Treating Women Drug Abusers: Action Therapy and Trauma Assessment

The authors suggest that action therapy, a group of techniques including psychodrama, drama therapy, and role training, warrants research attention to determine whether it is well suited to the special characteristics and needs of women clients. In addition, the authors call on researchers to develop a new standardized tool for counselors to use during initial interviews to determine whether women presenting for drug abuse treatment also have significant issues related to trauma. The authors believe the use of unassisted clinical judgment for trauma assessment in first interviews may drive patients away by probing for painful information that clients are not yet ready to confront or divulge.

Ann S. Uhler, M.A.
Olga V. Parker, Ph.D.

CODA, Inc.
Portland, Oregon

To be reasonably effective with women, drug abuse treatment programs must offer a basic roster of services, including child care, parenting classes, transportation, housing, and medical care. While such services are very useful for male patients, they are critical for women, who are more likely to be caregivers for small children, to be isolated and lack mobility, and to be poor.

At CODA, in addition to offering those fundamental services, we use distinct treatment strategies with our women patients. The strategies are designed to take into account experiences and responses that are especially characteristic of women drug abuse patients, such as being more likely to have histories of trauma and to place high value on interpersonal relationships. We believe that these strategies are largely responsible for improvements in treatment engagement and retention outcomes that we have measured since introducing our women-oriented programs. This article describes our women-oriented programs and their rationale. We also discuss two key features of our women-only programs—the use of action therapy and the handling of trauma—and suggest that they are worthy of attention from researchers.

CODA'S WOMEN-ORIENTED PROGRAMS

CODA has been providing gender-specific, residential and outpatient, drug-free, group counseling for women since the early 1980s. In the mid-1980s CODA began offering specialized prenatal groups, women-only groups, and child care to patients in our methadone clinic. In the mid-1990s we began offering women group psychotherapy that focuses on trauma-related issues. Residential and outpatient services exclusively for women with

children were started in 1990, and we now serve 90 residential and 180 day-treatment and intensive outpatient female clients each year. The women-only unit is designed to be a safe and reassuring setting for those women who have trauma and parenting issues. Having several gender-specific modalities allows flexibility in placement of women based on their needs. For instance, women with traumatic responses to men can be assigned to a women-only model.

CODA's co-ed residential program, designed for older clients involved in the criminal justice system, offers gender-specific programs for parents of both sexes and living accommodations for their children, and it serves 150 residential patients and 250 outpatients each year. A family activities and parents' interaction group for children who visit on weekends is another model for some families.

Counselors in CODA's women-only programs are Ph.D. clinical psychologists and M.S.W. social workers who are trained to treat women for alcoholism and drug addiction. These staff members also have special training for treating mental health problems commonly diagnosed in female drug abusers, including posttraumatic stress disorder and sexual and physical abuse. Highly qualified and specially trained personnel are necessary in part because of the dynamic group techniques used in action therapy, not only to support patients who may be dealing with intense experiences, but also to avoid potentially harmful effects of therapy, such as inducing false memories of trauma. We use general questions, without descriptions of possible outcomes, and nonverbal techniques for collecting information about the patient's attitudes and feelings, as well as art projects and collages. Counselors who work with trauma patients are trained to match verbal information to body language expressions. A part-time psychiatrist and part-time nurse-practitioner regularly review cases and monitor medical aspects of the patients' treatment.

We believe that our gender-specific services are the reason why women who come to CODA today remain in treatment as long as men and obtain outcomes that are roughly as successful as men's. Our internal statistics show that 70 percent of women patients complete residential treatment if they stay beyond 2 weeks in the program. Implementation of specialized trauma treatment increased rates of completion in the same residential program to 87 percent. This is a marked change from 15 years ago, when the gap between men's and women's treatment responses led us to introduce gender-specific services.

Treatment Objectives of CODA's "Deep Emotional Therapy" for Women

Patients learn to:

- develop personal definitions of what it means to be a woman;
- develop a sense of purpose in life;
- move away from illness and toward recovery;
- revise their personal sense of meaning;
- see themselves in connection with the universe (self, others, animals, plants);
- understand how their actions can have impact on all relationships;
- define their strengths and build on them.

