.9, $SD$ = 47.9 | $M$ = 8.6, $SD$ = 44.4 |
| Hours of Substance Abuse Training | $M$ =1.2, $SD$ = 2.5 | $M$ = 2.1, $SD$ = 5.7 | $M$ = 2.0, $SD$ = 5.4 |
| Score on Test | $M$ = 48.3, $SD$ = 6.9 | $M$ =43.8, $SD$ = 10.7 | $M$ = 44.5, $SD$ =10.3 |
| GPA | $M$ = 3.9, $SD$ = .14 | $M$ = 3.81, $SD$ = .23 | $M$ = 3.81, $SD$ = .22 |

As seen in Table 2, very few students in both groups had facilitated an individual and group counseling session around sexual abuse issues. Only 8.5% ($n$ = 7) of the total sample ($n$ = 83) had facilitated a group or individual counseling session around issues of childhood sexual abuse.

Approximately one fourth (25.3%) of students in both groups reported that they had facilitated a counseling session around sexual abuse issues (See Table 2). About three fourths of (75.9%, $n$ = 63) of social work and counselor education students had completed an internship that included childhood sexual abuse survivors among its clientele, and almost all of the sample had completed an internship that included clientele with substance abuse issues (90.4%, $n$ = 63) (See Table 2).

As seen in Table 2, over three-fourths (79.0%, *n* = 64) of the entire sample reported that they knew someone who had experienced childhood sexual abuse; however, very few students (2.4%, *n* = 2) reported that they completed an internship that offered services exclusively to childhood sexual abuse survivors. More students (7.2%, *n* = 6) reported that they completed an internship that offered services for people with substance abuse problems.

About one-third (31.3%, *n* = 26) of the sample had facilitated an individual counseling session around substance abuse, about 16% (*n* = 13) facilitated group counseling around substance abuse issues, and about 11% (*n* = 9) facilitated a family counseling session around substance abuse issues. A slightly greater proportion of counselor education students than social work students facilitated both individual and group counseling sessions around sexual abuse (See Table 2).

**Preparedness**

Tables 3 through 5 summarize response frequencies of counselor education students, social work students, and the combined sample on the variables measuring preparedness in the areas of substance abuse (Table 3), childhood sexual abuse (Table 4), and comorbid childhood sexual abuse and substance abuse among women (Table 5). Variables were re-coded to change response options such that 1 was changed to correspond to "strongly disagree," 2 was changed from "agree" to "disagree", 4 was changed from "disagree" to agree", and 5 was changed to correspond to "strongly agree." This was done to have the categories make more intuitive sense when examining the results of analyses. The original five categories of responses (viz., strongly agree, agree, not sure, disagree, and strongly disagree) were collapsed into three categories to simplify the manner in which participants' responses were presented below.

**Table 2: Training/Experience (N = 83)**

| Experience | Counselor Education *n* (%) | Social Work *n* (%) | Overall *N* (%) |
|---|---|---|---|
| Know someone who has experienced CSA | 8 (66.7%) | 56 (81.2%) | 64 (79.0%) |
| Facilitated individual counseling session on sexual abuse | 0 | 5 (7.1%) | 5 (6.1%) |
| Facilitated group counseling session on sexual abuse | 0 | 2 (2.8%) | 2 (2.4%) |
| Facilitated family counseling session on sexual abuse | 6 (50%) | 15 (21.1%) | 21 (25.3%) |
| Completed internship with CSA survivors among clientele | 9 (75.0%) | 54 (76.1%) | 63 (75.9%) |
| Completed internship that provided services exclusively for CSA survivors | 0 | 2 (2.8%) | 2 (2.4%) |
| Facilitated individual counseling session on substance abuse | 5 (41.7%) | 21 (29.6%) | 26 (31.3%) |
| Facilitated group counseling session on substance abuse | 2 (16.7%) | 11 (15.5%) | 13 (15.7%) |
| Facilitated family counseling session on substance abuse | 0 | 9 (12.7%) | 9 (10.8%) |
| Completed internship at agency includes people with substance abuse problems | 11 (91.7%) | 64 (90.1%) | 75 (90.4%) |
| Completed internship that provided services exclusively for substance abusers | 0 | 6 (8.5%) | 6 (7.2%) |

Tables 3, 4, and 5 show the proportion of respondents who either agreed or strongly agreed with the extent to which they were prepared in the areas of substance abuse (seven items), childhood sexual abuse (five items), and comorbid childhood sexual abuse and substance abuse (five items).

