Female Survivors of Child Sexual Abuse:
Subsequent Substance Use Disorder and Effective Therapies
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Female Survivors of Child Sexual Abuse: Subsequent Substance Use Disorder and Effective Therapies

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Abstract

A literature review was conducted of peer reviewed articles related to the effects of child sexual abuse (CSA) on female survivors. Substance use disorder (SUD) was shown as a common subsequent outcome of CSA. The relationship between child sexual abuse (CSA) and diagnosed posttraumatic stress disorder (PTSD) that leads to a substance use disorder (SUD) was examined. The symptoms of posttraumatic stress disorder have negative effects to the survivors' self-concept and can cause emotion dysregulation. Substances were often used by survivors to tolerate these symptoms. Therapy models that were successful for treating these disorders were examined. Research showed that the use of cognitive behavioral therapies, especially cognitive processing techniques, are the most successful in the treatment of clients with these diagnoses.

Keywords: child sexual abuse, sexual abuse and trauma, female trauma survivors, substance use disorder, self-medicating, numbing, therapies for treating trauma, cognitive processing therapy, eye movement desensitization and reprocessing, EMDR, in-vivo, exposure therapy, narrative therapy

Child sexual abuse (CSA) is a growing public health problem that affects an extraordinary number of children every year. According to McLean et al. (2014), it was estimated that 135,300 children became victims of childhood sexual abuse each year in the United States. As many as 88% of those children developed posttraumatic stress disorder (PTSD) by adolescence (McLean et al., 2014). The main path to developing a substance use disorder (SUD) as a result of childhood sexual abuse is due to the initial development of PTSD (Ulibarri et al., 2015). What factors have caused childhood sexual abuse victims to develop posttraumatic stress disorder? How does PTSD increase the likelihood of a subsequent substance use disorder? How does the use of therapies for the treatment of PTSD due to childhood sexual abuse lower the probability that the survivor will develop a subsequent substance use disorder? What treatment modalities might be effective?

Statement of the Problem

Victims of child sexual abuse (CSA) often develop posttraumatic stress disorder (PTSD). It is common that these victims develop a substance use disorder (SUD) to numb the PTSD symptoms. What therapy-driven treatment modalities might be effective for reducing PTSD symptoms derived from childhood sexual abuse?

Significance of the Study

According to the Administration for Children and Families (2020), in the United States in 2018, 678,000 children were determined to be victims of maltreatment, up from 674,000 victims in 2017. Of those children, 47,460 were sexually abused (Administration for Children & Families, 2020). According to the Division of Violence Prevention (2020), in 2015 one in four females in the United States had experienced child sexual abuse at some point in childhood (Division of Violence Prevention, 2020). The mental health and behavioral consequences

included depression, posttraumatic stress disorder, substance abuse, and suicide or suicide attempts (Division of Violence Prevention, 2020). In 2015, the total lifetime economic burden of child sexual abuse in the United States reached $9.3 billion (Division of Violence Prevention, 2020). A related crisis affecting children in the United States is that human sex trafficking is on the rise. Information obtained for the year 2020 stated that the Office for Victims of Crime (OVC) managed the largest amount of federal funding dedicated to providing direct services to survivors of human trafficking in the United States (Office for Victims of Crime, 2020). According to the Office for Victims of Crime (2020), from July 2018 through June 2019 human trafficking grantees who received federal funding reported serving 8,375 clients (Office for Victims of Crime, 2020). This was up 5,090 new clients from the previous reporting period (Office for Victims of Crime, 2020). Twenty-one percent of these clients were minors and 82% were female (Office for Victims of Crime, 2020). These figures were only inclusive of the survivors who were found and who sought help. The problem is likely much larger. It is critical that effective therapeutic modalities are being used in the treatment of child sexual abuse survivors.

Purpose of the Study

The purpose of this study is to provide therapists with information about how to effectively treat the symptoms of posttraumatic stress disorder (PTSD) in female survivors of child sexual abuse (CSA) to prevent or treat the development of subsequent substance use disorders (SUD).

Definition of Terms

Catastrophizing: “To exaggerate the negative consequences of events or decisions. People are said to be catastrophizing when they think that the worst possible outcome will occur from a

particular action or in a particular situation or when they feel as if they are in the midst of a catastrophe in situations that may be serious and upsetting but are not necessarily disastrous" (American Psychological Association, n.d.-e)

Child sexual abuse (CSA): "Any sexual contact with a child through the use of force, threat, or deceit to secure the child's participation, or any sexual contact with a child who is incapable of consenting by virtue of age (particularly pre-pubescent children), disability or power differential" (Karakurt & Silver, 2013, p. 79).

Complex posttraumatic stress disorder (C-PTSD): "The pathology of trauma subjects with a background of repetitive and chronic traumas" (Barglow, 2014, p. 125).

Emotion regulation (ER): "A set of interrelated psychological and physiological processes that allow individuals to modulate feelings, behaviors, and physiological responses to events that elicit emotion" (Mandavia, 2016, p. 423).

Dysthymia: "Generally, any depressed mood that is mild or moderate in severity" (American Psychological Association, n.d.-j).

Generalized anxiety disorder: "Excessive anxiety and worry about a range of concerns…accompanied by such symptoms as restlessness, fatigue, impaired concentration, irritability, muscle tension, and disturbed sleep" (American Psychological Association, n.d.-m).

Intervention: "Generally, any action intended to interfere with and stop or modify a process, as in treatment undertaken to halt, manage, or alter the course of the pathological process of a disease or disorder" (American Psychological Association, n.d.-n). "The selection of the intervention is guided by the nature of the problem, the orientation of the therapist, the setting, and the willingness and ability of the client to proceed with the treatment" (American Psychological Association, n.d.-n).

Major depressive disorder: “A mood disorder characterized by persistent sadness” (American Psychological Association, n.d.-o).

Posttraumatic Stress Disorder (PTSD): “A disorder that may result when an individual lives through or witnesses an event in which he or she believes that there is a threat to life or physical integrity and safety and experiences fear, terror, or helplessness” (American Psychological Association, n.d.-q).

Rumination: “Obsessional thinking involving excessive, repetitive thoughts or themes that interfere with other forms of mental activity” (American Psychological Association, n.d.-r).

Sex trafficking of a minor: “The recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age” (Office for Victims of Crime, 2020).

Substance use disorder (SUD): “A catchall diagnosis encompassing varying degrees of excessive use of a substance” (American Psychological Association, n.d.-u).

Delimitations of Research

A literature review was completed related to female survivors of childhood sexual abuse (CSA). Subsequent substance use disorders (SUD) were examined and therapy modalities that may be effective were identified. The research was limited to online government sites and professional organization sites, along with peer reviewed articles identified in the search engine provided by the Karrmann Library at the University of Wisconsin-Platteville. These resources were limited to those published from the year 2013 to present.

Method of Approach

Research was done to discover the therapy modalities that may be most effective in the treatment of substance use disorders (SUD) that developed as a result of Childhood Sexual Abuse (CSA) in females. The search terms that initiated the study were "child sexual abuse" and "substance use disorder" and "therapy". After research was done using these terms, additional combinations of search terms were used.