Patients engage in healthy self-creation through learning to:

- invest in a personal code of honor;
- use their personal power to make life choices;
- take charge of their own spirit;
- heal all wounds;
- practice new, positive ways of treating themselves.

Patients learn to build relationships with others by:

- balancing nurturing and assertive energies;
- practicing compassion and forgiveness;
- practicing healthy beliefs;
- bonding with others out of strength.

PROGRAM ORIENTATION AND GOALS

CODA utilizes a biopsychosocial and spiritual model of treatment to address our patients' problems with their addiction, mental and physical health, and spiritual growth. Program elements include case management, individual and group therapy, spirituality groups, child care, parenting classes, family and couples therapy, and living skills classes. Almost all therapy groups have educational and motivational components in addition to skill training.

In action therapy, patients adopt roles and act out situations or perform rituals related to their problems.

The aim of the program is to help each patient build a strong, conscious commitment to recovery and integrate into the community. Toward that end, we have adapted our program to respond to key characteristics that distinguish female drug abusers from their male counterparts, such as distinct reasons for starting and continuing drug abuse, patterns of use, psychosocial characteristics, reasons for relapse, and responsiveness to treatment. Important distinguishing features of women's drug abuse include the following:

- Women tend to have primary responsibility for child care and for managing the needs of other family members. A frequent impetus for a woman to leave treatment against medical advice is a phone call saying her children need her at home.

- Women experience higher levels of guilt, shame, depression, and anxiety about their addictions than do men (Reed, 1985). They are more likely to lack social support systems and to use drugs in isolation (Covington and Surrey, 1997).

- Women's addiction frequently is intertwined with issues of trauma (Stewart, 1996). Many women report that they began using drugs after a specific traumatic event in their lives (Doshan and Bursch, 1982; Kane-Cavaiola and Rullo-Cooney, 1991); incest and rape are common among the events cited (Hurley, 1991; Volpe and Hamilton, 1983). In studies of women in treatment, as many as 75 percent have reported sexual and physical abuse (Forth-Finegan, 1991; Miller et al., 2000; Root, 1989). Najavits and colleagues (1997) give estimates of posttraumatic stress disorder and indicate, "Women substance abusers, in particular, show high rates of this dual diagnosis (30 to 59 percent), most commonly deriving from a history of repetitive childhood physical and/or sexual assault." Other traumatic events that are reported to precipitate heavy drug use by women include physical illness, accidents, and disruptions in family life (Reed, 1985).

- Common triggers for relapse by the women we see at CODA include unresolved trauma, negative feelings about self, preoccupation with interpersonal problems, and thought patterns that lock women into the past.

ACTION THERAPY FOR WOMEN

For several years CODA has been offering a specialized group called "deep emotional therapy" to women who demonstrate sufficient stability on a mental health assessment. This group focuses on helping women develop strong, friendly relationships, reshape their beliefs, and develop a positive and constructive sense of themselves (see box, page 31). The group relies heavily on action therapy, an approach that includes drama therapy, psychodrama, and role training. In action therapy, patients adopt roles and act out situations or perform rituals related to their problems. Role-play and role reversal allow patients to portray their problems to themselves and others, see and experience the world from new perspectives, gain understanding and empathy, and practice new response patterns.

In psychodrama, for example, patients are asked to reenact real scenes from their lives that involve emotionally intense personal issues, such as childhood traumas or critical life dilemmas. The therapist guides the patient, who may play herself or another person in her life, and other group members, who also may portray the patient or others. The enactment provides emotional release and brings the patient's reactions and internal dilemmas into the open, where she—and the therapist and other group members—can witness and work on them. A patient who acts out a scene in which she relapsed to drug use, for example, may overcome a sense of shame and gain insight about avoiding future repetitions.

