

# Traumatic Victimization Among Adolescents in Substance Abuse Treatment:

## *Time to STOP IGNORING the Elephant in Our Counseling Rooms*

BY MICHAEL L. DENNIS, PhD

In more than a decade of work teaching addiction counselors how to do better intake assessments to guide their care, I've come to realize that the issue of traumatic victimization is an unspoken elephant in our counseling rooms. Physical, sexual, and emotional abuse is the norm, with the clinical implications increasing as a function of severity of the trauma (e.g., repeated exposure, someone trusted involved, multiple people involved, fear for life, sexual penetration, etc.). Though their clinical staff are legally designated as "mandated reporters," many substance abuse treatment programs do not systematically screen for victimization, and staff members often express concerns that (particularly early) screening might disrupt rapport (leading to early dropout) and/or that they have neither the training nor specialized services to address these needs. This is directly at odds with expert recommendations (CSAT, 1993, 1999, 2000; Dennis & Stevens, 2003) that have consistently encouraged early systematic screening and intervention among adolescents entering substance abuse treatment.

These expert recommendations are based on four major research findings.

*Physical, sexual, and emotional abuse is the norm, with the clinical implications increasing as a function of severity of the trauma.*

First, studies of adolescent substance users presenting for treatment have generally estimated that 40 to 90 percent have been victimized. The rates for these estimates increase when more detailed assessments are used. Second, 20 to 25 percent of these adolescents report being victimized in the past 90 days, or report concerns about it occurring again in the near future. Third, the severity of victimization interacts with level of care to predict outcomes and should be considered in initial placement decisions. Fourth, contrary to staff concerns, rapport and retention can be improved by early systematic screening achieved via multidimensional assessment instruments and competent interviewing. This article reviews several issues related to the prevalence, consequences, impact

on treatment outcomes, and implications for practice of traumatic victimization among adolescents presenting for substance abuse treatment.

### **Prevalence rates of victimization**

Because clinicians, researchers, and policy makers use several different definitions of victimization, estimates of the number of adolescents who are abused or victimized in the United States range from 826,000 to 3,000,000 or 3 to 12 percent of the U.S. population ages 12 to 17 (DHHS, 2001; Sedlack & Broadhurst, 1996). In a study of 803 adolescents admitted to 23 adolescent treatment programs in four major U.S. cities (Pittsburgh, Minneapolis, Chicago, and Portland, Ore.) and staying at least a month, 39 percent of the males and 59 percent of the females acknowledged a lifetime history of physical or sexual victimization when interviewed a month after intake (Grella & Joshi, 2003). In a second study of 214 (132 males, 82 females) adolescents admitted to 11 substance abuse treatment programs in three Illinois communities (Bloomington, Chicago, Dupage County), 48 percent of the males and 80 percent of the females acknowl-

edged a lifetime history of physical, sexual, or emotional victimization at intake (Titus, Dennis, White, Scott & Funk, 2003). Though rates vary by level of care, more than half of the adolescents in all levels of care report histories of victimization. Figure 1 shows the lifetime, past-year, and past-90 day rates of victimization based on data from 1,545 adolescents admitted to 14 adolescent treatment programs in 10 cities (Baltimore, Bloomington, Ill., Catonsville, Md., Los Angeles, Miami, New York, Oakland, Calif., and Phoenix, Shiprock, Tucson, Ariz.), (Adolescent Treatment Models [ATM] Cross-Site Analysis Workgroup Meeting, 2002).

Although physical, sexual, and emotional abuse can occur independently, it is somewhat common to see co-occurrence of multiple forms of victimization (being attacked with a weapon, physical abuse, sexual abuse, emotional abuse), a range of "traumagenic" factors (e.g., happening more than once, involving someone you trusted, where you feared for your life, where people did not believe you), and differences in ongoing concerns about

being victimized again. These factors have been combined into a dimensional measure called the GAIN's General Victimization Index (GVI; Dennis et al., 2003; Titus et al., 2003) that helps to address reluctance to report some acts (e.g., reporting sexual assault) and is a better predictor of consequences/outcomes than the individual measures of victimization on which it is based. Figure 1 also shows (in second column) the percentage of adolescents by level of care in the "acute" range on GVI (which is discussed further below).