- "sexual abuse" and "substance use" and "female"
- "child sexual abuse" and "substance use disorder" and "treatment"
- "child sexual abuse" and "substance use development" and "outcomes"
- "child sexual abuse survivors" and "substance use development"
- "rape victims" and "treatment"
- "sexual assault victims" and "therapy"
- "sexual assault victims" and "psychotherapy"
- "child sexual abuse" and "drug addiction"
- "victims of child sexual abuse" and "counseling strategies"
- "trauma" and "suicidality"
- "substance use disorder" and "spirituality"
- "sexual abuse" and "retraumatization"
- "sexual abuse" and "revictimization"
- "childhood sexual abuse" and "revictimization"

While reviewing the literature, a common theme was noticed. Substance use disorder (SUD) was commonly developed as a result of posttraumatic stress disorder (PTSD). PTSD was a response to the child sexual abuse, and a subsequent SUD developed to numb the symptoms of

the trauma. This information led to the inclusion of additional search terms such as “numbing”, “Post Traumatic Stress Disorder”, and “PTSD treatments”. Statistics regarding childhood sexual abuse (CSA), child maltreatment, human sex trafficking, and economic impacts were found via government sites. These sites were Division of Violence Prevention, Administration for Children and Families, and Office for Victims of Crime. When the word “female” was used in the search terms, the information was limited. However, information that pertained to child sexual abuse almost always assumed that the survivor was female. The information provided in this paper was in regard to females unless otherwise noted. The findings were summarized and synthesized in Chapter 2 of this paper. Conclusions and recommendations are included in Chapter 3.

Chapter Two: Review of Related Literature

According to Amado et al. (2015), 26%-28% of females worldwide experienced child sexual abuse (CSA). Child sexual abuse was much more likely to be experienced by females than by males. Approximately 8% of males experienced CSA worldwide (Amado et al., 2015). In 2015, one in four females in the United States were affected by CSA by the age of 18 (Division of Violence Prevention, 2020). In 2013, it was estimated that 20% of all females in the United States had experienced CSA (Sartor et. al., 2013). Internationally, in 2017 it was estimated that 19.7% of females experienced CSA before the age of 18 (Chang et. al., 2018). These statistics were thought to be much higher because many cases went unreported to authorities (McLean et. al., 2014). The sexual abuse was often kept secret due to feelings of guilt, shame, embarrassment, fear that the survivor would not be believed, and concern about the consequences toward themselves and the perpetrator (Foster & Hagedorn, 2014). Females seemed to develop more psychological injuries than males because they internalized the experience in a more personal way. Foster and Hagedorn (2014) stated that effects from CSA likely resulted in psychological damage that reached the core of the survivors' spirits. How were these females changed and influenced due to the negative psychological shifts to their self-structure?

Psychological Shifts to the Self-Structure due to Child Sexual Abuse

Female survivors of child sexual abuse (CSA) almost inevitably experienced destructive changes to their sense of self and to their worldview (Wright & Gabriel, 2018). Wright and Gabriel (2018) defined self-structure as "an element of an individual's personality which is fluid and develops as a child learns to organize and name experiences and integrate them into awareness" (p. 665). The most common symptom of child sexual abuse (CSA) is fear, followed

by sadness, anger, guilt, self-blame, confusion, and helplessness (Foster & Hagedorn, 2014). CSA had social, cognitive, academic, physical, spiritual, and emotional effects that might have become long-term if there had been no early intervention (Foster & Hagedorn, 2014). Several areas of the inner perspective of the self were skewed. The following is a list of challenges that might have developed when the female self-structure was affected by the experience of CSA:

- lack of trust of self and others
- denial of the abuse
- distorted victim identity
- dysfunctional acceptance and the loss of personal power
- disassociation and the resulting ideal of the absent self
- incongruent belief systems
- unhealthy interpersonal relationships (Wright & Gabriel, 2018)

Lack of Trust of Self and Others

Females who had experienced child sexual abuse (CSA) tended to feel a lack of safety with others, which created a hesitation to trust anyone, including those directly in their social circle (Parry & Simpson, 2016). They also found it difficult to trust themselves and their ability to make positive choices. Survivors of CSA developed negative beliefs that the world and its people were hostile and dangerous (Wright & Gabriel, 2018). These beliefs frequently continued throughout adulthood. The CSA survivors normalized this distrust as a response to the trauma they experienced (Parry & Simpson, 2016). As a result, mistrust and insecurity became the way CSA survivors felt about everything and everyone, which caused survivors to isolate from others as a form of personal and emotional protection. Often, the best way that survivors found to

avoid the fear that caused their distrust was to deny that the abuse had actually happened (Wright & Gabriel, 2018).

Denial of the Abuse

Survivors of sexual abuse often struggled with the idea that what they experienced was, indeed, abuse (Wright & Gabriel, 2018). Due to their distorted beliefs and thinking processes, the abuse experiences were ingrained into a core part of their identity. Denial of the abuse was often used as a form of self-protection from having to emotionally feel and cope with the tragic effects of what had happened to them (Wright & Gabriel, 2018).

Frequently, CSA was preceded by what is known as a grooming process. Grooming was a method used by a perpetrator to gain trust from the victim and perpetrators tricked victims into thinking that they were in debt to the perpetrator (Karakurt & Silver, 2013). This often involved the giving of gifts, individual attention, and special privileges offered over an extended period of time (Foster & Hagedorn, 2014). Victims then felt that they deserved what happened to them and that it was not wrong. Due to the grooming process, most survivors had never named their experience as actual abuse. They were unaware of the connection that the abuse had to their feeling, thoughts, and behaviors (Wright & Gabriel, 2018). These females who had experienced child sexual abuse adopted identities as victims instead of survivors.

Distorted Victim Identity

It was common that the child sexual abuse survivor had a sense of self that was significantly changed, which led to low self-esteem and feelings of unworthiness (Parry & Simpson, 2016). Survivors began to experience life as *victims* of child sexual abuse. The survivors may have developed the self-perception that they were, in some way, damaged and that there could be no resolution. This may have caused the survivors to feel vulnerable and exposed

(Wright & Gabriel, 2018). The survivors felt that this damage was a permanent fixture of their identities. According to Kealy et al. (2017), the high levels of shame that developed due to the abuse may have served as a means by which the abuser maintained control over their victims. This may have resulted in toxic shame, which may have been associated with suicidal thoughts, as the survivor's identity was built around the belief that they, as a whole person- both body and mind, were the problem (Wright & Gabriel, 2018). Shame featured feelings of embarrassment, fear of disbelief from others, and the continued thought of "how could I have let this happen to me" and "I am bad" (Parry & Simpson, 2016; Wright & Gabriel, 2018, p. 671). This might have contributed to the development of a victim identity because the survivors might not yet have recognized the strengths that are part of a survivor mentality and identity (Parry & Simpson, 2016). The continued victim identity led to a distorted acceptance of the abuse which then took away the victim's personal power (Wright & Gabriel, 2018).

Dysfunctional Acceptance and The Loss of Personal Power

The survivors of child sexual abuse (CSA) began to believe that the abuse was justifiable and that the only way through their mental confusion was to accept the abuse as some rational fact of their lives. According to Wright and Gabriel (2018), adult survivors of CSA, often while they were still minors, began to use avoidant coping strategies that included the abuse of either alcohol or other substances, or both, to diminish the feelings they had about themselves. The use of these avoidant-based coping strategies acted to deny the abuse and, in turn, to justify it. It created a way for the survivor to feel a sense of acceptance of the abuse, although the acceptance was very distorted. This distorted acceptance, also named dysfunctional acceptance, might have changed the survivors' entire belief systems (McLean et al., 2014). According to Parry and Simpson (2016), "a person's sense of self is irrevocably changed through CSA, leading to low

self-esteem and often a sense of unworthiness" (p. 794). These perceptions made it difficult to forge and maintain relationships with others.

Along with dysfunctional acceptance, came the notion that the survivor had lost their personal power. The thought of being a damaged victim stripped them of their natural moral compass (Karakurt & Silver, 2013). The survivor began to question their own judgment and developed a desperate need for reassurance. The power to maintain mental stability in everyday life was challenged (McLean et al., 2014). The less adequate the survivor felt, the less power they felt they had. The survivors then perceived themselves as incompetent and out of control (McLean et al., 2014). They felt a loss of the ability to make their own decisions and found it easier to separate the negative emotions from the rest of their consciousness. The dysfunctional acceptance the survivors maintained and the powerlessness they felt might have caused them to dissociate themselves from the abuse and to behave as if it had not happened.

