

Working with Addicted Survivors of Sexual Assault

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“There were many variations on a common theme - the women were sold by their mothers to neighbors for crack, or used as sex toys by stepfathers, or locked up in their own homes by their lovers, or beaten with two by fours by their legal husbands, or verbally abused by their own children, or dumped out of cars and left for dead, or gang raped and then set on fire. These women have had their dogs and their children killed in front of their own eyes. These women bear children that are their own siblings. And these stories are true. I have listened to stories in my clinic that made me want to escape the telling of them - that made me wonder how the woman sitting with me was strong enough to survive, to have children, and to get out of bed every day. These stories were being told by women that had been entrapped by their life circumstances, and could not see outside the room of pain that they had been locked into.”

Dr. Annie De Groot, IDCR June 2006 Infectious Diseases in Correction Report – Brown Medical School, Office of Continuing Medical Education



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The tools, assessments and group exercises presented were culled over years of experience and are referenced in the resource section of this manual.

Because gender-neutral language can be awkward, there will be times when gender specific language is used. Occasionally, gender-specific pronouns (e.g., “she” or “he”) will slip into the text. The aim is to be inclusive rather than exclusive. As in the field of experimental pharmacology when most testing is done on men and doctors may note that the results do not apply as well on women and children, sexual assault has been viewed as woman’s issue and the therapy, sexual assault research, advocacy and “how to’s” reflect this: the same approach does not necessarily work as well for men or for people from different cultures and backgrounds.

The word normal is deliberately avoided as much as possible; normal is mutable. For the people we counsel and advocate for, normal has many meanings. The perception of not being “normal” can lead to feelings of exclusion, shame and isolation. “Natural” is used instead of “normal.”

The bulk of this manual is based on real life observations, anecdotes and experiences over many years of working with survivors, although some research-oriented statistics are included.

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I. Research Overview and Statistical Background

How do researchers describe the common links between chemical dependency and sexual assault/abuse? Is there a different prognosis and strategy for counseling an addicted survivor than when treating an addict with no sexual abuse history? How does ongoing addiction affect the potential for revictimizing survivors of sexual violence? Do addicted survivors impact their children in ways different than non-addicted survivors? How does the sexual abuse component affect the addicted client's ability to remain sober, especially when there are ongoing trauma symptoms? This section is a literature review. There aren't any clear one-size-fits-all answers. Research in this field suggests and correlates connections between behaviors and outcomes.

General Substance Abuse Statistics in the US

There is a wealth of research on addiction regarding the prevalence of substance abuse in this country. Addiction can include drugs and alcohol as well as behaviors such as compulsive gambling, sex addiction, food addictions, internet pornography or other behaviors. According to The National Center on Addiction and Substance Abuse at Columbia University, "Nearly 14 million Americans meet diagnostic criteria for alcohol use disorders" (1998).

In 2001, an estimated 15.9 million Americans aged 12 or older were current illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 7.1 percent of the population aged 12 years old or older (Substance Abuse and Mental Health Services Administration, 2002).

According to the 2006 The National Survey on Drug Use and Health (NSDUH) findings an estimated 20.4 million people in the United States used some kind of illicit drug in the past 30 days. About 8.3 percent of all people aged 12 and over are involved in use of illegal drugs or the non-medical use of prescription drugs (Substance Abuse and Mental Health Services Administration, 2007).

The Connection between Substance Abuse and Sexual Violence

There are still many unexplored areas surrounding the intersection of sexual assault and substance abuse, notably research on men and special populations. There is a need to examine the relationship between child sexual abuse (CSA) and substance use disorders (SUDs) in populations that have been traditionally underserved: immigrants, poor clients, ethnically and racially diverse clients, those with disabilities, the elderly and lesbian, gay, bisexual, transgendered, queer and intersex (LGBTQI) populations.

Many researchers have documented a strong connection between chemical addiction and history of sexual abuse. These are still often seen as two separately cocooned fields.

Many researchers, counselors and advocates still have not connected the dots in how to approach working with the addicted survivor. Well-intentioned service providers often examine the client either from an addiction or an abuse perspective, instead of looking at the many connecting pathways and commonalities between the two fields.

Sexual abuse and addiction are not experienced as separate entities by the client. Some providers are trained in theory from both fields. It is helpful to recognize that there are two basic lenses through which service providers may see the addicted client, depending on whether the provider's mental health expertise is grounded in addiction or sexual abuse.

The substance abuse counselor often sees the addiction as the cause of the client's many problems and the rape crisis counselor often sees addiction as the outcome of sexual abuse. Both statements may be true. What is missing is the in-depth knowledge about the addicted survivor in both fields. What is needed is dialogue between both fields using tools and skills from both to treat the client holistically.

This is a complicated process of recovery and one that can serve the client well. A basic principle of clinical work includes knowing who the client is and what he/she brings into the treatment setting.

Is addiction genetic or learned?

Traditionally, addiction was viewed as a sign of lapsed morals and some people still hold that opinion. Now, most researchers believe genes play a role in addiction "Adoption studies allow researchers to look at individuals born to alcoholic parents but adopted into nonalcoholic households. Children of alcoholics have a higher risk for alcoholism, even when adopted into a nonalcoholic family." (Hesselbrock & Babot, 1994; Cadoret, O'Gorman, Troughton, & Heywood, 1986). The extent to which genetics influence women's vulnerability to alcoholism has been questioned. In some studies, women have a lower rate of alcoholism than their alcoholic family members, in other studies, the answer is unclear (Straussner, 2002). As health professionals in different The Traditional Addiction Perspective disciplines began revising their concepts of all disease, a more holistic view of health began to emerge that included the physical aspects of disease as well as the emotional, psychological, and spiritual aspects (Northrup, 1994). Alcoholics Anonymous (AA) was one of the first proponents of a holistic health model for the disease of addiction, encompassing the physical, emotional, psychological and spiritual aspects.

The Traditional Addiction Perspective

1. Active addiction can place the client (and the client's children) at risk for being vulnerable to abuse, legal problems, job loss, financial disaster, relationship disruption, etc.
2. The client's sexual abuse history is often unknown to the service provider.
3. It is the client's responsibility to make healthy choices using tools provided by the counselor/advocate.
4. If the sexual abuse is disclosed, the client will be referred out.
5. The primary emphasis is placed on understanding and maintaining sobriety.
6. This approach is more directive and assertive, using language that can be construed as victim-blaming.
7. This modality looks at what part the client plays in any situation.
8. The service provider may see avoidance behaviors (i.e. minimizing, justifying and/or rationalizing problems) as a trigger for relapse.
9. There may be gaps in service for special populations.

The Traditional Sexual Assault (Rape Crisis) Perspective

1. Sexual victimization can place the client at risk for lost wages, medical injuries, STDs, pregnancy, trauma, disruption of family, divorce, etc.
2. The client's addiction history is often unknown to the service provider.
3. Counseling is a collaborative endeavor where the counselor acts more like a coach, with strong input and decision-making from the client.
4. If the addiction is disclosed, the client may be referred out, especially if the rape crisis center provides only short-term counseling.
5. The primary emphasis is determined by the needs of the client and often centers on the client's healing.
6. This approach is more exploratory, uses language sensitive to victim-blaming and may require systems advocacy.
7. This modality places responsibility on the perpetrator/abuser.
8. The service provider may see avoidance behaviors (i.e. filling up every minute of the day) as a coping mechanism for intrusive thoughts and memories.
9. There may be gaps in service for special populations.

Overlap between Child Sexual Abuse (CSA) and Parental Substance Abuse

Child sexual abuse (CSA) is epidemic in the United States. It is important to note that numbers and statistics may vary somewhat between different studies, but all show that the prevalence of child sexual abuse is not insignificant in terms of many thousands of survivors of CSA, both male and female.

- The first national survey looking at prevalence and risk factors of child sexual abuse found that 22 percent of the United States population surveyed reported they were victims of sexual abuse (Finkelhor, Hotaling, Lewis, & Smith, 1990).
- Researchers noted that various forms of child abuse (physical, sexual, emotional abuse and neglect) overlap (Wekerle & Wolfe, 1996).
- One consistent, common link to all these forms of child abuse is parental substance abuse (Wand, 1998).

Links between Child Sexual Abuse (CSA) in Women and Substance Use Disorder (SUD)

A growing number of studies note a link between a history of female sexual victimization in childhood and subsequent use of drugs in adolescence and/or adulthood. The majority of women and a significant percentage of men seeking help for substance use disorders (SUD) are survivors of either physical or sexual abuse (Dansky et al., 1996; Najavits et al., 1997, 1998; Ouimette et al., 2000). Among SUD clients, lifetime physical or sexual abuse is associated with more

severe interpersonal problems and higher rates of other co-existing psychiatric disorders (Gil-Rivas et al., 1997; Windle et al., 1995). Please note that men were not included in the majority of the studies of sexual assault. Many clinical studies during the past decade also reported higher rates of CSA from women seeking treatment for alcohol and other drug problems than among women in the general population (Kovach, 1983; Miller et al., 1987).

Sexual Abuse, Substance Abuse and Post-Traumatic Stress Disorder

The role of sexual assault in the development of Post-Traumatic Stress Disorder (PTSD) was first observed in a national probability sample in which 31 percent of female rape victims experienced PTSD at some point in their lives compared with 5 percent of women who had never been victims of crime (Kilpatrick et al., 1992). Not all women who are sexually assaulted develop PTSD or are diagnosed with it.

There seems to be a connection between sexual abuse/assault of both adults and children and later substance abuse by teens (Holmes, 1997) and adults (Teets, 1995). Some studies associate PTSD with sexual abuse and sexual assault, and substance abuse frequently accompanies the PTSD diagnosis (Brady et al., 1994; Briere & Runtz, 1993), possibly as a means of self-medication. "Researchers have observed high rates of substance use disorders among individuals in the general population who have PTSD in association with traumatic events such as victimization or disaster. Almost 90

percent of the women and men who sought treatment for substance use disorders reported that they had experienced a sexual and/or physical assault during their lifetime” (Dan-sky et al., 1996).

II. Introduction

What comes first, addiction or sexual trauma? More importantly, does it really matter? The kind of care, attention and help the victim of sexual violence gets is what matters.

The first thing anyone working with a client of sexual assault is taught to say is, “You did everything necessary in order to survive. What happened was not your fault. You used your best judgment and you are sitting here, talking with me. I see courage and hope and strength and a willingness to move forward. How I can help you?”

When a client discloses to a counselor at a rape crisis center that s/he is an addict, what is the professional and ethical course of action? What should be done next? Does the agency screen the client out of the program because of a substance abuse problem or give that individual a referral to a drug treatment program (often with a long waiting list, if one even exists in the community)? Do they refer the client to a 12 Step Program?

Does the client know that residents staying at most shelters cannot be honest about any current drug use and remain there? Most ethical counseling programs require that the client remain sober during counseling sessions, but most crisis centers/shelters will not allow active addicts or alcoholics to live there.

What happens when a counselor/advocate discovers or suspects that the client has a substance abuse problem? If the client is staying in the shelter, does the advocate avoid asking about current substance use, thereby establishing an environment of silence and secrecy? Or worse, what happens when the service provider does not know how to ask, or does not have the vocabulary, training or experience necessary to ask the right questions?

The quote at the beginning of this manual does not specifically state that the women are addicts, yet hints at the fact that they are coping somehow. And this is generally how clients present to most advocates: as survivors who may feel that circumstances are beyond their control. Counselors and advocates have to learn how to listen better and dig deeper to uncover what their individual coping mechanisms are. If not, they may not be helping their clients. In fact, they may be harming them.

The dynamics of sexual assault and chemical dependency both include issues of power and control. In the case of

sexual assault the perpetrator exerts power and control over the victim’s body, forcing the victim to do things that s/he does not want to do. In the case of chemical dependency, it is the drug, whether willingly or unwillingly taken, exerting power and control over the victim’s body – sometimes the victim does things s/he might not choose to do when sober. And sometimes, when both chemical dependency and sexual abuse are present, the perpetrator can force and control the victim’s substance use.

Society often makes assumptions about users. They are not credible or reliable and it is a waste of resources to work with a victim until the chemical abuse completely ceases. Societal responses to addiction in women also tend to differ according to the woman’s social class and drug preference. Poor women who suffer from addiction are often threatened with the loss of their children. In contrast, pregnant middle-class women addicted to cocaine or marijuana are often counseled with no threats of losing custody of their children (Marwick, 1998). This raises many questions. How does one work with a client who comes for help, and is dependent on substances? Hopefully this manual will encourage the re-examination of beliefs about drug-addicted survivors of sexual assault.

The neurobiology of trauma in this manual is based in part on the work of Dr. David Lisak (2002). It is explained in everyday language. Understanding the neurobiology of trauma is crucial when working with clients. Unless the advocate or counselor can explain to the client how trauma manifests in one’s body and life, our best intentions, and the best intentions of the client, may result in unintended consequences or mixed messages.

When the client understands what is happening from a neurobiological perspective it can be easier to make the choice to move from a victim of a violent crime who is also a victim of chemical dependency to a survivor of both. This is hard emotional, psychological and physical work. Anyone who chooses to walk this path must be honored for this act of courage.

There are many different treatment models for recovery from chemical dependency. There are many ways to recover from a sexual assault or childhood sexual abuse. There is no such thing as a best recovery model – each person is unique. Each individual needs a customized treatment plan. Different treatment options and therapy models can be viewed as a “cafeteria plan” from which the client chooses. The counselor/advocate’s job is to explain what these treatment models are, how they work, what other clients have to say about them and provide resources for effective help.