Drama therapy is similar to psychodrama, but the scenes portrayed are mostly imaginary or improvised, rather than taken from the patient's actual experience. The goal is usually to help the patient explore alternative choices that she can use to achieve better outcomes in life situations that have turned out badly for her in the past. A patient might, for example, play out the likely consequences of choosing relapse or sobriety. Alternatively, she might envision a type of person she would like to become and then practice being that person in various scenes and rituals.

Role training is used to equip patients with specific skills, such as refusing drugs, managing cravings, coping with stress, communicating, and asserting themselves. A patient might learn, for example, an automatic response to rapidly remove herself from high-risk situations for relapse, before drug craving kicks in and sabotages her thinking.

Action therapy is popular among our women patients, and we sometimes have waiting lists for admission to these groups. We have found that women using action-therapy techniques engage more strongly with treatment, stay in treatment longer, complete treatment more often, and express more satisfaction with treatment. Because taking imaginary roles provides a layer of emotional distance, psychodrama and drama therapy are relatively safe and controlled ways for those women who have histories of trauma to uncover and address deeply felt issues (Emunah, 1994).

Research on women's experience in general suggests that the relational nature of action therapy may be particularly effective with women. For instance, research has suggested that females tend to experience life more in terms of their relationships to others than to abstract goals and achievements (Gilligan, 1982). Action therapy is well suited to this orientation because the patient interacts with others—whether actually present, remembered, or imagined. Given their primary focus on relationships, women conceive of change most readily in terms of altered relationships. In role playing, women can practice taking new stances in existing relationships or work out how it will feel to have new, more positive relationships.

The use of action therapy and its component techniques has not been proven scientifically in clinical trials. Given action therapy's theoretical basis in previous research on women's experiences and responses, and given our strong clinical impression that it may explain a portion of the improved outcomes we have obtained with our women patients over the years, we believe such trials are warranted. By confirming or discounting our impression that action therapy is effective, and by identifying optimal uses of its components, clinical trials could be of great value in addressing the unique treatment needs of women patients.

APPROACHING ISSUES OF TRAUMA

For women with trauma-related issues, the appropriate handling of those issues can be key to successful drug abuse treatment. At one time, clinicians generally seemed to agree that it was best to avoid dealing with a patient's abuse or trauma until she had achieved a reasonable period of abstinence—about 1 year. However, if highly charged, painful experiences are motivating factors for continuing drug abuse, many patients may be unable to maintain abstinence if their treatment ignores these issues.

Today, the consensus on when to raise questions about trauma has gone to the other extreme: Most programs now routinely ask patients detailed questions about their abuse histories in the intake interview. This practice recognizes that if a patient has had traumatic experiences, they can strongly affect the appropriate direction of treatment. For example, some women must be stabilized from acute trauma before they can proceed effectively with a drug abuse intervention. In light of a history of trauma and other factors, a woman may best be assigned to a women-only treatment model or to a counselor with special skills in treating traumatized patients. Or she may potentially benefit from involvement in a specialized support group—for example, survivors of incest or domestic abuse, or women-only Narcotics Anonymous. Moreover, patients who are currently suffering abuse need immediate attention to their safety.

Elements of CODA's Action Therapy

- **Psychodrama:** Reenactment of real scenes from life to provide emotional release and enhance understanding of past crises.
- **Drama therapy:** Portrayal of imagined scenes to help reveal alternative behavior choices.
- **Role training:** Practicing new skills and behaviors to prepare for future decision-making.

Despite the value of information about abuse and trauma, probing for possible history of such experiences before the patient is fully engaged in therapy is a delicate matter. On the one hand, patients approach treatment with their own agendas and may give a higher priority to relief from trauma-related emotional pain than to freedom from drugs. Unless they receive assurance that the program can help with their trauma-induced pain, they may leave. On the other hand, our experience and observations have convinced us that emotional reactions to questions about abuse and trauma may be a main reason some patients do not return after the initial interview. Most people are fearful and highly conflicted when they present for drug abuse treatment. Women, especially, experience high levels of guilt, shame, depression, and anxiety about their addictions. Intuitively, it seems likely that compounding these difficult feelings with the pain that accompanies recollections of abuse and trauma can drive patients away and even set off episodes of drug taking.

