The Role of Sexual Trauma in the Treatment of Chemically Dependent Women: Addressing the Relapse Issue

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A review of the literature indicates a high incidence of sexual trauma among women who seek treatment for substance abuse. Additionally, clients who have experienced sexual trauma appear to be more susceptible to relapse, the return to substance abuse. This article explores issues surrounding sexual trauma and chemical dependency. It aims to provide direction for relapse prevention with a relapse-prone population. Application of traditional milieu substance abuse treatment for sexual trauma survivors is explored. Recommendations for working with sexual trauma survivors who are also substance abusers are presented, as are suggestions for research.

A review of the literature indicates a high incidence of sexual trauma among women who seek treatment for substance abuse (Briere & Runtz, 1987; Moore & Fleming, 1988; Rohenew, Corbett, & Devine, 1988). The trauma may have been incest, childhood sexual victimization outside the family, or same-age rape or molestation. The rate of incest alone among substance-abusing women has been reported in the range of 40% to 80% (Evans & Schaefer, 1987; Kasl, 1989). This compares to the rate of 20% to 25% reported for the general population of women (Pinkelhor, 1979; Russell, 1986).

One might suspect that more women treated for substance abuse have been sexually abused than the just-mentioned figures indicate. When considering the denial used by clients to shield themselves from reexperiencing the painful feelings associated with sexual abuse and from the realization of chemical dependency, it seems surprising that reported rates of sexual abuse are this high. This may be particularly true if the substances are being ingested, at least in part, to numb the emotional pain of sexual abuse (Harrison, Hoffman, & Edwall, 1989).

Many authors indicate that childhood sexual abuse may be a reliable predictor of later substance abuse as well as other mental health problems (Miller, Down, Gondoli, & Keil, 1987; Rose, Peabody, & Strattegas, 1991). Therefore, it may be prudent to assume that many women entering treatment for substance abuse have also experienced sexual trauma. This assumption may be particularly efficient if, as appears to be the case, the discovery and subsequent treatment of such trauma would aid in relapse prevention.

Clients who have experienced sexual trauma appear to be more susceptible to relapse, the return to substance abuse (Kasl, 1989; Rohenew, Corbett, & Devine, 1988). Clients who have histories of childhood sexual trauma and have become chemically dependent may fully experience the pain of the trauma for the first time once the substance abuse has ceased. This may precipitate a return to substance use.

Other research seems to indicate that symptoms experienced by sexually abused clients leave this population prone to relapse (Brown, 1991; Rose, 1991). Some suggest that these clients need to confront the unfinished business associated with the trauma before the risk of relapse can be assumed to be reasonably low (Brown, 1991; Rohenew et al., 1988; Rose, 1991). Others maintain that abstinence from substance use should be the primary goal of treatment. Accordingly, issues such as childhood sexual trauma are secondary and should be addressed only after some period of “sobriety” or clean time has been obtained (Courtis, 1988; Underhill, 1986).

This article explores issues surrounding sexual trauma and chemical dependency. It aims to provide direction for relapse prevention with a relapse-prone population. Application of traditional milieu substance abuse treatment for sexual trauma survivors is explored. Recommendations for working with sexual trauma survivors who are also substance abusers will be presented as well as suggestions for further research.

SYMPTOMS OF SEXUAL TRAUMA AND SUBSTANCE ABUSE

Manifestations of a history of sexual trauma and substance abuse appear to be similar, if not identical. Because of this similarity, the counselor may have difficulty uncovering a client’s sexual trauma history. However, there are several indicators that can assist the counselor. Gelles (1983) indicated that because the client who has been sexually violated usually does not possess sufficient ego strength to address the trauma at the time it occurs, a host of seemingly unrelated complaints later surface that compel survivors to seek treatment.

Substance abuse is often reported by those who have experienced sexual trauma (Courtis, 1988). Other complaints associated with sexual trauma include shame, self-doubt, guilt, low self-esteem, depression, role confusion, feelings of isolation and despair, anxiety, perceived helplessness, eating disorders, dissociative and somatization disorder, sexual problems, unsatisfactory relationships, extreme difficulties with trust and intimacy, and suicidal ideation and intent (Briere & Runtz, 1988; Courtis, 1988; Courtis & Watts, 1982; Evans & Schaefer, 1987; Gorcey, Santiago, & McCall-Peza, 1986; McBride & Emerson, 1989; Siegel & Romig, 1988).