The stress of being a victim of a sexual crime, whether or not there is a criminal investigation, may cause trauma symptoms or other strong emotions to surface repeatedly. These

strong emotions, flashbacks, etc., can prompt the victim to turn to drugs or alcohol. If the client abused substances in the past, and was sober before the sexual assault, these stressors can lead to a relapse. It is vital to know how to pinpoint the signs of relapse, including the language, behaviors and signals a client may use right before relapse. (These issues are addressed in the relapse section.)

Nothing happens in a vacuum. Things to consider when working with addicted survivors include: what other systems (criminal justice, law enforcement, social services, family system) is the client involved in? How can you work collaboratively with these systems for the best outcome of the client? And when should you? How do you address the legal issues of confidentiality and privilege? Integration of services, or how your agency does outreach, educates community partners and the community at large about the intersection of sexual assault and chemical dependency, and is an important piece of the puzzle.

It is not the intention of this manual to train anyone to be a drug and alcohol counselor. It is not the intention to be a "best practices" manual. A best practice is what works the best for each individual client. When working with unique individuals, "best practice" is a misconception. Recovery is not a cookie cutter process.

It is the intent of this manual to offer some insight, explain some physical and neurological phenomena, show how evaluation tools can be used to gain more information and to provide some topics for support groups that advocates can use. The intent of this manual is to help each service provider think about immediate problem solving issues/solutions that will, hopefully, enable and empower the client to become a survivor by helping each to define a "new normal."

III. Neurobiology of Trauma

Trauma

The human brain is the result of millions of years of evolution. As a result the brain has a highly developed capacity to experience fear. Our survival depends on our capacity to react immediately to a threat – life or death decisions are often made in milliseconds. As fast as the cerebral cortex is at deciphering incoming information, it is not fast enough when faced with life or death situations - it is slow and logical, "the slow road to fear." Long before the cerebral cortex has a chance to respond to the perceived image of a gun and to verbalize, "gun!" the person usually reacts with defensive maneuvers.

Evolution created in human beings a system of hormones and neurochemicals to prepare us for the "fight, flight or freeze" response, which is activated without conscious

thought. This fast reaction comes from the old, reptilian part of the human brain, which can be called the "fast road to fear." In fact, the fast road stores a great deal of unconscious sensory information crucial to our survival. Consider this example:

Imagine a zebra bending down to drink at a water hole, every sense keenly alert for danger. Suddenly, from out of the grass nearby, a blur of brown hide lunges out. The zebra instantly spins, lunges and gallops away, alive for another hour. Thirst demands that the zebra return to the water hole. When it does, the particular stimuli that preceded it will now have been etched into memory – not at the cortical level – rather at far simpler, sub-cortical levels.

At the zebra's second visit to the water hole, should a gust of wind happen to sway the grass and cause a similar sound to that of the leopard's lunge, the poor animal will flee with the same experience of terror. If a zebra could think, it would say, "that was just the wind." However it will be 50 yards away when it does so. (Lisak, 2002)

This response also instantaneously alters the body's physiology. Within milliseconds, the brain releases a chemical cocktail that enters the bloodstream preparing the body for fight, flight, or freeze. Each person responds differently to this cocktail. Some may feel energized (shaking, talking, pacing, etc.). Some may shut down in response to perceived danger. Others may strike back either verbally or physically.

The reptilian brain interprets danger in a lightning quick and primitive way. It stores raw data as sights, smells, sounds and tactile perceptions, not as language, or as rational, logical or sequential thought. The memory is stored as disconnected fragments that can be difficult to access. Not only can these memories be hard to retrieve, they can also be less easily translated into language. The brain may be permanently altered – vigilantly watching for the same stimuli that were present at the time of trauma (which are now equated with danger).

Fear

Fear is the cornerstone of trauma. A person who has not been traumatized can use both the slow and quick road to process danger. A person who has been previously traumatized may have less flexibility to consider how to react. For the traumatized person, the quick road to fear may predominate. The client now carries a network of neurons that may be hyper-vigilant to cues present during the sexual assault. It could be the sound or tone of a voice; the feel of hands on a particular part of the body. The possibilities are limitless and personal to the individual. At the sound, touch or sight of those danger cues, the client may experience the same cascade of chemicals triggered during the actual assault. The client may flee in terror when a child unexpectedly touches his or her thigh. Or the client may freeze at the

familiar tone the cashier uses when asking, “paper or plastic?” The reactions are often not conscious choices or over-reactions, any more than the zebra’s flight from the sound of windblown grass. Both are reactions. This is a simplified explanation of PTSD.

Traumatic Memory

Trauma is usually defined as an event outside the range of usual human experience. Clients reveal trauma reactions to advocates and counselors when they say things like:

1. I don’t know what to believe anymore.
2. I feel like my underpinning’s undone.
3. The colors have been yanked from my eyes.
4. How can that dude be so messed up?
5. I can’t believe this has happened to me.
6. This is so surreal.

Statements like these are reactions. It is important to note the words the client uses help him or her to process the underlying feelings. This is not about the “dude” (rapist) being messed up, or “knowing what to believe.” It is about helping the client process the feeling from a reaction into a conscious understanding. If the client can learn how to pay attention to the feelings underlying the words, this can become a tool for transforming the unconscious into the conscious without shame, blame or guilt.

There is still a lot we don’t know about treating trauma or alleviating symptoms. Traumatic memory is not encoded or stored in the same way as a normal experience. Memory can be blocked or disrupted at any stage of the memory storage process. Short-term memories may become stored or stuck in the old reptilian brain instead of being transferred to long-term memory. Clients are often frustrated at the inability to accurately recall the traumatic event. Memories that do exist are often distorted, merged or chronologically rearranged in either minor or problematic ways.

This isn’t just a psychological or emotional problem – it’s like putting a Word document in a password protected folder in the reptilian part of the brain and then going to the normal Memory folder hoping to find the document in there, where it would normally be stored. This is a physiological problem in accessing a memory. The passwords are generally the raw sensory data that the reptilian brain takes in during trauma.

The extent to which the password keeps the client from accessing the memory is on a spectrum from mild to severe. The client may recall a very specific detail for a particular aspect of the experience (e.g., the way a pore looked on the rapist’s face), but be unable to identify the rapist from a lineup. There may be little or no recall of other facts. Other clients may recall the facts in extreme detail. When a traumatized client recalls a detail not remembered three weeks ago, it is not evidence of lying. It is characteristic of the way traumatic memories are stored and recalled. Do not push

the client or set expectations for details that the client cannot provide such as sequence, context, peripheral detail.

Traumatic memories can be very frustrating for the client. Supplying the client with content, speculation, filling in the gaps or making suggestions about what might have happened is unethical, even when the client wants and needs to know exactly what happened. It is a human trait to want to see our memories replayed in movie-like sequence. Be careful what you say or suggest in the client’s presence because a person in crisis may take any suggestion as an invitation to fill in the gaps. This is natural. Any prompting or speculation about what might have happened might lead the client to adopt this idea as truth.

Suggesting possibilities to the client can have strong negative implications in a criminal trial. If the case goes to court, and the client comes to believe it is part of the actual memory, the defense attorney may refute it. This places the client at the risk of further victimization for being called a liar in open court, seeing the case dismissed or the perpetrator set free. The client may also become more confused because implanted memories can feel real. The client may also feel hurt and angry enough to mistrust and reject everyone and everything. The client may not weather this kind of stress and trauma and may leave whatever program they are in. If, as a service provider, you have a theory about what happened, remember it is only a theory. Discuss it with other professionals with client permission and ethical discretion.

Post-Traumatic Stress Disorder (PTSD)

Working through the layers of PTSD with a client who is a survivor of sexual violence is challenging. Working through the layers of PTSD with a survivor who is also addicted presents even more challenges. The commonly held belief that one cannot counsel an addicted survivor of sexual violence until they are clean and sober is true, since the client cannot make healthy decisions and life changes while high. The paradoxical question is:

1. should the client work on their addiction in a recovery program before addressing the sexual violence issues, or
2. should the client address the sexual violence issues that trigger the desire to use before addressing the chemical dependency issues?

Implications for Addicted Survivors

Being aware of the unintended consequences of choosing to work on both issues at the same time is something the care provider needs to keep in mind. What counselors and advocates do not want is to trigger clients, thereby making it easier for the client to use. This is where the individual client needs to be carefully assessed before diving in to either issue. Some clients may be able to work on both issues at the same time and some may be too easily triggered to handle one, let alone both stressors. Regardless, a

client coming into a session while high is not an option. This boundary needs to be set with the client early, clearly and as needed. If this client continues to disregard this boundary, the service provider must be prepared to discuss other options, refer the client to other services and be prepared to terminate services until the client can adhere to agreed upon boundaries.

It is known that ongoing drug use places the client at a higher risk for sexual re-victimization. When triggered, the client often reacts to the environment, doing whatever it takes to survive. Often, the client knows the acting-out behaviors are self destructive and does not know how to change. Self-medicating to numb the triggered feelings can make trauma symptoms worsen over time, resulting in chronic PTSD (Cappell and Greeley, 1987; Chilcoat and Breslau, 1998). Additionally, the majority of women who are addicted suffer from feelings of shame and guilt as a result of the strong cultural bias against inebriated and drug-addicted women. This adds another layer of shame and guilt to that which co-exists as a result of sexual abuse.

The sexually abused and addicted client may describe feelings of:

- anxiety
- fear
- restlessness
- irritability
- anger
- depression
- insecurity
- fatigue
- mood swings
- insomnia
- guilt
- self-blame
- shame

The client may also report:

- An increase in the use of substances or other drugs such as nicotine
- Fear-based sexual abstinence or sexual compulsion
- Having aged in a short period of time
- Rapid weight loss or gain
- Headaches
- Digestive problems

Many aspects of the client's life may feel out of balance and may be reflected in a wide array of symptoms. The good news is that with a lot of work, the client can start on the adventure toward recovery.

IV. Victim vs. Survivor

Addicted survivors can experience conflicting issues of power and control vs. powerlessness and feeling out-of-control. Rape myths that blame the victim combined with negative attitudes toward addicts tend to contribute to these feelings. In addition, other cultural attitudes can add another layer of self-blame and may exaggerate feelings of victimization.

Defining the Word "Victim"

Webster's Dictionary defines a victim as "an unfortunate person who suffers from some adverse circumstance; a person destroyed or suffering grievous injury from another." Sexual assault victims are people who have experienced a traumatic crime through no fault of their own. These clients often tend to experience chaos in many areas of their lives after the sexual assault. People in this kind of distress often develop coping skills, some of them maladaptive, in an effort to feel safe and in control. The skillsets the client uses speaks to their will to survive. Counselors and advocates can address the practical skillsets the client uses to assess whether the results are helpful or harmful.

Defining Addiction

Behaviors that fall into the category of "addiction" are debatable. Most experts agree that overuse of substances represent clear examples of addictions. Addiction is a complicated condition, with biological, physiological, psychological, behavioral, and spiritual aspects. In 1972, the National Council on Alcoholism and Drug Dependence came up with this working definition, "Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic" (Henderson, 2000). Two elements often accompanying the definition are: (1) loss of control over the use of the substance, and (2) continued use despite negative consequences.

Disengaging from thoughts, feelings and reality is the ultimate in avoidance coping. Dissociation can range on a spectrum from absentmindedness to blackouts. There can be many causes for dissociation. The consequences of dissociating can be mild to severe.

The compulsive part of addiction is what makes behaviors hard to change. This is why addiction is referred to in 12 Step literature as "banging your head against a brick wall, expecting that the next time you will not get hurt." With addiction, there is a compulsion to repeat a behavior regardless of its consequences. The addicted individual may feel powerless over drugs and alcohol.

Addictions/compulsions can also be linked to food, adrenaline rushes, self-mutilation, gambling, anger, sex, shopping, other ritualistic behaviors and/or thoughts. Addiction has recently been called a chronic, relapsing brain disease where "addiction is tied to changes in brain structure and function is what makes it, fundamentally, a brain disease" (Leshner 1997).

The client may be struggling with multiple challenges: a brain disease, compulsivity, maladaptive coping skills and possibly other problems. Yet the client is working to define a new normal. This new normal is not necessarily easy to attain. It may be a normal the counselor is not comfortable with in terms of client safety. With the exception of safety for the client, those around them or those whom their behavior may affect, this new normal does not have to make sense to the counselor. If it is destructive, address this with the client by: 1) asking the client what outcome is expected, and 2) role play "what if" scenarios to highlight different possible outcomes.

12 Step philosophy is confrontive and directive. The group, and more specifically the sponsor, will tell the client what s/he is doing wrong and suggest ways of changing. A good therapist functions more like a coach, asking questions, listening and processing collaboratively to reach the client's stated goals. As an advocate/counselor two things are important: 1) to help the client to suspend nonworking belief systems; and 2) to allow the counselor or advocate to suspend his/her own beliefs, judgments and biases as long as it does not conflict with professional ethics or the safety of the client or others.

Trauma causes many clients to turn to substance abuse as a means of coping. The result of getting high is that the client represses feelings. When feelings are not experienced, a person is usually on automatic pilot, out of touch with life events and emotions. The client may miss the clues and cues that can help in assessing situations. This can create a setup for additional victimization. This cycle of victimization - substance abuse - re-victimization - substance abuse is particularly true for victims of chronic early childhood sexual abuse, who may have other conditioned or maladaptive responses that were created or encouraged by the abuser. It is important to know whether the client was molested as a child because it adds additional layers to the patterns of coping skills. The client may be unwilling or unable to disclose childhood abuse. Because of the way the drug, trauma and conditioning can skew perception, clients may have developed disclosure barriers and those barriers need to stay in place until the client is ready to disclose the abuse.