### Consequences of victimization

A lifetime history of victimization is associated with higher rates of substance use and HIV-risk behaviors at intake; high levels of traumatic victimization (based on the GAIN's GVI measure including multiple types, incidents, traumagenic factors and ongoing concerns) are further associated with more symptoms related to substance use disorders and co-occurring health and mental health problems (Stevens, Murphy, & McKnight, 2003; Titus et al., 2003). While there are significant

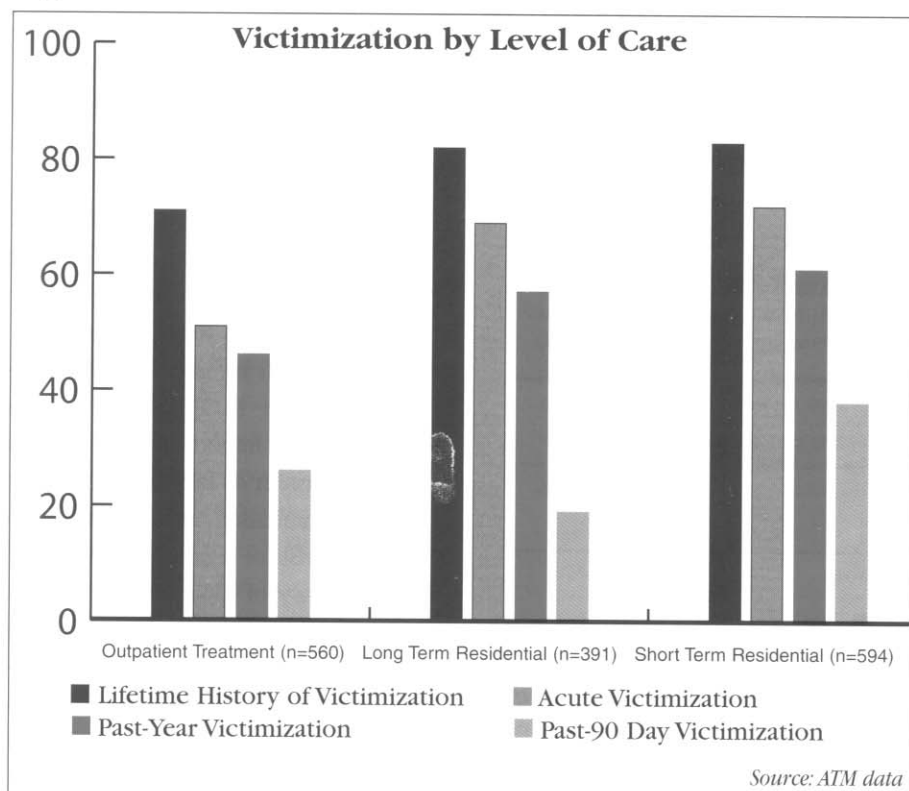
gender differences in the rates of victimization, the relationship between victimization and these other problems are primarily related to the traumatic severity of the victimization that has occurred.

One of the most prominent effects of child maltreatment is a dramatic increase in symptoms of traumatic distress (e.g., re-experiencing, avoiding, numbing, hyperarousal) that are sometimes referred to as complex posttraumatic stress disorder (PTSD) or disorders of extreme stress. It is important to realize that the traumatic distress resulting from child maltreatment frequently does not fit traditional PTSD-criteria, which were originally developed for adults exposed to a specific traumatic event in the past (e.g., combat, rape, natural disaster) (see Foa, Keane, & Friedman, 2000). For adolescent victims, there often are different types of ongoing multiple victimization incidents (the first of which are not even known). Yet, they have as much (or more) clinical significance. In a study of 378 adolescents from four substance abuse treatment programs in the state of Arizona, the number of traumatic distress symptoms went up with the severity of victimization (measured with GVI). For females, higher levels of distress were associated with higher levels of substance use, mental health, and physical health problems as well as greater HIV-risk behaviors, while differences were smaller or not significant for males (Stevens, Murphy, & McKnight, 2003).