Substance abuse clients are likely to report similar, if not identical, presenting problems. Feelings of isolation, emptiness, and alienation (relationship and intimacy problems), increased anxiety, low self-esteem, and external locus of control (associated with learned helplessness) are common complaints for substance abusers (Blume, 1985; Wallace, 1985; Yablonsky, 1989). It is evident from the simi-
larity of the two preceding lists that these symptoms are highly correlated for both populations.

Some researchers indicate that the symptomatology is likely to be chronic and more severe for the substance abuse client who also has a history of sexual trauma (Briere & Runtz, 1987; Harrison, Hoffman, & Edwall, 1989; Rose, Peabody, & Stratigeas, 1991). Harrison et al. suggested that the presence of antisocial behavior (particularly in women), suicide attempts, and the frequent use of drugs other than alcohol and marijuana among chemically dependent adolescents are indications that a sexual abuse history should be explored.

Evans and Schaefer (1987) cited a study that found that chemically dependent incest survivors reported using chemicals earlier in their lives. A substantial number (13%) of chemically dependent incest survivors admitted that they had sexually violated a minor themselves (Evans & Schaefer, 1987). Rose et al. (1991) found that the practice of self-mutilation was positively correlated with sexual trauma among alcoholic clients. Multiple personality disorder, as well as other dissociative disorders, can also be an indication of sexual trauma.

A blunting of sexual feelings or the presence of frequent sexual activity with multiple partners, particularly abusive partners, may be another clue to a past sexual trauma. Another possible indication of sexual trauma is the individual's inability to engage in sex without the ingestion of chemicals (Briere & Runtz, 1987; Evans, 1988; Evans & Schaefer, 1987). Given the high probability that a female client presenting with chemical dependency may have been sexually victimized, it is important that all counselors investigate this possibility. This is particularly true if any of the indicators just listed are present.

CHEMICAL DEPENDENCY, RELAPSE, AND SEXUAL TRAUMA

The relapse of chemically dependent clients is a notorious and frustrating problem. Daley (1989) cited numerous reports that document that the majority (more than 75%) of clients treated for substance abuse will return to substance use within the first year of treatment. Relapse rates among substance abusers who have a history of sexual trauma may be even higher. Rohsenow, Corbett, and Devine (1988) found that as many as 90% of their relapse-prone clients had been sexually abused.

Daley (1989) offered a review of the literature concerning relapse and relapse prevention for chemically dependent clients. In his review, he indicated several factors that are suspected of causing or being correlated with a return to substance abuse. Considering both the effects of sexual abuse and the relapse factors listed in Daley's work, it appears that chemically dependent clients who have been sexually abused are more at risk for relapse.

Depression and anxiety are reportedly major factors in a substantial number of relapses (Daley, 1989). The presence of these factors can lead the client to self-medicate by returning to drug use. As indicated earlier, both depression and anxiety are commonly encountered among clients who have been sexually abused.

A positive correlation was reported between a client's ability to maintain abstinence and the client's perception of their ability to cope with high-risk (high potential for drug use) situations (Daley, 1989). Perceived helplessness, which is an issue encountered in untreated sexual abuse (Pearson, in press), probably increases the client's risk of relapse. If the client believes either that she is helpless or that she is assertive will be met with negative consequences, as is the case with many sexually abused clients, she may not be able to resist social pressures to resume drug use.

According to other research cited by Daley (1989), those who lack social or family support are at higher risk for relapse. Considering that unsatisfactory relationships and extreme difficulties with trust and intimacy are associated with untreated sexual abuse, it makes sense that the client who has been sexually traumatized is at greater risk for relapse. This is particularly true if the client has learned that those closest to her cannot be trusted.

Another concern about potential relapse is somatization disorders reported by many sexual abuse clients. The chronic pain sometimes associated with this disorder may precipitate the use of over the counter or prescribed pain medications. This often fosters a return to substance abuse. As Daley (1989) indicated, chronic illness, pain, and the ingestion of mood-altering medications may directly trigger relapse.