Coping Skills

Some of the coping skills that addicted survivors, particularly of childhood sexual abuse, may use in an effort to survive are:

Lying and denial. Exaggerating or creating a more palatable internal reality is possible. When lying and denial become so ingrained that it is habitual, the client may even lie about things when it is simpler to tell the truth. If confronted with the simple truth "it is 10 a.m. and you are not ready to go to work," the addicted client may go into drama mode with justifications and rationalizations to deflect blame.

Sexuality and intimacy issues. If a client was sexually abused or assaulted, s/he may end up avoiding sexual or intimate relationships. The opposite can also happen, i.e. when the client becomes compulsively or habitually sexualized and is trained to become promiscuous. It is important to realize that early childhood sexualization is something the abuser imposed on the child. In particular, incest survivors are taught as children that they are valued primarily for their sexual availability. As a result, the client may use sex to feel powerful, loved or to get something s/he wants. Unconsciously, this can also be a way to get back at the perpetrator. It may help the client feel temporarily in control.

It is also possible for the client to have learned that sex is what others want and can be used for trade. Some addicted survivors trade sexual favors, even sometimes using their partners, children or family members to support their addiction. In doing so, this supports the cycle of victimization and dismisses the core value of all human beings.

Some survivors experience flashbacks during sex, which can be frightening and make it difficult to distinguish past abuse from present consensual sex. Also, due to early conditioning, some may feel that sex and intimacy are mutually exclusive and find it difficult to combine the two. This is especially true if the victim's sense of self was defined by someone they knew and trusted.

Food issues. Sometimes clients use their body weight consciously or unconsciously as a method to avoid further victimization. They may lose weight hoping to disappear. Sometimes clients gain weight to appear stronger or less sexual or even to hide behind their size. This can be a way to exert power and control over one's environment without hurting another person. Using food for comfort is socially acceptable.

Withholding or purging food can be a pattern of self-punishment, getting high (chronic hunger can create "floaty" feelings) and controlling what enters (or leaves) one's mouth and body. Some survivors have a distorted perception of how they really look, and may not recognize whether they are extremely overweight or underweight to a degree which can affect their health. Some researchers see an indirect relationship between eating disorders and sexual abuse (Petrie and Tripp, 2001). Eating disorders may add another layer, as many addicts substitute drugs and alcohol for a healthy diet.

Self mutilation or cutting. This is not always a suicide attempt. The client may perceive the letting of blood as a way of getting rid of negative emotions. Sometimes there is an emotional build up that feels physical. Cutting may function as a substitution for purging. Both behaviors expel perceived negative energies from the body. This is also a way to exert power and control over one's environment without hurting another person.

At times the client may be dissociated while cutting and have no memory of doing so later on. If the client is using it might be difficult to tell if the cutting behavior was done while in a dissociated state or during a blackout or both. In some cases, the individual may use a number of pain-inducing behaviors. They may cut, pierce, whip or burn themselves in a rage, as a way to release a buildup of anger. Some survivors learned to turn the anger inward on themselves as children because it was not safe to express it. This behavior continued into adulthood.

Self-harming behaviors can be very complex and vary greatly from individual to individual. One explanation is that cutting may also be an attempt to re-enact previous situations where the survivor was hurt and had no way to stop it or control the outcome. Strong pain, not completely unlike drugs, can be a tool to change the way one feels. Pain releases endorphins, despite the obvious dangers in the process. Some children and teens learn to hurt themselves as a way to reach a state of less panic and fear, as the endorphins they stimulate ultimately create a calmer state. Other survivors may choose pain inflicted by others and may consciously or unconsciously seek out dominant or abusive relationships with individuals or groups.

Eating disorders, sexual compulsions, paraphilias and ritual pain behaviors often engender large amounts of shame for the victim and are usually carefully guarded secrets. These secrets are often one of the last things the survivor will let the counselor know about (if at all) and may not come out until they have been in a counseling relationship for several years and have built up a large degree of trust. Since most counseling/advocacy relationships are short-term, the crisis worker may only know about these behaviors occasionally, or discover them by accident.

Legal difficulties (civil and/or criminal). The client's legal needs may include a wide range of charges including:

- Unpaid parking tickets
- Child custody disputes
- Termination of parental rights
- Murder
- Forged prescriptions
- Forged or bounced checks
- Unauthorized use of credit cards or identity theft
- Burglary

- Prostitution
- The making or selling of drugs

These legal difficulties impact the client's perceptions of self-esteem, especially if the legal difficulties include terminating of parental rights, the involvement of child protective services, and/or probation or parole. One legal issue can feel overwhelming to the client. Multiple legal issues can trigger relapse.

Financial difficulties. Many addicts spend a large portion of their time, energy and money on their addiction(s) and let everything else slide. They may borrow money from family and friends, pawn what they can, or borrow from loan sharks whom they cannot pay back. Usually they cannot hold down a job for long because their full time job is finding ways to feed the addiction(s). Paying off old parking tickets, utility bills, ex-landlords, overdraft charges at banks, not to mention possible legal action for financial irresponsibility, impacts their lives, both as a fact they have to address and the accompanying shame and guilt they may feel. Knowing what financial and legal resources exist in your community can be a great aid in an addict's recovery.

All these defenses in combination with denial, rationalization, minimization, and projection enable the addict to continue to nurture obsessions. In order not to care or think about what is really going on, addicts turn themselves off. One of the primary characteristics of addicts is that they don't care. Through their trance-like preoccupation and their fantasies, "addicts have come to numb their own emotional life. They are obsessed with [their addiction], but they cannot afford to let themselves feel the emotional pain of their enslavement so they cut off their feelings" (Griffin-Shelley, 1997).

As stated earlier, PTSD victims recovering from trauma with substance abuse issues may experience greater difficulty recovering, and the effects of PTSD often worsen. This often disrupts their personal relationships at a time when they most need a support system. The client often asks when things are going to return to normal, or if s/he will ever feel normal again. Having the client redefine "normal" can become a part of the treatment plan – it can translate into actions the client needs to take while working toward specific goals.

V. Different treatment models

There is an old joke that asks the question, "How many addicts does it take to change a light bulb?" The answer is none, unless they are motivated to change. As with all counseling, the client has to be motivated to change. What that means to each client is something different. Some motivators are external, like the court ordering the client into

rehabilitation. Some motivators are internal. Some clients may catch themselves saying hurtful things to their children that their parent(s) once said to them, or they may want to be clean and sober now because they are sick and tired of feeling badly. The list of possible motivations for recovery is endless.

Best practice is what works best for the client. The options available for treatment should be reviewed and discussed with the client. Questions to ask clients include:

- what they expect from a treatment model and why/how this model will work for them
- what they expect from a counselor and how will they know they are getting those expectations met
- how much time they think treatment will take
- how are they going to pay for counseling (if applicable)
- how are they going to get transportation needs met
- what time works best for them
- what they plan to do when they feel uncomfortable in counseling.

It is wise to make a safety plan with the client about counseling choices, because when the going gets tough, the vulnerable get going. Be sure both of you have a copy of this safety plan and refer to it as needed.

Try not to empathize with the client – sympathize, and end the discussion there. Recovery is hard emotional work. Be honest about what you have heard others say about recovery. List what others have done to help themselves through difficult times. If you yourself have gone through similar experiences, this is not the time or place to disclose what it felt like for you – you are working as a professional and professional distance is what is needed. Help the client think about situations ahead of time, because like a safety plan, the client is only going to remember the first two or three items on the list. Make those two or three items meaningful for the client and their chances of walking through another day increases.

When the client makes it through another day, make sure you acknowledge the strength, willingness and achievement the client displays by continuing to do the work. Next time, and there will be a next time, it may not feel so overwhelming or all-encompassing. The client now has this experience to build upon. This is how the client starts creating good memories. This is how the client finds her or his own voice and self-confidence.

Before referring a client to any treatment model, you must be able to answer questions and state the pros and cons of each model, have phone numbers, web sites, directions on how to get the physical location and available transportation as well as meeting schedules. Most importantly, the advocate should attend at least six local 12 Step meetings (if the client is referred) to accurately tell the client what to

expect.

Private Counseling

The counselor should clarify, in the first meeting with the client the following:

- The fee scale, method for payment and policy for last minute cancellation.
- Frequency of appointment.
- The counselors experience and expertise in working with addicted survivors of sexual assault.

The focus of therapy is internal; to help bring into consciousness what is unconscious in order to change what is not working in the client's life. Because 12 Step programs emphasize individual responsibility and self determination, the client may feel they are being blamed for the sexual victimization. It takes a skillful counselor to hold the client accountable for their addiction choices without implying or stating blame for the sexual assault. Unless the counselor understands the interconnected issues between sexual abuse and chemical dependency, the counselor may do more harm than good.

Rehabs

When advocates ask if the client has been to rehab, we need to know what we are asking. When the answer becomes a tick on the intake sheet we are losing an opportunity to gain valuable information. Here are questions designed to get more comprehensive information from the client. This information can give you a better understanding of how drugs play a part in the client's life:

How long where in you in Rehab? If the answer is seven days, two weeks or 28 days:

7 days - The client was admitted into a medical detox facility and was released after becoming medically stable. While in detox the client may have attended a 12 Step meeting or talked with someone who visited the facility from a 12 Step program. The focus is to get the client medically stable and to provide some information in written form about addiction and local 12 Step programs.

14 days - The client was in a medical facility due to the severity of withdrawal related to the drug of choice and/or insurance. This usually entails, after becoming medically stable, about a week of intensive case management in order to find safe housing and a maybe a few 12 Step meetings. In both the seven and 14 day detox models, the client has not had the chance to absorb any new information. The body is in shock and trying to get toxins out of the system. The brain is not at the point where it can take in new information easily. The main purpose of a seven or 14 day stay is to stabilize the client medically and to hopefully find safe housing.

28 days - This is all insurance will pay for. The client usually

spends the first week detoxing before attending life skill classes, 12 Step meetings, counseling and case management. The emphasis is to establish a base for a 12 Step program and find sober living conditions. The client's family is usually involved in some aspect of the treatment because addiction is a family disease – it affects everyone in the family. If the client is being released to live with the family and the family dynamics have not changed, the client is at greater risk for relapse.

Over 28 days - There are some private programs that are 45 days in length. There are some public programs that are 90 – 180 days (or longer). Usually the client has the option of leaving the program after 90 days. Publicly-funded programs over 28 days are probably prisons or transitional sober houses (a sober house is usually a transitional living facility, not covered by insurance, the people who live in this facility are expected to pay rent, attend 12 Step meetings, do house chores and attend weekly house meetings). Asking if the client paid fees to live in a rehab indicates it was a transitional living program, either a sober house or a Therapeutic Community. Anything over 28 days helps the client develop tools, skills and self-awareness as a base to recovery. When a person is in rehab, they are not in recovery. The client is not facing everyday problems or making everyday decisions. There is a roof over the client's head and all other amenities are provided. People are paying attention to the client. Needs are getting met. The real work of recovery begins when the client leaves rehab.

What drugs were you detoxing from? Was there more than one drug? Were you detoxing from your drug of choice or some other drug? It is very common for the client to state the drug "kicked" in rehab and not mention the other current drug and/or alcohol use. The client justifies and rationalizes the drug(s) use because it has not currently caused any life problem(s). This is valuable information for advocates to have: keeping secrets, lying to oneself, is not the behavior or action of a client moving forward. Exploring the client's use and the reason the client gives for the use, may reveal some insight into the client's patterns and behaviors.

How many times have you been in rehab? This question may tell you if the client has been court-ordered, if the family placed the client, or if it was a voluntary commitment. Does the client chronically relapse? How long is the client able to remain sober? Can the client pinpoint what causes the use? (The client may not be able to answer this question.)

These questions may make the client think about patterns of substance abuse. It may help the client connect the dots between certain behaviors, places, things, feelings that trigger the desire to use. This information can be incorporated into a safety plan and a treatment plan.

How long has it been since your last rehab stay? How long

ago? Did you stay for the full term of the rehab? Don't assume that because the client has been to rehab, the client has the basic concepts of recovery mastered. This may not be true. For many, life in a rehab facility presents challenges, one of which is living with and getting along with others without the use of a substance. What has the client done since leaving rehab to promote their health and well being? Many addicted survivors have never been to rehab. Many do not have insurance, cannot afford the expense of rehab or have been in trouble with the law. Some may be using secretly, hiding the use from family and friends. Some may try to hide their substance use from advocates or counselors.

12 Step programs

"Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other so that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership... the primary purpose is to stay sober and help other alcoholics to achieve sobriety."

Alcoholics Anonymous

In 1935, Bill Wilson and Dr. Bob Smith established the "anonymous" tradition by codifying the process by writing the 12 Steps of Alcoholics Anonymous and the "Big Book." Over the years other programs have adapted the 12 Steps of AA: Al-Anon (for family and friends of the alcoholic)/Alateen (for children of the alcoholic), Adult Children of Alcoholics (ACA), Overeaters Anonymous (OA), Gamblers Anonymous (GA), Debtor's Anonymous (DA), Narcotics Anonymous (NA) and Nar-Anon (for family and friends of the addict), Sex, Love and Addiction Anonymous (SLA), to name a few. When the word Anonymous is present in the name (most often the groups are referred to by their initials, GA, DA, OA), those are the meetings for the person suffering with the addiction issue. When the word "Anon" is present after the identifying word, these groups are for the family and friends of the addict.