### Impact on outcomes

Traumatic victimization is also related to the response to treatment. High levels of traumatic victimization (measured with GVI) and being female are associated with larger reductions in days of victimization and substance use between the three months before and after treatment (Titus et al., 2003). A study with data from 73 outpatient and 114 inpatient adolescents from Bloomington, Ill., further demonstrates a complex relationships with level of care (Funk et al., 2003). Across levels of care in Figure 2, adolescents with high levels of

**Figure 1**



traumatic victimization (measured with GVI) have higher rates of substance use. Adolescents with high GVI scores in inpatient treatment respond to the treatment (i.e., reduce their substance use) while those in outpatient treatment do not (Funk et al., 2003). This is not to say that no outpatient treatment program will work, merely that it will be more difficult (particularly if abuse is ongoing).

Continued child maltreatment also was associated with the long term victim-to-abuser spiral in a study of 446 adolescents admitted to nine therapeutic community (TC) programs located in the United States and Canada (Hawke, Jainchill, & De Leon, 2003). Approximately 40 percent reported histories of childhood abuse at intake and 52 percent reported additional abuse experiences following separation from TC

treatment. Moreover, 58 percent of the adolescents indicated they engaged in serious violent behaviors (e.g., beatings, threatening or using weapons against other people, or violent crimes such as assaults, rapes, murders) toward others in the five years following their separation from TC treatment. The investigators found that the primary predictor of this post-treatment violence toward others was ongoing or subsequent victimization. Males reported higher rates of violence and physical victimization than females, and females reported higher rates of sexual victimization. The findings suggest that violence in young adulthood for males is primarily related to increasing involvement in violent lifestyles that include drug trafficking, while violence among females is primarily associated with the social and

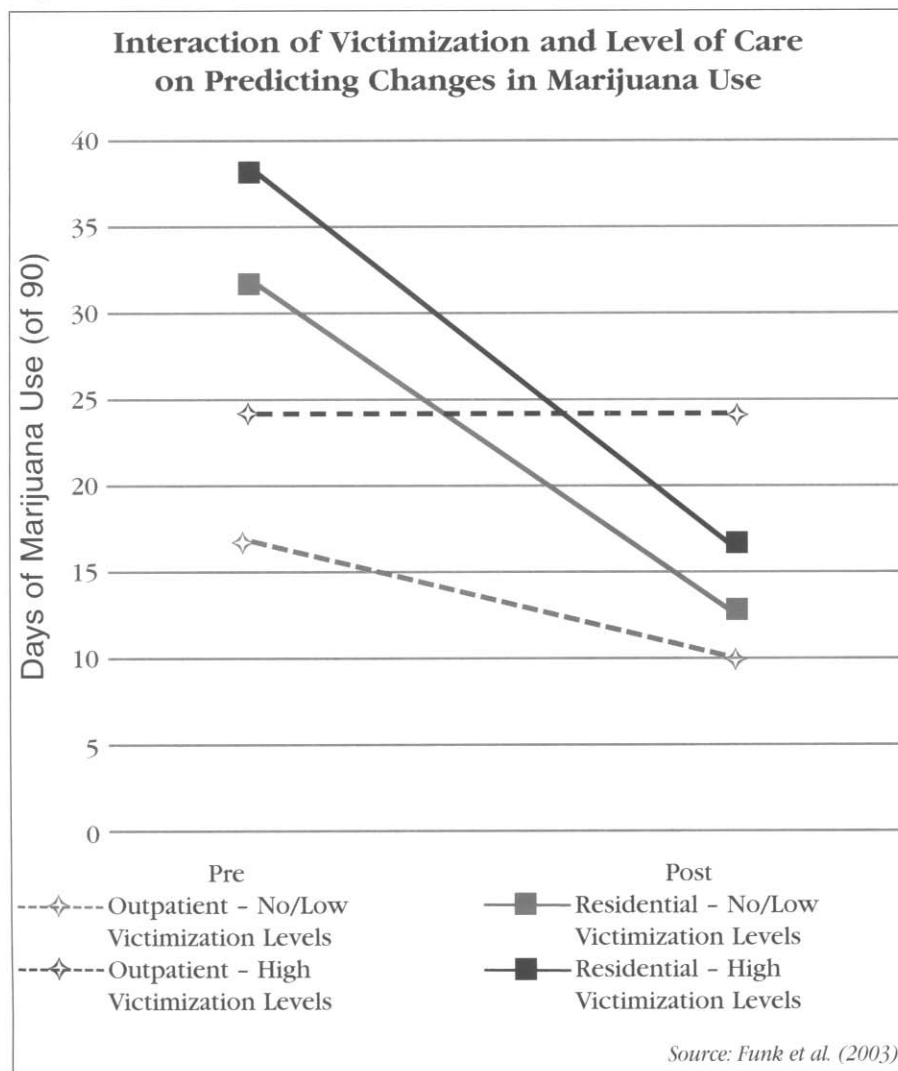
psychological consequences of drug involvement and victimization.