As seen in Table 3, social work and counselor education students responded similarly to all questions except for the areas about whether differences among men and women were discussed and whether research-based theories could be explained. On both questions, counselor education students agreed more often.

**Table 3: Proportion of Counselor Education (*n* = 12) and Social Work Students (*n* = 71) Who Agreed or Strongly Agreed With Questions About Preparedness: Substance Abuse (*N* = 83)**

| Area of Preparedness | Counselor Education *n* (%) | Social Work *n* (%) | Overall *N* (%) |
|---|---|---|---|
| Discussed differences among women and men who abuse substances | 8 (66.6%) | 38 (53.5%) | 46 (55.4%) |
| Possess knowledge and skills to work w/women with substance abuse problems | 4 (33.3%) | 29 (40.9%) | 33 (39.7%) |
| Read about differences among women and men | 6 (50%) | 37 (52.2%) | 43 (56.8%) |
| Feel confident about ability to explain | 9 (75%) | 46 (64.8%) | 55 (66.3%) |
| Encountered text readings about substance abuse | 12 (100%) | 57 (80.3%) | 69 (83.1%) |
| Discussed differences with supervisors | 4 (33.3%) | 12 (16.9%) | 16 (19.3%) |
| Could explain research-based theories | 6 (50%) | 29 (40.8%) | 35 (42.2%) |

A little over two-thirds of the sample (66.6%, *n* = 55) of counselor education students (*n* = 12) agreed or strongly agreed that they had discussed differences between men and women who abuse substances in at least one class session, and little over half (53.5%, *n* = 38) of the sample of social work students (*n* = 71) agreed or strongly agree that they had done this. Half (50%, *n* =6) of the counselor education sample (*n* = 12) agreed or strongly agreed that they could explain research-based theories underlying interventions about substance disorders. Less than half (40.8%, *n* =29) of the social work students (*n* = 71) agreed or strongly agreed to this

question. A greater proportion of counselor education than social work students reported preparedness in five of the seven areas around substance abuse.

**Table 4: Proportion of Counselor Education (*n* = 12) and Social Work Students (*n* = 71) Who Agreed or Strongly Agreed With Questions About Preparedness: Childhood Sexual Abuse (*N* = 83)**

| Area of Preparedness | Counselor Education *n* (%) | Social Work *n* (%) | Overall *N* (%) |
|---|---|---|---|
| Feel confident about ability to screen | 7 (58.4%) | 35 (49.3%) | 42 (50.6%) |
| Know where to refer clients | 7 (58.3%) | 43 (60.6%) | 50 (60.3%) |
| Have encountered required text readings | 6 (50%) | 50 (70.4%) | 56 (67.5%) |
| Feel confident about ability to explain signs | 6 (50%) | 46 (64.8%) | 52 (62.6%) |
| Can explain research based theories | 1 (8.3%) | 19 (26.8%) | 20 (24.1%) |

As seen in Table 4, at least half of the overall sample agreed or strongly agreed that they felt confident about their abilities in the area of childhood sexual abuse and substance abuse among women except for one area. Less than one fourth (24.1%, *n* = 20) of students agreed or strongly agreed that they could explain research based theories around childhood sexual abuse. In terms of proportions, over three times as many social workers than counselor education students agreed that they could explain research-based theories. A greater proportion of social work than counselor education students reported preparedness in three of the five areas of sexual abuse.

As seen in Table 5, fewer than half of the whole sample agreed or strongly agreed on four of the five items asking about their preparedness in the area of comorbid childhood sexual abuse and substance abuse among women. Well over three-fourths 86.8%, *n* = 72) of the students agreed or strongly agreed that they felt confident about their ability to explain comorbidity to a colleague. A greater proportion of social work than counselor education students reported

preparedness on three of the five areas around comorbid childhood sexual abuse and substance abuse among women.