Things to Know about 12 Step Programs

The Big Book of AA was written in 1935 by two middle aged, well-educated, upper middle class white men. The relevance that the 12 Steps has for people who are not middle aged, well educated, white, upper middle class and male, should be explored by the person who is entering the program.

Different meetings have different feelings to them: some may be more spiritual, some may use a literal interpretation of the Big Book. If you refer a Client to a 12 Step meeting, have a list of the meeting times available in your office. It's recommended that the client attend at least 6 meetings for each group recommended, to get an idea of what to expect. For example, if the smokers at one group stand in front of the door before meetings, it may appear that a person has

to push through the crowd. If this is the client's first meeting, this may feel like a barrier. If the client is a shy person, or someone who fears crowds, or even a woman pushing through a crowd of men, this may not be the appropriate meeting to attend. Having that list can enable the client to find another meeting. Providing the client with accurate information is one of the best gifts we can give.

In chemical dependency treatment the client is told to focus on the part he or she played in the choices that were made. In healing from sexual abuse the emphasis is to reassure the client that the blame for the sexual abuse resides with the perpetrator. These are two diametrically opposing counseling strategies.

What happens when the client hears these opposing views? Explain that using drugs is something the client may have some control over. The client has no control over the actions of other people. Consider the neurobiology of trauma, the negative self-talk the client may have, and the possible brainwashing or manipulation the abuser has wrought. These dynamics between what the abuser was responsible for and the client's use may create an internal crisis for the client that can trigger using. Good intentions do not sanitize a bad impact. Talk to the client about these opposing dynamics.

The 12 Step program suggests that clients "take what you like and leave the rest." Initially the client will probably need to process what is heard in group. Although group talk is confidential, it is permissible for the client to process their concerns with their counselor.

There are 12 Step groups that meet online. Anonymity is not a problem. Remind the client that people met online are strangers. No personal information should be exchanged, and going into a private chat room or physically meeting that person is strongly discouraged.

Religious 12 Step Groups

Many 12 Step meetings are held in houses of worship. This detail does not make them religious in nature. Religious 12 Step groups are religious in nature, using religious literature, references and beliefs to help the client travel the road of recovery and maintain a sustainable sobriety. For some clients this is a comfort and a way to attain serenity. For others it is not. Almost all religious 12 Step groups have a church affiliation. To find a religious 12 Step group, go to your favorite search engine on the internet and enter "religious 12 Step groups."

The Church of Scientology calls its abstinence program Narconon. Narconon does not use the 12 Steps and is not related to either Narcotics Anonymous or to Nar-Anon. Narconon presents the Scientology doctrine and practices as therapy for drug uses. There can be some confusion because

of the similarity of the names.

Therapeutic Communities

In general, the Therapeutic Community (TC) is a drug-free residential setting that uses a hierarchical model with treatment stages reflecting increased levels of personal and social responsibility. Peer influence, mediated through a variety of group processes, is used to help individuals learn and assimilate social norms and develop more effective social skills.

TCs differ from other treatment approaches principally in their use of the community (treatment staff and those in recovery) as key agents of change. Those in the addiction field refer to this approach as "community as the therapy." TC members interact in structured and unstructured ways to influence attitudes, perceptions, and behaviors associated with drug use.

Many individuals admitted to TCs have a history of social/educational/vocational skills and community and family ties that were eroded by their substance abuse. For them, recovery involves rehabilitation. They must relearn or re-establish healthy functioning skills and values, as well as regain physical and emotional health. Other TC residents never acquired functional lifestyles. Recovery for them involves habilitation. TC is usually their first experience in living with rules, regulations and life skill processes.

In addition to the importance of the community as a primary agent of change, a second fundamental TC principle is "self-help." Self-help implies that the individuals in treatment are the main contributors to the change process. "Mutual self-help" means that individuals also assume partial responsibility for the recovery of their peers- an important aspect of an individual's own treatment. Therapeutic Communities often incorporate specialized strategies and services to treat those with special or complex needs. These include people with:

- substance abuse and other problems such as multiple drug addictions
- involvement with the criminal justice system
- lack of positive social support
- mental health problems (e.g., depression, anxiety, PTSD, and antisocial and other personality disorders).

TCs are usually gender-specific. The client is usually not asked during intake about sexual abuse/assault. Addicted clients with sexual assault issues may have a hard time adjusting to a TC because they will be confronted by staff and other TC residents on their language and behaviors. This confrontive and assertive culture may trigger those who have histories of abuse. This may not be the best model for those triggered by confrontive methods. If an addicted survivor is considering going to a TC, discussing this option in counseling is a good idea.

Other Models

These models, except for Rational Recovery, all have schedule meetings and literature. A list of schedule meetings and where literature can be purchased can be found on each group's website.

16 Steps of Discovery and Empowerment

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

SMART Recovery (Self Management And Recovery Training)

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

White Bison, Inc

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

Women for Sobriety

This New Life program is designed to help achieve sobriety and sustain ongoing recovery by focusing on 13 positive statements that encourage emotional and spiritual growth. The program has been effective in helping women over-

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

Secular Organizations for Sobriety (Save Our Selves)

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

Rational Recovery (RR)

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

Moderation Management

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

Dual Recovery Anonymous (DRA)

This is a fellowship of men and women who meet to support each other in their common recovery from two no-fault conditions. They believe that emotional or psychiatric illness and chemical dependency are not the fault of the addict.

There are two requirements for membership:

- A desire to stop using alcohol or other intoxicating drugs.
- A desire to manage the emotional or psychiatric condition in a healthy and constructive way.

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

VI. Recovery

Recovery from Substance Abuse

The term substance abuse is often used in conjunction with, and at times, interchangeably with, the terms chemical dependency, alcoholism, addiction, drug habit, drug addiction and the disease of addiction. All these terms refer to a condition that is characterized by the addiction to a mood-altering chemical. Substance abuse includes abusing both drugs (legal and illegal) and/or alcohol. The chemically dependent person is unable to stop drinking or taking the drug of choice despite the serious health, financial, jobs, family and relationship consequences and/or legal difficulties. Addiction is usually a progressive and chronic condition, and, if left untreated, can be life-impairing or fatal.

A person who is chemically dependent loses the power of choice to addiction. The client may be able to stop for a while but usually can not sustain sobriety over the long haul. The client usually returns to using the substance again despite all best intentions and exertions of logic and will power. This is why it is said that addiction is a chronic relapsing condition.

Chemical dependency is characterized by continuous or periodic binge use. This includes preoccupation with the drug of choice and compulsive thoughts such as:

- How much do I have?
- Where am I going to get it?
- How am I going to pay for it?

Denial

The addict continues using despite the negative consequences, distorted thinking and denial. Typically the addict is the last to admit he or she has a problem. Denial is an integral part of the process and a major obstacle to recovery,

and also a major factor in relapse. Denial is a mechanism that keeps the user in the dark about their existing life problems. If a chemically dependent client is in denial, the client cannot engage in the recovery process. One cannot solve a problem unless there is acknowledgement that it exists. The client will make statements like:

- I only use a little.
- I only use after the kids are in bed.
- I can stop any time I want.
- I am in control.

Many addiction specialists believe addiction cannot be cured; only treated, arrested and kept in remission. Addiction is more complex than the use and abuse of mood-altering chemicals. Recovery is more complex than becoming abstinent. Many users believe that after becoming drug and alcohol free their life will be "happy, joyous and free." Addicts believe this because they have heard how much better life is without the drug. Detox alone is rarely enough. In order to maintain abstinence the addict must make personal, interpersonal and lifestyle changes. Most addictions specialist and long-term recovering addicts and alcoholics who have ten or more years of abstinence believe recovery is a life-long process.

Addictions and trauma are intrinsically related. A sustainable recovery program addresses both the addictive patterns and the underlying pain. Addressing one issue and not both can cause the addict to become rigid in their daily life and avoid relationships. This can increase despair and isolation.

Dynamics of Consent

Although sexual violation can include elements of sexual gratification on the part of the abuser, there are often power and control issues on the part of the perpetrator. Consent to sex includes clearly saying or indicating, "yes." Some people are unable to give consent because of a physical, mental or chemical impairment. Saying nothing or acquiescing under duress, coercion or force does not equal consent. It equals, at best, co-operation under extreme circumstances or doing what it takes to survive.

Recovery From Sexual Assault

Common Reactions

A common reaction either during or after a sexual assault is, "This can not be happening to me" (derealization). During the rape some victims commonly believe they are in danger of being seriously injured or killed. The attacker makes this intention clear by verbal threats, physical force and/or weapons.

Most people in a sexual assault situation experience a feeling of powerlessness - there is nothing they can do about the situation. The perpetrator is in control and accountable. Being high or drunk does not merit a sexual assault. To sug-

gest otherwise is victim-blaming. Blaming language can be re-traumatizing and may place another road block in the client's way.

Some clients are clear about what happened during the sexual assault. Others may describe the assault in the language of consensual sex. They may want to minimize or excuse what happened, especially since most sexual assaults are committed by someone the client knows. Each client's situation is unique. Recovery after a sexual assault is a process. From the beginning, the client needs accurate information and enlightened education. Questions clients usually ask:

- How do other people react after they have been raped or sexually assaulted?
- How do they feel afterwards?
- How do they cope?
- How do they put their lives back together?
- How long does it take to "get over it?"

Enlightened information includes being honest. Some days are going to be harder than others, sometimes with good reasons – court appearances, anniversary dates – and sometimes for no clear reason. Assure the client everyone reacts and recovers differently. Whatever the client is feeling is their natural reaction to an unnatural stressful circumstance.

Spiritual Help

If the client request spiritual counseling, suggest the client ask a trusted friend or a family member to make a recommendation if the client does not have spiritual or religious mentor, priest, rabbi or clergy person. The client can also do a search online. As a matter of professional ethics, the religious beliefs of the counselor must be kept separate from the choices of the client.

Listening Skills

Listen to what the client says. Reassure the client that giving details of the assault is her or his choice; divulging details is not necessary for the healing process. If it helps, you are there to listen. And then listen – give the client that listening space. Allow for awkward silences. As a listener, it is important not to jump in and fill the silences. Give yourself the permission to sit, listen and not try to fix anything. Often the client has no other safe place to discuss what happened and their feelings surrounding the assault.

Systems Advocacy

Sometimes the client is involved with other systems, e.g., criminal justice, law enforcement and/or child protective services. These agencies usually want a cohesive, sequential, logical account of the assault. As an advocate, understanding how these systems operate and interconnect will help you guide the client into systems that do not always work quickly or efficiently. If an agency has a victim assistance advocate, introduce yourself to the advocate and learn about the different philosophies of each organization.

These systems may demand the client respond within certain parameters. These parameters may conflict, overlap or compete with each other. With so many systems involved, interdisciplinary cooperation is needed. Are there signed consent forms allowing you talk to each other regarding the client? If the client is in a shelter or rehab that requires the client to do certain chores at certain times in order to stay in the program and the client is ordered by the court to take parenting classes that conflict with your program's requirements, how is that handled by both agencies? Asking the client to choose which requirements to ignore is not an option. This needs to be figured out proactively, especially for addicted survivors who may not be able to focus in the first stages of recovery.

What other systems in the community are available to help with specific services? Faith-based organizations usually respond quickly to hygiene and clothing needs, among other services like literacy education or on-site Bible studies, which is important to some clients. What educational systems, medical systems or day care facilities are available? Are there community colleges, universities, agricultural extensions agents (who offers advise on growing a garden or recipes for cooking healthy meals), that can come on-site and do educational groups on nutrition, exercise, child development, budgeting, vocational training or GED classes? Thinking outside of the box and examining what exists in the community and then bringing it into the facility can help the client in all aspects of their lives.

Effects of Sexual Assault

Sexual violence is traumatizing. It is an intimate and personal form of violence. The stress of this experience can last for days, weeks, months or years and can have far-reaching effects for the victim. These responses include, and are not limited to:

Sleep disturbances and fatigue. Some clients will have insomnia, while others will sleep all the time. Nightmares of the assault are common. If a client understands beforehand that this can happen and it is just a dream, this information often goes a long way to help the client self-soothe.

Inability to concentrate. Trauma makes it hard to focus and/or think in a logical systematic sequential manner. This fact decreases the victim's ability to perform at their job, school, work, parenting, etc.

Triggers and anxiety attacks. Memories, smells, sights, sounds and touch often trigger the release of fear-based neurochemicals, and the victim reacts. Things that were normal before the rape now interfere with daily life (depending on where the assault took place, the victim may have a hard time returning to school, work, home, the gym, etc.). To the client, this generally causes more distress.

Sexual dysfunction. Sexual situations may trigger feelings of danger and panic, even in a consensual loving relationship; or the client, especially if they are a survivor of childhood sexual assault, may confuse the assault for love and affection and may engage in risky and/or abusive sexual relationships.

Hypervigilance. Because the amygdala is now on the constant lookout for clues of danger, the client may show signs of extreme defensiveness and may be quick to anger. The client may be jumpy, unable to fall into a deep sleep, unable to relax and have difficulty trusting others.

Eating disturbances. In a crisis situation, blood is rushed to the extremities in preparation for fight or flight. If the client is in a constant state of hypervigilance, this can cause nausea in some after eating, as well as heartburn and weight loss. Some overeat to self-nurture. Some stop eating in an effort to disappear. Some clients use food as a way to numb feelings.