### Implications for practice

Traumatic victimization is relatively common, interacts with a wide range of other co-occurring problems, and relates to treatment placement and outcomes. It is time for the treatment field to open its eyes, make an honest appraisal of the totality of this elephant, and take concrete steps to address it. Some of the specific steps that can and should be taken include:

- *Systematically screen for victimization and the degree of trauma "at intake."* Including simple but explicit questions about victimization at intake and/or more detailed screener's to gauge the severity of trauma (e.g., the GAIN's General Victimization Scale — see [www.chestnut.org/li/gain](http://www.chestnut.org/li/gain)) can actually help to "normalize" the process for both clients and staff.
- *Train staff in how to respond to victimization,* not only in terms of mandated reporting, but the timing and facilitation of assessment, diagnosis, and treatment placement as well as intervention implications. Ideally, staff should be trained in the larger syndrome of outcomes associated with child maltreatment so if there is a pattern of traumatic distress, including health and/or somatic complaints, they are alerted to the possibility of victimization (or other major problems) that might have been missed by the screener.
- *Incorporate information about victimization into placement decisions.* It is important to understand the breadth of the trauma, recency of victimization, and current prevalence/risk of ongoing victimization. A history of high levels of trauma may suggest the need for additional mental health screening or treatment. Current or ongoing victimization may suggest the need to closely evaluate the recovery environment

**Figure 2**



and consider inpatient treatment to ensure the client's safety.

- *Recognize that addressing victimization is complex.* Initially it may be necessary to move the adolescent into a new or controlled environment to protect them. Family members can run the gambit from being very supportive, hurt/angry at the perpetrator, disbelieving, or they may even include one of the abusers. Even where there has been victimization, the adolescent will often still have a strong bond to the aggressor. It is important to provide staff training on these issues and/or partner with local social work agencies that have staff familiar with them. For these reasons, it usually is best to start working with people individually until a clear sense of the problem has been achieved and the individual's readiness for group-type activities is ascertained.
- *Recognize that there also will be incidents where a person is both a victim and an abuser.* Moreover, this may be playing out "during" the treatment period. Thus such adolescents may not be appropriate for group sessions, either emotionally or because they would put others in the group at risk.
- *Track victimization in diagnosis and for program planning.* Most programs have inadequate protocols or services to deal with victimization. It is, therefore, important to document the extent of the problems to guide your program planning and gain additional assistance from public and private funders (e.g., local children and family services, the Center for Substance Abuse Treatment, foundations). While there is no current diagnostic code for disorders of extreme stress related to child maltreatment, it is important to get the above information to funders and professional groups developing the next generation of guidelines.

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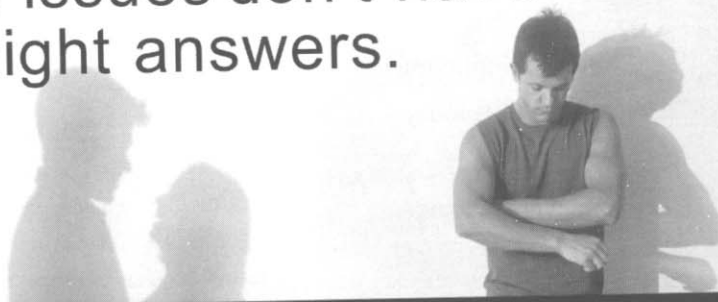


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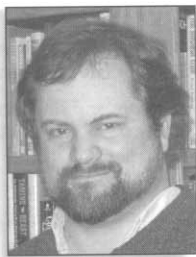
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• *Address other staff concerns about screening for victimization.* Many staff are personally uncomfortable talking about victimization and project their feelings onto the client. This can be because they have no frame of reference (which can lead to disbelief or blaming the victim) or because they have personal experiences with victimization (often for which they received little or no help). Ideally, part of training staff will include time for them as individuals to explore and address these issues from their personal perspective. This will help them keep the assessment focused on the client before them instead of their own personal issues.