Dissociation and the Resulting Ideal of the Absent Self

In a case study done by Barglow (2014) with a 25-year-old woman who was sexually abused as a child, the woman experienced dissociation. The APA Dictionary of Psychology described dissociation as a defense mechanism in which threatening thoughts and emotions are compartmentalized from the rest of the mind (American Psychological Association, n.d.-i). She stated that she recalled the event, "like a third person observer," and not as herself (Barglow, 2014, p.122). Survivors seemed to dissociate from their senses of self as a form of protection from the negative emotions that resulted from the abuse (Barglow, 2014) They often felt one hidden inside self, and another visible, or public, self (Barglow, 2014). On the outside, they may have appeared to have good self-esteem and have a positive sociable demeaner, but on the inside they felt insecure, anxious, and lacked trust (Parry & Simpson, 2016). These two representations

of themselves lacked cohesion with each other. The inside self was absent of self-worth and self-esteem, and was anxious, insecure, and distressed (Parry & Simpson, 2016). The way the survivors portrayed themselves on the outside was as content and outgoing people (Parry & Simpson, 2016). Wright and Gabriel (2018) stated that many sexual abuse survivors found it distressing when they initially discovered and learned about their identity because they had hidden themselves for a long period of time. The lack of connection from body to mind to emotional reaction often led to unrealistic and damaging beliefs about themselves.

Incongruent Belief Systems

The ideas that were conjured up in the survivors' rationale were often vitally skewed. The skewed beliefs were reinforced by frequent self-repetition of the thoughts that were restructured to make sense of the abuse (Wright & Gabriel, 2018). The incongruent beliefs became part of the survivors' core belief system (Wright & Gabriel, 2018). According to Holtzhausen et al. (2016), maladaptive beliefs that were related to the abusive events included: a sense of guilt for their role in the abuse, anger that parents did not know that the abuse had happened or continued to happen, feelings of powerlessness, a sense that in some way they were damaged, and fear that people would inevitably treat them differently. These beliefs redefined morals, values, self-perception, and how they imagined to be perceived by others (Holtzhausen et. al., 2016). Survivors found it difficult to see how their beliefs had been transformed into ideas that were unrealistic and that this was due to the abuse they had experienced (Wright & Gabriel, 2018). As a result, survivors remained unaware of the challenges it continued to create for themselves and in their relationships with others.

Unhealthy Interpersonal Relationships

As the survivors' lives and mental health continued to morph, the ability for survivors to have meaningful relationships with others became difficult. The survivors began to assume that they knew what other people were thinking about them and also assumed that they knew how situations would evolve before these situations happened (McLean et al., 2014). The survivors then convinced themselves that they knew that others had negative judgment towards them, and, therefore, isolation from others continued (McLean et al., 2014). Interpersonal relationships began to suffer for the survivors due to the deterioration of important relational skills such as, empathy, compassion, and acceptance towards others (Wright & Gabriel, 2018). The survivors' skewed negative beliefs caused problems in the development of positive personal connections.

The foundation of survivors' personality development was a secure sense of bonding with the people who cared about them and when that connection was lost, the survivor disconnected with their basic sense of self (Wright & Gabriel, 2018). The ability to connect with themselves and others was a critical developmental task, and when that ability was damaged, its repair became extremely challenging (Wright & Gabriel, 2018). Survivors of CSA had lost a sense of trust for and safety with others and, therefore, they faced difficulties in forging and maintaining relationships (Parry & Simpson, 2016). Survivors needed to relearn how to trust and connect with themselves if they wanted to begin to trust and connect with others.

Potential Clinical Disorders

Considering all of the areas of the survivors' self-structure that were altered due to child sexual abuse, it was not unlikely for psychological disorders to surface. It was extremely common for childhood trauma, especially sexual abuse, to initiate a chain reaction of additional traumas and the development of clinical disorders across the life cycle (Parry & Simpson, 2016).

Common disorders included posttraumatic stress disorder (PTSD), complex posttraumatic stress disorder (C-PTSD), and substance use disorder (SUD). Other disorders not addressed in this paper, that were commonly identified by survivors included depression, anxiety, promiscuity, self-harm such as cutting, suicidal ideation or action, risk taking, impulse control issues, and chronic self-degradation (Sartor et al., 2013). The most prevalent of those disorders were posttraumatic stress disorder (PTSD), complex posttraumatic stress disorder (C-PTSD), and substance use disorder (SUD).

Posttraumatic Stress Disorder

The psychiatric disorder that was most often linked to CSA was posttraumatic stress disorder (PTSD) (Chang et al., 2018). The severity of PTSD that was experienced by the survivors was determined by the type, duration, and frequency of the sexual abuse, along with the relationship between the survivor and the perpetrator (McLean et al., 2014). According to the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (DSM-5) (2013), for a diagnosis of PTSD to be made, the patient must have been exposed "to actual or threatened death, serious injury, or sexual violence" (p. 143). Survivors of sexual abuse had the highest risk for developing PTSD compared to survivors of any other trauma (Nixon et al., 2016). Posttraumatic stress disorder that was related to CSA was characterized by intrusive and reoccurring thoughts of the sexual abuse, the avoidance of reminders of the trauma (places, people, sounds, smells, and other sensory triggers), the attempt to numb emotionally, irritability, and trouble with sleep and concentration (Holtzhausen et al., 2016). According to Resick et al. (2014) approximately 37.5 percent of all female CSA survivors in the United States met the criteria for a PTSD diagnosis at some point in their lifetimes.

The residual effects of child sexual abuse might have resulted in PTSD, complicated by problems with shame and guilt, emotion regulation difficulties, depression, and re-traumatization, all of which are described in the sections to follow (Dorrepaal et al., 2014). Among adolescents who were sexually abused as children, the rate of PTSD was estimated to be 38.5% in non-clinical samples of adolescents, and as high as 88% in clinical samples of adolescents, (Chang et al., 2018). Females were at an increased risk of PTSD. The factors that placed females at greater risk included gender-specific psychobiological responses to trauma, the age at which females experienced trauma, negative cognitive appraisal, and lower levels of social support (Steven Betts et al., 2013). The presence of psychiatric disorders prior to the experience of trauma were also associated with PTSD vulnerability and increased symptoms (Steven Betts et al., 2013).

PTSD and Symptoms of Shame and Guilt. A common symptom among most CSA survivors was the tremendous amount of shame and guilt that began to consume the survivors' thoughts (Wright & Gabriel, 2018). Guilt typically involved a gut-wrenching belief that somehow survivors were to blame for the abuse (Wright & Gabriel, 2018). Once the survivor was overridden by this guilt and the belief that the abuse was a consequence of their own making, the emotions of shame and guilt amplified (Wright & Gabriel, 2018). Thoughts became overridden by the need to dissect the sexual abuse and find every possible way that they could have prevented it from happening (Wright & Gabriel, 2018). It was important to note that these individuals may not yet have had the ability to accept that the sexual assault was never their fault (Barglow, 2014). The distress that was caused by holding such guilt commonly reinforced many forms and intensities of shame (Wright & Gabriel, 2018). The difference between guilt and shame was that guilt was a feeling that the situation was bad and that they may have been able to

avoid it. Shame, however, caused the survivors to be unable to perceive the *situation* as bad, and instead, the survivors internalized *themselves* as bad. The diverse situations of abuse that were experienced by survivors made it highly improbable to assume all had the same personal abilities to handle the trauma (Wright & Gabriel, 2018). In women, high levels of shame due to CSA were found to be persistent and long lasting (Kealy et al., 2017). If the emotions of shame and guilt were not addressed and worked through in therapy, the possibility of recovery might have been diminished.