Substance abuse. In an effort to alleviate symptoms, relax or sleep, some clients self-medicate. Using substances can put the client at further risk of victimization.

Physical Illness. Clients frequently complain about headaches, stomachaches, neck and back pain. They may report frequent illnesses, high blood pressure, depression or any number of illnesses. The client needs professional medical help from a licensed practitioner who understands the medical consequences of a sexual assault.

The victim also may suffer a number of losses:

- **Loss of Innocence** – The client will not look at themselves, others or the world in the same way again. For victims who were sexually abused and have used chemicals since childhood, a recent sexual assault may bring up old, unresolved issues, one of which may be the loss of their childhood.
- **Loss of Safety** – Most of us live with the illusion of safety. We don't think something traumatic is going to happen to us. Our clients no longer have that illusion.
- **Loss of Trust and Faith** – Sexual assault is generally committed by someone the client knows. The client is usually introduced to drugs by someone known to him or her. If the people the client trusted were hurtful, how does the client now go about trusting others?
- **Loss of Virginity** – If the client's first sexual experience is nonconsensual and unwanted, this may cause the client to question spiritual beliefs especially if they come from a traditional religious background. It may be a comfort for the client to understand that virginity is something offered to a loving partner. Virginity cannot be taken without consent.
- **Financial Loss** – Victimization can come with medical

bills, legal expenses, relocation costs and loss of wages, to name a few.

- **Loss of Relationship(s)** – Family, friends and significant others often become impatient with all aspects of the recovery process and/or they might blame the client for the attack. The client may lose important and significant relationships at a crucial time.
- **Loss of Control** – This is probably the most profound loss for the client. The loss of control over one's own body is traumatic.
- **Loss of the Future** – Loss of any kind requires a person to redefine their plans and vision of the future they have imagined. Often a client re-envision the future with the sexual assault as the defining event in their life.

There are three basic stages of recovery process:

1. **Impact** – The assault literally leaves the client in shock, numb and in disbelief and denial. At this stage of the recovery process, it is important to address the immediate needs of the victim; the immediate physical and safety needs, emotional support, and to give the client information about what is going to happen next.
2. **Recoil** – The client often experiences a cataclysm of emotions as she or he goes through this stage and tries to create distance from the assault. The client might question previous core values and beliefs in an effort to make sense of what happened.
3. **Reorganization** – The client begins to regain a sense of balance and comes to term with what happened. The client may begin to re-define the future.

All of the responses and losses mentioned above can happen at any time, throughout any stage of the recovery process. It is important to stress to the client that feelings are a natural reaction to an unnatural traumatic circumstance. The confusion, the inability to place the event in a chronological logical order and the roller coaster of emotions are the results of the body doing exactly what it was designed to do, keep the victim alive and safe.

Eight Ways to Help

There are also some identified ways to immediately help when responding to trauma survivors. One group of researchers (Ruzek et al, 2007) listed eight core actions:

1. **Contact and Engagement**
Goal: Respond to contacts initiated by affected persons, or initiate contacts in a non-intrusive, compassionate and helpful manner.
2. **Safety and Comfort**
Goal: Enhance immediate and ongoing safety, and provide physical and emotional comfort.
3. **Stabilization (if necessary)**
Goal: To calm and orient emotionally-overwhelmed/distraught survivors.

4. **Information Gathering: Current Needs and Concerns**
Goal: Identify immediate needs and concerns, gather additional information and tailor psychological first aid interventions.
5. **Practical Assistance**
Goal: To offer practical help to the survivor in addressing immediate needs and concerns.
6. **Connection with Social Supports**
Goal: To reduce distress by helping structure opportunities for brief or ongoing contacts with primary support persons or other sources of support, including family members, friends and community helping resources.
7. **Information on Coping Support**
Goal: To provide the individual with information (including education about stress reactions and coping) that may help them deal with the event and its aftermath.
8. **Linkage with Collaborative Services**
Goal: To link clients with needed services and inform them about available services that may be needed in the future.

Recovery from Substance Abuse and Sexual Assault

One of the first things many counselors hear when they work with addicts is “if their lips are moving they are lying.” Lying can be seen as evidence that the client has developed survival skills. Even though the client may be beaten down at this point in time, these skills speak to their intelligence, their willingness to live and their capacity to learn, even if these skills are now outdated and are causing them negative consequences. Instead of looking at the client as manipulative or deceitful, try to see the client as someone whose coping skills are not serving his or her best interest. What does the client need to re-learn and do differently to achieve the stated goals?

During intake at a drug and alcohol rehab, the client is rarely screened for a history of sexual violence. The screening tools often contain hints of past abuse. Counselors can learn to connect the dots during in-take screening in order to help the client get off the roller coaster ride of victimization. Sometimes counselors unintentionally set the client up for failure. The client may leave the program with the same vulnerabilities as well as the internal anguish.

The hope is that the victim will transition into a survivor. It is important to set to the tone of empowerment from the beginning. The client may be overwhelmed with the program’s rules and regulations. For people who have struggled with oppression and/or have internalized oppression, the program rules may seem like more oppression. Explaining the purpose of the forms may be helpful. A good program is not going to judge the client.

The empowerment process can be initiated from the beginning:

Tell the client: “When you leave here, if you are clean and sober, and cannot tell me why you are clean and sober, this program has failed you. When you leave here and you tell me you are going to use and can tell me why you are going to use, the consequences and how you are going to handle those consequences, then this program has served you well. We are here to offer you new coping tools and skills. We are here to help you make conscious decisions and to learn to act rather than react.”

Additional Concerns of Addicted Survivors

Social Concerns

The client may feel increased distrust toward others generally and men specifically, especially if the rapist and/or their dealer is a man. The client may have a shorter temper, be afraid of authority figures, or cry easily. Some reactions may result from a specific component of the assault or of the ritual of using. Some clients may feel a strong need to get away, leave school or change jobs. All of these reactions are natural, representing what the client thinks is needed in order to regain control. Avoiding problems by moving to a different locale is called “geo-fixing.” Geo-fixing is a temporary band-aid. It is also a clue that the client is avoiding a problem.

Psychological Concerns

Denial of the effects of the assault and/or drug usage is a common reaction. Denial/avoidance may be the client’s way of initially catching his or her breath before processing and resolving trauma and learning new coping tools.

When a victim first enters into a shelter and/or rehab, they are in shock. While it is important to screen for mental illness, waiting until the client has had time to recover from the neurochemicals that were released in response to the trauma, as well as getting their system clear of any drug(s) they may have taken, will give a more accurate evaluation. In fact, it may take many months of abstinence from drugs before the clinician is able to determine how many of the patient’s problems are neurochemical, temporary drug effects derived from use and how many are truly psychological in nature. The experience of drug abuse and addiction itself leads to massive social and psychological disruption (Bean, 1981).

Sexual Concerns

The assault may disrupt the sexual life of the survivor because sex was used as a weapon to break a personal boundary for the purpose of humiliation, punishment and/or control. It may take some time for the client to disassociate the sexual assault from consensual sex, especially if the survivor was a virgin at the time of the assault. For the addicted client sex may have been used as a manipulative tool,

to bargain for housing, food, clothing or drugs, or they may have been forced to perform by a pimp.

In either case, the client lost their sense of personal boundaries and their ability to say no. Some survivors experience physical pain during sex, have difficulty relaxing or are indifferent to sex. At the other extreme, some survivors may desire sex all the time. The survivor may be concerned that their partner will feel differently toward them. Because of the range of stresses the survivor experiences after an assault, consensual sexual relationships and other friendships can be placed under heavy strain. Current statistics indicate that about half of all survivors lose their love relationships within a year of sexual assault (Grice, et al, 1995).

Physical Concerns

The client may report continuing gynecological/genital problems. If physically beaten, the client may continue to experience physical pain. Sexually transmitted diseases and pregnancy are also concerns. Nightmares may cause the client to lose sleep or fill their waking hours. It is not uncommon for an addict to have “using dreams” and wake up craving their drug of choice or feeling high. Depending on the drug used and where it is stored in the body, the client may smell like the drug, when the body releases the drug via sweat or urine.

Physical concerns can cause exhaustion, impatience, argumentativeness, depression, frustration and self-pity, which can make the client difficult to work with. Doctor’s appointments should be written down and kept. The client needs education on the importance of a balanced diet and a regular sleep cycle to recovery.

Three Needs of Clients

The three major needs of a client entering a shelter are to feel safe, be able to express emotions and to know what comes next. Without knowing what comes next the client can expect too much of themselves and of others. An advocate’s job is to provide a safe place where the client can express themselves freely and ask questions about what comes next in what ever system they are involved in.

First Aid for the Brain

Helpful things that client can do to re-establish equilibrium:

1. Exercise – moderate to strenuous exercise to manage stress.
2. Fluids – to flush out excessive chemicals in the body: water, juice. No alcohol and no caffeine. Fruits and vegetables are also a good option.
3. Verbalization – the sooner the client identifies and states what they are feeling, the easier it is to own the feeling and work through it.
4. Writing – keeping a journal with a narrative can help the client identify and clarify their triggers, when and where the triggers were felt and how to address the situation in the future.

5. Nutrition – a body that is damaged due to substance abuse may be malnourished. Poor health and hunger produce stress. A daily diet containing a balance of vegetables, fruit, carbohydrates, proteins, fats and dairy products is recommended. A nutritionist can help the client figure out a specific diet.

Additional Considerations

1. *Personality.* What coping mechanisms does the client already possess? How successfully have they coped with stress and trauma in the past? How can they adapt their coping skills?
2. *Support System.* Does the client have a strong system of friends and family for emotional support? Will the support group treat the client with empathy? Does the client want to attend a survivor’s group?
3. *Existing Life Problems.* Is the client experiencing a divorce or another type of break-up? Does he or she have emotional or psychological problems? Was the client clean and sober before the sexual assault? If the client had life’s problems under control prior to the assault, the trauma of the assault may reactivate the use or desire to use.
4. *Prior Sexual Victimization.* Was the survivor assaulted previously or a victim of incest or childhood sexual assault? If so, recovery may be much more difficult.

Regaining a sense of control over one’s life is the primary focus of recovery.

VII. Relapse

Twofold process

The obvious solution to recovery from drugs is to abstain from them in the first place. That sounds so simple, and yet it isn’t necessarily easy. Addictions are cunning and baffling. If they weren’t, people would not relapse.

Relapse is often called a twofold process. The first part of the process starts long before a person uses again and the addict gets triggered. Triggers can be in the form of individual people, places, noises, images, smells, tastes, feelings, animals, films, scenes within films, tones of voice, body positions, bodily sensations, weather conditions, time factors, or combinations thereof. Triggers can be subtle and difficult to anticipate and sometimes exacerbate Post-Traumatic Stress Disorder, a condition where trauma survivors cannot control the recurrence of traumatic or repressed memory. The pain and discomfort of the trigger can be so overwhelming the client thinks that using cannot be any worse than staying sober.

In this first phase of relapse, denial is prominent and the client is out of touch with feelings, and therefore cannot share them with others. The client may be concerned about maintaining sobriety and may be unwilling to talk about these concerns because of the denial. In order to tolerate these periods of worry, fear and anxiety, the client ignores or denies these feelings in the same way they denied the addiction. The client may try to cope by reverting to old coping behaviors, thinking and language.

The second phase of relapse is characterized by avoidance and defensive behavior. In this phase, the client does not want to think about anything that will cause painful and uncomfortable feelings. The client may be convinced that "I'll never use again," and proclaims this loudly and often to others. The client so firmly believes this that the need for a daily recovery program seems unimportant. The client's focus is generally external, so the tendency is to worry about others.

Defensive, compulsive and impulsive behaviors may materialize, e.g., defensiveness when no defense is necessary, rigid thoughts or actions. There may be a tendency to repeat the same behavior over and over again without a good reason. The client may appear to be the model of recovery. Impulsive behaviors can occur at times of high stress. This may cause the client to make decisions that have an adverse impact on their life and recovery program. The client may begin to spend more time alone, avoiding others, which results in loneliness. Instead of dealing with the loneliness the client may become more compulsive and impulsive.

Checklist of Relapse Symptoms

- Exhaustion
- Dishonesty
- Impatience
- Argumentativeness
- Depression
- Frustration
- Self-pity
- Cockiness
- Complacency
- Expecting too much from others
- Letting up on discipline
- Use of mood-altering chemicals
- Wanting too much too soon
- Forgetting gratitude
- "It can't happen to me" attitude
- Feelings of omnipotence

(www.soberrecovery.com)

The Most Common High Risk Situations for Those in Recovery

- Being around people, places and situations previously associated with using
- Feeling bored, lonely, angry, guilty, helpless, anxious and/or dwelling on past mistakes

- Severe stress at home or on the job
- Having positive feelings that in the past were associated with getting high
- Exhaustion or fatigue
- Doubting you have a problem and believing you can safely return to controlling your use
- Hearing or telling "war stories" and/or romancing the "good times"
- Continuing other addictive behaviors: sex, eating, gambling, working, etc.
- Having a lot of cash on hand
(Gorski, 1994)

Ten Tips for Those in Recovery When Dealing with High Risk Situations

- Plan ahead, plan ahead, plan ahead.
- If you find yourself in a high-risk situation, get out of it immediately. Don't act helpless. Don't make excuses for being there.
- Don't go to bars, clubs, or parties where it will be difficult to resist using.
- Avoid talking or being with people who will use in your presence.
- Talk openly and honestly about your high-risk situations before you are confronted with them.
- Have a list of 5 supportive people you can call when feeling vulnerable.
- Make sure someone supportive accompanies you when faced with unavoidable high-risk situations: family reunions, holidays.
- Display the list of high-risk situations in a place you will see often.
- Have alternate activities/plans available in case the plans fall through or you find yourself in an unexpected high-risk situation.
- Think positively in the face of the unexpected. Remember to breathe and say to yourself, "I am smart," "I can figure this out," and "I will feel much better about myself after I have successfully coped with this situation."
- Physical activity, like team sports, walking or jogging, to release the frenetic energy that is common for people in recovery.

