ARTICLE

Trauma and Short-Term Outcome for Women in Detoxification

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Abstract—The present study documents short-term outcomes for women receiving inpatient detoxification. We also aimed to determine the association between trauma history and these outcomes. One hundred and one randomly selected inner-city women completed a structured questionnaire covering demographic, treatment, and trauma history. All received follow-ups to trace postdischarge disposition; 59.4% (n = 60) were classified with positive short-term outcome. Statistically significant relationships were found between positive outcome and both number of previous detox hospitalizations (R = .20, p < .05) and attendance at outpatient programs (R = .35, p < .05). No significant relationships were demonstrated between outcome and histories of violence, use of drugs, or any demographic characteristics. Identifying histories of trauma did not interfere with treatment completion or further treatment seeking. Our results suggest that for women with heavy drug and alcohol problems, the capacity to accept and utilize help may be developed over repeated treatment exposures rather than related to intrinsic character traits.

Keywords—trauma; women; drug abuse; treatment outcome; detoxification.
have recognized the need to treat coexisting disorders such as posttraumatic stress secondary to childhood sexual abuse. Exposure to violence of all kinds has more recently been identified as a significant, but often hidden, problem in the lives of inner-city female substance abusers (Fullilove, Lown, & Fullilove, 1992; Hien & Levin, 1994; Paone, Chavkin, Willets, Friedmann, & Des Jarlais, 1992). It has been posited that failures to address the problems associated with violence is one of the reasons women do not complete treatment programs (Bollerud, 1990).

This article describes a study conducted in an exclusively female drug and alcohol detoxification unit located in New York City. In spite of the high costs of inpatient detoxification it is notable that little formal research has evaluated its efficacy or the factors that may predict positive treatment outcomes for women. The present study aimed to document short-term outcome in a gender-specific treatment setting where aftercare planning took into consideration factors such as cultural identification, religious affiliation, and child care. In light of the increased accessibility to specialized aftercare programs, we were interested not only in what percentage of women completed the actual detoxification, but what percentage went on to participate in the recommended next level of care (i.e., inpatient drug or alcohol rehabilitation, outpatient drug-free substance abuse treatment, methadone maintenance). We also aimed to determine which factors in a woman’s history or current life experience, such as childhood and adulthood trauma and sexual abuse exposure, were associated with short-term outcomes.

**MATERIALS AND METHODS**

**Subjects**

Study participants were 101 randomly selected women receiving alcohol and drug detoxification on an all-female inpatient unit of a public hospital serving an inner-city minority community. The length of stay ranged from 5 to 14 days depending on the amount of substances consumed and a woman’s pregnancy status. The average age of participants was 34 (SD = 7.9). The ethnic composition of the sample was 61.4% (n = 61) African-American, 22.8% (n = 23) Latina-American, 11.9% (n = 12) Caucasian, and 2% (n = 2) other ethnicities. Education level of the sample was as follows: 14.9% (n = 15) had never attended high school, 32.7% (n = 33) were high school drop-outs, 25.7% (n = 26) had completed high school or a GED, and another 33.7% (n = 34) had either taken college courses or completed college. Most (80.2%, n = 81) were supported by SSI or Public Assistance, 15.8% (n = 16) were self-supporting through legal or illegal work, and another 6.9% (n = 7) were supported by their families. Most of the sample were single and had never been married (54.5%, n = 55), although 19.8% (n = 20) were living with a partner; 13.9% (n = 14) were pregnant at the time of interview. Most lived with some family member (64.4%, n = 65), although 15.8% (n = 16) were either living in a shelter or homeless at the time of interview; 78.2% (n = 79) had at least one child, with an average of two (SD = 1.9).

**Procedures**

Between the Spring and Fall of 1994, all women who could read simple English and had been on the detoxification unit for a minimum of 3 days were asked to participate in a study (approved by the institutional review board of the hospital) aimed at learning more about female substance abusers and their treatment experiences. They were informed that participation in this study would involve answering a brief questionnaire about their life experiences lasting approximately 0.5 hour. They were also informed that participation was voluntary, that they would not receive any direct compensation, and that the research team would be making a follow-up phone call to the referral setting or to their home to find out whether or not they had followed through with the referral. Fewer than 5% of women refused study participation.

Those women who were interested in participating were given a consent form that stated the purpose and procedures, risks, and benefits of study participation to read and sign. In the presence of a member of the research team (female social worker, psychologist, or research assistant) participants were administered the structured questionnaire in a group setting.

A separate release of information was filled out for the treatment program that the participant intended to attend postdischarge. The referral program was then called 1 week postdischarge by a social worker or psychologist to ascertain whether the client had attended their scheduled appointment. If this information was not available, the client was reached directly at the number she had provided. Short-term outcomes were ascertained for all 101 study participants.