Remembering and reexperiencing feelings associated with sexual trauma is a major precipitant of relapse. Harrison et al., (1989) and Miller et al., (1987) found that their sexually traumatized chemically dependent clients used drugs more frequently and were more likely to report using drugs to reduce tension, pain, and discomfort than those chemically dependent clients who had no history of sexual trauma. Harrison et al. (1989) and other researchers (Briere & Runtz, 1987; Brown, 1991; Underhill, 1986) expressed concern that coming to terms with sexual abuse may lead clients to use the familiar coping mechanism of substance misuse.

SUBSTANCE ABUSE TREATMENT AND THE SEXUALLY ABUSED CLIENT

Traditional approaches to substance abuse treatment may be both problematic and exacerbating when treating women who have been sexually abused. Most traditional approaches are designed for a male population, use a confrontational approach, and focus exclusively on substance usage (Turnbull, 1989; Underhill, 1986). Many times sexual trauma is treated as a secondary issue (Courtois, 1988), indicating some reluctance on the part of mental health professionals to address sexual trauma. These approaches may encourage a client who has a history of sexual abuse to deny or be silent about the abuse.

Daley (1989) indicated that male substance abuse clients exceed female substance abuse clients by a 5 to 1 ratio, indicating that those receiving substance abuse treatment traditionally have been male. Because of this, substance abuse treatment is designed for a male population. This male bias may make it difficult for the female client to disclose sexual abuse and receive the support required for healing. According to Underhill (1986), the dynamics in mixed gender groups tend to replicate that of sex-role training. She reported that women allow men to dominate the group and tend to focus on supporting and nurturing the men in the group. As Underhill (1986) indicated, this dynamic is often counterproductive to the therapeutic needs of the women in the group.

Male bias seems to have had an effect on the development of chemical dependency treatment philosophy. Meth and Patrick (1990) indicated that males are socialized to believe they are to be in control, competitive, and independent. Chemical dependency treatment is designed to confront these typically male self-concepts in an attempt to address the denial of their addiction and the need for support in recovery from chemical dependency (Yablonsky, 1989). This confrontational philosophy is in conflict with the approach most often recommended by those who treat women for addictions (Kasl, 1989; Underhill, 1986) and for sexually abused women (Pearson, in press). These authors indicated the necessity of a more empowering,
supportive, and encouraging approach than is commonly found in
traditional chemical dependency treatment.

Although the field of substance abuse treatment is beginning to
address the needs of sexual trauma clients through the development
of treatment strategies for “shame based issues,” a review of the lit-
erature indicates only a smattering of specific information on the
behavior of sexually abused clients. For instance, the authors found
that in a special issue of a journal specifically addressing alcohol
and substance abuse in women and children (Daley, 1989), no dis-
charge was offered of sexual abuse as a predisposing factor or even
as a condition with a high correlation to substance abuse. Needless
to say, treatment strategies for working with substance-abusing women
who have been sexually abused were absent. Similarly, in another
substance abuse journal’s special issue (Potter-Efron & Potter-Efron,
1987) within which shame and guilt were addressed, sexual abuse
was only mentioned as a cause of shame. Only one article dealt with
sexual trauma, and then only within the context of chemically de-
pendent and abusive families.

Last, a journal focusing specifically on alcohol and substance abuse
in women and children (Stimmel, 1986) gave little attention to the
topic of sexual abuse in its special issue on relapse prevention, al-
though, as stated earlier, the presence of sexual trauma in a client’s
history seems to indicate a high risk of relapse. This absence of cor-
relative and treatment-specialization information about sexual abuse
in the chemical-dependency literature seems to indicate a “tread lightly”
attitude when it comes to sexual trauma.

In spite of recommendations to the contrary by those who work
with the sexually traumatized and write about sexual abuse therapy,
there seems to be a reluctance to address the issue in chemical-depen-
dency treatment. Courtot (1988) stated that incest is treated as a
secondary issue by many of those who treat substance abuse, with
abstinence from chemical use being a priority of treatment. Underhill
(1986) recommended a minimum of 6 months to a year of abstinence
from substances prior to addressing sexual abuse issues. She stated,
“Early recovery must focus on staying sober. . . . During this period,
a woman has not developed the coping mechanisms necessary to deal
with the overwhelming pain and fear that accompany sexual abuse”
(p. 47).

Taking a softer line, Evans (1988) and Harrison et al. (1989) rec-
commended sensitivity to timing when addressing sexual abuse is-
issues with chemically dependent women. Although they did not provide
a specific waiting period before addressing sexual abuse issues, they
did indicate that caution should be exercised so as not to precipitate
a relapse.