(www.lifetips.com)

Post Acute Withdrawal Syndrome (PAWS)

When people think about addiction, they usually think about the drug-based symptoms rather than the sobriety-based symptoms which can make sobriety a challenge. Recovery causes a great deal of stress. Many addicts have not learned to manage stress without the use of chemicals. Research indicates the presence of brain dysfunction in 75-95 percent of the recovering alcoholics/addicts tested (Gorski, 1994) that disappear over time. The stress of recovery can aggravate the brain dysfunction and makes the symptoms worse.

Helping the client to understand the sobriety-based symptoms of PAWS may go a long way in preventing relapse. Recovery from the damage caused by substance abuse requires abstinence. The damage caused by the substance abuse interferes with the ability to abstain. This is the paradox of recovery. For this reason it is necessary to do everything possible to reduce the symptoms of PAWS.

PAWS occurs after the acute withdrawal phase. PAWS is biopsychosocial syndrome resulting from the combination of damage to the nervous system caused by the drugs and psycho-social stress of coping with life. PAWS symptoms usually peak in intensity over a 3 month to 2 year period after withdrawal. Depending on the severity of the client's brain dysfunction and the psychosocial stress the client experiences in recovery, the nervous system requires anywhere from six to twenty-four months to readjust.

Symptoms of PAWS

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

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

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

Managing PAWS Symptoms

The less a client does to prepare for a PAWS episode, the higher the risk of relapse. Conditions that put the client in a high risk situations are usually lack of self-care – recovering without a relapse means being aware of the stressful situations in the client's life and how to handle those situations when they occur. It is not the situation that makes the client vulnerable; it is the client's reaction.

Because stress can trigger and intensify the symptoms of PAWS, learning to manage stress by identifying its source early is important. Proper diet, exercise, regular habit, and positive attitudes play important roles in controlling PAWS.

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

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

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

Education and Retraining

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

Learning about the symptoms of PAWS, knowing what to expect and not overreacting to the symptoms all increase the client's ability to function appropriately and effectively.

Self-Protective Behavior

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

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

Exercise

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

Relaxation

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

Playing is a necessary form of relaxation that is often neglected. It is difficult to define play because it is not so much what one does as how one does it, how one spends time having fun, laughing, being childlike and free. There are a variety of relaxation exercises: books, tapes and meditationns. Finding a method that the client finds relaxing and will use can help in reducing stress.

Cravings

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

The craving cycle is marked by obsession (out-of-control thinking about use), which quickly turns to compulsion (an overwhelming urge to use though the client knows it is not

in their best interest to do so), which becomes a craving (obsession and compulsion merged into a full blown physical craving), which leads to drug-seeking behaviors.

Psychological Cravings

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

(Gorski, 1990)

Social Cravings

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

(Gorski, 1990)

Preventing Cravings

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

Craving Intervention

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

1. Recognize the craving. Do not deny the feeling

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

(Gorski, 1990.)

Addictions and Cravings and the Power and Control Wheel

Explaining addictions and cravings using the power and control wheel can be powerful visual for understanding the addiction/craving cycle.

(New South Wales Government, NSW Police Force, Australia)

- Remorse Phase – Client experiences shame, guilt and disgust about use.
- Pursuit Phase –Pursues recovery by either going to meetings, entering a rehab, going to counseling.
- Honeymoon Phase –Believes the recovery process, as it is right now, will stay this way forever, without having to exert too much effort.
- Build-up Phase – Unrealistic expectations are debunked, life stressors occur, frustration sets in, denial of feelings to self and others.
- Stand-over Phase - Drug seeking behaviors start: cruising old neighborhoods, euphoric recall, socially isolation, out of control thinking.
- Explosion – The client uses.

VIII. Integration of Services

Global Approach

In order to help the client, it is necessary to understand how the client self-identifies, what the client's world view is and the client's definition of "fitting in". This entails know where the client is

- Culturally - does the client identify with any group? How can she/he connect with that group? What foods give nourishment as well as comfort and joy? Music? Holidays and traditions? What brings connection with others? Frames of reference are always different and unique to each client.
- Personally – how does the client feel about herself/himself? What are the hopes and dreams for the future?
- Intellectually – Is the client curious? Does the client read? How does the client process information?

- Spiritually – Is the client religious and not spiritual, or spiritual and not religious? Or both? Does the client distinguish between the two? Or does the client hold an alternative view? How do the client's beliefs play out in real life?

Global Approach for Identifying Goals

To get the client thinking about a global approach, ask the client about his/her hopes and dreams! Write down what the client tells you. Together take the list and put it into categories. Prioritize the items within the categories. This is the basis of the client's goals and can be used as part of a treatment/case management plan.

If the client is in treatment, point out how this compliments and adheres to your program's rules, regulations and procedures. This is also easy to use in a rape crisis short-term counseling setting. Explore with the client how this ties in with education, jobs, spirituality, a 12 Step program, and how it connects the client culturally and personally to a self-identified place in the world.

Interdisciplinary

It is possible that the client might be involved with a number of other service providers such as substance abuse counselors, victim advocates, criminal justice advocates, Child Protective Services (CPS) and medical personnel, to mention a few. Working with these systems to advance the client's well being is systems advocacy. Each agency has specific goals and set ways to obtain their stated goals in order to help the client. An advocate who can, along with other agencies, define the goal/outcome for the client, communicate and advocate assertively, educate fellow advocates and follow-up with the client's progress, is an invaluable asset to the client and the agency. This interdisciplinary effort requires a long-term, sustained effort by a number of people.

Another part of an interdisciplinary approach can involve faith-based organizations. These organizations can be helpful in finding clothing and jobs. At the client's request, faith based organizations can help with the spiritual or religious needs.

Education

In order to do interdisciplinary work, and to work with addicted survivors of sexual assault, it is important for advocates to be educated in trauma and PTSD issues and the effects they have on sexual assault and chemical dependency recovery. With this knowledge advocates can educate the client, other agencies and the community.

IX. What works for the Individual

A few tips on working with various populations:

Women

Some women are well-acquainted with powerlessness, especially women who grew up in dysfunctional or abusive families. Some women might equate powerlessness with internalized oppression. For this type of women, phrases like “we are powerless over our addictions” might feel further disempowering. Defining what powerlessness means for this type of client might be more helpful (Covington, 1999).

Parents

One of the worst labels our culture can place on someone is that of bad parent. The client is generally in denial about how much the children have seen and heard and know. The sad truth is the client’s children experience everything about the client, indirectly. Denial works in some clients to make them genuinely believe that they did everything possible to keep their children safe. This is not always the case, as addiction skews one’s perception, making the client’s knowledge incomplete. Having this illusion disturbed is going to be hard on the client, especially if the client was a childhood victim of sexual assault.

Men

A man is generally raised to believe he can defend himself against all odds, therefore the idea of being a victim is hard for him to imagine and can make him angry. Generally a man’s goal is to recover as an addicted survivor as quickly as possible, so he can move on to the next challenge. Spell out for the male client how he contributes to his own recovery. Men may prefer to sit side-by-side when talking about emotional issues. Social research indicates that a man will more likely acknowledge his needs if he trusts that he will not be judged for being honest. (Scare, 1997).

What a man may need to know:

- He is not permanently impaired.
- He can put his life back in order.
- Although the rape may never be forgotten, he can overcome his wounds and addiction.
- He has the inner strength to resist the stigma and shame.

Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI) people

When a crime is committed against individuals in this population, the clients may feel they are to blame because of their sexual orientation. The perpetrator may have told the clients in no uncertain terms that they were getting what they deserved because of their sexual orientation. The clients may forgo the necessary medical care, especially if they are not “out” to their family, friends or employers. Clients may fear retribution, especially if the perpetrator was a partner.

In addition to a sexual assault that occurs within the context of a non-heterosexual relationship, service providers

who are intolerant or uncomfortable about accepting of a person’s sexual orientation can further add to the client’s shame and guilt. Working with any client means that service providers, advocates and counselors must all put aside their biases and listen with an open mind to what the client has to say about their needs and wants.

Prostitutes

“Investigations of women who prostitute themselves on the streets have revealed systematic (and life-long) patterns of abuse, exploitation, and degradation at the hands of men, including fathers, brothers, intimate partners, clients, and pimps” (Earls, 1990). Prostitutes can be men, women or minors. If the client, regardless of gender, is under the age of 17, this is rape of a minor and falls under different state laws.

Every rape survivor has the right to make a criminal complaint. Serial rapists may prey on prostitutes because they know that some police will not pursue investigating the rape of a prostitute. Prostitutes, like all everyone, are protected by the law; no one asks to be raped. This population comes with its unique set of rules, language, culture and experiences. Within this population, there are subsets that range from the high-end prostitutes, to street prostitutes to runaway teens. Some have arrest records, while others do not. Some come into counseling or treatment voluntarily; others are court ordered.

When a drug-addicted prostitute who is a victim of sexual assault enters any program, the issues of authority, following rules, disclosing, hygiene, health and clothing often surface, sometimes in surprising ways. Because details of this culture may be unknown to the service provider, asking questions can be helpful to all involved for the purpose of clarifying the communication.

If the prostitute keeps talking about not getting paid, this may be due to an angry pimp waiting for the money. Formulate a safety plan with the client and ask what options the client needs to remain safe.

Cultural Differences and Religious Communities

Cultural differences vary from family to family, neighborhood to neighborhood, city to city, state to state. Service providers can expect cultural and religious misunderstandings to occur. Being proactive and preparing for diverse clients is an ethical responsibility. Service providers must educate themselves about the cultural and religious makeup in the community. Who in the community can be called upon as a resource for the client?

Appropriate cultural and religious resources can be a valuable tool for recovery. Be aware of the different ways messages are conveyed. Best intentions may be undermined by a client’s old assumptions. The job of service providers is to try to understand the culture of the client and

to ask questions when they don't.

A neutral environment feels safer for the client. To make the office and yourself neutral remove all religious pictures and artifacts from the office and personal religious jewelry from yourself while you are at work.

Adults Molested as Children (AMAC)

Clients who were sexually abused as children (children of sexual abuse, CSA) develop original coping strategies intended to help them survive their childhood. Some of these coping strategies may become rigid and fixed. Some of these clients develop a strong sense of denial in order to pretend that everything is OK. This denial meshes well with their addiction. Trauma exists on a scale from mild to severe, depending on age of contact, resilience, chronicity (how often the abuse happened) and other factors. There can be a wide range of symptoms, or there can be few.

There is a strong correlation between CSA and addiction, although it is important to stress that not all or even the majority of adult survivors of CSA are addicts. Child sexual abuse can create a negative self-image, negative self-talk, depression and a wide variety of other symptoms. The client may have little experience in forming healthy relationships. The client often feels guilty and places the blame on themselves, for a variety of reasons. Abandonment often plays a large role in the client's life, especially in the ways the client repeatedly connects and disconnects with others.

Diana Russell, in her research on female incest victims, discovered that many CSA's rejected religion. "The most striking finding is that 42 percent of the incest victims reported no religious preference compared to 31 percent of the women who had never been incest victims" (Russell, 1999). Some CSA's who are addicts may view AA as a religious program, instead of a spiritual program and resist anything 12 Step related, especially attending 12 step meetings. Helping the client understand the difference between spirituality and religion, as well as offering AA alternatives, may be helpful.

Rape in Marriage/Committed Relationships

Many people still do not view marital rape as "real rape" (Searles, 1995). One study describes a common view of forced marital sex as "an unpleasant, but not particularly serious, marital squabble" and lists "three types of marital rape: battering rape, force-only rape, and obsessive rape" (Finkelhor and Yllo, 1985). Victims of marital rape cope with acute fear, self-doubt and uncertainty regarding if and when it will recur. Committing to a relationship does not give the abuser the right to control or own their partner's body. Marital rape is also part of a domestic violence pattern where the spouse may batter the client in other ways.

Safety planning is a strong need since issues of betrayal and

trust are part of the addict's history. This client may have tried to stop the drug use only to be thwarted by their partner; however, this can also be a convenient excuse. If there are children in the relationship, the client may be even more overwhelmed and there may be possible DPRS involvement.

The addicted client may have tried unsuccessfully to leave the relationship and to stop the substance abuse many times. This is complicated when the abuser controls or supplies the drugs and the addict is haunted by the past failures. Many marital rape victims may not know that rape in marriage/committed relationships is a crime. This is especially true in immigrant populations.

X. Outside-the-Box Tools

Screening/Assessment Material

Social service agencies do not need more screening and assessment materials; there is ample paperwork. Information is lost due to the failure to connect the dots during intake. In learning how to connect the dots, service providers can gain valuable insight and information about the client.

The screening assessment tool any agency uses should include a substance abuse history as well as a social/psych history. In addition to the standard rape crisis screening questions, the initial evaluation should include:

- substances used
- age of first use
- significant periods in which the client experienced serious problems getting along with others
- age when the client started having these problems who abused the client
- how old the client was when the abuse started

The answers to these questions can provide another tale, a tale of when and where the abuse and the drug use started, assuming the client remembers the abuse details. This information can also provide some clues to the client's history and coping skills. Example: If the client started using at 10 years old and has a lifetime of conflict with an uncle, this may be an indication that something happened with the client's uncle at that time or these two pieces of information may be coincidental. The answers may provide an opportunity to explore addiction patterns and life choices. When the only option the agency can provide is short-term crisis counseling, this information may be the basis for a referral for substance abuse counseling.