Our experience and observations have convinced us that emotional reactions to questions about abuse and trauma may be a main reason some patients do not return after the initial interview.

The counselor's goal in the initial interview is to obtain enough information to determine whether factors related to physical or sexual abuse will play a part in treatment, not to obtain complete details or to trigger reexperience of any abuse or trauma. Later, during treatment, the counselor/therapist working with the patient will address any abuse issues and the patient's perceptions and feelings regarding abuse. At CODA, our guidelines are as follows.

First, *counselors must convey to every patient in initial assessment that the counselor understands issues of abuse and other traumatic experiences and that the program can help patients who have suffered them.* The

message can be conveyed in general language that does not force patients with traumatic histories to confront those experiences; for example, the counselor may say, "Many women have issues around physical and sexual trauma, and treatment offers an opportunity to work past them." Second, *counselors must determine whether the patient is in a crisis related to ongoing abuse or recent trauma that calls for immediate attention.*

Third is a key concept, but one that leaves much to the counselor's discretion: *Counselors should obtain the information necessary for a preliminary treatment plan, but probing further into any traumatic experiences the patient may have had should take place only during therapy, rather than during assessment.* In practice, during the initial interview, CODA therapists focus on establishing an empathetic bond, avoid direct questions about trauma, and observe the patient's emotional reactions before proceeding to more pointed questions. If the counselor picks up indications of trauma or abuse, but senses no immediate crisis, the counselor usually will delay focusing on those issues until later sessions. At that time, the therapeutic relationship will have had time to mature and the counselor will be better able to provide support. The counselor will know the patient better and can more accurately assess the effects of past traumas on the patient's anxiety level, sense of herself, and social phobias.

Some standard assessment tools can be used later to measure anxiety and depression: These are the Somatic, Cognitive, Behavioral Anxiety Inventory (Lehrer and Woolfolk, 2000) and the Costello-Comrey Depression and Anxiety Scales (Costello and Comrey, 2000).

The CODA guidelines for approaching issues of trauma conflict with many States' mandates to obtain information about sexual and physical abuse during intake interviews. However, the purpose of these mandates is related not to drug abuse treatment, but to the States' general data collection. In addition to our belief that following these mandates may actually cause failure to engage some women in therapy, we question the quality of the data collected. Very often patients provide incomplete or inaccurate information on such topics because they are not yet ready to reveal their experiences or do not feel safe doing so.

We believe CODA's guidelines keep more patients actively engaged in treatment. The guidelines are very general, however. Scientific studies would be very useful—to CODA and, we believe, to drug abuse treatment programs in general—that could provide precise and objective information about the best timing and methods for raising questions about abuse and trauma in therapy. Key study aims would be:

- What questions, when asked in the initial assessment, are associated with lower rates of patients' engagement in therapy?

- How do various questions about abuse and trauma—or ways of asking them—affect drug abuse patients' anxiety levels, as measured by available anxiety scales?

- What techniques can counselors use to recognize when questions about abuse and trauma start to push the patient into a counterproductive emotional reaction?

- While a number of instruments have been tested and validated for assessing trauma histories, none has been tested for its ability to promote—or its danger of reducing—treatment engagement of women. Can a questionnaire be constructed to assist the counselor in the intake interview, with cutoffs when the patient's responses signal that further probing could be dangerous?

SUMMARY AND CONCLUSIONS

Action therapy appears to be useful with women in CODA's drug abuse programs, in particular those who have achieved at least 30 days' abstinence and are stable both physically and mentally. Patients who have unresolved trauma or relational issues appear to benefit from action therapy; however, clinical trials of patient outcomes are needed to confirm this impression. We would welcome such trials, which could also provide programs with guidance on the optimal uses for such action therapy component techniques as are proven effective with women drug abusers.