PTSD and Symptoms of Emotion Dysregulation. Survivors of child sexual abuse had extreme challenges with emotion regulation (ER) that resulted in difficulties with the management of feelings of anger and other overwhelming emotions (Parry & Simpson, 2016). Emotion regulation was described by Mandavia et al. (2016) as a set of interrelated psychological and physiological processes that allowed individuals to regulate feelings, behaviors, and physiological responses to events that enticed emotion. Problems with emotion regulation (ER) might have led to difficulty with the management of negative emotional states and might have impaired the survivors' ability to function successfully (Mandavia et al., 2016). Emotion regulation difficulties then developed into emotion dysregulation. Emotion dysregulation (ED) was described by Mandavia et al. (2016) as problems with emotion regulation that led to impaired management of negative emotions and might have led to impaired functioning. Mandavia et al. (2016) also stated that ED might affect the survivors' ability to "understand and be accepted by others, or to enjoy themselves" (p.423). Emotional regulation begins in infancy and continues to develop throughout childhood, and research suggested that exposure to CSA was a strong risk factor for emotional dysregulation (ED) in adulthood (Mandavia et al., 2016). Children became unable to label emotions correctly when they were

exposed to harmful or unsupportive home environments or when they had experienced sexual abuse in or around these environments (Mandavia et al., 2016).

Emotion regulation deficiencies were also linked to addictive and aggressive behaviors (Schäfer et al., 2017). One study found that survivors who had experienced early onset, chronic trauma that included CSA reported significantly higher scores on all measures of emotion dysregulation compared to survivors of late onset trauma (Chang et al., 2018). The ways the survivors of CSA perceived their own emotion regulation might have contributed to PTSD development as the traumatized survivors might have maintained dysfunctional beliefs about their abilities to cope with the aftermath of the abuse (Chang et al., 2018). Emotion dysregulation might have caused difficulties in the ability to process negative thoughts and may have led survivors to engage in rumination to cope with these difficulties (Chang et al., 2018). Rumination, or repeated focus on negative thinking, often occurred in the context of depression (Chang et al., 2018). Survivors who were given a PTSD diagnosis were likely to also have depressive symptoms.

PTSD and Symptoms of Depression. The survivors with posttraumatic stress disorder (PTSD) were at a significantly increased risk for the development of a depressive disorder as compared to individuals who did not develop PTSD (Chang et al., 2018). CSA survivors who had pre-existing depressive disorders resulted in a threefold greater risk for developing PTSD after trauma (Chang et al., 2018). Survivors who developed depressive symptoms more frequently used negative emotion regulation strategies, such as rumination, catastrophizing, and thought suppression (Chang et al., 2018) The strategies were used as an attempt to control the content of their thoughts and rid their thoughts of undesired ideas and images (Chang et al., 2018). Depressive symptoms might have been exacerbated when emotion regulation difficulties

increased PTSD severity (Chang et al., 2018). This relationship suggested that the treatment of depressive symptoms might have improved PTSD symptoms (Chang et al., 2018).

PTSD and Symptoms of Re-Traumatization. As survivors of child sexual abuse worked through their PTSD and depressive symptoms, re-traumatization might have occurred. Re-traumatization might have happened if the survivor became traumatized again by the original trauma they were working through (Roberge et al., 2019) It may have felt as if they were experiencing the abuse all over again. Emotion regulation strategies that were used by survivors could have actually induced re-traumatization (Chang et al., 2018) These strategies might have included rumination, the notion to catastrophize, and the tendency to blame themselves (Chang et al., 2018). Re-traumatization during treatment was minimized when survivors developed healthy emotion regulation skills. (Mandavia et al., 2016). These skills helped the survivors better tolerate the negative emotions and thoughts that resurfaced when they discussed the traumatic experiences.

Complex Posttraumatic Stress Disorder (C-PTSD)

Barglow (2014) described complex posttraumatic stress disorder (C-PTSD) as, "the pathology of trauma subjects with a background of repetitive and chronic traumas" (p. 125). C-PTSD might have developed in survivors who experienced multiple traumas, and many times these traumas were of different types and intensities. This differs from the survivors who experienced a single trauma and had a PTSD diagnosis. It was suggested that 23% of children impacted by sexual abuse in the United States were likely to display indications of impairment consistent with a C-PTSD diagnosis (Hébert & Amédée, 2020). Females were more likely than males to be diagnosed with C-PTSD (Hébert & Amédée, 2020). The World Health Organization proposed to the International Classification of Diseases (ICD) that the C-PTSD diagnosis be

available as an alternative diagnosis to PTSD because the multiple traumas encompassed unique difficulties with emotion regulation, with the quality of personal relationships, and with the distortion of the survivors' self-concepts (Hébert & Amédée, 2020). Complex posttraumatic stress disorder is only one of the most common consequences of CSA (Sch*ä*fer et al., 2017).

Substance Use Disorder

While PTSD and C-PTSD were the most common psychological diagnoses, substance use disorder (SUD) was the most frequent behavioral diagnoses of CSA survivors (Sch*ä*fer et al., 2017). Substance use disorder (SUD) was defined by the American Psychological Association as "a catchall diagnosis encompassing varying degrees of excessive use of a substance" (n.d.-u) As per the diagnostic criteria from the DSM-5 (American Psychiatric Association, 2013), "substance use disorder is used to describe the wide range of the disorder, from a mild form to a severe state of chronically relapsing, compulsive drug taking" (pp. 230-231). CSA has been linked to substance use disorders, including alcohol and illicit drug use (Mandavia et al., 2016).

Survivors who experienced childhood sexual abuse and then developed PTSD or C-PTSD were at a great risk for developing a subsequent substance use disorder (Ulibarri et al., 2015). The symptoms of PTSD or C-PTSD often led to the development of a substance use disorder (SUD) as a coping mechanism (Barglow, 2014). The prevalence of the comorbidity of SUD and PTSD tended to be higher in females, (Sch*ä*fer et al., 2017). Sch*ä*fer et al. (2017) studied child sexual abuse as a portion of their research on childhood abuse and neglect (CAN). Sch*ä*fer et al. (2017) concluded that substance use disorders (SUD) were among the most frequent behavioral consequences of CAN. Of female survivors in the United States with a reported history of CAN who sought treatment for SUD, 16.3-60.9% reported sexual abuse

during their childhoods (Schäfer et al., 2017). Among the survivors with a history of CAN who were treated for SUD, 26-52% had a diagnosis of PTSD at some time in their lives (Schäfer et al., 2017). Many of the survivors with a substance use disorder suffered more complex psychological consequences typically including pervasive disturbances in emotion regulation, a diminished and defeated sense of self, and difficulties in interpersonal relationships (Schäfer et al., 2017). A 2013 study found that 96.5% of those with SUDs had experienced at least one traumatic event in their lifetimes (Mandavia et al., 2016).

Substance use often emerged as a maladaptive strategy used to manage the negative results of trauma exposure that included child sexual abuse (Mandavia et al., 2016). According to Mandavia et al. (2016), the connection between CSA and SUD was significant and might have been explained by the self-medication theory of addictive disorders. Researchers speculated that SUD happened in response to emotion regulation vulnerabilities (Mandavia et al., 2016). Negative emotions and a lack of coping skills to help manage those emotions led to the use of alcohol and/or other substances to temporarily relieve the undesirable feelings of negative emotional states (Mandavia et al., 2016).