**Table 5: Proportion of Counselor Education (*n* = 12) and Social Work Students (*n* = 71) Who Agreed or Strongly Agreed With Questions About Preparedness: Comorbid Childhood Sexual Abuse and Substance Abuse Among Women (*N* = 83)**

| Area of Preparedness | Counselor Education *n* (%) | Social Work *n* (%) | Overall *N* (%) |
|---|---|---|---|
| Know how to explore for a history of CSA | 6 (50%) | 29 (40.9%) | 35 (42.1%) |
| Feel confident in ability to develop treatment plan | 2 (16.7%) | 25 (35.2%) | 27 (32.5%) |
| Discussed comorbid childhood sexual abuse | 4 (33.3%) | 36 (50.7%) | 14 ( 48.2%) |
| Feel confident about ability to explain comorbidity | 12 (100%) | 60 (84.5%) | 72 (86.8%) |
| Believe most women with substance abuse problems | 0 (0%) | 23 (32.4%) | 23 (27.6%) |

Prior to collapsing the five response options into three categories, a Mann Whitney *U* test was used to examine differences between counselor education students and social work students on the ordinal ranking (1-5) of perceived preparedness in each of the three areas. Significant differences emerged on two items: whether differences and similarities among women and men who abuse substances were discussed in class ($U = 267.5$, $p < .05$) with counselor education students responding in agreement in greater proportions, and whether respondents believed that most women with substance abuse problems were childhood sexual abuse survivors ($U = 263.0$, $p < .05$) with social work students responding in agreement in greater proportions.

**Associations Between Experience and Training Variables**

Using the entire sample of 83 students, Pearson's product moment correlation coefficient was used to examine relationships among interval-level variables such as GPA, number of hours of training, scores on test, age, and number of years of paid experience. A significant relationship emerged between age and number of years paid experience, ($r = .5$, $p < .05$).

## Chapter 6: Discussion

This research examined to what extent counselor education and social work students are knowledgeable, trained, and prepared to work with women who have experienced childhood sexual abuse and are also experiencing substance abuse problems. Previous research (Lendhart,1994; Lemieux and Schroeder, 2002) indicated that social work and counselor education programs are offering at least some training and content in both curricula in the area of substance abuse, perhaps more now than in past years. However, research on counselor education and social work student preparation in the area of childhood sexual abuse and substance abuse among women has not been conducted.

Both social work and counselor education students will likely encounter women with substance abuse problems who are sexual abuse survivors when they graduate, thus, it is important to obtain preliminary information about students' educational background in an area that is receiving increased attention in the field in recent years. No study to date has compared counselor education and social work students' knowledge, training, and preparedness in the areas of substance abuse, childhood sexual abuse, and comorbid substance abuse and childhood sexual abuse among women. Research examining students' knowledge, training, and preparedness in the area of substance abuse has relied on self-report data of students' perceptions, to investigate these variables (Lendhart, 1994; Lemieux and Schroeder, 2002). In addition to self-report data, this study used an objective test to supplement students' self-reported competencies, which was then compared with measures of training and other related variables.

### Discussion of Differences in Knowledge and Training of SW and CE Students

The results of this study indicate that social work and counselor education students are not different on measures of knowledge and training around substance abuse, childhood sexual

abuse, and comorbid childhood sexual abuse and substance abuse among women. These results are consistent with current research on counselor education (Lendhardt, 1994) and social work substance abuse (Gassman, Demone & Parillo, 2002) education.

Because this body of literature suggests that counselor education and social work students are receiving similar preparation (e.g., training, course content) in the area of substance abuse, it is not surprising that these two groups did not differ significantly in knowledge in the areas of comorbid childhood sexual abuse and substance abuse among women. This was also true for measures of training of counselor education and social work students. In both cases, the null hypothesis of no difference between counselor education and social work students was not rejected.

