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Impact of Remembering Childhood Sexual Abuse on Addiction Recovery for Young Adult Lesbians

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This article examines the impact of childhood sexual abuse on young adult lesbians' sexual identity and their recovery from chemical dependency. The authors recommend that counselors assess for sexual orientation (past and present), sexual abuse, and possible dual diagnosis. Implications for counselors are discussed.

Sexual assault, unfortunately, continues to occur in the United States for both men and women. Women are sexually assaulted more often than men, with an estimated 3% to 27% of women experiencing some form of sexual assault during their lifetime regardless of sexual orientation or identity (Eaton et al., 2008; Finkelhor, Hotaling, Lewis, & Smith, 1990; Kilpatrick, Saunders, & Smith, 2003; Patterson, 2009; Tjaden & Thoennes, 2006). Childhood sexual abuse (CSA) is not uncommon for women, including women who self-identify as lesbian. An estimated one in 16 children were victimized by sexual abuse during 2007 (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009). Approximately 28% of lesbians report CSA (Descamps, Rothblum, Bradford, & Ryan, 2000), and approximately 11% of women report having sex with other women (Mosher, Chandra, & Jones, 2005). In their study, Saewyc, Bearinger, Blum, and Resnick (1999) found that bisexual and lesbian respondents (22%) were more likely to report a history of sexual abuse compared with their heterosexual counterparts (13% to 15%).

Women who experience CSA or sexual abuse as adolescents often suppress the experience. Instead of acknowledging the abuse, they ignore it, hoping it will not affect the rest of their life; however, many find that this is an ineffective coping strategy (van der Kolk & Fisler, 1995). Unconsciously, the experience and the trauma associated with sexual abuse bleeds into other areas of the individual's life and can often manifest in many ways, ranging from mental health disorders, including substance abuse, to relationship issues throughout adolescence and, if untreated, into adulthood. In the United States, the

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prevalence of serious psychological distress (SPD) is roughly 10% of the adult population, with young adults representing the highest percentage rate at 18%. Approximately 13% of the female population has experienced SPD. Moreover, 22% of adults reporting SPD also reported substance dependence or abuse, whereas the rate among adults without SPD is 7.6% (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). Furthermore, 85% of adults between the ages of 18 and 25 years and 43% of adolescents between the ages of 12 and 17 years have reported using alcohol during their lifetime. In addition, approximately 7.7% of the total U.S. population and 5.1% of the female population will be diagnosed with alcohol dependence or abuse (age 12 years and older). Nearly 17% of young adults (between the ages of 18 and 25 years) will have received a diagnosis of alcohol abuse or dependence in the next 12 months. More specifically, approximately 12% of young adult women will receive an alcohol abuse or dependence diagnosis (SAMHSA, 2007).

Surprisingly, approximately 54% of the population who need treatment do not receive treatment, and, of those who receive treatment, only 33% receive mental health treatment. Moreover, only 24% will receive substance abuse treatment, and only 10% will receive treatment for both mental illness and substance abuse simultaneously (SAMHSA, 2009). Furthermore, some therapists believe that sexual abuse that occurs in childhood or around puberty will manifest through a sexual orientation other than heterosexuality (i.e., homosexuality, bisexuality, or asexuality; Brannock & Chapman, 1997). This article examines (a) the impact of CSA on young adult lesbians' sexual identity, (b) their recovery from chemical dependency, and (c) the implications for counseling.

IMPACT OF CSA ON YOUNG ADULT LESBIANS' SEXUAL IDENTITY

The development of a sexual identity can begin early or later in life depending on an individual's experiences, place in the life span, and resources. *Coming out* is the most used term in the lesbian community; it is a process each person navigates in her own time. Many of the factors that contribute to the development of a lesbian's sexual identity are different from those that contribute to the development of a heterosexual man's or woman's sexual identity (Cass, 1979). Society plays a large role in sexual identity and the feeling of acceptance. In the United States, some parts of society still view being a lesbian as different and abnormal. These types of societal viewpoints force individuals to develop a type of hypervigilance to protect themselves. Pratt (1991) described it as "the tense inner barrier that had guarded me for years from how I might be recognized as a dyke out in the world; the barrier that kept one aspect of myself always apart, expecting hate, not joy" (p. 85). When a person receives direct and subtle messages from all angles (e.g., society, religion, family, the media) that there is something wrong or abnormal about being a lesbian, it is difficult to acknowledge or express her sexual identity. Therefore, a person

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often responds through self-preservation, placing a barrier between herself and the expectation of others responding with hate.