Groups Done Differently

The 12 Step Approach alone is not always the best approach for an addict with sexual abuse problems. Sexual assault recovery alone may not be the best approach for an addict. Some of the AA dogma that emphasizes powerlessness and surrender may be extremely triggering and feel victim-

blaming to a sexual assault survivor who has had all choice taken away. The language of AA tends to be dogmatic (black and white), and can sound controlling in its conviction. The following group exercises have been modified to reflect the dual issues of addiction and sexual violence. This is by no means the only way to do groups. They are merely suggestions.

Inner Voice Exercise (May not be appropriate if the client is highly dissociative, diagnosed with dissociative identity disorder (DID), hallucinatory, etc.)

In order for the client to heal and recover, they have to know how to live honestly within themselves. A good way for clients to learn about living honestly is to listen to their own internal voice. How do they learn to listen to that voice?

- Ask the client to close his/her eyes and remain quiet for about 3 seconds.
- With eyes still closed, ask the client if they can hear their inner voice.
- It will be that quiet inner voice that underlies their everyday thoughts. (Sharing is always optional.)
- The client might want to write down his/her hopes and dreams.
- If the inner voice is bringing up shame and blame, the client may choose to work on these issues.
- The client can learn to get past the denial, get in touch with feelings that surface and learn to deal with the feelings in safe and concrete ways.

Recovery is about hope, about the power of personal truth and how to apply that truth into one's life. Before anyone can commit to the hard work of recovery they have to believe a healthy and happy life is possible: that it is possible to find a way out of the shame and confusion and the client has personal power worth claiming. The advocate/counselor functions as a witness and a reality checker for the client. It's the advocate's job to listen to what the client has to say, to challenge the perception of being forever wounded, psychologically damaged, and emotionally crippled.

Stereotypes often shame victims into silence. Telling the truth is a simple idea. It is not necessarily easy, especially for someone who has learned to lie as a survival skill. Listening without judging or interrupting the client gives the client the occasion and the reason to speak the truth. It encourages the client to find the words to convey their needs and wants. The client needs to understand that the only expectation recovery comes with is honesty.

Many addicted survivors of sexual assault enter your agency in a full armor of Teflon coating. Nothing is their fault because nothing sticks to them. The client comes replete with rationalizations, justifications and explanations for everything. These were the skills that have helped them to survive until now. Now these skills are outdated. They no longer

work well, or as one client once stated "I woke up in the hospital strapped into the bed and then later I was placed in a straight-jacket. I remember thinking 'this is what my best thinking got me.'

Early recovery is probably the most frightening, painful and distressing to the client – authority figures are telling the client something that was always suspected: the client is fundamentally wrong. This is a devastating confirmation to have.

In order for change to happen the client has to want change and believe it is possible. Even if the client wants change, the client may not know how to go about manifesting a lifestyle change. Social service providers can help the client with realistic goal setting and talking about a future the client hopes to create by following concrete plans towards a goal.

The following activities can be done with an individual client or with various types of client groups. Having paper and a writing implement handy for the client(s) is recommended. This is an exercise in problem solving and communication: Imagine you're locked up with someone who doesn't speak your language -- and you don't speak theirs. For extra fun, your favorite music is blaring from the boom box, and there is a very long loud freight train passing through outside of your window. To make matters worse you have nothing to write on and you need to communicate with this person. How will you do it?

Processing

- What is it you want to communicate?
- How do you show you understand?
- How do you show you don't understand?
- How will you know if you are understood?

Read and Talk about the 12 Promises and the 12 Rewards of the 12 Step program:

The 12 Steps contains some suggestions and promises for individuals. One does not have to follow a 12 Step program to read what the Big Book says about hope and personal dreams. Talk about the hope the client has for the future and then read the 12 Promises and the 12 Rewards. This can be a way of introducing to the 12 Steps. Explain that the 12 steps can be used as tools for attaining the promises and rewards. Please note 12 Step language is written as "we". For this exercise "I" has been substituted for "we".

The 12 Promises

1. If I am painstaking about this phase of our development, I will be amazed before I am halfway through.
2. I am going to know a new freedom and a new happiness.
3. I will not regret the past nor wish to shut the door on it.

4. I will comprehend the word serenity and I will know peace.
5. No matter how far down the scale I have gone, I will see how my experience can benefit others.
6. That feeling of uselessness and self-pity will disappear.
7. I will lose interest in selfish things and gain interest in my fellows.
8. Self-seeking will slip away.
9. My whole attitude and outlook upon life will change.
10. Fear of people and of economic insecurity will leave me.
11. I will intuitively know how to handle situations that used to baffle me.

Adapted from the A. A. Big Book

The 12 Rewards

1. Hope instead of desperation
2. Faith instead of despair
3. Courage instead of fear
4. Peace of mind instead of confusion
5. Self-respect instead of self-blame
6. Self-confidence instead of helplessness
7. The respect of others
8. A clean conscience instead of a sense of guilt
9. Real friendships instead of loneliness
10. A conscious life instead of a purposeless existence
11. The love and understanding of our families and/or friends
12. Freedom to make conscious decisions and have a happy life

Adapted from: <http://www.geocities.com/oneexdrunk/>

Processing

After reading the 12 Rewards, how did this make you feel? Which statements made you feel happy? Sad? Skeptical? Confused? Why? Do you believe this potential life is possible for you? Why or why not?

Adult Children of Alcoholics (ACA or ACOA)

ACA is a program for people who grew up in alcoholic/dysfunctional homes. Members of this program acknowledge common experiences and discover how childhood affected them in the past and influence them in the present. ACA has identified 13 problems and 12 solutions presented below. Talking about the problems and solutions in a group setting provide many clients with a shared understanding.

The Problems

1. We tend to isolate and give too much power to others.
2. We may seek approval and lose our identity in the process.
3. Anger and personal criticism can deter us from listening to our own inner voice.
4. We may become substance users, form relationships with other users or both.
5. We tend to have an overdeveloped sense of responsibility.
6. It is easier for us to focus on others rather than ourselves; this enables us avoid dealing with our own problems and growth.
7. We tend to form relationships with others we can "fix," so we don't have to fix ourselves.
8. We feel guilty when we stand up for ourselves; we sometimes give our power away to others.
9. Excitement/drama is a habitual pattern that we tend to seek out. Much like substances, the purpose of drama is to change the way we feel.
10. We sometimes stuff our feelings and numb ourselves to avoid pain. This also includes feelings of joy and happiness.
11. We tend to judge ourselves more harshly and hold ourselves more accountable than we do others.
12. We depend on others for validation rather than nurturing ourselves.
13. We may react, rather than act or be proactive.

The Solutions

1. Addiction is a threefold disease: mental, physical and spiritual.
2. Many of our parents were addicted to something. Learning about and understanding the disease is
3. the beginning of self-awareness. There are 3 Cs of family of origin addiction: we didn't
4. cause it, we can't control it and we can't cure it. We learn to balance the focus between ourselves and others.
5. We learn to detach with love and to hold others responsible for their own actions.
6. Some find comfort in the Al-Anon slogans "Let Go and Let God," "Easy Does It," "One Day at a Time,"
7. "Keep It Simple" and "Live and Let Live." Learn to recognize our feelings, to accept them and to express them.
8. Through working the Steps many learn to develop their own power. In the process of working the
9. Steps, we are no longer powerless over the addiction or the abuse.
10. We learn to love ourselves. In this way we are able to love others in a healthy way.
11. We use telephone therapy with people we relate

to. It is very helpful at all times, not just when problems arise.

12. The Serenity Prayer can help us change old attitudes we learned in childhood.

Processing

Ask the group: Do the problems and solutions make sense to you? Why or why not?

Do any of the problems make you feel uncomfortable? Which problem(s) makes you feel the saddest? Change the wording of the problems from "we" to "I." How does that make you feel?

Which solution makes you feel uncomfortable? Which solution makes you feel the happiest? Which solution gives you hope? Change the wording of the solutions from "we" to "I." How does that make you feel?

Principles behind the Steps

Materials needed

- flip chart
- markers and tape
- paper and pens/pencils

Many clients do not like the 12 Steps. Many programs, especially drug programs, require clients to complete the Steps as a measure of the client's progress. This does not mean the client understands the principles behind each step or will remain substance free. The client needs tools and skills to make different choices. Understanding the principles behind the 12 steps may be helpful. Ask the client for his/her definition of:

- Step 1 - awareness, unmanageability
- Step 2 - faith, sanity
- Step 3 - control, surrender, decision making
- Step 4 - fearlessness, self-inventory
- Step 5 - admitting and naming behavior patterns
- Step 6 - readiness, personal knowledge
- Step 7 - relinquishment, humility
- Step 8 - discernment, willingness
- Step 9 - amends, action, responsibility
- Step 10 - discipline (as in a way of life)
- Step 11 - prayer, meditation, conscious contact
- Step 12 - talking the talk, walking the walk

Processing

How can the client apply these definitions to everyday life?

What challenges can the client foresee?

How can the client be proactive?

Are there any words that might trigger/affect a sexual assault client?

Are there any words that might trigger/affect an addicted client?

Are there any words that might trigger/affect an addicted survivor of sexual assault?

Re-Writing the 12 Steps

Materials needed

- flip chart
- markers and tape
- paper and pens/pencils

Ask the client to re-write the 12 Steps in their own words using "I" instead of "we." "I" statements can give the client ownership of the step.

Some examples of what other past clients have written:

Step 1

I admit I'm obsessed with _____ and due to this obsession my life is out of control.

Step 2

I believe there is order to the Universe. I have no idea what that order is and that is OK.

Step 3

I make the decision to turn my obsession over to the universe.

Step 4

I am willing to take a look at myself.

Step 5

I admit the results of what I find and tell someone if I want to.

Step 6

I am willing to explore new coping skills.

Step 7

I am ready to practice my new coping skills.

Step 8

I can make a list of people whom my actions have harmed.

Step 9

I can make amends whenever possible, except when it would injure others or me.

Step 10

I continue to look at my self. When I am aware that I am doing is wrong, I will admit it and change my behavior.

Step 11

I will continue to explore the things that drive my old non-working behaviors and change what I can.

Step 12

I will take responsibility for living in a way that exemplifies a healthy belief system.

The point of this exercise is to eliminate the client's resistance to the language of the 12 Steps by encouraging the client to have a vested interest in recovery. If the client is still resistant, discrete questions about their literacy and education levels may be in order, as well as asking the client why they are making the choice to resist this exercise.

Each step is done in two group sessions. In the first group session, the client works on rewriting the steps. In the second group session, the client (if desired) can share their step and give an example of using the step in the client's life. Depending on the size of the group, and how detailed the group becomes, the exercise can be extended to more group sessions. After everyone has shared, the group may decide to rewrite a step combining different phrases and ideas.

Processing

- Much like a brainstorming exercise, write the step in the clients' words on the flip chart.
- Ask the group to discuss the meaning of this step as written.
- Ask how important it is to use words we know and understand.
- When the clients have finished defining the step, tear the page from the flip chart and tape it to the wall.
- The take away assignment (homework) is to ask the group members to write how they are going to apply the step to their life and how they will know when they have strayed from that step.
- As the advocate, you can make a worksheet for the clients using different suggested questions about a specific step from other 12 Step programs: Alanon, Debtors Anonymous, Alateen, etc.
- After the second group, gather everyone's paper (have them write their names on each paper), make a copy for the client and place the original in their file. The papers can be stapled together and labeled STEP ____.

Some clients are going to have a very hard time accepting a High Power. 12 Step programs state the client has the right to have a Higher Power of their understanding or none at all. If the client chooses themselves or another person as a Higher Power, a conversation about why the client made this choice and how the client defines personal empowerment is advised.

Recovery from both sexual assault and chemical dependency can happen in tandem, depending on the client, the circumstances and the individual situation. It is the job of the advocate/counselor to support recovery in all areas of the client's life. Listening without judgment when the client or the group speaks is part of that process.

Codependency

There is a belief among some chemical dependency counselors that if you scratch an addict, underneath there is a codependent person. This may be an area of group discussion that is both educational as well as emotional.

Over the years, codependency has expanded into a definition which describes a dysfunctional pattern of living and problem-solving developed during childhood by family

rules (or lack thereof). Codependency is defined as a set of behaviors that are:

- maladaptive
- compulsive
- rigid

These behaviors can be learned in homes where there is chemical dependency, chronic mental illness, chronic physical illness, physical abuse, sexual abuse, emotional abuse, verbal abuse or neglect. Some of the symptoms of codependency include:

- controlling behavior
- distrust
- perfectionism
- avoidance of feelings
- intimacy problems
- care-taking behavior
- hypervigilance
- physical illness related to stress
- secrecy
- protecting the addicted parent(s) at all costs
- family loyalty

A codependent person is not likely to get too involved with people who have healthy boundaries because they function within a dysfunctional communication system where often:

- it's not okay to talk about problems
- feelings are not be expressed openly
- there is indirect communication
- one person acts as messenger between two others (triangulation)
- the message is to be strong, good, right, perfect
- there are lax personal boundaries and privacy
- there is inconsistency and the rules may change frequently
- people expect others to be mind readers

These kinds of rules can constrict healthy childhood development. As a result, children can develop behavioral characteristics, reactions and problem solving techniques that can become problematic when the child leaves home.