**Discussion of Differences in Preparedness of SW and CE Students**

The hypothesis that stated that counselor education and social work students would not be different on the measure of preparedness was not supported. Counselor education and social work students differed significantly on two questions on the measure of preparedness. "Since the beginning of my program of graduate study, I have discussed the differences and similarities among women and men who abuse substances" and "I believe that most women with substance abuse problems are childhood sexual abuse survivors." On the former question, a significantly greater proportion of counselor education students agreed or strongly agreed ($n$ = 8, 66.8%) with this question than social work students, ($n$ = 38, 53.5%). On the later question, significantly greater proportion of social work students ($n$ = 23, 32.4%) agreed with this question than counselor education students, ($n$ = 0). When investigating possible reasons for the differences between counselor education and social work students on the question about discussing differences between men and women, Table 3 has one interesting difference between counselor

education and social work students that could explain this significant finding. It should be noted that a larger proportion of counselor education students (33.3%) agreed they had discussed differences between men and women who abuse substances with a supervisor than did social work students (6.9%). It is only speculation, but issues that are discussed in an internship, could be more likely to be brought up and discussed in a classroom setting. If counselor education students are more often discussing in class what they discuss at their internships, this could be why they have discussed the differences in class more often. Nevertheless, it is also necessary to state that these differences could be an artifact of a small sub-sample.

Possible reasons for the differences in response rates on the question about women who abuse substances being childhood sexual abuse survivors, could lie in Table 1 which reveals that social work students reported more hours of training in the area of substance abuse, more hours of training in the area of childhood sexual abuse, and more years of paid practice experience than counselor education students. Another speculation is that many of the social work students with paid practice experience identified themselves as "Office of Community Service" workers, whereas the counselor education students did not. The Office of Community Services in Louisiana is known to handle many childhood sexual abuse cases, and to be in contact with many substance abuse cases, and in particular women who abuse substances. Therefore, that would make social work students more likely to have come in contact with women who abuse substances and who also experienced childhood sexual abuse. Thus, it makes sense that these social work students would agree more often that most women with substance abuse problems are childhood sexual abuse survivors. Although counselor education students and social work students differed on these two questions on preparedness, these differences do not speak to any substantive issues given the overall results on the measure of preparedness.

**Discussion of Knowledge of the Whole Sample**

The first research question asked how much knowledge students have in the area of comorbid childhood sexual abuse and substance abuse. The mean score on the test of knowledge for the entire sample ($N = 83$) was 44.5%, ($SD = 10.3$). The low score was 25% and the high score was 70%. Less than half of the sample scored 50% on the test, less than one-third of the sample scored a 55% or higher on the test, and about 60% of the sample scored below 50% on the test. If this measure proves to be a valid measure of knowledge, these students' test results indicate established a somewhat low benchmark of knowledge about comorbid childhood sexual abuse and substance abuse among women.

**Discussion of Training of the Whole Sample**

The second research question asked how much training students had in the areas of substance abuse, childhood sexual abuse and comorbid childhood sexual abuse and substance abuse among women.

On the measure of training, well over three-fourths of all students reported that they knew (79%) someone who has experienced childhood sexual abuse, and about three-fourths (75.9%) reported that they had completed an internship at an agency that included childhood sexual abuse survivors among its clientele. Despite those results, only two of the students reported they had facilitated a group counseling session around childhood sexual abuse issues, and only five reported they had facilitated an individual counseling session around childhood sexual abuse issues. About one-fourth reported that they had facilitated a family counseling session around childhood sexual abuse issues. It can be concluded that although many students are being placed at agencies that include childhood sexual abuse survivors as clients, relatively few students are facilitating counseling sessions with them.

Of the entire sample, most students reported they had completed an internship at an agency that serves people with substance abuse problems, and of those, about one-third reported they had facilitated an individual session around substance abuse issues, 13 reported they had facilitated group counseling around substance abuse issues, and 9 reported they had facilitated a family counseling session around substance abuse issues.

Although more students reported facilitating in group, individual, and family sessions around substance abuse issues than around sexual abuse issues, the conclusion can be drawn, that most students are not are not facilitating these different types of sessions around substance abuse issues.