Another part of the coming out process is coming to terms with others' expectations. Califia (1999) depicted the obstacles some individuals face as they begin their coming out process as trying to "defeat the shaming voices of self-obliteration and reject the temptation to live for others' gratification and approval rather than our own" (p. 277). (*Note*. Pat Califia made this comment when he still identified as a lesbian. In 1999, he began his transition process from female to male. He now identifies as male but is still respected in the lesbian community.) Individuals who have been immersed in a group that shuns homosexuality, such as a religious group, an ethnic group, or family, have to overcome the tendency to live their life pleasing others. Individuals who have been extremely close to their families, or very involved in their religious organizations, often find it difficult to ignore others' expectations and make their own goals (Degges-White, Rice, & Myers, 2000). In the process of self-acceptance, a person navigates and comes to the realization that she has the right to live her life as she sees fit.

Adolescents often explore their sexuality and begin to gravitate to one sex or the other, whereas others live the heterosexual lifestyle for many years, marry, have children, but then discover they are not happy. The reason for their unhappiness is that they are living a lie, or they become tired of trying to be happy in a lifestyle that does not match their sexual identity.

When a person decides to come out and begins to develop her own sexual identity as a lesbian, she may turn to popular lesbian icons such as Ellen Degeneres, Melissa Etheridge, k.d. lang, or Minnie Bruce Pratt to gather information about the community. Eventually, a person will begin to find out what works for her, how she identifies within the community (i.e., butch, femme, lipstick lesbian, stud), and which type of woman she is most attracted to for companionship. Being part of a community and getting support from others who are experiencing similar circumstances can help with this process (Cass, 1984; Degges-White et al., 2000). At the same time, being able to connect with another person and feel that there is someone who can help navigate this journey helps with the feelings of loneliness and isolation.

IMPACT OF CSA ON HUMAN DEVELOPMENT

Human development is affected by many different variables, and perhaps one of the most devastating blows is the act of childhood or adolescent sexual abuse. This is especially true because adolescent development stages are the foundation for self-worth and developing relationships, as well as cultural identity, sexual identity, and self-identity (Baruth & Manning, 2007; Phillips & Daniluk, 2004). As early as 1969, Bowlby began to explore the effects that grief during childhood and adolescence had on human development, including the impact

traumatic events had on a person's ability to develop healthy attachments as an adult. Professionals in the field of childhood trauma have conducted extensive research in the area of attachment. This research has made it apparent that CSA can be a traumatic event that has a possibility of affecting adult relationships and adult coping skills (Phillips & Daniluk, 2004). Bowlby believed that this breach needed to be grieved over before a secure attachment and identity could be developed. However, this breach can be difficult to grieve over because the client may not be able to remember the entire trauma (van der Kolk & Fisler, 1995). The client may be hesitant to explore the violation because she may feel that it is not important because she cannot remember all the details. Erikson (1997) discussed the importance of being successful through each developmental stage, and the potential impact on the subsequent stage of development if some sort of breach occurred. More recently, an ecological model developed by Bronfenbrenner that discusses human interaction is being used to explore the impact of CSA on adult development (Price, 2003). Current research and clinicians have well established that CSA has an impact on adult relationships to some degree; however, there is no evidence that CSA causes someone to develop a sexual identity as lesbian. It does influence or affect women's sexual awareness and interactions with others (Robohm, Litzenberger, & Pearlman, 2003).

IMPACT OF SEXUAL ABUSE ON THE LESBIAN POPULATION

The effects of sexual abuse in childhood or adolescence on emotional development and sexual orientation have been a topic of ongoing discussion among counselors and researchers. Descamps et al. (2000) examined a national sample of 1,925 lesbians who participated as respondents in the National Lesbian Health Care Survey (NLHCS, conducted in 1984–1985), which surveyed lesbians who had experienced CSA and intimate partner violence. The authors found that there was significantly more daily stress, depression, and alcohol abuse for lesbians who have experienced CSA and/or intimate partner violence than for the general population, which is also true for heterosexual women seeking treatment for CSA. Hyman (2009) explored the mental health of lesbians dealing with violence throughout the life span and the effect of living in a heterosexist society, as well as the prevalence of CSA among lesbians and the association of lifetime alcohol abuse with sexual abuse clients. Hyman's results suggested that there is a strong correlation between the variables, with a high prevalence of substance abuse among lesbians who have experienced CSA.

