Exploring the Nature of the Relationship between Child Sexual Abuse and Substance Use among Women

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Stranded. Caught in the crossfire.

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1.1 PREVALENCE OF CSA

Estimating the prevalence of CSA is notoriously difficult for a number of reasons. The secrecy and stigma surrounding the issue is likely to hamper survivors' willingness to disclose. Moreover, there is evidence that prevalence rates are strongly influenced by methodological procedures, such as the style of questioning, the use of surveys versus interviews, and the definition of CSA (Wyatt and Peters, 1986a; Wyatt and Peters, 1986b; Haugaard and Emergy, 1989).

Epidemiologic Catchment Area studies

The lowest estimates of prevalence come from Epidemiologic Catchment Area (ECA) studies. The large, representative samples used in these studies increase the chances that these estimates will accurately reflect population prevalence. Yet, even between these studies, there is a high variability. For example, of 1,660 women interviewed in Los Angeles, Burnam et al. (1988) found that 16.7% had experienced sexual assault some time in their lives. The prevalence rate for sexual assault before age 16 was 6.8% (Siegel, Sorenson, Golding, Burnam and Stein, 1987).

In contrast, a North Carolina study found that only 5.9% of the 1,157 women interviewed had ever experienced sexual assault (Winfield, George, Swartz and Blazer, 1990) while the percentage who had experienced CSA was not reported. Although this disparity between the two prevalence rates might reflect different demographics across the samples, it might also have been influenced by the different emphasis on the use of force in the sexual abuse definitions. The definition from the North Carolina study of a situation in which "someone pressured you against your will into forced contact" does not encompass situations involving verbal persuasion which are common in childhood experiences. The focus of the Los Angeles study's definition on situations involving *either* pressure or force may explain why their estimated rate for any sexual assault was almost three times that of the North Carolina study.

Still higher rates were reported by Murphy et al. (1988) in a South Carolina follow-up study of 391 women. They reported that 15.1% of women had been sexually abused before age 12 and 32.2% before age 18. These higher rates might be due to the inclusion of non-contact sexual behaviour (such as exhibitionism or attempted molestation). A later report by Saunders, Villeponteaux, Lipovsky, Kilpatrick and Veronen (1992) excluded non-contact behaviour and the prevalence dropped to 24.6%. This is an important distinction because their study showed that CSA involving physical contact was a significant risk factor for a range of mental disorders but this was not so for non-contact CSA.

The figures reported by Murphy et al. (1988) for children 12 years and under were comparable to those found by Mullen, Romans-Clarkson, Walton and Herbison (1988) in a New Zealand study of 314 women. Mullen et al. (1988) reported that 13.1% (9.9%, after weighting for a larger, original sample) of subjects had experienced `sexual abuse' in this age range.

Definition and prevalence of CSA

Among studies specifically investigating CSA, the earliest statistics were reported by Finkelhor in 1979. He defined CSA on the basis of a five year age discrepancy between the child and the abuser, thereby excluding sexual experimentation between peers. Abuse at ages 13-16 was defined by a 10 year discrepancy. In his sample of college students, 19% of women had experienced sexual abuse before age 16 that involved either physical contact or non-contact behaviour. These results were replicated by Fromuth (1986) who reported a CSA rate of 22% among female college students. With a modified definition that included the child's opinion of whether the experience was abuse, Finkelhor (1984) reported a prevalence of 15% among women in a randomised study.

Other community studies have used Finkelhor's (1979) age discrepancy definition but excluded non-contact behaviours. These include Nash and West (1985) who found a rate of 20% among female GP clients and 30% among female university students. In 1992, Elliott and Briere surveyed 2,963 professional women and found that 26.9% had experienced CSA.

Finkelhor's two prevalence studies have been compared to two other major US studies investigating CSA, Wyatt and Peters, 1986a and Wyatt and Peters, 1986b. The first, by Russell (1983) employed no age discrepancy rule. Her definition included incestuous experiences up to age 17, extrafamilial experiences up to age 13 and rapes or attempted rapes up to age 17. Non-contact experiences were not included. The second study by Wyatt (1985) used a definition similar to that of Finkelhor (1984), including non-contact CSA, but extended the age limit up to 17 years.

In these two studies women participated in face-to-face interviews and were asked behaviourally specific questions to facilitate recollection of abuse incidents. In comparison, the studies by Finkelhor (1979, 1984) CSA survivors were identified by a screening question in a self-administered questionnaire. These differences in the definitions of CSA and data collection methodology were reflected in higher prevalence rates. Russell (1983) found that 38% of women had experienced CSA involving physical contact before age 18, and 28% before age 14. Wyatt's (1985) reported rate of 45% is the highest among the reviewed studies.