**Measure**

A 58-item structured self-report questionnaire developed by the authors to obtain basic demographic characteristics, treatment and trauma history, and attitudes about treatment assessed the following areas:

**Sociodemographic Characteristics.** The questionnaire assessed client’s age, race, educational attainment, religious preference, marital status, number of children, employment status, arrest history, housing situation, and psychiatric history.

**Alcohol/Drug Use History.** Regular drug use, age of onset, age at first drug use, types and frequency of prior treatments were assessed. Clients rated perceived efficacy of prior treatment of a 5-point Likert-type scale.
Outcome for Women in Detox

Trauma/Life History. Lifetime frequency of homelessness, adulthood interpersonal violence, child and adult loss, sexual abuse, rape, sex for drug exchange, serious physical accidents, witness to murder and mutilation were ascertained (see Table 1). If an event had occurred, subjects were asked to rate severity and to indicate whether the event had occurred within the past 6 months.

Self-Rating of Detoxification Experience. Relationship with staff and family, reason for pursuing detoxification, factors rated as influencing program completion, likelihood of accepting and following through with treatment referral were assessed using 5-point Likert-type scales.

RESULTS

Patient Characteristics

Thirty-five percent (n = 35) of the sample reported a history of previous psychiatric treatment, and 17.8% (n = 18) reported at least one previous psychiatric hospitalization; 24.8% (n = 25) reported at least one suicide attempt; 46.5% of the sample (n = 47) reported a history of arrest, with 55.3% (n = 26) of the arrests leading to time spent in prison; 56.4% (n = 57) of the women reported child welfare involvement.

Alcohol and Drug History

Sixty-four percent (n = 65) reported a lifetime history of regular and heavy alcohol use, 51.5% (n = 52) reported regular use of crack, 50.5% (n = 51) regular use of heroin, 38.6% (n = 39) regular use of cocaine, and 24.8% (n = 25) reported regular use of marijuana. In the month prior to detox, 48.5% (n = 49) of the women in our sample reported that they had regularly used alcohol, 45.5% (n = 46) regularly used crack, 41.6% (n = 42) regularly used heroin, 26.7% (n = 27) regularly used cocaine, and 8.9% (n = 9) regularly used marijuana, and 8.4% reported regular use of other drugs (i.e., sedative-hypnotics).

Substance Abuse Treatment History

The mean number of previous substance abuse detoxifications was 2.2 (SD = 2.3) with a range of 0–16. Seventy-eight percent (n = 79) of the women had attended at least one previous detoxification. Fewer women had received previous outpatient substance abuse services (48.8%, n = 49), rehab treatment (32.6%, n = 33), therapeutic community treatment (15.8%, n = 16), and halfway house stays (7.9%, n = 8). Thus, it appears that the women in our sample tend primarily to use inpatient detoxification to treat their substance abuse problems when they become unmanageable, and many had not been exposed to other forms of substance abuse treatment.

Traumatic Life Events

Sixty-three percent (n = 64) of our sample reported a history of childhood trauma, including direct physical or sexual abuse, or witnessing extreme parental violence as a child; 69.3% (n = 70) reported a history of adulthood partner violence or assault by a stranger, and 57.4%, (n = 58) reported a history of adulthood sexual assault or participation in sex-for-drug exchanges. See Table 1 for a further breakdown of types of violent trauma reported.

Short-Term Outcome

The findings revealed that 59.4% (n = 60) of the sample could be classified in the category of short-term “positive outcome.” In these cases, subjects followed through with the referral from detox and successfully kept their first appointment at the referral site. The remaining 40.6% (n = 41) could be classified in the category of short-term “negative outcome.” In these cases, either a referral was not kept or the patient was discharged prior to referral due to treatment noncompliance. Possible positive outcomes were successfully held first appointments at a drug-free program (55.4%, n = 56) or a methadone program (4.0%, n = 4). Possible negative outcomes were leaving the detox against medical advice (5.0%, n = 5), refusal of offered referral (5.0%, n = 5), or failure to contact referral site (30.7%, n = 31).

Predictors of Outcome

Univariate chi-square tests and Pearson correlations were conducted to determine the characteristics that were associated with “positive” versus “negative” outcomes. Statistically significant relationships were found between “positive” short-term outcome and both number of previous detox hospitalizations (R = .20, p < .05) and atten-
dance at outpatient programs \((R = .35, p < .05)\). A positive history of heavy alcohol use prior to admission was also significantly associated with better outcomes, \((\chi^2 (1) = 6.03, p < .01)\). Findings revealed no significant relationship between histories of child or adulthood violence, use of drugs, or any demographic characteristics. No relationship was found between outcome and severity of abuse in those who reported child or adulthood histories of physical or sexual abuse.