Recently, Stoddard, Dibble, and Fineman (2009) examined 324 lesbians, their heterosexual sisters, and the effects of sexual abuse on both siblings. The sample included English-speaking women living in California, 40 years and older, who identified themselves as lesbians. Each participant was asked to recruit her heterosexual sister by giving her a survey to complete. The researchers discovered that, during childhood, significantly more lesbians than their heterosexual

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sisters reported physical abuse and sexual abuse, with 27% of lesbians and 16% of their sisters who reported experiencing CSA. This study seems to support the clinical notion that women who experience CSA have a greater chance of self-identifying as lesbian; however, Stoddard et al.'s findings contradict those of Brannock and Chapman (1997). Brannock and Chapman found that the only significant difference between the two groups (lesbians and heterosexual women) was that heterosexual women were more likely to report multiple categories of traumatic experiences, such as incest, molestation, rape, and physical assault by men, whereas lesbians were more likely to report experiences in only one category of trauma. Even though this NLHCS research is over 20 years old, it is one of the largest research studies to date on the topic and was significant at the time. One conclusion that might be drawn from this survey is that, for lesbians, the impact of one traumatic experience with a man was enough to distance themselves sexually from men. The contradictory conclusion can also be drawn that, because heterosexual women report more than one traumatic experience with a man, sexual abuse does not affect sexual orientation.

PSYCHOLOGICAL IMPACT OF CSA

Russell, Jones, Barclay, and Anderson (2008) explored the emotional effect of CSA on survivors and the importance of appropriately working with the classical aspects of a self-identified lesbian client (e.g., coming out, internalized homophobia, mistrust), which may come up in counseling, along with the issue of sexual abuse. It is critical for counselors to be aware that some lesbians may feel that their sexual abuse had an effect on their sexual orientation and may consider their feelings about their orientation invalid. Some participants in Hall's (1998) study "[described] how their histories of sexual abuse in childhood made them apprehensive about their authenticity as lesbians" (p. 17). Counselors need to be affirmative about their clients' sexuality and help them with the issue of self-doubt. Often, CSA is accompanied by many issues that may manifest in feelings of self-doubt about sexual orientation. The lesbian client should explore self-doubt, with the assistance of a counselor, so that she can have a meaningful and positive relationship with a significant other.

Robohm et al. (2003) explored the connection between CSA and emotional/behavioral difficulties, feelings about sexuality, and the coming out process using a sample of 227 self-identified lesbians of whom 38% reported CSA. Many participants in the survey reported that their childhood sexual experiences affected their ability to trust men or to be involved with men. Moreover, some participants in the survey distinguished between their sexual orientation and sexuality. An interesting point in their findings was that the women reported that the abuse made them more aware of their sexual selves, but it did not affect their choice of partners. Hall's (1998) research analyzed 20 lesbians' narrative stories, which support Robohm et al.'s findings. One such experience was

that no participant expressed a belief that her sexual orientation was a result of CSA. Second, Hall identified a pattern of substance abuse in adult women who have experienced CSA. Finally, participants reported having to deal with their experiences being invalidated by people who would state or imply that their CSA was just child's play or that they had asked for it.

Hyman (2009) explored the mental health of lesbians across the life span with an emphasis on (a) violence, (b) living in a heterosexist society, (c) the prevalence of CSA, and (d) the association of lifetime alcohol abuse with sexual abuse. Evidence strongly suggests that CSA and substance abuse coincide. Hyman's results indicate a high prevalence of substance abuse among lesbians who have experienced CSA. Ross and Durkin (2005) sampled 19 self-identified lesbians and 39 self-identified heterosexual women. Both groups had a history of alcohol or substance abuse. Moreover, all the lesbians reported childhood physical and/or sexual abuse, 89% met the criteria for major depression, and 58% met the criteria for borderline personality disorder (BPD). In comparison, 58% of the heterosexual women reported childhood physical and/or sexual abuse, 72% met the criteria for major depression, and 44% met the criteria for BPD. As a result, Ross and Durkin concluded that the co-occurrence of alcohol and other drug abuse, childhood trauma, depression, and BPD could be found in lesbians at higher levels than in heterosexual women.