The only major Australian study of prevalence was conducted by Goldman and Goldman (1988), who used the same definition and methodology as the first Finkelhor study (1979). Their rate of 28% for experience of contact and non-contact CSA among female tertiary students was somewhat higher than comparable studies (Finklehor, 1979; Fromuth, 1986).

The diversity of results from ECA and other studies focusing on CSA demonstrates the complexities of measuring the prevalence of CSA in a community. This review shows a range extending from 6.8% to 45%, depending on the age criteria, types of behaviour included, and styles of questioning. Despite its breadth, this range of prevalence statistics offers a baseline for comparisons with clinical samples to assess the extent of the relationship between CSA and substance misuse.

1.2 CSA AND SUBSTANCE MISUSE

Most pertinent to this study is the strong evidence for a relationship between CSA and substance misuse among women. This evidence is derived from studies of (a) non-clinical and clinical samples of adult CSA survivors, (b) non-clinical and clinical samples of women with substance misuse, and (c) adolescent clinical samples.

Women survivors of child sexual abuse

Evidence from ECA studies by Burnam et al. (1988) and Winfield et al. (1990) indicates that women who were sexually abused had a higher risk of alcohol and other drug abuse or dependence. Burnam et al. (1988) showed that the difference between abused and non-abused people in substance misuse was significant regardless of whether the substance misuse began before or after the abuse.

Reflecting on the complexity of causal hypotheses, Burnam et al. (1988) argued that a relationship may exist ". . . because sexual assault increases risk for disorder, because disorder increases risk for sexual assault, or because a third factor . . . increases risk for both" (p846). Their results indicated that alcohol abuse or dependence was more highly related to assault as a consequence than a precursor while drug abuse or dependence was related to assault both as a precursor and a consequence.

Pribor and Dinwiddie (1992) found that incest victims had a substantially higher lifetime prevalence of alcohol and other drug abuse or dependence, compared with either general population rates or a psychiatric comparison sample. In a study of women attending gynaecological services, Walker et al. (1992) found a strong association between CSA and lifetime diagnoses of drug abuse. Studies of psychiatric patients have also shown that women with a CSA history have an increased chance of alcohol or other drug problems, compared with non-abused women (Beck and van der Kolk, 1987; Briere and Runtz, 1987).

Women with substance misuse

The diversity of CSA prevalence rates in community samples is reflected in the few studies of prevalence among women with substance misuse. Rohsenow, Corbett and Devine (1988) showed how clinical estimations of the prevalence of CSA vary according to the method of data collection. For example, the prevalence of CSA based on spontaneous self-reports of women in a chemical dependency rehabilitation program was 21%. With the introduction of systematic, routine inquiry by staff about CSA, the prevalence rose to 74%. Similar results were found for adolescent girls. High rates were also reported by Copeland and Hall (1992a) in a study of 160 Sydney women in treatment for substance misuse. They found that 47% of women reported having experienced self-defined `sexual abuse' during childhood.

A study by Paone, Chavkin, Willets, Friedmann and des Jarlais (1992) found that 51% of their sample of 146 female crack users had experienced a forced sexual encounter and 23% had this experience before age 17. One factor contributing to this relatively low estimate of CSA might have been the inclusion of substance using women outside treatment, as well as treatment clients. Kovach (1986) reported a similar estimate (25%) for incest survivors among a sample of Alcoholics Anonymous (AA) participants outside treatment. If CSA and substance misuse are related, women without a CSA history

may have less severe drug problems and be less inclined to enter treatment. In partial support of this idea, Bushnell, Wells and Oakley-Browne (1992) found that among substance misusing women outside treatment, incest survivors had more alcohol misuse symptoms than other women but not more drug misuse symptoms.

Paone et al. (1992) suggested two alternative explanations for their findings. First, women might use substances as self-medication to cope with the trauma of abuse. The relationship between CSA and substance misuse would be mediated by negative affective states, such as depression or anxiety (Rohsenow et al., 1988). In support of this `self-medication' model, mixed-sex clinical studies of substance misuse have shown that mood management is a popular reason for drinking (Orford and Keddie, 1985) and relapse (Marlatt and George, 1984).

The alternative model proposed by Paone et al. (1992) to explain their findings was that substance misuse might be an attempt to combat the impairment of self-esteem arising from abuse and other negative experiences. Singer, Petchers and Hussey (1989) also thought that individuals who feel alienated and lack self-esteem because of the abuse, might be drawn to substance misuse because it is a way of socialising that involves minimal interpersonal closeness. Various researchers (Moore and Fleming, 1989; Simons and Whitbeck, 1991; Paone et al., 1992) have argued that the relationship between CSA and substance misuse might culminate in a vicious circle of dependence and further abuse.