In the same vein, very few students reported they had completed an internship at an agency that provided services exclusively for people with substance abuse problems, and even fewer reported they had completed an internship at an agency that provided services exclusively for childhood sexual abuse survivors.

**Discussion of Preparedness of the Whole Sample: CSA**

The final research question asked how prepared students felt to work with childhood sexual abuse survivors, substance abusers, and women experiencing substance abuse and who have also experienced childhood sexual abuse.

Examining response rates on the measure of preparedness, students felt more prepared to work with childhood sexual abuse survivors, less prepared to work with substance abuse survivors, and the least prepared to work with women who are childhood sexual abuse survivors who are also experiencing substance abuse problems.

The response rates on preparedness to work with childhood sexual abuse survivors is not what was expected after the variable of training was examined on childhood sexual abuse. Most

students reported they had not facilitated group, individual, or family counseling sessions around childhood sexual abuse issues, yet on questions measuring preparedness to work with this population, more than half of the sample agreed to every question with the exception of one. That question was: "I can explain research theories underlying interventions for childhood sexual abuse survivors." The fact that less than one-fourth (24.1%) of the students agreed they could do this is inconsistent with the finding that over half of the students agreed that they were prepared in all of the other areas. The question can be posed: If most students do not agree they can explain theories underlying intervention for childhood sexual abuse survivors, how can they perceive that they are prepared to work with them?

**Discussion of Preparedness of the Whole Sample: Substance Abuse**

When compared with students' response rates on the measure of preparedness to work with childhood sexual abuse survivors, fewer students agreed that they were prepared to work with substance abusers. This is inconsistent with students' measures of training in the area of substance abuse. More students responded that they had facilitated a group, individual, and family session around substance abuse issues than sexual abuse issues, yet fewer students agreed that they were prepared to work with substance abusers. It is not known why fewer students reported preparedness in the area of substance abuse than in the area of sexual abuse. One possible explanation is more training. Students did report, on average, more than four times as much sexual abuse training (8.6 hours) in seminars and conferences, than substance abuse training (2 hours). Another possible explanation is that students were confusing their willingness to work with childhood sexual abuse survivors with their preparedness to work with childhood sexual abuse survivors. Students may be more willing to work with this population than with substance abusers.

**Preparedness of the Whole Sample: Comorbid CSA and Substance Abuse Among Women**

In the area comorbid childhood sexual abuse and substance abuse among women, fewer students agreed on questions measuring their preparedness than in the distinct areas of childhood sexual abuse and substance abuse, with the exception of one question which read, "I feel confident in my ability to explain comorbidity to a colleague." Most students (86.8%) reported they agreed that they could do this.

**Discussion of Associations Between Experience and Training Variables**

Interestingly, knowledge test scores were not correlated with measures of training and experience. Because the training variables separately measured childhood sexual abuse and substance abuse, but not comorbid childhood sexual abuse and substance abuse among women, it is possible that students correctly answered questions pertaining to these two separate areas, and incorrectly answered questions about comorbid childhood sexual abuse and substance abuse. An item-by-item analysis of students' test responses should be undertaken to identify the strengths and deficits in specific knowledge areas. This type of analysis may shed additional light on the relationship between training experiences and knowledge. Subscales of the instrument should be created in each of the three knowledge areas (substance abuse, sexual abuse, and cormorbid childhood sexual abuse and substance abuse), and these subscales should be correlated with training, experience, and other relevant variables to determine whether significant associations exist. Cronbach's alpha should be computed to assess inter-item consistency of the three subscales and of the overall scale in order to determine whether the test used in this questionnaire is a reliable measure of knowledge.

## Limitations

As with all social science research, this study had a number of limitations. The first limitation is the issue of statistical power. Although an a priori power analysis was undertaken, the sample size of 83, which was slightly larger than the required minimum (80), may have resulted in a Type II error. Thus, there may have been insufficient power to detect a true difference. Therefore, the results of bivariate tests of statistical significance should be interpreted with caution.

This research was conducted using a convenience sample of one class of counselor education students and one class of social work students. Thus, the results cannot be generalized with confidence to students in other counselor education and social work programs.