An exclusive focus on substance abuse behavior may reflect
what appears to be resistance on the part of mental health provid-
iers in addressing sexual abuse issues. Rose, Peabody, and Stratigas
(1991) found that among a population of 89 clients requiring in-
tensive case management, 75% of whom were substance abusers,
only 3 had had communication with mental health providers about
their abuse backgrounds. Of these 3, none indicated any follow-
up activity (e.g., referral to a support group or therapeutic special-
ist). A report by the National Institute on Drug Abuse cited by
Moore and Fleming (1989) indicated that 86% of all women in

treatment for substance abuse stated that “their counselors never
addressed sexuality or sexual concerns” (p. 188). Briere and Runz
(1987) cited several authors who noted that “mental health practi-
tioners are unlikely to ask about sexual abuse routinely and, when
told of such a history, may discount or even disbelieve their cli-
ents” (p. 375).

Reluctance to ask about sexual abuse, discounting it when it
surfaces, or fragile handling of the client when it comes to sexual
issues may communicate that this issue is not appropriate for dis-
cussion. Unfortunately, many of these clients often received the
same message from their perpetrators. Side stepping the issue only
delays the inevitable confrontation and resolution needed for qual-
ity recovery.

This is not to say that clients should be zealously confronted
about treatment issues. Evans (1988) warned counselors against
the use of “old style heavy confrontations (hot seat techniques)”
that are used to break down denial and acknowledge powerlessness
over the substance of abuse (p. 174). This type of approach may
increase resistance in those with sexual abuse histories. More dra-
matically, they may leave the client feeling as if she has been fur-
mor violated.

The concept of powerlessness, used almost universally in sub-
stance abuse treatment (Johnson, 1980; Yablonsky, 1989), may be
problematic for those who have experienced sexual abuse. The expe-
rience itself sends a message to the victim that she does not have the
treatment to choose when and with whom she will be sexual. Insisting
on the admission of powerlessness may be both frightening and
revictimizing for these clients. According to Pearson (in press), sev-
eral authors stress the importance of allowing the client to control
the direction and pace of the therapeutic process.

Group therapy is the treatment of choice for chemical dependency
(Blume, 1985; Yablonsky, 1989). Through self-disclosure within the
group, the client can escape the feelings of isolation and alienation
reported by so many chemically dependent clients. However well
intended, the group approach typically used in chemical-dependency

treatment is problematic for sexual trauma victims. Considering both
the fear and mistrust of men by most female sexual trauma clients,
and the fact that men are the majority of those in treatment for sub-
stance abuse (Turnbull, 1989), attending a group for substance abuse
treatment may be overwhelming for these women. Self-disclosure
by sexually abused clients in such a group is an unrealistic expecta-
tion. Disclosure of abuse is best facilitated by providing a safe, nur-
turing atmosphere within which the violation can surface. This may
necessitate the use of individual counseling (Evans, 1988) or an all-
female group setting whose focus is sexual abuse issues, or both
(Westerlund, 1984).

RECOMMENDATIONS

Addressing and working with sexual abuse issues in women who are
substance abusers is fundamental to the process of obtaining quality
recovery and hence relapse prevention. Because research indicates
that most chemically dependent women have been sexually abused
and that unresolved sexual abuse issues may be a major precipi-
tant to relapse, addressing sexual abuse should be a routine aspect of
substance abuse treatment. Several recommendations for the inte-
gration of substance abuse and sexual abuse treatment were gleaned
from literature on the treatment of sexual abuse.

Enhancing Awareness

As most of those working in the chemical dependency field are aware,
a problem must be realized before it can be addressed. Most of the
surveyed literature recommended addressing the issue of sexual trauma
directly and being proactive in the discovery of sexual trauma (Briere
& Runz, 1987; Kasl, 1989; Rohsenow et al., 1988; Rose et al., 1991;

The research of Rohsenow et al. (1988) indicated that direct,
routine, and repeated inquiry into the sexual abuse history of chemi-
cally dependent clients facilitates their awareness of the abuse. In
their study, the rate of disclosure of sexual trauma in chemically dependent women tripled as a result of their proactive stance. Several of their clients who had chronically relapsed had never disclosed their sexual abuse history because “no one ever asked me before” (p. 17).

