

California State University, San Bernardino

**CSUSB ScholarWorks**

---

Theses Digitization Project

John M. Pfau Library

---

1993

## Sexual abuse as a determinant of female amphetamine abuse

Diane Hutt Anderson

Follow this and additional works at: <https://scholarworks.lib.csusb.edu/etd-project>



Part of the [Gender and Sexuality Commons](#), and the [Substance Abuse and Addiction Commons](#)

---

### Recommended Citation

Anderson, Diane Hutt, "Sexual abuse as a determinant of female amphetamine abuse" (1993). *Theses Digitization Project*. 716.

<https://scholarworks.lib.csusb.edu/etd-project/716>

This Project is brought to you for free and open access by the John M. Pfau Library at CSUSB ScholarWorks. It has been accepted for inclusion in Theses Digitization Project by an authorized administrator of CSUSB ScholarWorks. For more information, please contact [scholarworks@csusb.edu](mailto:scholarworks@csusb.edu).

2 SEXUAL ABUSE AS A DETERMINANT OF  
FEMALE AMPHETAMINE ABUSE 2

---

A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

---

In Partial Fulfillment  
of the Requirements for the Degree  
Master of Social Work

---

by

Diane Hutt Anderson

June, 1993

SEXUAL ABUSE AS A DETERMINANT OF  
FEMALE AMPHETAMINE ABUSE

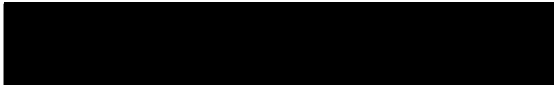
---

A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino


---

by  
Diane Hutt Anderson  
June, 1993

Approved by:

  
Dr. Marjorie Hunt, Ph.D.

5/25/93  
Date

  
Ms. Marta Diaz-Bormotino, LCSW, BCD.

  
Dr. Teresa Morris, D.S.W.

### Abstract

The purpose of this study was to study the possible relationship between child sexual abuses and addiction to amphetamines (this includes meth-amphetamine). A review of cases at a dual diagnosis clinic was conducted. This data will explore the relationship between women who use "speed" and a history of sexual abuse. The results of this study may impact how social workers assess and design treatment plans in the future for such drug-dependent clients.

## TABLE OF CONTENTS

Abstract . . . . .	iii
List of Tables . . . . .	v
Introduction . . . . .	1
Literature Review . . . . .	3
Methods . . . . .	9
Sampling . . . . .	11
Analysis . . . . .	12
Results & Implications . . . . .	13
Appendix A: OADP Treatment Services Intake Form . . . . .	18
Reference List . . . . .	26

## LIST OF TABLES

TABLE 1:	Table illustrating distribution of cases between prior history of sexual abuse and amphetamine use. . . . . .	10
TABLE 2:	Chi-Squared analysis of prior history of sexual abuse and amphetamine dependence. . . . . .	12

## Introduction

Women who have been victims of abuse become heavy work/heavy service users within the mental health environment. The term "heavy work/heavy service" means that these clients require intensive treatment and types of intervention. Often these clients do poorly in treatment. The women who are sexually abused that present for treatment are often chemically dependent. If a relationship could be established between past life trauma such as sexual abuse and chemical dependency, a benefit would be realized to the direct practice environment in terms of improved insight into the dynamics of a chemical dependency.

It is important to define the determinants of drug abuse so that current types of treatment can become more effective. With treatment funding decreasing each year, demands on mental health services become harder to meet. Even when women are in treatment for chemical dependence, they have a greater than fifty percent chance of relapsing into their addiction (Morris & Schinke, 1990). The social worker needs an understanding of the possible determinants of drug abuse. Thus, it is imperative that research be conducted to enhance and improve the present state of treatment for women suffering from chemical dependency.

Recently, the State of California initiated a pilot program to treat the dually diagnosed patient. Briefly, dual diagnosis is a term used to describe someone who has a

primary Axis I diagnosis, via the DSM-III-R, (the Diagnostic and Statistical Manual used in the Mental Health environment) such as Major Depression and another Axis I diagnosis of some form of chemical dependency. One of the seven pilot project sites is located within the community of Chino. This site is also one of two clinics responsible for treating chemical dependency in San Bernardino through the department of Mental Health.

Study has been done in San Bernardino County on Meth-amphetamine abuse recently (Helschober, Miller 1991). Between 1986 and 1988 admissions to the Redlands Community adolescent drug treatment program had 80% of the 12-20 year-olds using meth-amphetamine as the drug of choice. The San Bernardino County Trauma registry indicated that for those individuals who were 15 to 24 years of age, were five times more likely to be addicted to meth-amphetamine than to cocaine. The typical meth-amphetamine user entering treatment between 1988 to 1990 was a white female between the ages of 21 to 30 (Helschober, Miller 1991). The preferred way to take the drug is inhalation. The California Department of Alcohol and Drug Programs reports a steady increase in the numbers of amphetamine addicted individuals entering the treatment environment. The amphetamine dependent woman is a challenge that is demanding more from the services available.

Direct Practice social workers are constantly aware of



the challenge in treating the chemically dependent (CD). One clinic supervisor estimated that over 50% of the chemically dependent who begin treatment drop out (Mulinski, 1988). The derivation of this research study is the challenge faced in treatment by the direct service provider. This study will focus on increasing understanding of the determinants related to addiction.