Although the instrument was pre-tested with a comparable population, additional reliability analyses should be carried out to ensure that the instrument consistently measures knowledge, training, and preparedness among counselor education and social work students.

A pre-test of students' knowledge was not used in this study. In future research, a pre-test administered to students as they begin their respective programs would enable the researcher to determine whether students increased their knowledge base in the areas of substance abuse, sexual abuse, and comorbid childhood sexual abuse and substance abuse among women, over time. A pretest-posttest design may also allow the researcher to draw more definitive conclusions about the relationship between students' knowledge and curricular content.

## Research, Practice, and Educational Implications for this Research

This is the first known study that examines the knowledge, training, and preparedness of social work and counselor education students around the issues of comorbid childhood sexual abuse and substance abuse among women. In recent years, this issue has been receiving

increased attention in research and popular texts on substance abuse and has important implications for practice, education, and research.

The way substance abuse treatment is carried out for women who have experienced childhood sexual abuse has implications for the graduate social work and counselor education curricula. Because research of this manner has not been carried out before, this study provides a benchmark of how knowledgeable, trained, and prepared students are to work with women experiencing comorbid childhood sexual abuse and substance abuse. Based on the students' responses in this study, it is vital that social work and counselor education curricula educate students about these issues in order to keep up with the changing pace of practice, which increasingly emphasizes issues pertaining to diversity. Differences among men and women who are substance abusers are being studied and documented. If students are not learning about these differences in their curriculum, they will be ill-prepared to work with women who are substance abusers who also are sexual abuse survivors.

It has been acknowledged that counselor education and social work students need basic information about substance abuse assessment (Buckalew & Davis, 1986; Gassman et al., 2001) and intervention, but as the knowledge about substance abuse treatment has become more sophisticated, many of the implications,(e.g, gender issues) have not found their way into actual curricular changes. Research indicates that in the past, substance abuse treatment has usually been tailored for men and to include primarily men's issues (Jones, 2004). However, women generally have different needs than men when being treated for substance abuse (Cramer, 2002). Further, sexual abuse is often related to substance abuse in women (Freeman et al., 2002). Women often drop out of treatment because of sexual abuse issues not being addressed

(Copeland & Hall, 1992). Therefore, changes are in order in the curricula of these disciplines to properly train students to treat women for substance abuse who also have experienced childhood sexual abuse. The way substance abuse treatment is carried out with women starts with preparing professionals to work with relevant issues, which in turn leads to better practice. An analysis of curricular content in the major texts used by counselor education and social work graduate students may shed some light on the extent to which substance abuse, childhood sexual abuse, and comorbid childhood sexual abuse and substance abuse among women are differentially covered. Pretests of students' knowledge should be undertaken to examine how much scores improve from the foundation year to advanced year of study.

This research provides a starting point for ongoing research examining the issues of knowledge, training, and preparedness of graduate students in counselor education and social work programs. Because most students disagreed on the measures of preparedness to work with comorbid childhood sexual abuse and substance abuse issues among women, future studies are warranted. Replication of this study with a larger and more representative sample of counselor education and social work students should be carried out, to ascertain how knowledgeable, trained, and prepared students are in other schools of social work and counselor education programs. The instrument for this study may also warrant refinement. An item-by-item analysis of the knowledge test questionnaire will identify the areas that students demonstrate the most and least amount of knowledge.

## Chapter 7: Summary and Conclusions

This research aimed to examine whether counselor education and social work students differed in knowledge, training, and preparedness in the area of comorbid childhood sexual abuse and substance abuse among women. It also asked how knowledgeable, trained and prepared graduate social work and counselor education students were in the area of comorbid childhood sexual abuse and substance abuse among women. We found that there was no difference between the two groups in the areas of substance abuse, childhood sexual abuse and comorbid childhood sexual abuse and substance abuse among women. Thus, this sample of students have similar knowledge, are receiving similar training, and feel similarly prepared in these areas. However, students knew less than half of the items on the test of knowledge. Students were more prepared to work with childhood sexual abuse survivors than with substance abusers, and they were least prepared to work with women experiencing comorbid childhood sexual abuse and substance abuse.

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## Vita

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