The desired outcome of self-medicating through the use of substances was the numbing of the psychological effects of CSA. Words used to describe numbing included: anhedonia (the inability to find pleasure in activities or experiences) (American Psychological Association, n.d.-d), depersonalization (a dreamlike state of mind which the individual feels that their mind is separate from their body) (American Psychological Association, n.d.-g), derealization (an altered feeling of reality due to a changed perception, often because of trauma, in which external reality feels unfamiliar and unreal) (American Psychological Association, n.d.-h), dissociation, emotional dulling, flat affect (the attempt to eliminate all emotion responses) (American

Psychological Association, n.d.-l), and alexithymia (the inability to express or explain emotions in words or actions) (American Psychological Association, n.d.-c, American Psychological Association, n.d.; Barglow, 2014). Additionally, individuals who had been exposed to multiple traumatic events who then developed posttraumatic stress disorder and/or depression may have resorted to the use of substances to alleviate the long-term negative effects of the trauma exposures (Mandavia et al., 2016). These long-term effects might have included a greater severity of psychiatric symptoms such as shame, guilt, or emotion dysregulation as discussed previously in this paper (Mandavia et al., 2016). The feelings associated with these symptoms may have then led to substance use to evade those emotions (Mandavia et al., 2016).

Exposure to CSA increased the risk of emotional dysregulation (ED), and ED might have been a vulnerability factor for the development of substance use problems (Mandavia et al., 2016). Survivors of CSA who had emotion regulation challenges also had an increased probability of the development of a substance use disorder in adulthood (Mandavia et al., 2016). According to McLean et al. (2014), substance use disorders intensified as the CSA survivor increased in age. It was also suggested that a major predictor of the development of a substance use disorder in adulthood was the beginning use of alcohol or substances in adolescence (LeTendre & Reed, 2017). Substance use increased the risk of sexual traumas, as did sexual trauma increase the likelihood of substance use (Barglow, 2014). This might be why early intervention for CSA survivors was extremely vital. When survivors used substances as a coping mechanism, they often put themselves in situations which could then result in additional traumas, such as being under the influence of a substance which may have made it easier to be taken advantage of sexually. As substance-related traumatic events occurred, the likelihood of becoming substance dependent increased, and recovery from addiction became, arguably, as

important as the treatment for PTSD or C-PTSD (Haroosh & Freedman, 2017). The relationship between CSA and SUD might have been a difficult concept for counselors to process with the survivor. Survivors may have not yet understood that one of the reasons they developed a substance use disorder might have been so that it could be used as a coping mechanism to help them work through their CSA trauma. Research has shown that trauma-related substance use disorder might be most successfully addressed and worked through in therapy with a professional who was trained in the areas of both trauma and substance abuse (LeTendre & Reed, 2017). When therapy began, there were several therapeutic preparations that needed to be discussed between the survivor and the therapist.

Therapeutic Preparations

It was important to consider what types of therapies would be most beneficial for helping survivors work through their traumas and substance use disorders. It was vital to account for the stressors that the survivors were having as therapy was about to begin. According to Mandavia et al. (2016), CSA survivors who received earlier interventions were less likely to develop a substance use disorder. Survivors who experienced longstanding trauma, such as CSA that extended over several critical times in their development, might have demonstrated severe symptomatology unless there was therapeutic intervention (Holtzhausen et al., 2016). Without early intervention, exposure to traumatic events during childhood and adolescence might have had effects on the survivors' well-being across their lifespans (Holtzhausen et al., 2016).

Survivors had a difficult time discussing their trauma experiences soon after the trauma occurred. The overwhelming psychological injuries endured by the survivors caused intense fears, shame, guilt, and an overall assumption that the narrative of the experience would not be believed (Kealy et al., 2017). The initial treatment phase might have been challenging because

of the feelings had by the survivors. Survivors were hesitant to attend treatment because of the unease felt when they talked about the abusive experiences (Capella et al., 2016). This unease might have limited initial clinical discussions of the trauma during therapy (Kealy et al., 2017). It was important to first address topics that included the need to build rapport, develop safety and boundaries, practice active listening, and transition from a victim mentality to a survivor mentality.

Build Therapeutic Rapport

The single most important factor in the successful treatment of sexual abuse survivors was the initial establishment of an effective therapeutic alliance (Parry & Simpson, 2016). During the primary stage of therapy, focus was on the development of the patient-therapist rapport (Capella et al., 2016). This relationship was based on mutual connection, ease, and trust (Capella et al., 2016). Survivors began to confide in and form a meaningful relationship with their therapist as trust began to build between the two of them (Parry & Simpson, 2016). Therapists could help develop trust with their clients by creating a feeling of equality between the two of them (Parry & Simpson, 2016). When the survivor shared their abuse histories, it was important that therapists conveyed honesty and a willingness to confront the client on inconsistencies (Parry & Simpson, 2016). The survivors also became more willing to talk openly when they felt they were being believed and not judged. These qualities helped the survivors feel that the therapist was worthy of hearing their story (Parry & Simpson, 2016). Survivors who developed positive therapeutic alliances with their therapists were better able to connect positively with themselves, and thus further developed their own positive self-concept (Parry & Simpson, 2016).

Develop Safety and Boundaries

Another consideration when therapeutic rapport was being built was that a safe environment with established boundaries needed to be developed. Boundaries appeared to be important for two main reasons. First to establish the therapeutic relationship as safe, and second, to help the survivors enable their healing outside of therapy (Parry & Simpson, 2016). The victim's boundaries had been detrimentally violated during their abuse experiences; therefore, it was imperative to teach about and create healthy boundaries in the therapeutic relationship (Parry & Simpson, 2016). Respect for therapists and the therapeutic relationship was strengthened when survivors felt they worked with a therapist who conveyed honesty, competency, and trustworthiness (Parry & Simpson, 2016). Psychotherapy needed to be an environment that allowed for the discovery of new insights that then helped form an alternative perspective with respect to the abusive situation (Capella et al., 2016).

Therapies that helped the survivor narrate their experience included the freedom to find words for trauma, to safely say those words aloud, and for the trauma account to be not only listened to, but also believed (Parry & Simpson, 2016). Bonding was facilitated both interpersonally and intrapersonally when the survivor put their story into words and shared their story with someone who listened to and believed in them (Parry & Simpson, 2016). CSA survivors began to learn to trust and safely connect with others, therefore internalizing trust which helped improve their view of the world (Parry & Simpson, 2016).

Practice Active Listening

Survivors expressed a need to feel that their therapist genuinely heard the words of the difficult narrative as it was being discussed. The use of active listening was vital. "Active listening" was defined in the American Psychological Dictionary of Psychology as:

> A psychotherapeutic technique in which the therapist listens to a client closely, asking questions as needed, in order to fully understand the content of the message and the depth of the client's emotion. The therapist typically restates what has been said to ensure accurate understanding. (American Psychological Association, n.d.-a).

Survivors appreciated when therapists demonstrated they were listening by repeating back to the survivor what the survivor had said (Parry & Simpson, 2016). Therapists helped normalize the reactions that the survivor had in response to their traumatic past (Parry & Simpson, 2016). Normalizing emotional trauma reactions aided in the accuracy of the narratives that were recounted (Parry & Simpson, 2016). While active listening was vital in the narrative process of therapy, it was also important that the therapist prepared the survivor for the physical and emotional reactions that might have developed from their disclosure.

It was important that survivors were equipped with some basic coping skills before they began discussion about their abuse experience because the physical and emotional reactions might have been uncomfortably intense. Survivors needed to be taught how to practice general relaxation strategies, how to effectively use deep breathing skills, and how to practice grounding techniques (Capella et al., 2016). Grounding referred to ways that the client could remain in a present frame of mind because at times that the disclosure became intense, the survivor may have actually felt they were physically in the abusive situation again (Capella et al., 2016). Grounding included the survivor's physical touch of the things around them which helped them verbally acknowledge where they were physically at the present moment and that they were safe in this environment (Capella et al., 2016). The transition from a victim mentality to that of a survivor occurred when the survivor became more comfortable with the disclosure of their experiences.