At the Chino clinic, the majority of female patients have been diagnosed as suffering from amphetamine abuse or dependence. Because this is a dual diagnosis clinic other mental health issues are assessed at the time of intake. A high percentage of amphetamine dependent women were found to have histories of various types of abuse (i.e., sexual, physical and/or emotional abuse). Therefore, the primary hypothesis of this study came from practice data which strongly suggested that woman who abuse amphetamines are likely to have a history of sexual abuse.

Women who have been sexually abused often have serious problems later in life. Often signs of sexual abuse are demonstrated later in various ways. Such signs are: self mutilation and substance abuse. Often, past trauma is not assessed by mental health clinicians.

### Literature Review

In a review of the literature, certain drugs seem to have received "a lion's share" of the attention. For

example, within the studies of alcohol, researchers have discussed actual models of the determinants causing alcohol dependence (Donovan, 1986). Thomas Glynn (1983), in a review of over 200 studies on women and drug addiction, gathered information on age, ethnicity, geographical area and drug of choice. The majority of studies concentrated on heroin and cocaine addiction. No studies specific to amphetamine addiction were focused upon (Novacek, Raskin and Hogan, 1990). In observing the course of treatment these patients frequently drop out of therapy, relapse sooner and act out in destructive ways to themselves or to others, namely their children.

Within the body of literature of the study of addiction most of the research is conducted using male subjects (Burt, Glynn & Sowder, 1979). While these studies have contributed to the knowledge of addiction, the findings can only approximate the addictive experience in women. When comparative studies were done on the psychological characteristics between male and female addicts, women were found to function poorer psychologically (Burt, et al, 1979). In earlier studies, amphetamine use was frequently done through legally prescribed medications. Many women used amphetamines under the care of their physicians and often use became abuse (Guitierres, Patton, Raymond & Rhoads, 1984). Studies often included amphetamines as one of the prescribed medications that could become addictive.

This is one possible reason why little specific literature is found on the use of amphetamine or meth-amphetamine. Women who were dependent on amphetamine and other prescribed medication were often referred to as "soft drug users" (Guitierres, et al, 1984). Therefore, these women were unidentified as addicts and were not given assistance by any health or drug program.

Mulinksi (1989), found that a majority of women addicts came from abusive environments. These women often were unable to demonstrate good judgement, had poor impulse control and placed themselves in high risk situations. Drug dependent women have experienced a greater incidence of rape, incest, neglect and abuse versus non-addicted women as children (Morris, Schinke, 1990).

In a much earlier study, researchers studied the nature of the addictive process. As early as 1964, studies showed that prior to becoming addicted women had serious family problems (Chien, Lee and Rosenfield, 1964; Chambers, Hinesley & Moldstad, 1970; Guitierres, et al, 1984). It appears that from the literature reviewed that prior abusive trauma such as sexual abuse had an effect on women in terms of drug addiction. Little in the research revealed knowledge about the amphetamine addicted women. No studies reviewed thus far discuss the specific determinants of amphetamine addiction.

Evidence does support the idea that sexual abuse does

have harmful effects on women later in life. A larger percentage of women are entering the treatment environment. These women show symptoms of chemical dependency and mental illness (Mulinski, 1989). These women are frequently misdiagnosed and lost in the mental health system. According to the Alcohol, Drug Abuse and Mental Health Administration, at least 50% of the two million Americans with severe mental illnesses use illicit drugs or alcohol as compared to fifteen percent of the general population (Sciacca, 1991). Could this heavy drug abuse be perceived as a coping mechanism?

Stanton Peele (1985) explains that when a person has an addiction, it becomes a part of the addict's ability to exist. Addiction is not a matter of a pursuit of pleasure. An addiction is an extremely dysfunctional attachment to a harmful experience that a person is helpless to stop. An addiction is a way of modifying a person's feelings and sensations. Addictions provide a reward because it gives gratification to the user. This gratification is inferior to something that is genuinely rewarding but for the addict it is enough to continue a self-destructive pattern of behavior. Peele also views the addiction as an experience that is vital to the addict to tolerate the environment around him. For the addict, the ordinary, normal feeling of self-awareness is uncomfortable. The inability of the addict to be comfortable within his world is important. The

addiction is the filter in which the addict must hide behind in order to survive.

Many times mental distress begins as a result of a terrible trauma such as sexual abuse. The proper assessment of past abuse often goes unattended and untreated. Brown & Finkelhor (1986) in a study of women who have been sexually abused found that 60% were emotionally disturbed, 52% were mildly to moderately disturbed and 14% were seriously disturbed. Women who have been sexually abused have problems coping with feelings of fear, guilt and anger. In terms of long term effects, depression is most common. Frequent self-destructive behavior such as attempted suicide are seen. In a study done on sexual and physical abuse undetected in the mental health system, Rose, Peabody and Strateigeas (1984) cited that currently the risk of being sexually abused is 1 out of 10 for boys and greater than 1 in 3 for girls. Rose, et al (1984) found that between 70 to 80 percent of the female psychiatric patients they sampled had a history of sexual abuse. Discovery of this high percentage was "accidental" by mental health professionals while reviewing intake data.

How does child abuse, specifically sexual abuse, fit in the development of an addiction? In reviewing life experiences of women with mental health problems, three kinds of experiences are shared by these women, they are:

- 1.) Women grew up in families where one or more of the

adults had a major drug and/or alcohol problem.