Our observations suggest that the timing and manner in which counselors identify and approach trauma-related issues affect whether women engage in drug abuse treatment and how well they do, but the absence of systematic study leaves counselors with only their own clinical instincts to guide those decisions. Researchers could provide a great service by working with clinicians to generate and validate a standardized assessment tool to enhance clinicians' identification of trauma and clients' vulnerability to the issue. Such a tool could be used to select appropriate interventions in all stages of treatment.

CORRESPONDENCE

Ann Uhler, M.A., CODA, Inc.,1027 East Burnside, Portland, OR 97214; e-mail: AnnUhler@codainc.org.

REFERENCES

Costello, C.G., and Comrey, A.L., 2000. Costello-Comrey Depression and Anxiety Scales (CCDAS, 1967). In K. Corcoran and J. Fischer (eds.), *Measures for Clinical Practice: A Sourcebook*. 3rd Ed. (2 vols.) New York: Free Press, vol. 2, pp.213-218.

Covington, S.S., and Surrey, J.L., 1997. The Relational Model of Women's Psychological Development: Implications for Substance Abuse. In R.W. Wilsnack and S.C. Wilsnack (eds.), *Gender and Alcohol: Individual and Social Perspectives.* New Brunswick, NJ: Rutgers Center of Alcohol Studies, pp. 335-351.

Doshan, T. and Bursch, C., 1982. Women and substance abuse: Critical issues in treatment design. *Journal of Drug Education* 12(3):229-239.

Emunah, R., 1994. *Acting for Real: Drama Therapy: Process, Technique, and Performance.* New York: Brunner/Mazel.

Forth-Finegan, J.L., 1991. Sugar and Spice and Everything Nice: Gender Socialization and Women's Addiction_A Literature Review. In C. Bepko (ed.), *Feminism and Addiction.* New York: Hawthorn Press, pp. 19-48.

Gilligan, C., 1982. *In a Different Voice.* Cambridge, MA: Harvard University.

Hurley, D.L., 1991. Women, alcohol and incest: An analytical review. *Journal of Studies on Alcoho*l 52(3):253-268.

Kane-Cavaiola, C., and Rullo-Cooney, D., 1991. Addicted women: Their families' effect on treatment outcome. *Journal of Chemical Dependence and Treatment* 4(1):111-119.

Lehrer, P.M., and Woolfolk, R.L., 2000. Somatic, Cognitive, Behavioral Anxiety Inventory (SCBAI). In K. Corcoran and J. Fischer (eds.), *Measures for Clinical Practice: A Sourcebook.* 3rd Ed. (2 vols.) New York: Free Press, vol. 2, pp. 793-798.

Miller, B.A.; Wilsnack, S.C.; and Cunradi, C.B., 2000. Family violence and victimization: Treatment issues for women with alcohol problems. *Alcoholism: Clinical & Experimental Research* 24(8):1287-1297.

Najavits, L.M; Weiss, R.D.; and Shaw, W.R., 1997. The link between substance abuse and posttraumatic stress disorder in women: A research review. *American Journal on Addictions* 6(4):273-283.

Reed, B.G., 1985. Drug misuse and dependency in women: The meaning and implications of being considered a special population or minority group. International *Journal of the Addictions* 20(1):13-62.

Rolfe, B., 1977. *Behind the Mask.* Oakland, CA: Persona Books.

Root, M.P.P., 1989. Treatment failures: The role of sexual victimization in women's addictive behavior. *American Journal of Orthopsychiatry* 59(4):542-549.

Stewart, S.H., 1996. Alcohol abuse in individuals exposed to trauma: A critical review. *Psychological Bulletin* 120(1):83-112.

Volpe, J., and Hamilton, G., 1983. How women recover: Experience and research observation. *Alcohol Health & Research World* 11(1):46-47.

RESPONSE: TREATING WOMEN ON THEIR OWN TERMS

R. Lorraine Collins, Ph.D., William Cornely, M.H.S., and Christine Grella, Ph.D.

We don't know what strategies work better or worse for eliciting sensitive information, such as a history of trauma, and this can have a major impact on the treatment process.