The breadth of recommendations further demonstrates the need to see and address the total elephant, not just parts of it as we have in the past. We need to stop simply reporting prevalence and co-occurring problems and recognize the cluster of problems associated with child maltreatment and how they interact with outcomes over time. We need to replicate the matching effects found by Funk and colleagues (2003) with other programs and provide more explicit guidance for program placement. We also need to adapt or develop protocols for helping the victims of child maltreatment so that they can be more readily used in adolescent substance treatment programs. Finally, we need to rigorously evaluate their effectiveness in terms substance use, co-occurring problems, violence, and future victimization. ©



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#### References

- Adolescent Treatment Models (ATM) Cross-Site Analysis Workgroup (2002). *Summary report from June 27-28, 2002 meeting*. Rockville, MD: Northrop Grumman Information Technology Health Solutions and Services Division.
- Center for Substance Abuse Treatment (CSAT; 1993). *Screening and assessment of alcohol- and other drug-abusing adolescents, Treatment improvement protocol series, Number 3* (No. 93-2009). Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Center for Substance Abuse Treatment (CSAT; 1999). *Screening and assessing adolescents for substance use disorders, Treatment improvement protocol series, Number 31* (No. 99-3344). Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Center for Substance Abuse Treatment (CSAT; 2000). *Substance abuse treatment for persons with child abuse and neglect issues, Treatment improvement protocol series, Number 36* (No. 00-3357). Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Dennis, M. L., & Stevens, S. J., (Eds.). (2003). Maltreatment issues and outcomes of adolescents enrolled in substance abuse treatment [special issue]. *Journal of Child Maltreatment, 8*(1): 3-6. See <http://www.sagepub.com/journalIssue.aspx?pid=15&jid=6072>
- Dennis, M. L., Titus, J. C., White, M., Hodgkins, D., & Unsicker, J. (2003). *Global Appraisal of Individual Needs (GAIN): Trainer's Training Manual and Resources*. Bloomington, Illinois: Chestnut Health Systems. Retrieved from <http://www.chestnut.org/li/gain>
- Foa, E. B., Keane, T. M., & Friedman, M. J. (2000). *Effective treatments for PTSD. Practice guidelines from the International Society for Traumatic Distress*. New York, NY: The Guilford Press.
- Funk, R., McDermeit, M., Godley, S. H., & Adams, L. (2003). Maltreatment issues by level of adolescent substance abuse treatment: The extent of the problem at intake and relationship to early outcomes. *Journal of Child Maltreatment, 8*(1): 36-45.
- Grella, C. E., & Joshi, V. (2003). Treatment processes and outcomes among adolescents with a history of abuse who are in drug treatment. *Journal of Child Maltreatment, 8*(1): 7-18.
- Hawke, J. M., Jainchill, N., & De Leon, G. (2003). Post-treatment victimization & violence among high risk adolescents following residential drug treatment. *Journal of Child Maltreatment, 8*(1): 58-71.
- Sedlack, A.J. & Broadhurst, D.D. (1996). *The third national incidence study of child abuse and neglect (NIS-3)*. Washington, D.C.: U.S. Department of Health and Human Services.
- Stevens, S. J., Murphy, B. S., & McKnight, K. (2003). Traumatic stress and gender differences in relationship to substance use, mental health, physical health, and HIV risk behavior in a sample of adolescents enrolled in drug treatment. *Journal of Child Maltreatment, 8*(1): 46-57.
- Titus, J.C., Dennis, M.L., White, W.L., Scott, C.K., & Funk, R.R. (2003). Gender Differences in Victimization Severity and Outcomes Among Adolescents Treated for Substance Abuse. *Journal of Child Maltreatment, 8*(1): 19-35.
- U.S. Department of Health and Human Services. (2001). *Child Maltreatment 1999*. Washington, DC: U.S. Government Printing Office.