The few studies of women with substance misuse estimate a prevalence of CSA from 18% to as high as 74%. In comparison with the baseline established in general population studies from 6.8% to 45%, these results support the idea that CSA is somehow related to women's substance misuse.

Adolescent clinical samples

Studies of adolescent clinical samples provide an opportunity to examine the relationship between CSA and substance misuse closer to the time of the abuse. In particular, these studies provide further evidence for an association between CSA and an early onset of substance misuse.

In a study of 597 drug and alcohol treatment clients, aged between 12 and 19 years, Edwall, Hoffman and Harrison (1989) reported a prevalence of 35.2% for sexual abuse. Over half of the CSA survivors (57%) had been sexually abused by someone outside the family, while 22% had experienced incest and 20% had experienced both extrafamilial abuse and incest.

Harrison, Hoffman and Edwall (1989) reported significant differences in substance use between the sexually abused girls and non-abused girls in this study. Significantly more of the abused girls had used alcohol before age 11. Although the two groups did not differ in their current alcohol consumption, regular use of stimulants, sedatives, hallucinogens, opiates, tranquillisers and over-the-counter drugs was more common among CSA survivors. Harrison et al. (1989) suggested that CSA survivors might use sedative drugs for anaesthesia and stimulant drugs to assist self-protective vigilance.

In a mixed-sex study of adolescent clients, Cavaiola and Schiff (1989) found that adolescents with a history of either sexual or physical abuse had an earlier onset of alcohol and other drug use. Flanigan, Potrykus and Marti (1988) found an earlier onset of alcohol and cannabis use in a comparison of female adolescents in treatment for incest with US adolescent statistics. The incest survivors were

more likely than other female adolescents to be moderate or heavy drinkers and had more frequent alcohol intoxication. The authors concluded that ". . . the incest survivors were more similar in overall patterns of use to combined male and female comparison groups than to female comparisons" (Flanigan et al., 1988; p247).

Similar patterns of more frequent use of alcohol and other drugs and intoxication by sexually abused male and female adolescents, were reported by Singer et al. (1989). They also found that adolescents with a history of sexual abuse were significantly more likely to use cocaine and stimulants on a regular basis than matched control subjects. Singer et al. (1989) compared the ages of first substance use and first sexual abuse. The majority of their abused group (55%) were sexually abused before they first used alcohol or other drugs, 23% had been abused in the same year that they first used and 23% were abused subsequent to their first drink or drug use.

Moore and Fleming (1989) described how substance misuse could isolate the adolescent from her female peer group and impede her ability to effectively resist sexual victimisation. "With her judgment process disrupted by chemicals, the adolescent female can be coerced into behaviors that are dissonant with both her beliefs and her peer group's sexual code of conduct" (Moore and Fleming, 1989; p191). Whether or not the sexual victimisation or the substance misuse occurs first, the adolescent may soon be caught in a viscious circle, compounded by an increasing sense of isolation and low self-esteem.

The adolescent studies confirmed the observations from studies of adult CSA survivors and women with substance misuse that there is a relationship between CSA and substance misuse among women. CSA survivors appear to have an earlier age of onset and a greater risk of developing problems with substance misuse. Although the link between CSA and substance misuse is well-established in the literature, its nature still remains relatively unexplained. Explanatory models posit substance misuse as a potential risk factor for sexual victimisation as well as a coping response to deal with psychological distress and impaired self-esteem arising from the sexual trauma.

1.3 SYMPTOMS OF PSYCHOLOGICAL DISTRESS

In addition to substance misuse, there is considerable evidence that women who have experienced CSA are more likely than other women to have a range of mental health problems. For example, Burnam et al. (1988) found that sexual assault at any age was a risk factor for subsequent development of major depressive, phobic, panic and obsessive-compulsive disorders. In particular, their analysis revealed that sexual assault during childhood was a consistent predictor of depression and phobia. Among women in treatment for substance misuse, Swift, Copeland and Hall (in press) found that self-defined CSA was associated with higher scores on the General Health Questionnaire (GHQ), indicating greater levels of psychological distress among CSA survivors.

The observation of co-morbidity of psychiatric problems and substance misuse among CSA survivors provides further support for the idea that women might use substances as a means of overcoming negative affect (Paone et al, 1992). At the same time, the substance misuse can exacerbate negative symptoms such as depression or sexual dysfunction. The psychiatric problems that have been most strongly associated with CSA among women are depression, somatisation, suicidality, impaired self-esteem, various types of anxiety, sexual dysfunction, dissociation, eating disorders and self-mutilation. The evidence for each of these is briefly summarised below.