Transition from a Victim Mentality to a Survivor Mentality

The goal of therapy was to help transition the client from a victim mentality to a survivor mentality (Foster & Hagedorn, 2014). When the survivor was in a victim mentality, they tended to identify with negative emotions such as shame, guilt, anger, and resentment (Foster & Hagedorn, 2014). They held on to self-blaming thoughts and focused on negative self-pity (Foster & Hagedorn, 2014). When the survivor moved into a survivor mentality, they were focused on overcoming the negative way that they had thought and then began to feel the success of surviving a traumatic event (Foster & Hagedorn, 2014). This shift between mentalities might have been promoted through a variety of therapeutic interventions, nine of which have been explained below.

Effective Therapeutic Interventions

Psychoeducation was the first necessary intervention. Information needed to be provided to the survivors about the types of therapy that they would take part in, how the survivor would participate, and what some of the expected reactions, both physical and emotional, could be. This education helped to prepare the survivor for the following interventions and helped to ease the fear of the unknown. The CSA survivor needed to be prepared for the treatment of emotion dysregulation, the analysis of their irrational beliefs, and the treatment for their lack of self and social coping skills (Dorrepaal et al., 2014). When the survivor was emotionally prepared, they were able to progress in subsequent treatments. Successful therapy included a process of understanding their trauma experiences, mourning the emotional pain of their experiences, and then adjusting to a new way of thought about the experiences (Barglow, 2014). Trauma-focused cognitive behavioral therapy (TF-CBT) was an effective intervention which included therapeutic

techniques that were specific to the individual survivor's trauma experiences (Holtzhausen et al., 2016). These techniques are described below.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Holtzhausen et al., (2016) described trauma-focused cognitive behavioral therapy (TF-CBT) as a means to:

> provide psycho-education and assist clients in developing coping mechanisms for when they are confronted with any abuse-related memories and feelings. Consequently, this process aims to lessen the anxiety that underlines in PTSD as well as depression. Included in trauma work is the need to address feelings of shame, emotional distress, and depression. (p.512)

Hotlzhausen et al., (2016) explained that TF-CBT was a hybrid therapeutic model that integrated elements of exposure-based, cognitive-behavioral, attachment, family and empowerment therapies into a treatment that could address the individual needs of survivors who had experienced trauma such as sexual abuse. TF-CBT has been recognized by some as the best treatment of PTSD symptoms for CSA survivors (H*é*bert & Amédée, 2020). An additional goal in TF-CBT was to teach the client how to react differently both physically and emotionally during situations that were distressing (Holtzhausen et al., 2016). There were several components of trauma focused cognitive behavioral therapy (TF-CBT) that might have been beneficial for the treatment of female survivors of childhood sexual abuse who had developed a substance use disorder. Trauma-informed treatment approaches led to more successful treatment outcomes in regard to symptom reduction and treatment retention (LeTendre & Reed, 2017). The part of TF-CBT that encompassed the most beneficial therapeutic interventions for CSA

survivors that had developed a substance use disorder was cognitive processing therapy (Hébert & Amédée, 2020).

Cognitive Processing Therapy. Cognitive processing therapy (CPT) emphasized thought pattern change as a way to more productively alter erroneous thinking that had emerged due to trauma (American Psychological Association, n.d.-f). There are several aspects of CPT that were found to be beneficial in the treatment of female survivors of CSA. CPT resulted in the reductions of unhelpful thoughts, depression, and PTSD (Nixon et al., 2016). Therapists needed to first consider the severity of the abuse, the relationship the survivor had with the perpetrator, and then carefully assess each client's experience as unique (Kealy et al., 2017). They also considered any substance use disorder that might have developed. Cognitive processing therapy (CPT) was the most effective TF-CBT component and highlighted several specific areas that included:

- eye movement desensitization and reprocessing (EMDR)
- in-vivo desensitization
- narrative therapy
- meaning making
- self-efficacy and self-compassion
- cognitive restructuring
- group therapy (Holtzhausen et al., 2016)

Eye Movement Desensitization and Reprocessing (EMDR). Eye movement desensitization and reprocessing (EMDR) was a recommended therapeutic approach with trauma survivors. EMDR was defined by the APA Dictionary of Psychology as "a structured therapy that encourages the patient to briefly focus on the trauma memory and simultaneously experience

bilateral stimulation (usually eye movements)" (American Psychological Association, n.d.-k). The survivor imagined or talked through a traumatic experience while they moved their eyes from left to right. The approach was developed to help settle symptoms that resulted from unresolved, disturbing life experiences such as childhood sexual abuse (CSA) (Holtzhausen et al., 2016). EMDR reduced trauma-related symptoms such as anxiety, sleep disturbances, flashbacks, and negative thoughts (American Psychological Association, n.d.-k). These were some of the symptoms that caused the survivors to resort to substance use. This approach was based on a model that claimed that inadequately processed events caused symptoms to arise and that these symptoms could be eliminated once the memories were fully worked through with the use of EMDR (Holtzhausen et al., 2016). The use of EMDR helped clients focus on specific aspects of their trauma memories, while they simultaneously engaged in horizontal eye movements or other bilateral stimulations, such as taps on their hands (Marotta-Walters et al., 2018). Trauma could be better processed when the survivor could hold dual attention on traumatic memories and on sensory-based bilateral stimulation (Marotta-Walters et al., 2018). The dual attention effectively helped the survivor tolerate the emotional discomfort of the trauma and the discomfort slowly dissipated (Marotta-Walters et al., 2018). As survivors named and acknowledged their experiences as abuse and better understood how the abuse had impacted them, they were able to accept that the trauma was just a part of their lives (Wright & Gabriel, 2018). It did not have to define who they were.

In-vivo Desensitization. In-Vivo or exposure therapy was described by Holtzhausen et al. (2016) as the gradual introduction of trauma reminders to survivors that might have included certain places or people, or specific emotions and memories connected to the traumatic event. The goal was to slowly reduce distress and trauma-related reactions when the survivor had

memories of the traumatic event (Holtzhausen et al., 2016). Regular exposure treatments may have been unsuitable for CSA clients in their first phase of treatment (Dorrepaal et al., 2014). Exposure therapy was an intense attempt to remove the negative feelings associated with tangible and intangible parts of the trauma (Dorrepaal et al., 2014). The survivor needed to be secure in their ability to tolerate PTSD triggering memories and conversations. It was important that the initial focus was on the stabilization of PTSD symptoms (American Psychological Association, n.d.). Exposure therapy helped reduce avoidant behaviors but did not seem to help reduce the want for numbing (Barglow, 2014). Exposure therapy, alone, did not reduce the likelihood of the development of a substance use disorder. During the following stages of therapy, the survivors began to narrate and process their traumatic experiences, which was an uneasy challenge but helped to ease the urge to numb their feelings (Capella et al., 2016). The use of narrative therapy as an approach to put their experience into words, helped survivors begin to stop the avoidance of feeling their emotions.

Narrative Therapy. Narrative therapy is defined in the APA Dictionary of Psychology as:

> treatment for individuals, couples, or families that helps them reinterpret and rewrite their life events into true but more life-enhancing narratives or stories. Narrative therapy posits that individuals are primarily meaning-making beings who are the linguistic authors of their lives and who can reauthor their life stories by learning to deconstruct them, by seeing patterns in their ways of interpreting life events or problems, and by reconstruing problems or events in a more helpful light. (American Psychological Association, n.d.-p)

Participating in narrative therapy has been found to be extremely beneficial to survivors (Wright & Gabriel, 2018). Before narrative therapy began with the survivors, it was beneficial for the topic of sexual abuse to be addressed for the survivor to feel secure in speaking about their own experiences (Capella et al., 2016). This helped the survivor feel more comfortable when they recalled events without the provocation of severe emotional responses (Capella et al., 2016). It was important that the therapist allowed the survivor the opportunity to progress and express themselves at different rates (Parry & Simpson, 2016). When the survivor felt they could tell their story at their own pace, they were better able to develop a narrative that incorporated both the past abuse and their present ability to make their own choices (Parry & Simpson, 2016). It was found that as survivors discussed their abuse experiences, they arrived at a more complex and multidimensional understanding of the abuse as such (Wright & Gabriel, 2018). Sometimes written accounts were used to help put a fragmented memory into a coherent story that could be narrated in spoken word (Resick et al., 2014). This helped the survivor explore the erroneous beliefs about their role in the event or the implications about themselves or others (Resick et al., 2014).