Many authors indicated that if the sexual trauma of a chemically dependent client is not addressed, relapse is highly probable (Brown, 1991; Evans, 1988; Harrison et al., 1989; Kasl, 1989; Rohsenow et al., 1988; Rose, 1991; Underhill, 1986). Kasl (1989) stated that without attention to sexual abuse sometime in sobriety, relapse often occurs. Rohsenow et al. (1988) stated that “failure to address these [sexual abuse] issues may lead to relapse” (p. 17).

Rose (1991) quoted Crainic and her associates, “In fact, the longer the [sexual] abuse goes untreated, the greater the repression and the more ingrained the symptomatology” (p. 262). Substance abuse is a primary exemplar of the “symptomatology” mentioned. An important point made by Kunzman (1990) is that sobriety alone will not cure the effects of childhood sexual abuse.

Many sexual abuse survivors will not offer information about the abuse unless specifically questioned about it. Rohsenow et al. (1988) suggested systematically asking questions about different abuse experiences (during different phases of treatment) and addressing the issues openly so as to “create a comfortable environment for such disclosure” (p. 17). The reader is referred to Evans and Schaef er (1987) for a list of behavioral and psychological cues, as well as specific questions to be asked of clients. Evans (1988) also offered an “Incest Continuum” table, which lists family dynamics present in incestuous families from which client questions can be developed.

In addition to facilitating disclosure of the sexual abuse, Bass and Davis (1988) and Briere and Runz (1987) recommended educating the client about the possible effects of dealing with the abuse, so that they are somewhat prepared when and if these things occur. This type of educational preparation may encourage the client to resist relapse, particularly if it is combined with information about the exacerbating effects of substance abuse. Emergency phone numbers and referral to specialists in the area of sexual abuse treatment should also be available for these clients (Miller et al., 1987).

Recommendations for Counselor Educators

Counselor education in the area of sexual abuse is strongly recommended when one is working with chemically dependent women. Moore and Fleming (1989) retained an on-staff sex therapist to assist in treatment planning for their substance-abusing female adolescent clients when they found themselves faced with “the inadequacies of chemical dependency counselors to treat sexual concerns” (p. 190). In an attempt to increase clinicians’ awareness, Briere and Runz (1987) suggested that information on the incidence of sexual abuse and its effects should be widely disseminated to mental health practitioners. They argued that because of the denial and secretiveness associated with the abuse, it is counselors’ responsibility to recognize sexual abuse and facilitate the clients in addressing the issue.

In addition to familiarity with the symptoms of sexual abuse, it is important for the counselor to be familiar with proven approaches and philosophies for sexual abuse work. Evans and Schaef er (1987) and Pearson (in press) concurred on the importance of a nondirective, client-paced approach to counseling sexual trauma victims. Therefore, counselors planning to work with sexually abused or chemically dependent women should be skilled in counseling approaches that emphasize the importance of the therapeutic relationship and of empowering the client.

Abreaction therapy, the emotional catharsis resulting from psychologically reexperiencing the sexual trauma and reclaiming the feelings involved, was seen as key to the process of healing from sexual abuse (Evans & Schaef er, 1987). Accordingly, counselors should be familiar with approaches that facilitate emotional catharsis. Gestalt techniques, role playing, and psychodrama, as well as hypnotherapy and guided imagery facilitate the reliving and grieving process that many authors reported as necessary for recovery from sexual trauma.

Pearson (in press) and Briere and Runz (1987) suggested the use of cognitive restructuring techniques to address low self-esteem and shame associated with the sexual trauma. Knowledge of cognitive-behavioral approaches to counseling is, therefore, also recommended.

Recommendations for Practitioners

Most authors stress the importance of the therapeutic relationship. Pearson (in press) stated, “Considering the damage done by abusive authority figures, counselors are advised to use a nondirective approach when working with adult survivors of sexual abuse” (p. 4). Harrison et al. (1989), Westerlund (1984), Evans (1988), Evans and Schaef er (1987), and Strean (1988) echo this advice in recommending a supportive, nondirective, and encouraging therapeutic relationship.

Same sex groups focusing on sexual issues are recommended as a course of treatment for survivors (Rohsenow et al., 1988; Westerlund, 1984). These could easily be incorporated into the chemical dependency treatment milieu with the option of individual therapy if there are not enough women to constitute a group.