- 2.) These women had experienced extensive sexual and/or physical abuse.
- 3.) After being abused, all developed behavior problems such as self-mutilation, substance abuse and long unsuccessful involvement with the mental health system. (Rose, et al, 1984.)

In Rose's study, eighty percent of mentally ill women were victims of sexual abuse. In addition, fifty percent of all mentally ill were experiencing chemical dependency. A prior history of sexual abuse seems to place women at risk of developing a drug dependence. But what are the specific determinants between sexual abuse and chemical dependency? From a practice standpoint, greater understanding of this link would bring effective skills into the treatment environment.

It is now appropriate to identify more specifically the determinants or factors that lead to speed addiction in women. One potential factor, sexual abuse had been identified based on the evidence discussed from past research. Does sexual abuse predetermine one to abuse drugs, specifically speed? The goal of this study is to describe the question fully and to report its findings. This study includes the realm of mental health because the female addict is seen in large numbers at treatment clinics. It is not possible to divide the issue of sexual abuse from

women who are chemically addicted. Research points to a relationship between the traumatized women of abuse in treatment (Mulinski, 1989) and the struggle she experiences with various chemical dependencies (Mulinski, 1988; Williamson, Bouding, Howe, 1991).

#### Methods

For the purposes of this study, women experiencing either speed dependence or abuse were included in the sample. The term "speed" was used and is a slang definition for street-sold amphetamine. This study is descriptive. Its purpose is to determine if being sexually abused is associated with a chemical dependency on speed.

Data were collected from the case records of both open and closed cases in the Chino Multiple Diagnosis Clinic. The time period ranged from the clinic's opening in January of 1992 until December 1992. The case review concentrated on female case histories. Each case was coded for having a history of sexual abuse as positive (1) or negative (2). Following this, a review of the admission diagnosis was made. Each case was coded, based on primary diagnosis. Amphetamine use as the primary diagnosis was coded (P), amphetamine use as the secondary diagnosis was coded (S). If the woman used more than one drug (that could include amphetamine) this pattern of drug use was coded under Polysubstance Abuse (P.S.). This diagnostic term refers to the DSM-III-R diagnostic criteria specifying Polysubstance

abuse as a chemical dependency of more than one substance used at the same time.

The data was taken directly from a survey of case records. No interviews with patients were conducted. The information was assigned to a frequency grid (see Table 1).

TABLE 1: Table illustrating distribution of cases between prior history of sexual abuse and amphetamine use.

	Positive	Negative
Amphetamine Use	01,02,03 04,05,06 07,08	26,27,28,29 30,31,32,33 34,35
Primary Diagnosis	F <sub>o</sub> =8	F <sub>o</sub> =10
Secondary Diagnosis	09,10,11,12,13 F <sub>o</sub> =5	36,37,38,39 F <sub>o</sub> =4
Polysubstance Abuse	14,15,16,17,18 19,20,21,22,23 F <sub>o</sub> =12	40,41,42,43,44 45,46,47,48 49 F <sub>o</sub> =11

N=50

Mental Health records were not randomly selected, because they needed to meet two criteria: one, that the patient be female and two, that the patient be seen for a drug problem (not only a psychiatric problem). Selection was not based on any other criteria or restraints. As mentioned earlier, information was taken directly from the intake form presently in use at the Chino Dual Diagnosis



Clinic (see Appendix A, information relevant to study is highlighted). The intake form was designed by Mental Health staff and is not in use in other site programs.

Each case was recorded on a grid reflecting the independent or dependent variable. Each case was recorded using the six digit chart number assigned to each mental health case.

To ensure anonymity, the grid entries were renumbered beginning at 01 through 50. The lists of chart numbers and the renumbered list were kept in separate locations by the researcher.

#### Sampling

Individuals who come to the dual diagnosis clinic fall between the ages of 14 to 65. If they meet the admission criteria they may come from any part of San Bernardino County to seek treatment. The socioeconomic status for the clients is mid to lower level. Many of the women served are on Medi-Cal and AFDC. The primary ethnic groups served are Caucasian and Hispanic. Some of the women seen for treatment are court-ordered into the program for drug related crimes or for child custody reasons.

Both open and closed charts were selected for review, from January 1992 to March 1993. Approximately 50 mental health records were reviewed. The primary source of data regarding the individual's history of sexual abuse was taken from the clinic's intake form. The diagnostic information

was taken from the clinic's treatment plan form.

### Analysis

Analysis of the data was made using a Chi-Square test. The goal of the analysis was to demonstrate a difference in the number of cases using amphetamine and being sexually abused as compared to those individuals who were polysubstance abusers and who hadn't been sexually abused.

The cases fell within the frequency grid showing little difference between the independent variable of sexual abuse. For example, total number of Polysubstance Abusers who were sexually abused were 12 and compared to Polysubstance Abusers who were not sexually abused were 11. Out of fifty charts, the same number of cases revealed a history of sexual abuse (25) as those who did not (25). Findings are reported below (see Table 2).

TABLE 2: Chi-Squared analysis of prior history of sexual abuse and amphetamine dependence.