IMPACT OF REMEMBERING ON RECOVERY

Recovery from substance abuse disorders is a lifelong process, with most individuals experiencing a relapse sometime during their attempt to remain sober or clean. Even though relapse is a common occurrence, only approximately 60% of people in recovery experience a full-blown relapse (Gorski & Miller, 1982; Marlatt & Donovan, 2005). In addition, a full-blown relapse probably occurs outside of treatment and even prior to attending the first session because many people will attempt to stop drinking or using on their own. Berg and Miller (1992) and Prochaska, Norcross, and DiClemente (1995) supported the notion that most people attempt to stop using prior to their first treatment. Furthermore, Berg and Miller believed that some individuals may achieve sobriety without professional substance abuse treatment. Substance abuse counselors have a history of blaming clients with alcohol dependency for their relapse, even though the counselors claim that addiction is a disease that is not the clients' fault. Relapse may not be solely the clients' fault because treatment providers may miss important clues, coexisting issues, or other diagnoses. Therefore, relapse is a process and is not limited to the event of drinking or using, but the end result can be using (Gorski & Miller, 1982; Marlatt & Donovan, 2005).

Many triggers can start the relapse process, but often the progression seems subtle to the recovering person, family, sponsor, support group, and counselors (Gorski & Miller, 1982; Marlatt & Donovan, 2005). Moreover, the progression

of relapse can be long or quick; therefore, it does not become obvious until right before the use or after the use has occurred. Once the relapse process is understood by the recovering person and people involved, the signs of progression are not so subtle, and the relapse process can be interrupted at any point prior to using. Furthermore, relapse can be used as a therapeutic tool to help clients return to the recovery journey and learn from their experiences. The relapse process can be triggered by a crisis event, subtle changes in the client, or changes in the client's environment (Gorski & Miller, 1982; Marlatt & Donovan, 2005). Likewise, a perceived threat to clients' understanding of their recovery or of themselves can trigger the relapse process; moreover, emotional healing or remembering traumatic events (such as CSA) are considered crisis events that have a high probability of triggering a relapse, with using as the outcome. Remembering such a traumatic event can be particularly harmful if the event (or the complete memory) is being recalled for the first time. Memories of a childhood trauma such as CSA are often revealed as a result of a client receiving substance counseling and remaining sober or clean, because the substance use is no longer masking the pain or dulling the memories (Courtois, 2001). Counselors may hesitate to address secondary issues or emotional issues in the beginning of recovery for fear of triggering a trauma or a relapse; however, the Center for Substance Abuse Treatment (2005) and others have called for simultaneous treatment for individuals with dual diagnosis or coexisting issues, particularly if recovery is in jeopardy. This process is a delicate balance because clients are at risk of relapse if their coping skills and support systems are not in place or if their counselor is not skilled in working with both addictions and other mental health diagnoses or trauma issues (Finnegan & McNally, 1987). It is important for counselors working with coexisting issues and dual diagnoses to move slowly and balance recovery with other issues (Center for Substance Abuse Treatment, 2005). In addition, it is not uncommon for clients to leave addiction counseling feeling confident about their recoveries only to return to counseling a few months or years later to work on secondary issues that they recognize are affecting their recoveries. This situation is particularly true if the issues or traumas have been repressed or denied (Courtois, 2001). The return to treatment is often precipitated by recognizing the signs of starting the relapse process and fear of drinking or using or if they have completed the relapse journey by use of alcohol or a drug.

COUNSELING ETHICS AND HOMOSEXUALITY

Although the American Counseling Association (2005) has ethical standards regarding nondiscrimination, some counselors struggle with their own professional understanding of sexual orientation and consequently may cause harm through this lack of understanding, specifically about the coming out process. Herman and Herlihy (2006) discussed the ethical implications of the case of a counselor who, because homosexuality was not acceptable according to the counselor's religious

beliefs, refused to meet with a lesbian client who wanted to discuss relationship issues. Because of the ongoing stigma concerning homosexuality and coming out, it is important for counselors to be sensitive to their own reactions, particularly in light of Russell et al.'s (2008) discussion that CSA can manifest itself in the therapeutic relationship via the transference–countertransference matrix. That is, because of the sexual abuse experience, clients may feel that the only way to continue a satisfying relationship is to approach the relationship sexually; thus, they may begin to interact with the counselor in a seductive or provocative way, transferring those feelings onto the counselor. It is vital for the counselor to be aware of this dynamic and confront it during counseling so the client will have the opportunity to work through her transference issues. The counselor can help the client find another way of relating not only to the counselor but also to others who may be helping her (Russell et al., 2008).