When survivors acknowledged and accepted the reality of the abuse, it helped them to unify their trauma experiences and to express the experiences into self-narratives (Wright & Gabriel, 2018). As narrative therapy began, some survivors found it difficult to articulate certain feelings because they had never developed the language for explaining their experiences in emotional terms (Parry & Simpson, 2016). Many CSA survivors stayed silent for such a long time that the disclosure of the abuse in words became a path toward freedom for them (Parry & Simpson, 2016). Despite the difficulties in doing so, this discussion appeared to be a vital first step in the survivor beginning to understand their experience and helped to reduce some of the

power of the abuser (Parry & Simpson, 2016). It also helped to alleviate the desire to use substances to self-medicate and numb their uncomfortable emotions.

During the ending phase of narrative therapy, survivors understood how their therapy had progressed, and acknowledged their own personal achievements and growth (Capella et al., 2016). When the narrative therapy process was completed, survivors often found it to be effective (Capella et al., 2016). They realized that they had put forth a great deal of effort to seek change (Capella et al., 2016). This improved their self-efficacy and overall attitude toward their ability to handle their truth (Capella et al., 2016). A reduction of nightmares, depressive feelings, and aggressive behaviors was seen after the abuse was narrated (Capella et al., 2016). Survivors began to notice changes in their worldview (Capella et al., 2016). They saw the world as less threatening and more secure and became more comfortable as they began to believe that people were generally kind (Capella et al., 2016). The narrative incorporated their experiences into their histories, without allowing it to define them any longer (Cappella et al., 2016). The survivors narrated their stories and it helped them to make sense of their experiences which allowed them to create new meanings and more accurate versions of their lives (Capella et al., 2016).

Meaning Making. An additional and equally important early stage of healing happened when the survivor was able to realize that the abuse was never their fault. This could be achieved through meaning making therapy (Wright & Gabriel, 2018). This therapy was highly individualized with meaning making of the survivor's trauma being most important (Wright & Gabriel, 2018). The survivor might have needed a therapeutic intervention that helped to change old self-beliefs and self-concepts, and to restore their reality to be more accurate (Wright & Gabriel, 2018). Survivors developed the ability to reconsider the self-blame and feelings of guilt

and shame related to the abuse (Wright & Gabriel, 2018). It was only when survivors began to recognize how deeply the experience of CSA had negatively changed the way that they viewed the world and themselves that the pain and healing began (Wright & Gabriel, 2018).

Self-Efficacy and Self-Compassion. Self-efficacy and self-compassion were two characteristics that needed to be strengthened by the survivor to manage their doubt in their own abilities to cope. Self-efficacy was the survivors' perception of their capability to successfully respond in a given situation and attain their desired results (American Psychological Association, n.d.-t). Survivors needed to begin to learn their own strengths and skills without total reliance on their therapists (Parry & Simpson, 2016). Therapy focused on self-esteem and skills to rebuild feelings of self-worth and confidence (Kealy et al., 2017). These skills were developed through mindfulness, acceptance, and self-compassion, which reduced shame-related affects (Kealy et al., 2017). The survivors' affect could be described as the experience of feeling any emotion, that ranged from grief to excitement and the reaction had by feeling that emotion (American Psychological Association, n.d.-b). Survivors responded better to treatment interventions as they learned to trust themselves and others. This then helped them to alleviate feelings of isolation or the need to self-medicate through substance use (Wright & Gabriel, 2018). The shift toward self-efficacy appeared to be an important step to finding an independent adult identity (Parry & Simpson, 2016). The survivors were better able to introduce self-compassion into their lives.

Many studies identified how therapy enhanced self-compassion, which linked to the development of a more positive sense of worth (Parry & Simpson, 2016). Self-compassion involved the development of the ability to keep a non-critical attitude toward the survivors' inadequacies and mistakes (American Psychological Association, n.d.-s). Self-compassion might have aided in the survivors' well-being when they had learned how to better forgive their

shortcomings which had caused many of their negative emotions (American Psychological Association, n.d.-s). The survivors needed to accept themselves with a more positive perception of their capabilities and an acknowledgement of their personal strength and resiliency (Wright & Gabriel, 2018). Self-acceptance improved well-being, self-esteem, confidence, self-reliance, and assertiveness (Wright & Gabriel, 2018). Through the survivors' work with their therapists, survivors began to analyze their unique core beliefs, the reasons they held those beliefs, and how those beliefs had impacted their lives (Wright & Gabriel, 2018). The survivors were then able to create more accurate and self-congruent beliefs that better suited their new way of thought (Wright & Gabriel, 2018). Cognitive restructuring was able to occur as the survivors had developed new senses of efficacy and more compassionate views of themselves.

Cognitive Restructuring. Cognitive restructuring was described by Holtzhausen et al. (2016) as "identifying inaccurate and unhelpful thoughts and beliefs (for example, self-blame) associated with traumatic events and developing more adaptive ways of understanding and drawing conclusions about the trauma and the victim's reactions to it" (p. 515). Cognitive theories of emotion stated that a survivor's beliefs about their own ability to regulate their emotions were directly related to how well they responded to the treatment of their symptoms (Chang et al., 2018). CSA survivors found that when they understood their experiences, it helped in the development of positive and adaptive coping strategies (Parry & Simpson, 2016). It was important that survivors talked about and understood the lack of control they had when making past choices. They lacked the necessary skills, as children, to distinguish between positive and negative choices (Parry & Simpson). They may not have truly understood that they had never been taught the skills needed to make choices that would benefit their lives (Parry &

Simpson, 2016). The survivors likely felt lonely in their experiences and as if there was no one who had similar trauma symptoms and emotions.

Group Therapy. The need of "*not feeling alone"* was a common necessity for survivors of child sexual abuse and those who developed a substance use disorder (Parry & Simpson, 2016). Some survivors found that, in group therapy, they were able to find out more about themselves through listening to others (Parry & Simpson, 2016). The survivors were able to empathize with other survivors and develop a new perspective of their abuse (Parry & Simpson, 2016). Survivors found strength through hearing other survivors' stories. They experienced warmth and acceptance within these relationships (Parry & Simpson, 2016). It was vital that the survivors realized that if others did not deserve to be abused, then neither did they (Parry & Simpson, 2016). This realization reduced victim mentality as survivors learned that their abuse experiences were similar to that of other survivors (Wright & Gabriel, 2018).

Group therapy helped provide a new context for the survivors' experiences. This implied that the connections the survivors made with each other helped in the meaning making processes in regard to their pasts and helped them to develop their own sense of selves (Parry & Simpson, 2016). There were significant benefits in connecting peers who also had similar experiences of trauma (Bicanic et al., 2014). Group therapy was extremely beneficial to survivors who had developed substance use disorders as it decreased isolation and stigmatization and helped increase a sense of being understood (Bicanic et al., 2014). It also created a safe and encouraging environment to share one's trauma narrative (Bicanic et al., 2014). When the survivors talked about their traumatic experiences, shared feelings, and were able to count on the support of others who had similar experiences, the recovery process progressed (Capella et al., 2016). Posttraumatic growth, or the development of positive perceptions post-trauma, helped the

survivors to cope with the negative effects of the traumatic events (Haroosh & Freedman, 2017). Posttraumatic growth increased when survivors collaborated with other traumatized survivors about ways to cope and make positive life choices (Haroosh & Freedman, 2017).