Previous History Of Sexual Abuse	<u>Amphetamine Use</u>		
	<u>Primary</u> N=18	<u>Secondary</u> N=18	<u>Polysubstance</u> N=23
NO	10	4	11
YES	8	5	12

$\chi^2 = .38$  using 3df  $p < .05$  N=50

No statistical significance was found between the independent variable and the dependent variable. The data

did not prove if sexual abuse was a determinant for a woman to become addicted to speed. No change in the difference was seen if the cells for primary or secondary amphetamine abuse were calculated.

### Results & Implications

Because there was no statistical difference between a woman's history of sexual abuse and use of amphetamines other confounding variables may need to be controlled for a clearer conclusion to be made. While information was gained through this case study, more research is necessary in studying female chemical dependence.

Each case that was reviewed contained a great deal of information on an individual. All the individual characteristics of the client were collected and assessed for treatment. It is these characteristics that assist in influencing how a client chooses or is drawn to a particular drug. For example, we know from the literature that individuals who have a personality disorder are more likely to have drug problems. This creates two possible variables that need to be controlled or studied separately. One, those who have a personality disorder and chemical dependency would have to be excluded since these individuals have already been shown to be at high risk and two, those individuals who do have a personality disorder are more likely to be survivors of early trauma such as incest since personality disorders happen early in the person's

development.

The environment is an area to be considered when designing a study like this. According to reports given to the researcher, many women who were sexually abused were also using speed. However, during closer examination, it was found that methamphetamine is made in abundance in the Chino/Ontario area. This would make the drug easy to come by and relatively cheap.

However, not all the women treated at the clinic were from either Chino or Ontario. The clinic is able to treat anyone in San Bernardino County, if the person meets the criteria as outlined earlier in the Samples section. Geography may be an important variable to control for because the types of drugs that are available in the community may reflect the kind of drug dependencies that the clinic sees and treats.

Another area to consider is the reliability of the data gathered. The data was gathered solely from the standard intake form. If an interviewer was uncomfortable with asking the patient about sexual abuse, it would be easy for the worker to leave the question blank or to make it no or "N/A." Also based on the worker's interviewing skills, a patient's vague or ambivalent answers may be noted as "no", when there may be abuses that the patient is resistant or embarrassed to discuss. This would mean that the issue of abuse would not be correctly assessed, diagnosed or, in this

case, studied effectively. Lastly, there still exists different operational definitions of what sexual abuse is and what are its consequences. Such differences may skew a interviewer's interpretation of what a patient is showing. In further studies, a clearer definition of sexual abuse is necessary and assistants should be trained in how to assess women (using this definition) using a standard instrument. This would entail more hours of research but could provide more reliable data.

In reviewing the data, it is noted that 50% of the women studied had a history of speed use. This is an important characteristic of the women coming in for treatment. For whatever reasons, this substance is assisting women to dysfunctionally cope with their lives. There are over twenty substance disorders listed in DSM-III-R. How this drug commands such a high percentage of the sample should raise some questions as to why.

This study does support earlier research findings that women who use drugs often have experienced sexual abuse. Fifty percent of the charts studied indicated that the women were survivors of sexual abuse. This percentage is conservative but just as compelling as Surrey's (1990) work which revealed 64% of women were sexually abused. This study was conducted in an outpatient mental health clinic. Also shown is the multiple problems women experience as they come in for treatment. It supports the concept of the dual

(or rather) multiple diagnosis approach. It should also support improving treatment for such illnesses as personality disorders which is certainly not being done now in the current mental health environment. Not studied here, but noted by this researcher was that many of the sample, if not sexually abused, had been physically or emotionally abused.

Because one out of two women seeking treatment at the Chino clinic have been abused, treatment skills and sensitivity to this issue are important to have as clinicians, not only skill in drug rehabilitation. Regardless how long a patient's sobriety may be, if she cannot function interpersonally because of her abuse history, she is not completely healed. She cannot become a functional part of her social world and environment. As social workers, we are bound to help people achieve this goal.

There seemed to be a lack of empirical knowledge on the topic of amphetamine abuse, even though studies exist on other drug dependencies. How can we treat a drug dependence when we have not studied it sufficiently. We cannot and therefore, must work harder if we are to be taken seriously in treatment. The statistics from this study reveal that it doesn't seem to matter what kind of drug is used if a women seen at the clinic had been sexually abused. No elevation or increased frequency of amphetamine cases were shown if

the women had been sexually abused or not. Therefore, while the hypothesis being studied was not supported, other points are implied as a result of this project. They are:

1. During intakes, workers should not assume that because a woman has been sexually abused she is destined to use amphetamines.
2. Past research has shown that women who are chemically dependent are often victimized by sexual abuse. Yet, research has also shown mental health workers reluctant to discuss sexual abuse issues with a patient or many even avoid assessing this area entirely. Workers should be educated to be comfortable and competent in assessing a woman's abuse history. This knowledge can better aid the worker in determining the course of treatment for the woman. Knowledge in drug rehabilitation is not sufficient or effective.

In reviewing the case similarities between the non-abused woman and those who have been abused, the numbers were identical. It looked like very little difference can be seen between these groups of women. This may imply that greater similarities may exist within the experience of the woman addicted to drugs and their environment. Another implication may be that as we discover what the determinants of amphetamine abuse are, these determinants are likely to be interrelated and transactional.