IMPLICATIONS FOR COUNSELORS

Although not an overwhelmingly large population of clients, but perhaps a population that goes unnoticed, are clients who identify as lesbian, have an early onset of alcohol dependence, and are affected by CSA memories. With effective treatment for both alcohol dependence and trauma, a client can psychologically grow and developmentally catch up with her peers (i.e., can leave treatment both psychologically and chronologically in young adulthood). However, in treatment, the client will need to be sincere in her recovery from addiction; work through the suppressed CSA memories that are potential triggers for a relapse; and, if necessary, receive appropriate pharmacology treatment for depression. Furthermore, she will need to discuss her confusion regarding her sexual identity and learn ways to cope with her CSA without drinking. It will be important to have a strong lesbian, gay, bisexual, and transgender recovery community, as well as a mental health center that specializes in dual diagnosis recovery. It is essential for counselors to recognize the importance of finding the right combination of counseling modalities and recovery support to stabilize clients who are feeling powerless, scared, victimized, and in jeopardy of losing their sobriety. By no means is this article suggesting that counselors should push clients to explore their sexual identity. However, it is suggesting that counselors need to be sensitive, alert to unrevealed sexual identity confusion, and willing to inquire about as well as be open to discussing their clients' sexual identity and behaviors.

REFERENCES

American Counseling Association. (2005). *ACA code of ethics.* Alexandria, VA: Author.

Baruth, L. G., & Manning, M. L. (2007). *Multicultural counseling and psychotherapy: A lifespan perspective* (4th ed.). Upper Saddle River, NJ: Pearson Education.

Berg, I. K., & Miller, S. (1992). *Working with the problem drinker: A solution-focused approach.* New York, NY: Norton.

Bowlby, J. (1969). *Attachment and loss.* New York, NY: Basic Books.