**DISCUSSION**

As expected, the women in our sample were primarily ethnic minorities from disadvantaged backgrounds who supported themselves financially with public assistance. Most of the women had contact with multiple institutional systems and settings over their lifetimes: psychiatric hospitals, jails and prisons, child welfare, detoxification units. To a lesser extent, they had involvements with outpatient substance abuse services. Fewer had received substance abuse treatment at inpatient rehab, halfway house, and therapeutic community settings.

Our findings revealed a very high rate of detoxification completion. Ninety-five percent of our sample successfully finished their designated detoxification. Although this study cannot fully address the role that gender-specific treatment may have upon women’s rates of completion, our subject drop-out rates were very low, suggesting that detoxification with group treatment for women-only can result in high retention rates. On self-report, the women in our study commented that they preferred the single-sex setting over the standard co-ed detoxification that they had received. Of course, shortened lengths of stay may also have contributed to the high completion rate. In our study group, the average length of stay ranged from a minimum of 4 days to a maximum of 7 days.

On short-term follow-up, nearly 60% of the sample was considered to have “positive” outcome. When a referral site was contacted, the client had successfully attended her first scheduled visit, even though 96% were referred to drug-free outpatient or residential programs as opposed to methadone maintenance. Given that drug-using clients have notoriously low treatment compliance rates, on the surface this finding appears relatively high. It should be emphasized, however, that we did not study whether the client remained in treatment or achieved abstinence, only that she attended her initial intake appointment.

Considering greatly improved treatment services for women, this finding is less optimistic. Every woman in the detox had extensive counseling and case management to ensure goodness-of-fit between client and program (i.e., child care, Spanish-speaking, religious orientation, location, travel time, etc.). Prior to disposition, nearly all women in our sample rated themselves as “extremely likely” to follow through with their referral and all stated their reason for seeking detox as for “personal benefit” rather than in response to family or legal pressures. Yet when offered the opportunity to be escorted to their program by a counselor, most declined. In spite of most women’s self-expressed desire for treatment and the array of programs available to them, 40% did not follow through.

It appears that a combination of self-assessed desire for help and treatment accessibility are not enough to surmount the power of the addictive process. Particularly for those residing in economically disadvantaged communities where drugs are abundant and social supports lacking, relapse can be an expected part of the recovery process. High rates of recidivism may not necessarily be reflective of “poor” outcome in all cases. In fact, among all the variables we surveyed, prior detoxification was the only factor significantly correlated with our measurement of positive outcome. Those women who had previously received multiple detoxifications were more likely to have gone on to pursue further help. This finding indicates that it may require a number of attempts before an individual is ready to accept the need for ongoing treatment, an unpopular view in this era of managed care and reduction in level and amount of services.

Consistent with reports of high rates of traumatic life events in populations of drug-using women (e.g., Fulilove, Lown & Fullilove, 1992; Miller, Downs & Testa, 1993; Paone et al., 1992), our findings document the presence of high rates of childhood exposures to violence as well as those in adulthood. Nearly two thirds of the sample report a history of childhood physical or sexual abuse, and over two thirds reported adulthood exposures. Particularly salient were reports that a majority of our study participants had experienced physical abuse in partner relationships.

There was no significant relationship, however, between a history of violence and short-term outcome. This is of interest, given the clinical question of whether underlying traumatic experiences contribute to treatment noncompliance for women. It may be necessary to differentiate those women with psychological sequelae of a type that would likely have negative consequences (such as posttraumatic stress symptoms) from those without to answer this question. Even when subjects with traumatic exposures were categorized into groups with mild, moderate, and severe trauma on the basis of chronicity, no association was found between severity of trauma and short-term outcome.

Our findings do suggest that identifying and discussing early histories of sexual abuse and other traumatic events does not interfere with completion of detoxification or negatively impact further treatment seeking. Wallen (1992) reported similar findings, countering a commonly held clinical assumption that open discussion of trauma too early in a treatment will lead to acting-out and premature termination. It was our impression that women were very willing to share their experiences or “war stories.” Asking subjects about whether or not an
event occurred must be distinguished from reviving affects associated with traumatic events. Intense exploration of the latter type is contraindicated without the establishment of a therapeutic alliance.

In summary, our study reveals that the more experience a chemically dependent woman has in drug treatment, the more likely she is to pursue a referral for ongoing counselling and assistance. Whereas individual circumstances and life events may certainly influence treatment follow through in the long term, we did not discern any specific predictors of short-term compliance.

As is widely accepted in the field, clinical presentation is not indicative of which clients will succeed in recovery and which will not. Our results suggest that the capacity to accept and utilize help may be developed over repeated treatment exposures rather than related to intrinsic character traits. Unfortunately, in this era of streamlined services, drug- and alcohol-dependent women may not get the opportunity to build on this experience as access to treatment will surely be limited.

REFERENCES