Therapeutic Drop-Out Risk and Duration of Sessions

There had been no specific research done that had identified a specific length of treatment for CSA survivors who developed a subsequent substance use disorder (SUD) (Hotzhausen et al., 2016). There have been suggested timelines, but all have been debated. It, too, was difficult to predict a length of time that the survivor would tolerate therapy. Often survivors tended to stop treatment as it became more intrusive to their traumatic experiences. It was important to set a goal with the survivor and then aim to reach that goal.

Therapy Drop-Out

Drop-out during the therapeutic process was a valid concern and a barrier to successful recovery for survivors. Drop-out risk was the highest for survivors as they began to narrate their abuse experiences and as they began the first exposure sessions (Dorrepaal et al., 2014). Survivors found it so emotionally difficult to tolerate the spoken words and the specific trauma memories that they often quit therapy as soon as this process began. As emotion regulation improved, negative mood decreased and a stronger therapeutic alliance developed, which aided in retention (Dorrepaal et al., 2014). Survivors who experienced more frequent abuse were at a higher risk for discontinuing therapy (Resick et al., 2014). Some of the survivors' abuse situations might have led to more uncomfortable conversations and might have caused the survivors to drop-out due to fear of the discussion. Drop-out was also higher with survivors who had complex posttraumatic stress disorder, especially when exposure therapy was introduced into treatment (Dorrepaal et al., 2014). It was common for survivors who had developed a substance

use disorder to drop-out of therapy while they were discontinuing their substance use (LeTendre & Reed, 2017). It might have been difficult for these survivors to remain abstinent from all mood-altering substances long enough for therapy to be productive.

Therapy Closure and Maintenance

There eventually came a time when the survivor reached their final goals and regained emotion regulation, so therapy sessions might have been needed less often or might have been discontinued. The closing process of therapy might have been a sad and difficult time for the survivors. Although maintenance therapy would continue on an occasional basis, likely lifelong, the survivors had to separate from the regular contact with their therapist whom they had developed a close and trusted relationship (Capella et al., 2016). The goal was that posttraumatic growth (PTG) would have resulted from the process of change that had taken place during therapy for the treatment of sexual abuse trauma and substance use (Haroosh & Freedman, 2017). Once the survivors had changed their perspectives of themselves and others, healing was expedited toward the development of a cohesive whole adult self, independent from the trauma of the past (Parry & Simpson, 2016). There came a point in treatment when the survivors became empowered by learning new tools and life lessons which aided in the development of their social and interpersonal skills (Capella et al., 2016). When this happened, survivors referred to a feeling of growth and maturity, a greater sense of self-confidence, independence, autonomy, and individuality (Capella et al., 2016). They were ready to move forward in their lives.

At the conclusion of therapy, difficulties arose from survivors feeling that they were losing support and connections, therefore bringing back feelings of lack of safety and grief (Parry & Simpson, 2016). It was important that the therapist made it known that the survivor

would maintain the opportunity to continue in an aftercare program that could be collaborated between the two of them. The therapist would ensure that the survivor be taught how to detach from therapy slowly with their new gained self-efficacy (Parry & Simpson, 2016).

The ongoing, multifaceted, and complex journey of recovering from the trauma of CSA rarely has a finishing point (Wright & Gabriel, 2018). The experience of healing was often continuous and facilitated through the development of trust, safety, equality, and connecting with others (Parry & Simpson, 2016). Goals of treatment included helping the CSA survivor find optimism, hope, and resiliency (Foster & Hagedorn, 2014). An important part of continued recovery was occasional time spent in the strongly developed therapeutic relationship (Wright & Gabriel, 2018). Therapists helped survivors recognize the progress they had made, and the survivors were able to identify their own positive personal characteristics, envisioning a stronger self (Capella et al., 2016). They acknowledged that their future could continue to improve. It was important to maintain occasional reinforcement of these ideas.

Therapy Duration and Long-Term Care

There was a growing debate amongst trauma specialists about how long treatment for CSA survivors should last (Holtzhausen et al., 2016). It was implied that some survivors with long histories of abuse required multi-modal interventions applied consistently over a long period of time, such as several years (Holtzhausen et al., 2016). For TF-CBT and CPT therapies, the ideal length of treatment was 12 to 16 weeks for lasting change to take place (Hotzhausen et al., 2016). Part of the survivor's ability to remain independent and self-accepting was the inclusion of self-care (Wright & Gabriel, 2018). It was important for survivors to develop confidence in their abilities to make choices and be in control of those choices (Parry &

Simpson, 2016). The duration of treatment was largely varied based on the complexities of each survivor's unique experiences.

Summary

Female survivors of child sexual abuse (CSA) might have experienced many changes to their self-structure that caused psychological injuries. Survivors might have turned to alcohol and/or substances to cope with their emotional disorientation and may then have developed a substance use disorder (SUD). It was important to use effective therapy modalities to treat these female CSA survivors and their subsequent SUD. The goal of these therapies was to move the survivor from a victim mentality to a survivor mentality and to build confidence in their abilities to cope.

Chapter Three: Conclusions and Recommendations

Research has shown that female survivors of child sexual abuse (CSA) often develop symptoms that lead to diagnosable posttraumatic stress disorder (PTSD). Survivors might use substances to numb the uncomfortable PTSD symptoms and may go on to further develop diagnosable substance use disorder (SUD). Female CSA survivors often have difficulties with emotion regulation and experience psychological injuries to their self-structure. Psychoeducation and early intervention add to the success of therapy modalities that might be most helpful in alleviating the symptoms of PTSD and the use of substances.

There were several effective therapies that were identified to aid in the treatment of such diagnoses. The most beneficial of these therapies was trauma-focused cognitive behavioral therapy (TF-CBT), which includes cognitive processing therapy (CPT). The seven components of CPT that were shown to be effective are as follows:

- eye movement desensitization and reprocessing (EMDR)
- in-vivo desensitization
- narrative therapy
- meaning making
- self-efficacy and self-compassion
- cognitive restructuring
- group therapy

(Holtzhausen et al., 2016)

Client retention strategies and necessary duration of therapy are topics that need further research. More research about the long-term success of post-traumatic growth is also recommended. However, researchers must be careful in the study of therapy considerations for

survivors of child sexual abuse because of the risk of re-traumatization during therapy- which might cause more harm to the survivor. Other challenges to the research of therapeutic considerations for survivors of CSA include the lack of parental consent for participation in studies and the reluctance of children or adults to discuss the abuse (Foster & Hagedorn, 2014).

More training for health care professionals in how to adequately respond to patients with a history of abuse is needed (Schäfer et al., 2017). Psychoeducation for parents, school counselors, social workers, and others working in the helping professions needs to be increased to reduce the number of CSA survivors who suffer in silence. Attention should be given to warning signs that abuse may have occurred and in teaching children about this topic in developmentally appropriate ways.

Many survivors heal through therapy and by working with other survivors. There are several effective therapy modalities that help female CSA survivors improve in emotion regulation and self-worth. Further research of the numbing theory of substance abuse will help clinicians to better serve CSA survivors. With continued research in this area, counselors can assist CSA survivors to learn substance-free alternative coping strategies so that they may have a more fulfilling and successful future.

Clinicians will be able to serve survivors much more effectively as they gain more education about the link between child sexual abuse and substance use disorder. The use of the therapy modalities suggested in this research paper offer great hope for the future. Survivors will have gained the tools necessary to fully engage in a more satisfying lifestyle and will be able to see how their experiences can serve a purpose that is of benefit to others. The connection made when one survivor can relate to another survivor is immeasurable. Not only will clinicians be better able to help survivors find recovery and a positive sense of self, but, in addition, they will

more easily see signs of possible child sexual abuse in others. In this way, clinicians can be part of CSA prevention and, ultimately, substance use prevention, globally.

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