As we sharpen our ability to treat dual disorders, it is pertinent that we develop the ability to treat trauma.

Trauma can be caused by a variety of experiences, including but not limited to, childhood physical abuse, incest, sexual abuse, rape, torture, domestic violence, or witnessing extreme violence. People who experience trauma often report having nightmares, nervousness, depression, extreme anxiety, and flashbacks years after the traumatic experience(s).

Left untreated, unresolved feelings around trauma can lead to psychiatric decompensation and/or a return to drug use. If we looked closely at patterns, we might see that some clients become sober and/or psychiatrically stable. While stable, they become overwhelmed as feelings around the trauma begin to surface. Guilt, shame, and anxiety surface, and the client deals with these feelings by returning to drug use or by gradual decompensation.

A review of numerous research studies reveals that 60% to 85% of chemically dependent women were either sexually abused as girls or raped as women. According to Jean Kinny, chemically dependent women also report more recent episodes of violence when they enter treatment. Sherryl Hubbard, a chemical dependence women’s specialist, believes that recent episodes of domestic violence can be a major relapse trigger for chemically dependent women. Sherryl states, “Many of my clients continue to use drugs because of the abuse.”
Combine chemical dependence with mental illness, and the problem is further exacerbated. Women in the midst of psychiatric crisis are at greater vulnerability of abuse or assault. Department of Mental Health statistics reveal that 90% of mentally ill women who are homeless have experienced sexual trauma.

During the early phases of the development of MISA treatment in the 1980s and 1990s, emphasis was placed on defining a dual disorder, stages of change, and the development of the components of a MISA program. Perhaps we are at a phase in the development of MISA treatment in which we can start to become more specific in our approach to treatment. A starting point would be on a focus on treating trauma. We could begin our journey by receiving training and learning as much as we can about working with clients who have experienced trauma. As a field, we often make referrals when we do not have the expertise to address some of our clients’ areas of concern. Perhaps this can work okay for a while. We should keep in mind that many clients who were traumatized or who were victims of sexual abuse as children often told someone early on about their abuse. They often report that the first person they told didn’t want to hear the story or shunned or shamed them. This made it difficult for them to tell their stories again. Perhaps when we make outside referrals for clients who report having experienced trauma, we may inadvertently be sending a message to the client, “I don’t want to hear it.” As we develop our ability to work with clients around trauma, they will be able to receive treatment for their whole experience.
ABOUT THE AUTHOR

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