Counselors working with such clients need to have addressed their own sexual issues. According to Westerlund (1984), this allows the counselor to be better able to “hear incest material” (p. 25). She adds that the client can sense if the counselor is uncomfortable with the issue and will probably not feel safe disclosing the abuse. Counselors who have not addressed their sexual issues may respond with avoidance or indicate disbelief, thereby reinforcing feelings of isolation and helplessness in the client. Similarly, Strean (1988) warned counselors to remain in touch with and monitor their own sexual fantasies when working with sexually abused clients. If the counselor has not addressed these issues, he or she cannot help their clients to “master these difficult experiences” (p. 467). Evans and Schaef er (1987) stressed that the counselor receive ongoing supervision from a supervisor who is knowledgeable in the field of sexual abuse. They stated that counselors are vulnerable to transference and countertransference issues without this assistance.

Often during chemical dependency treatment, touching the client (e.g., hugging) is considered to be therapeutic. When working with clients who have a high probability of having experienced sexual abuse, one should be very cautious. Evans and Schaef er (1987) suggested asking permission before touching a client, keeping in mind that touch may have been experienced as abusive by the client. By asking for permission, the counselor is modeling respect for the client and the setting of appropriate boundaries for clients who often have difficulty in these areas.

In the same vein, Evans and Schaef er (1987) recommended the firm delineation of appropriate boundaries in the therapeutic relationship. They warn that clients with sexual abuse histories frequently have poor boundary-setting abilities, as their own boundaries were
so brutally violated at an age before the ego was well formed. In an effort to protect one's self from burnout, provide an atmosphere of safety for the client, and model appropriate boundary setting, the counselor needs to maintain and articulate the limits of the therapeutic relationship.

Another word of caution about boundaries with these clients is offered by Strean (1988), who stated that some clients may relate sexually to their counselors. This may be particularly true of sexually abused clients, because of the sexualization of dependency needs and intimacy they have experienced. Sexual abuse may have been the only form of nurturing they received. It makes sense that these clients, when faced with the intimacy that most counselors seek to facilitate with clients, would unconsciously relate in a manner they have relied on in the past to foster intimacy. It is imperative that the counselor be clear to him- or herself, as well as to the client, that sexual relations are not a part of the therapeutic relationship.

Last, and perhaps most important, is the question of the need for client abstinence from mood-altering substances or behaviors (e.g., abusive sex, bulimia, self-mutilation) when she is coming to terms with sexual abuse. Some would argue that absolute abstinence for a specific period of time is required before the issue is addressed (Underhill, 1986). Others (e.g., Harrison et al., 1989) state that unless the issues are dealt with, a client cannot be expected to maintain abstinence.

The present authors are in agreement with Harrison et al. (1989), who stated that "Relapses need to be considered within the context of total recovery" (p. 397). This is not to say that quality therapy can be accomplished if the client is still actively abusing substances. Much of the work of addressing sexual abuse is affective work (Briere & Runtz, 1987; Evans & Schaefer, 1987; Westerlund, 1984). Substance use is often an attempt to anesthetize the feelings associated with abuse. Therefore, relapse may signal that the client is preparing to do the emotional work required to heal. Relapse may be indicative of the overwhelming pain experienced by the client in coming to terms with the trauma and not an indication of an unwillingness to abstain from mood-altering substances or harmful behavior.

**CONCLUSION**

Addressing and working with sexual abuse issues in women who are substance abusers is fundamental to the process of obtaining quality recovery. Most chemically dependent women have been sexually abused, and acknowledging this trauma is a major precipitant of the return to substance abuse. Treatment of sexual abuse issues should be an assumed aspect of substance abuse treatment in women. Future research should examine the correlation between onset of alcoholism and sexual abuse experiences (i.e., age at onset of abuse, type of abuse, and relationship to abuser). Additionally, given the possible implications of male bias in many treatment programs, future research is needed to examine the effects of treatment programs designed specifically to meet the needs of female substance abusers.

Providing the therapeutic atmosphere required for healing from sexual trauma may be difficult if traditional chemical-dependency treatment is being provided. Education of treatment staff, counselors, and clients about sexual abuse and its implications for the treatment of chemical dependency and relapse prevention is imperative. Quality recovery and freedom from the painful experience of relapse depends on addressing sexual abuse issues in sobriety as soon as possible.


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