DOI: -

Brannock, J. C., & Chapman, B. E. (1997). Negative sexual experiences with men among heterosexual women and lesbians. *Journal of Lesbian Studies, 1,* 251–255. doi:10.1300/J155v01n02_07
Califia, P. (1999). Layers of the onion, spokes of the wheel. In J. Larken (Ed.), *A woman like that: Lesbian and bisexual writers tell their coming out stories* (pp. 276–289). New York, NY: Avon Books.
Cass, V. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4,* 219–235.
Cass, V. (1984). Homosexual identity formation: Testing a theoretical model. *The Journal of Sex Research, 20,* 143–167.
Center for Substance Abuse Treatment. (2005). *Substance abuse treatment for persons with co-occurring disorders* (Treatment Improvement Protocol Series 42, DHHS Publication No. SMA 05-3922). Rockville, MD: Substance Abuse and Mental Health Services Administration.
Courtois, C. A. (2001). Implications of the memory controversy for clinical practice: An overview of treatment recommendations and guidelines. *Journal of Child Sexual Abuse, 9,* 183–210.
Degges-White, S., Rice, B., & Myers, J. E. (2000). Revisiting Cass' theory of sexual identity formation: A study of lesbian development. *Journal of Mental Health Counseling, 22,* 318–333.
Descamps, M. J., Rothblum, E., Bradford, J., & Ryan, C. (2000). Mental health impact of child sexual abuse, rape, intimate partner violence, and hate crimes in the National Lesbian Health Care Survey. *Journal of Gay & Lesbian Social Services, 11,* 27–55. doi:10.1300/J041v11n01_02
Eaton, D. K., Kann, L., Kinchen, S., Shanklin, S., Ross, J., Hawkins, J., . . . Wechsler, H. (2008). Youth risk behavior surveillance—United States, 2007. *MMWR Surveillance Summaries, 57,* 1–131. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5704a1.htm
Erikson, E. H. (1997). *The life cycle completed.* New York, NY: Norton.
Finkelhor, D., Hotaling, G., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse & Neglect, 14,* 19–28.
Finkelhor, D., Turner, H., Ormrod, R., Hamby, S., & Kracke, K. (2009). *Children's exposure to violence: A comprehensive national survey* (OJJDP Juvenile Justice Bulletin No. 227744). Retrieved from http://www.ncjrs.gov/pdffiles1/ojjdp/227744.pdf
Finnegan, D. G., & McNally, E. B. (1987). *Dual identities.* Center City, MN: Hazelden.
Gorski, T. T., & Miller, M. (1982). *Counseling for relapse prevention.* Independence, MO: Herald Publishing House.
Hall, J. M. (1998). Lesbians surviving childhood sexual abuse: Pivotal experiences related to sexual orientation, gender, and race. *Journal of Lesbian Studies, 2,* 7–28. doi:10.1300/J155v02n01_02
Herman, M. A., & Herlihy, B. R. (2006). Legal and ethical implications of refusing to counsel homosexual clients. *Journal of Counseling & Development, 84,* 414–418.
Hyman, B. (2009). Violence in the lives of lesbian women: Implications for mental health. *Social Work in Mental Health, 7,* 204–225.
Kilpatrick, D. G., Saunders, B. E., & Smith, D. W. (2003). *Youth victimization: Prevalence and implications* (NCJ Publication No. 194972). Retrieved from http://www.ncjrs.gov/pdffiles1/nij/194972.pdf
Marlatt, G. A., & Donovan, D. M. (2005). *Relapse prevention* (2nd ed.). New York, NY: Guilford Press.
Mosher, W. D., Chandra, A., & Jones, J. (2005). *Sexual behavior and selected health measures: Men and women 15–44 years of age, United States, 2002* (Advance Data From Vital and Health Statistics, No. 362). Retrieved from http://www.cdc.gov/nchs/data/ad/ad362.pdf
Patterson, D. (with Laskey, S.). (2009). *The effectiveness of sexual assault services in multi-service agencies*. Retrieved from http://www.vawnet.org/Assoc_Files_VAWnet/AR_DualPrograms.pdf
Phillips, A., & Daniluk, J. C. (2004). Beyond "survivor": How childhood sexual abuse informs the identity of adult women at the end of the therapeutic process. *Journal of Counseling & Development, 82,* 177–184.
Pratt, M. B. (1991). *Rebellion: Essays 1980–1991.* New York, NY: Firebrand Books.
Price, D. (2003). A development perspective of treatment for sexually vulnerable youth. *Sexual Addiction & Compulsivity, 10,* 225–245.
Prochaska, J. O., Norcross, J., & DiClemente, C. (1995). *Change for good: A revolutionary six-stage program for overcoming and moving your life positively forward.* New York, NY: Avon Books.
Robohm, J. S., Litzenberger, B. W., & Pearlman, L. A. (2003). Sexual abuse in lesbian and bisexual young women: Associations with emotional/behavioral difficulties, feelings about sexuality, and the "coming out" process. *Journal of Lesbian Studies, 7,* 31–47. doi:10.1300/J155v07n04_03
Ross, C. A., & Durkin, V. (2005). Childhood trauma, dissociation and alcohol/other drug abuse among lesbian women. *Alcoholism Treatment Quarterly, 23,* 99–105.

Russell, J. D., Jones, R. A., Barclay, K., & Anderson, M. (2008). Managing transference and countertransference in the treatment of gay, lesbian and bisexual survivors of childhood sexual abuse. *Journal of Gay & Lesbian Mental Health, 12,* 227–243.

Saewyc, E. M., Bearinger, L. H., Blum, R., & Resnick, M. D. (1999). Sexual intercourse, abuse and pregnancy among adolescent women: Does sexual orientation make a difference? *Family Planning Perspectives, 31,* 127–131.

Stoddard, J. P., Dibble, S. L., & Fineman, N. (2009). Sexual and physical abuse: A comparison between lesbians and their heterosexual sisters. *Journal of Homosexuality, 56,* 407–420.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2007). *The NSDUH report: Gender differences in alcohol use and alcohol dependence or abuse: 2004 and 2005*. Retrieved from http://www.oas.samhsa.gov/2k7/AlcGender/AlcGender.pdf

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). *Treatment Episode Data Set (TEDS): Highlights—2007. National admissions to substance abuse treatment services* (DASIS Series S-45, DHHS Publication No. SMA 09-4360). Retrieved from http://wwwdasis.samhsa.gov/teds07/tedshigh2k7.pdf

Tjaden, P., & Thoennes, N. (2006). *Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey* (NCJ Publication No. 210346). Retrieved from http://www.ncjrs.gov/pdffiles1/nij/210346.pdf

van der Kolk, B. A., & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *Journal of Traumatic Stress, 8,* 505–525. doi:10.1002/jts.2490080402