Christine Grella: The authors describe a very good program and it may be that the role playing is tied up with other characteristics of the program that may be efficacious. They suggest that they have seen improvement in outcomes for women in their program since they instituted the women-only treatment components. But it may be that they have very well-trained staff, it is a well-run program, that there are other program-related characteristics associated with their good outcomes, and that the role-playing component is part of it. We don't know because we don't have data. The role playing should be isolated and tested.

Lorraine Collins: I think we have to separate out how patients feel and react when they are in a therapeutic setting and what therapy enables them to do when they are back home 6 months later. A woman might really feel good and be able to role-play assertiveness or whatever in the therapy setting, but then be unable to assert herself when she has moved outside of the clinical setting. You may find that the treatment has not actually been effective. In the case of any promising treatment, followup is very important when you look at outcomes, especially in the first 3 months, when we know a lot of relapsing occurs.

William Cornely: One of the mistaken beliefs among providers is that people can enter a program and have talk therapy for 30 to 60 days and then experience some sort of event—'break through' their trauma issues. But it's a much more complex and lengthy process than that.

Grella: The authors are correct that we don't know what strategies work better or worse for eliciting sensitive information, such as a history of trauma, and that this can have a major impact on the treatment process. And they are correct in suggesting that we need empirical studies of different methods for eliciting such information.

We have looked at the issue in terms of whether traumatized women will stay in treatment and what the impact on the treatment process would be; for example, how will women's HIV risk behaviors, which can be related to trauma experience, be affected?

Collins: I support what the authors are saying about women, because that is the group where most trauma occurs. But it might be worth mentioning men also, because of what we know about risky sexual behavior and, often, trauma of young men related to sexuality issues.

There is a type of communication research that could be relevant here. For instance, the research we have suggests that people are willing to disclose certain kinds of information—such as their alcohol consumption and drug use—to computers, though they would not disclose face-to-face. You can do the intake [interview] as a warm, 'let's get to know each other' session, where you put the patient in front of a computer, let him or her respond to whatever questions you put there, and then filter the results through the warm get-together later. That would be very easy to study.

At our research institute, we have a clinical research center where all of our clients go through a computerized assessment that we call our 'core data base.' And they seem to handle it really well—men and women, alcohol and drug problems. I don't have specific information about trauma, though.

The computer programs are efficient because of the way linkages are programmed, but a particular treatment facility might find that kind of software development expensive. Once the programming is done, though, it can be used across a number of settings. It's not as though each facility would have to create a new system.

Grella: The best source of guidance would be our patients: We could design a study of individuals who have gone through treatment—perhaps through different modalities—and ask them when they would be most comfortable and how—in what format—they would be most comfortable providing this kind of sen-

sitive information. I think if we elicited those suggestions from patients, we could set up a sound design to test different approaches empirically.

Cornely: With Dr. Thomas McLellan at Treatment Research Institute, we are going to start testing a system in September: Half of the women will fill out a computerized version of the Addiction Severity Index and half will have the traditional questionnaire.

Collins: I think that's a great start. If the computerized approach works, then it would be much more efficient once the investment in hardware and software has been made.

Grella: I don't think we're going to find one single method that will work for all women, let alone all men and women. It is going to depend on lots of different variables: How recent was the trauma? How severe? I would like to see a discussion of the variability in traumatic experience and how women present it and, therefore, the impact on assessment and treatment processes. Some events might be very distal and not associated with the client's immediate needs. The next step seems to be eliciting information about the reaction, severity, centrality of the trauma for the individual in treatment.

Cornely: The level of staff training and education with trauma varies across programs. My experience has been that many treatment personnel enter into counseling without any training. That can also be detrimental. Some sort of questionnaire is needed to assess the staff's level of training and awareness of the issues of sexual abuse, incest, and the like. People can take a course or two and think they are experts, but I have seen counselors do harm. &