## APPENDIX A

### OADP TREATMENT SERVICES

#### Intake Form

DATE: \_\_\_\_\_

( ) New Patient  
( ) Re-admit

#### I. [IDENTIFYING DATA]:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Ethnic Background: ( ) Caucasian      Marital Status: ( ) Never Married  
( ) Hispanic      ( ) Married/Common-law  
( ) Black      ( ) Widowed  
( ) Asian      ( ) Divorced  
( ) American Indian      ( ) Separated  
( ) Other \_\_\_\_\_

Primary Language: ( ) English      Referral Source: ( ) Court (Muni./Superior)  
( ) Spanish      ( ) Probation/Parole  
( ) Other \_\_\_\_\_      ( ) CPS/Juvenile Court  
( ) Self

Social Security Number: \_\_\_\_\_ ( ) Family

Education: (Highest Grade Completed) \_\_\_\_\_ ( ) Dept. of Mental Health

Degrees: \_\_\_\_\_ Typical Grades: \_\_\_\_\_ ( ) Health Care Provider  
( ) Dept. of Voc. Rehab.

Parents or Next of Kin: \_\_\_\_\_ ( ) School

Address: \_\_\_\_\_ ( ) Other \_\_\_\_\_

Phone: \_\_\_\_\_

Person to Contact in Case of Emergency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

#### II. [PRESENTING PROBLEM]: (Patient's Statement of the Problem) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### III. [CURRENT PROBLEM]: (Behavioral Support for Diagnosis) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



IV. [ALCOHOL HISTORY]: Age/Year of First Use: \_\_\_\_\_ Last Use: (Date) \_\_\_\_\_

Frequency of Use: ( ) Daily ( ) Occasional  
 ( ) \_\_\_\_\_ times per week ( ) Binge/Periodic  
 ( ) \_\_\_\_\_ times per month

Type of Beverage: ( ) Beer Quantity: \_\_\_\_\_  
 ( ) Wine \_\_\_\_\_  
 ( ) Hard Liquor \_\_\_\_\_

Symptoms of Alcohol Use: ( ) Blackouts ( ) Abdominal Pain ( ) Increased Tolerance  
 ( ) Confusion ( ) Memory Lapses ( ) Other \_\_\_\_\_

Type of Withdrawal Symptoms: ( ) Nausea ( ) DT ( ) Depression ( ) Vomiting  
 ( ) Tremors/Shakiness ( ) Hallucinations/Delusions  
 ( ) Other \_\_\_\_\_

Prior Alcohol Treatment and Dates: \_\_\_\_\_

DUI/DDP Programs & Dates: \_\_\_\_\_

V. [DRUG HISTORY]:

TYPE OF DRUG	AMOUNT	ROUTE OF ADMIN.						FREQUENCY OF USE							YR OF 1st USE	DATE OF LAST USE
		(Specify per day/wk/etc.)	I.V.	INHALATION	SMOKING	ORAL	I.M.	OTHER	Ø USE PRIOR MONTH	LESS THAN 1 X PER WK	1 X PER WK	SEVERAL X PER WK	1 X DAILY	MORE THAN 1 X DAILY		
AMPHETAMINES																
CANNABIS/HASHISH																
COCAINE/CRACK																
SEDATIVES/ HYPNOTICS																
TRANQUILIZERS																
HALLUCINOGENS																
INHALANTS																
OPIATES/HEROIN																
OTHER (SPECIFY)																

Symptoms of Drug Use: ( ) Hyperactivity ( ) Changes in Pupil Dilation  
 ( ) Aggressiveness ( ) Increased Tolerance  
 ( ) Sleepiness ( ) Hallucinations/Delusions

Type of Withdrawal Symptoms: ( ) Tiredness/Fatigue ( ) Headaches ( ) Muscle Aches  
 ( ) Irritability ( ) Nausea ( ) Depression  
 ( ) Muscle Reactions ( ) Other \_\_\_\_\_

Previous Drug Treatment and Dates: \_\_\_\_\_

VI. [SOCIAL HISTORY]:

Place of Birth: \_\_\_\_\_ Birth Problems: ( ) None ( ) Premature  
( ) Forceps  
Patient's Birth Order Position: \_\_\_\_\_ ( ) Other \_\_\_\_\_

No. of Male Siblings: \_\_\_\_\_ No. of Female Siblings: \_\_\_\_\_

Patient was Raised in: ( ) an intact home ( ) a foster home  
( ) a blended family ( ) an adopted home  
( ) a single parent family ( ) the home of relatives

Patient's Parents: ( ) Remained married  
( ) Divorced when patient was \_\_\_\_\_  
( ) Mother/Father remarried when patient was \_\_\_\_\_  
( ) Mother/Father abandoned patient when he/she was \_\_\_\_\_  
( ) Mother/Father passed away when patient was \_\_\_\_\_

(Optional for Adults) \_\_\_\_\_ Developmental Milestones: \_\_\_\_\_  
( ) Violence ( ) Enuresis ( ) Delinquency ( ) Hyperactivity  
( ) Encopresis ( ) Firesetting ( ) Other \_\_\_\_\_

Family and Peer Relationships: \_\_\_\_\_

History of: ( ) Sexual Abuse Ages and by Whom: \_\_\_\_\_  
( ) Emotional Abuse  
( ) Physical Abuse