Group discussion centers on family rules. Ask:

- Does the client like this family rule?
- How did this rule manifest in the lives of the client's grandparents, parents, aunts/uncles, siblings, cousins and the client?
- If the client has children, have they handed this rule to them?
- What would the client's life look like without this rule?
- If the client would be happier without this rule, why is the rule still there? Is it a good rule, a fair rule?
- If the client takes this rule out of their life, will the client replace the rule? What is the replacement rule? Why?

Child Development

Many addicted survivors missed out on childhood by having expectations that far exceeded their developmental capabilities, e.g., children do not have the dexterity to tie their shoes at two years of age. A three year old is not capable of babysitting, or cooking dinner or changing a diaper of a younger child. Many the clients had many repeated incidents like these. Unrealistic expectations placed upon a child can cause developmental deficits. The client often parents the same way the client was parented. A group on child development, without placing blame, can be both educational and an exercise of self-forgiveness.

Is there is an Early Childhood Intervention (ECI) agency, university, community college, or day care in the area, that could come present life skills group for several weeks on child development? If not, choose a Child Developmental theorist (Erickson, Anna Freud, Piaget, Skinner, Bowlby) and structure some groups around their theories. Or compare and contrast different theorist in these groups.

Note: It is not unusual for the client to get emotional during these groups. They may bring up painful memories that trigger the client. For this reason, every precaution should be taken to include a licensed counseling professional to co-facilitate this group. There should also be emotional after-care provided, as needed, after the group ends.

Shame vs. Guilt

Material needed:

- Paper
- Pen/pencil

Issues:

- Shame is an overwhelming feeling that who I am is not OK.
- Guilt is a feeling that what I have done is not OK.
- If I have done something wrong, I can take action to correct it.
- If someone else has done something wrong, it is not my responsibility to fix it, and I should not feel shame or guilt for what they did.

Most people confuse shame and guilt. To make the distinction clear, ask the client(s) to write the answers to the following questions:

- What is the difference between a feeling and an action?
- When you think about shame, what do you feel?
- How do you act when you feel ashamed?
- When you think about guilt, how do you feel?
- How do you act when you feel guilty?
- What can you do about a feeling of shame?
- What can you do about an action?
- Who suggested you should feel ashamed and/or guilty?

- Is it true that you should feel shame? Why or why not?

This is a scary exercise for many clients, often triggering and can result in tears, anger or any number of responses. A licensed counseling professional should help co-facilitating this group. There should also be emotional aftercare available after the group ends.

Shame work sheet

After discussing shame and guilt in group, the following worksheet can be used as homework:

Shame can be a powerful force in anyone's life – it is a trademark of dysfunction.

Guilt is the feeling or thought that what a person did is not OK. It indicates that the behavior needs to be corrected or amends need to be made. Shame is an overwhelming negative sense that an individual isn't OK. Shame is a no-win situation. Shame can propel a person into self-defeating and self-destructive behaviors.

Some of the things that cause me shame:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

I may feel ashamed when I have a problem or someone I love has a problem.

I may feel ashamed for making a mistake or for succeeding. I may feel ashamed about certain feelings or thoughts I may have.

I may feel ashamed when I have fun, feel good, or am vulnerable enough to show myself to others.

I may feel ashamed just for being me.

Shaming me is a way for someone to control me. Learning to reject shame can change the quality of my life. It's OK to be who I am. I am good enough. My feelings are OK. It's OK to have problems, make mistakes and struggle to find my

path. It's OK to be human and to cherish my humanness.

Accepting myself is the first step toward recovery. Letting go of shame about who I am is the next important step.

Today I will watch for signs that I have fallen into The Shame Trap. Those signs are:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

My life might not be perfect and I might not have yet achieved the goals I thought I would and I might not yet be living the kind of life I want. I am grateful for this day, right now, and the fact that I have made a commitment to myself to live my life where I treat myself with respect and dignity.

If I get hooked into shame, I will get myself out of shame by:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

I will use this day as a gift, one that I've given myself because I deserve it. I will use this day to be glad for all I have accomplished.

I am deserving, worthy and valuable.

Today I thank the person who helped me understand how lovable I am: me.

Waiting vs. Patience

Materials needed

- Paper
- Pen/pencil

On a piece of paper ask the client(s) to define:

- Patience
- Waiting
- Fulfillment
- Dreams
- Heaven
- Paradise
- Relationship

Hand out another piece of paper upon which is written: "If you knew you'd find the relationship that would answer your prayers, fulfill your dreams and make your life heaven on earth, how long would you be willing to wait?" Paradise is within your grasp.

Waiting is _____
Patience is _____

1. What is the difference between waiting and patience?
2. What is the difference between heaven and paradise? (Think outside of biblical/religious references)
3. How do you think your definitions of patience, waiting, paradise, heaven and relationships affect your sobriety and recovery?

A Facilitated Discussion

Back in the 1990's a trainer at Sea World inadvertently left open a gate and three trained dolphins escaped. Every effort to lure the dolphins back failed.

About a week later, golfers at a country club in Key West reported seeing three dolphins performing tricks at 10 a.m., 2 p.m. and 4 p.m., presumably for food.

Questions for discussion:

- Why do you think the dolphins escaped?
- Do you think attempts to lure them back will fail?
- Why were the dolphins performing tricks?
- Are you like the dolphins? In what way?
- If the ocean represents freedom to the dolphins does staying in recovery represents freedom to you? Is this a new environment for you? How does that make you feel?
- If you bring old baggage into your new “ocean” what do you think might happen?

Facilitator’s Note: The purpose of this exercise is to encourage group members to think about the coping skills they learned as addicts can harm them as they work toward recovery as well as to understand the reasons these behaviors were learned. The group members should come to these conclusions on their own, so facilitators should refrain from leading the discussion unless it becomes clear that the discussion is headed in an unproductive direction.

Power and Control Model for Substance Abuse

Threats – to hurt client/children/family friends if uses/not uses drugs

Emotional Abuse – make the client feel bad about self, make the client think they’re crazy, put the client down for drug use

Physical Abuse – inflicting or attempting to inflict physical pain, hurting the client for getting/not getting high

Isolation – controlling when and where the client goes and whom the client sees; preventing the client from going to support groups or from contacting people who support the client.

Minimizing – abuser makes light of client’s substance abuse, doesn’t take the client’s concerns seriously, says the client cause “the problem” by drug use.

Sexual Abuse – forces client to prostitute for drugs and/or money (for the abuser, the client or both of them)

Encouraging Use – introduces client to drugs; encourages client’s use/dependence

Economic control/abuse – forces client to sell drugs

Discuss each example.

How has it affected the client?

Serenity Prayer

Materials needed

- flip chart
- markers and tape
- paper and pens/pencils

Changing one word in the serenity pray turns the prayer into an affirmation rather than a plea:

A. A plea

God grant me the serenity
To accept the things I can not change;
The courage to change the things I can;
And the wisdom to know the difference.

B. An affirmation

God grants me the serenity
To accept the things I can not change;
The courage to change the things I can;
And the wisdom to know the difference.

Suggestions for group discussion

On a flip chart or dry erase board write both prayers without identifying them as a plea and an affirmation. Ask the clients:

1. To repeat both prayers silently to themselves.
2. If they felt a difference when saying the prayers?
3. If so, describe that difference.
4. Define plea (and not in legal terms).
5. Define affirmation.
6. What is the difference between a plea and an affirmation?
7. Which prayer would they prefer to use? Why?

Amends or Why “I’m sorry” Is Not Good Enough (Modified from BIPP Program)

Saying “I’m sorry” is not good enough. It is not good enough to offer as an apology to someone you have offended, nor is it good enough to receive as an apology from someone who has offended you.

In order to say “I’m sorry” and have it be good enough, the amends has to contain four elements:

- what the action was;
- how this action affected the person;
- state what the offender is going to do differently;
- Understand that the offender may not be forgiven AND that is not the purpose of the amends.

Amends are delivered as “I” statements.

Example:

“I know I lied about doing the dishes. That was a crazy thing to do, because when you walked into the kitchen, you saw that the dishes were not washed. I know you hate being lied to and you now distrust me. There is nothing I can do to take back what I said, and I regret lying to you. I used to lie as a habit. I am working on breaking that bad habit. My goal is to never lie to you, or anyone else. I know that you may not forgive me. The reason I am telling you this is to acknowledge that I lied to you and I have hurt your feelings.”

When making an amends would cause physical or emotional

harm to the client or the other person, indirect amends or living amends can be made. Indirect or living amends are

made by making a change in the behavior:

- If a client is late to work, appointments, meeting friends, as a living amends, the client can change that behavior and show up on time instead of apologizing for being late.
- If the amends is for someone who has passed on, e.g., the client's grandmother, and the client regrets not helping grandma more, volunteering at a nursing home or Meals on Wheels is a way of making a living amends

Amends are not about forgiveness. Amends are about acknowledging and trying to change a behavior pattern.

Group discussion

Ask:

- Who are you willing to make an amends to?
- When is it safe to make an amends?
- What does injuring someone while making the amends mean?
- How will you act when the amends is not accepted?
- Can you make an amends indirectly?
- What does a "living amends" mean to you?

Other Topics for Groups

- Acceptance
- Doubts Are What Get You Educated
- Truth
- Trust
- Choice
- Loneliness
- Boundaries
- Concentrating on specifics rather than generalities
- Communications Sometimes Cause Difficulties
- Anger
- Disappointment
- Worry
- Meditation
- Willingness
- Creativity
- Peacefulness and Serenity
- Staying focused
- Simplicity
- Honoring Self/Honoring others
- Non-Judgment
- Awareness
- Freedom
- Fun
- Compassion
- Authenticity
- Discipline
- Balance
- Expansion
- Joy
- Gratitude lists

XI. A Note for Social Service Providers

"There is only one corner of the universe you can be certain of improving, and that's your own self. So you have to begin there, not outside, not on other people. That comes afterward, when you've worked on your own corner."

-Aldous Huxley

Perpetual giving is not possible. Often counselors/advocates take on more and more professionally, often at unexpected times, because that is the nature of the work service providers do.

Service providers need to recognize their own personal limitations. The number of people an advocate can care for and support will vary, but everyone has a maximum tolerated dose! Taking on too much work professionally causes burn-out and ineffective care for the client. Work-related stress can cause havoc in one's professional and that may result in:

- Irritability
- Criticism or cynicism
- Feelings of failure
- Social isolation or depression
- Insomnia, exhaustion
- Poor concentration
- Seeing clients as objects
- Poor staff relationships
- Poor relationships with family and friends.

Communication problems rank high on the list of work-related stress, making individuals more vulnerable to the above symptoms. Paradoxically, in burn-out, the job can become the sole source of satisfaction, which makes detaching from it increasingly difficult. The personal support system that service workers have is important. Friends and family sometimes mention their concern for the service provider's welfare. Comments may include statements regarding working too hard or not having a personal life. This support system can help the counselor/advocate keep a balanced lifestyle. Listen to them.

XII. Resources

National Websites

Accessing Safety Initiative (ASI)
www.accessingsafety.org/

FBI Uniform Crime Reports
www.fbi.gov/ucr/ucr.htm

Rape, Abuse & Incest National Network (RAINN)
www.rainn.org

The National Center for Victims of Crime
www.ncvc.org

The National Center for PTSD.
www.ncptsd.va.gov/ncmain/index.jsp

National Sexual Violence Resource Center
www.nsvrc.org

National Violence Against Women Prevention Research Center
www.vawprevention.org

Sexual Violence Research Initiative (SVRI)
www.who.int/svri/en/

Substance Abuse Treatment Facility Locator
www.findtreatment.samhsa.gov/gov/facilitylocator.htm

U.S. Department of Justice Office on Violence Against Women
www.ojp.usdoj.gov/vawo

U.S. Department of Justice Office for Victims of Crime
www.ojp.usdoj.gov/ovc

Violence Against Women Online Resources
www.vaw.umn.edu

VAWnet Online Resource Library
www.vawnet.org

Women's Calendar
www.womenscalendar.org

Texas Websites

Texas Office of the Attorney General Sexual Assault Prevention and Crisis Services
www.oag.state.tx.us/victims/sapcs.shtml

Texas Office of the Attorney General Crime Victims Compensation
www.oag.state.tx.us/victims/cvc.shtml

Texas Department of Criminal Justice Victims Services Division

www.tdcj.state.tx.us/victim/victim-home.htm

Texas Office of the Governor Criminal Justice Division
www.governor.state.tx.us/divisions/cjd

Adult Protective Services
www.dfps.state.tx.us/Adult_Protection/About_Adult_Protective_Services/

Child Protective Services
www.dfps.state.tx.us/Child_Protection/About_Child_Protective_Services/

Texas Department of Health Council for Sex Offender Treatment
www.dshs.state.tx.us/csot/default.shtm

Texas Department of Human Services Office of Immigration and Refugee Affairs
www.dhs.state.tx.us/programs/refugee/

Texas Department of Public Safety Crime Statistics
www.txdps.state.tx.us/administration/crime_records/pages/crimestatistics.htm

Texas Advocacy Project
www.women-law.org/
People Against Violent Crime
www.main.org/pavc/home.htm

Arte Sana
www.arte-sana.com/

Texas Council on Family Violence
www.tcfv.org

Children's Advocacy Centers of Texas
www.cactx.org/index.shtml

Texas CASA
www.texascasa.org/

XIII. References

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