Family History of Substance Abuse: \_\_\_\_\_

Support System: \_\_\_\_\_

Marital: # \_\_\_\_\_ Marriages #1 From age \_\_\_\_\_ to \_\_\_\_\_ #3 From age \_\_\_\_\_ to \_\_\_\_\_  
#2 From age \_\_\_\_\_ to \_\_\_\_\_ #4 From age \_\_\_\_\_ to \_\_\_\_\_

Childrens' Names and Ages: \_\_\_\_\_

Current Spouse: \_\_\_\_\_

Current Living Arrangements: ( ) Apt ( ) House With Whom: \_\_\_\_\_

Sources of Income: ( ) AFDC ( ) SSI ( ) SDI ( ) Family Support/SO  
( ) Illegal Activities ( ) Retirement/Pension

Amount Per Year: \_\_\_\_\_

Employment: ( ) Unemployed ( ) Seasonal/Intermittent  
( ) Employed Full Time ( ) Employed Part Time

Occupation: \_\_\_\_\_ Previous Jobs: \_\_\_\_\_

Legal: ( ) Never Arrested ( ) Arrested # \_\_\_\_\_ Substance related offenses  
# \_\_\_\_\_ Other offenses

List Offenses & Dates: \_\_\_\_\_

( ) Currently ( ) Previously on ( ) Probation ( ) Parole

[SOCIAL HISTORY]: (Continued)

Military: ☐ N/A  
☐ Army ☐ Navy  
☐ Air Force ☐ Marines  
☐ Coast Guard

WHEN: \_\_\_\_\_  
RANK: \_\_\_\_\_  
DISCHARGE: \_\_\_\_\_

VII. [PHYSICAL HEALTH HISTORY]:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: ☐ None ☐

Abnormal Movements: ☐ None ☐

Disabilities: ☐ None ☐ Auditory ☐ Visual ☐ Orthopaedic ☐ Other

Current Health Problems: ☐ None ☐ Pregnancy ☐

Current Meds for Physical Problems: ☐ None ☐

Childhood Health: ☐ No significant problems reported  
☐ Usual childhood diseases  
☐

Major Adult Illnesses: ☐ None ☐ Venereal Diseases: \_\_\_\_\_  
☐ Hypertension ☐ Gastrointestinal  
☐ Diabetes Problems \_\_\_\_\_  
☐ Asthma ☐ Other \_\_\_\_\_

Hospitalizations: ☐ None ☐ Childbirth ☐

Doctor's Name, Address, and Phone: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

W O M E N  
M E N  
E F F E C T S  
O F  
M E N S E S: ☐ No significant problems ☐ PMS ☐ Dysmenorrhea  
☐ Other \_\_\_\_\_  
P R E G N A N C I E S / C H I L D B I R T H: ☐ Gravida ☐ Para  
☐ History of complications \_\_\_\_\_

Sleep: ☐ No disturbance ☐ Early morning awakening ☐ Insomnia  
☐

Appetite: ☐ No disturbance ☐ Increased appetite ☐ Decreased appetite  
☐

Eating Disorders: ☐ None noted ☐ Anorexia ☐ Bulimia

Sexuality Problems: ☐ None reported ☐ Increased sexual desire  
☐ Difficulty w/performance ☐ Decreased sexual desire  
☐ Sexual identity problems ☐

Seizures, Periods of Unconsciousness: ☐ None ☐

[PHYSICAL HEALTH HISTORY]: (Continued)

Other Neurological Symptoms or Problems: ( ) None ( ) Head Injuries \_\_\_\_\_  
( ) \_\_\_\_\_

Tobacco Use: ( ) None ( ) \_\_\_\_\_

VIII. [MENTAL HEALTH HISTORY]:

Family History of Mental Illness: ( ) None ( ) \_\_\_\_\_

Age When Patient's Emotional Problems Began: \_\_\_\_\_ History of Problems: \_\_\_\_\_

Ward B Hospitalizations: ( ) None ( ) \_\_\_\_\_  
(Specify if 5150) \_\_\_\_\_

Other Inpatient Hospitalizations: ( ) None ( ) \_\_\_\_\_

Outpatient Treatment and When: ( ) None ( ) \_\_\_\_\_

Suicide History: ( ) None ( ) Circumstances, Methods, and When: \_\_\_\_\_

Current Meds for Emotional Problems: ( ) None ( ) \_\_\_\_\_

Previous Meds: ( ) None ( ) \_\_\_\_\_

IX. [MENTAL STATUS EXAMINATION]:

Appearance/Hygiene/Self-Care:

( ) Neat	( ) Adequate hygiene	( ) Dressed in age & sex appropriate street clothing
( ) Disheveled	( ) Poor hygiene	( ) Inappropriate clothing
( ) Little/No attention to appearance	( ) Well nourished	____ Not age appropriate
	( ) Poorly nourished	____ Not sex appropriate
		____ Over-dressed
		____ Atypical clothing

<u>Posture:</u>	<u>Body Movements:</u>	<u>Eye Contact</u>	<u>Rapport:</u>
( ) Normal	( ) Normal	( ) Good	( ) Good
( ) Rigid	( ) Slow/Lethargic	( ) Fair	( ) Fair
( ) Limp	( ) Restless/Fidgety	( ) Poor	( ) Poor

[MENTAL STATUS EXAMINATION]: (Continued)

Intelligence/Intellectual Functioning:

- ( ) Average ( ) Somewhat above average  
( ) Significantly below average

Orientation: ( ) Person ( ) Place  
( ) Time ( ) Situation

Notable Deficits: ( ) Poor vocabulary

- ( ) Poor problem solving skills  
( ) Poor general information  
( ) Impaired abstract ability  
(concrete thinking)  
( ) Impaired calculation ability

Explain any problems: \_\_\_\_\_

Memory: ST: ( ) No problem noted or reported  
( ) Impairment noted ( ) Mild ( ) Moderate ( ) Marked  
LT: ( ) No problem noted or reported  
( ) Impairment noted ( ) Mild ( ) Moderate ( ) Marked

Thought Content:

- ( ) Delusions  
( ) Phobias/Fears  
( ) Obsessions/Compulsions  
( ) Fantasies/Recurrent Dreams  
( ) Blocking  
( ) Preoccupation/Perseverations  
( ) Depersonalization  
( ) Grandiosity  
( ) Nihilism  
( ) Ideas of ( ) Reference ( ) Influence ( ) Persecution

Associations:

- ( ) Appropriately tight  
( ) Loose associations  
( ) Circumstantial  
( ) Illogical  
( ) Jumpy  
( ) Difficult to follow

Suicidal/Homicidal Assessment:

	<u>Ideation</u>		<u>Plans</u>		<u>Attempts</u>		<u>Potential</u>		
SUICIDAL	Yes	No	Yes	No	Yes	No	Low	Med.	High
HOMICIDAL	Yes	No	Yes	No	Yes	No	Low	Med.	High

Risk Factors: \_\_\_\_\_

Impulse Control:

( ) Good ( ) Average ( ) Fair ( ) Poor \_\_\_\_\_

Insight:

- ( ) Good  
( ) Average \_\_\_\_\_ Patient acknowledges presence of problems  
( ) Fair \_\_\_\_\_ Patient perceives multiple determinants for problems  
( ) Poor \_\_\_\_\_ Patient mostly blames others or circumstances for problem  
( ) Limited  
( ) Spotty

Judgment:

- ( ) Good  
( ) Average \_\_\_\_\_ Impairment noted with regards to substance use only  
( ) Fair  
( ) Poor in certain \_\_\_\_\_ Impairment generalized to several areas of patient's  
situations life  
( ) Impaired

[MENTAL STATUS EXAMINATION]: (Continued)

Behavior in Session:

- |   |  |
|---|--|
| <input type="checkbox"/> Appropriate/Cooperative    | <input type="checkbox"/> Talkative/Excited/Agitated  |
| <input type="checkbox"/> Apprehensive/Anxious       | <input type="checkbox"/> Mute/Catatonic              |
| <input type="checkbox"/> Manipulative/Controlling   | <input type="checkbox"/> Fearful                     |
| <input type="checkbox"/> Resistive/Argumentative    | <input type="checkbox"/> Withdrawn/Pensive           |
| <input type="checkbox"/> Guarded/Suspicious/Evasive | <input type="checkbox"/> Angry/Hostile/Threatening   |
| <input type="checkbox"/> Histrionic/Dramatic        | <input type="checkbox"/> Submissive/Overly Compliant |
| <input type="checkbox"/> Confused                   | <input type="checkbox"/> _____                       |

SPEECH:

- | <u>Rate:</u>                               | <u>Amplitude:</u>                       | <u>Quality:</u>                           | <u>Organization:</u>                               |
|--|---|---|--|
| <input type="checkbox"/> Normal            | <input type="checkbox"/> Well-modulated | <input type="checkbox"/> Clear/Audible/   | <input type="checkbox"/> Logical/Concise           |
| <input type="checkbox"/> Well-paced        | <input type="checkbox"/> Low            | <input type="checkbox"/> Coherent         | <input type="checkbox"/> Repetitious/Perseverative |
| <input type="checkbox"/> Slow              | <input type="checkbox"/> Loud           | <input type="checkbox"/> Slurred/         | <input type="checkbox"/> Circumstantial            |
| <input type="checkbox"/> Variable          |   | <input type="checkbox"/> Incoherent       | <input type="checkbox"/> Neologisms                |
| <input type="checkbox"/> Excited/Pressured |   | <input type="checkbox"/> Halting/Hesitant | <input type="checkbox"/> Word Salad                |
| <input type="checkbox"/> Fast/Manic        |   | <input type="checkbox"/> Stuttering       | <input type="checkbox"/> Tangential                |
|  |   | <input type="checkbox"/> Lisp             | <input type="checkbox"/> Vague/Poverty of Content  |
|  |   |   | <input type="checkbox"/> Wordy/Verbose             |
|  |   |   | <input type="checkbox"/> Clang Associations        |
|  |   |   | <input type="checkbox"/> _____                     |

Affect:

- |   |  |
|---|--|
| <input type="checkbox"/> Appropriate to thought content   | <input type="checkbox"/> Histrionic          |
| <input type="checkbox"/> Inappropriate to thought content | <input type="checkbox"/> Flat                |
| <input type="checkbox"/> Blunted/Bland                    | <input type="checkbox"/> Silly               |
| <input type="checkbox"/> Labile                           | <input type="checkbox"/> Superficial/Shallow |
| <input type="checkbox"/> _____                            | <input type="checkbox"/> _____               |

Mood:

- |   |   |
|---|---|
| <input type="checkbox"/> Depressed/Sad        | <input type="checkbox"/> Bland/Unvarying              |
| <input type="checkbox"/> Hostile/Veiled Anger | <input type="checkbox"/> Anxious/Apprehensive/Fearful |
| <input type="checkbox"/> Elated/Euphoric      | <input type="checkbox"/> Labile                       |
| <input type="checkbox"/> _____                | <input type="checkbox"/> _____                        |

Perceptions:

- ☐ No evidence of a perceptual disorder
- ☐ Evidence of/admission of hallucinations \_\_\_\_\_ Auditory \_\_\_\_\_ Visual \_\_\_\_\_ Somatic \_\_\_\_\_

- ☐ Perceptions are marked by \_\_\_\_\_ Occasional illusions
- \_\_\_\_\_ Frequent illusions \_\_\_\_\_

Sensorium: ☐ Clear ☐ Cloudy ☐ Confused ☐ \_\_\_\_\_

Attention & Comprehension:

- ☐ Alert, average attention span/comprehension unimpaired
- ☐ Easily distracted/short attention span
- ☐ Phases in and out
- ☐ Impaired ability to comprehend

Feelings About Self: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Goals in Life: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Psychological/Emotional Strengths: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

X. [TREATMENT RECOMMENDATIONS]:    ☐ Accept Patient Into Program

1. ☐ Substance Abuse Counseling

☐ Individual

☐ Weekly

☐ Marital/Family

☐ Bi-Weekly

☐ Group \_\_\_\_\_

☐ Monthly

2. ☐ Evaluation and follow up by Medical Director to include random urine testing.

3. ☐ Referral to:

☐ NA/AA/ACA

☐ DMH-OPD

☐ Vocation Rehabilitation

☐ Residential Treatment Facility

☐ Other \_\_\_\_\_

4. ☐ Adjunct Treatment by: \_\_\_\_\_

5. ☐ Other: \_\_\_\_\_

Date: \_\_\_\_\_

Intake Worker's Signature

Date: \_\_\_\_\_

Medical Director's Signature

### Reference List

- Browne, A. & Finkelhor, D. (1986). Impact of Child Sexual Abuse: A Review of the Research. Psychological Bulletin, 99(1), 66-77.
- Burt, M.R., Glynn, T.J. & Sowder, B.J. (1979). Psychosocial Characteristics of Drug Abusing Women. National Institute on Drug Abuse. 8-29.
- Chambers, C., Hinesley, R.K. & Moldestad, M. (1974). Narcotic Addiction in Females: A Race Comparison. The International Journal of the Addictions, 9(2), 289-300.
- Chien, I., Gerard, D.L., Lee, R.S., & Rosefeld, E. (1983). The Female Addict. In T. Glynn (Ed.), Women and Drugs. U.S. Department of Health and Human Services. (Original work published 1964)
- Donovan, J.H. (1986). An Etiologic Model of Alcoholism. American Journal of Psychiatry, 143, 1-11.
- Glynn, T. (Ed.). (1986). Women and Drugs. U.S. Department of Health and Human Services.
- Guitierres, S.E., Patton, D.S., Raymond, J.S. & Rhoads, D.L. (1984). Women and Drugs: The Heroin Abuser and the Prescription Drug Abuser. Psychology of Women Quarterly, 8(4), 354-369.
- Helschober, B. & Miller, M.A. (1991). Methamphetamine Abuse in California in Methamphetamine Abuse: Epidemiologic Issues and Implications. In Miller, M.A. & Kozel, N.J. (Eds.). Research Monographs (pp 60-71). National Institute on Drug Abuse.
- Morris, S.K., & Schinke, S.P. (1990). Treatment Needs and Services for Mothers with a Dual Diagnosis; Substance Abuse and Mental Illness. Clinical Treatment of the Criminal Offender.
- Mulinski, P. (1988). Alcoholism and Coexisting Psychiatric Disorders. Social Casework, March, 141-144.
- Mulinski, P. (1989). Dual Diagnosis in Alcoholic Clients: Clinical Implications. The Journal of Contemporary Social Work, June.
- Novacek, B., Raskin, R. & Hogun, R. (1991). Why Do Adolescents Use Drugs? Age, Sex and User Differences. Journal of Youth and Adolescence, 20(5), 475-491.



- Peele, S. (1985). The Meaning of Addiction, Compulsive Experience and Its Interpretation. Lexington: Lexington Books.
- Rose, S.M., Peabody, C.G., & Stratigeas, B. (1991). Responding to Hidden Abuse: A Role for Social Work in Reforming Mental Health Systems. Social Work, 36(5), 408-413.
- Sciacca, K. (1991). An Integrated Treatment Approach for Severely Mentally Ill Individuals with Substance Disorders. New Directions for Mental Health Services, 50, Summer.
- Surrey, J., Swett, C., Michaels, A. & Levin, S. (1990). Reported History of Physical and Sexual Abuse and Severity of Symptomatology in Women Psychiatric Outpatients. American Journal of Orthopsychiatry, 60(3), 412-417.
- Williamson, M.J., Bordin, M.C. & Howe, A.B. (1991). The Ecology of Adolescent Multitreatment: A Multilevel Examination of Adolescent Physical Abuse, Sexual Abuse, and Neglect. Journal of Consulting and Clinical Psychology, 59(3), 449-457.