Depression

Men and women in drug and alcohol treatment programs have similar levels of depression. Ross, Glaser and Stiasny (1988) estimated that between 16% and 22% of their mixed-sex sample were experiencing depression at the time of treatment. In a review of the literature, Copeland, Hall, Didcott and Biggs (1993) have drawn a distinction between depression due to the impact of substance use and withdrawal on the central nervous system and primary depression that precedes substance dependence. They have suggested that female drug and alcohol clients might have a greater prevalence of primary depression than male clients. Evidence indicates that female clients benefit more from its detection and treatment (Rounsaville, Dolinsky, Babor and Meyer, 1987).

A number of studies of both community and clinical samples have reported evidence for an association between CSA or incest and depression (Briere and Runtz, 1988; Burnam et al., 1988; Hunter, 1991; Bushnell et al., 1992; Elliott and Briere, 1992; Pribor and Dinwiddie, 1992; Saunders et al., 1992; Walker et al., 1992) or depressive symptoms (Beck and van der Kolk, 1987; Sansonnet-Hayden, Haley, Marriage and Fine, 1987). Although Walker et al. (1992) reported that women with a history of CSA had a 10 fold risk of lifetime diagnoses of major depression, a logistic regression indicated that much of this difference could be explained by the high levels of somatisation in the CSA group.

Somatisation

Somatisation disorder involves recurrent and multiple somatic complaints with no apparent physical cause. Symptoms can include pain, involvement of the gastrointestinal or cardiopulmonary systems, pseudo-neurological symptoms and problems with sexual or menstrual function.

The association between CSA and somatisation identified by Walker et al. (1992) has been supported in some other studies (Briere and Runtz, 1988; Bushnell et al., 1992; Pribor and Dinwiddie, 1992). However, there have also been studies that found no evidence for this relationship (Sansonnet-Hayden

et al., 1987; Murphy et al., 1988).

Suicidality

A particularly disturbing finding in the research is that women with a history of CSA have an increased propensity for suicidal ideation or suicide attempts. In a community study, Saunders et al. (1992) found that sexual abuse before age 18 was significantly associated with suicidal thoughts or attempts. Clinical studies have shown similar trends for crisis centre clients (Briere and Runtz, 1987) and psychiatric inpatients (Brown and Anderson, 1991; Sansonnet-Hayden et al., 1987).

Studies of women and girls in treatment for substance misuse or dependence have also highlighted the increased risk of suicide among CSA survivors. Edwall et al. (1989) found that adolescent clients who had been sexually abused were more likely than other girls to have had suicide ideation and attempts in the previous year. Swift et al. (in press) also found an increased risk of suicidality among women clients who had experienced CSA.

Self-mutilation

Self-mutilation refers to behaviours other than suicide where the person deliberately cuts, burns or in some other way causes harm to her own body. It seems to differ from suicidality in its underlying psychological processes. Whereas suicidality is associated with severe depression, self-mutilation appears to be motivated by intolerable flashbacks and the need to regain self-control (Rose, 1991), a desire for self-punishment (Shapiro, 1987; Lacey, 1993) or an impulsive means of relieving tension (Lacey, 1993).

In a study of female referrals to a bulimia clinic, Lacey (1993) found a significant association between substance misuse and repeated self-cutting. In their sample of clients of acute and emergency psychiatric services, Rose, Peabody and Stratigeas (1991) have linked self-mutilation to sexual and physical abuse, including child abuse.

Eating disorders

A review by Krahn (1991) demonstrated considerable evidence of a relationship between eating disorders and substance misuse. One explanatioin for this relationship is that the two behaviours are different expressions of the same underlying problem. Although Krahn (1991) proffered a genetic explanation, another possibility is that they are both responses to early trauma such as CSA.

CSA has also been found to be associated with eating disorders in non-clinical samples (Smolak, Levine and Sullins, 1990; Calam and Slade, 1989), and among women with eating disorders CSA has been linked to the severity of symptoms (Bulik, Sullivan and Rorty, 1989; Abramson and Lucido, 1991). Most studies reported that the relationship between CSA and eating disorders was mediated by family variables such as the reliability of the parents during childhood and adults' reactions to disclosure.

Dissociation

The work of Briere and colleagues has particularly emphasised dissociation as an after-effect of CSA. In a clinical sample, Briere and Runtz (1987) found that a history of CSA was associated with dissociative symptoms such as `spacing out', feeling that things were unreal, and feeling outside one's body. Further studies (Briere and Runtz, 1988; Elliott and Briere, 1992) confirmed the strong relationship between CSA and dissociation.

Briere and Runtz (1987) hypothesised that dissociation first develops as a way for the child to cognitively disengage from aversive stimuli during abuse episodes and later becomes a more autonomous response to a variety of situations. This cognitive process can be understood in terms of the `accommodation syndrome' proposed by Summit (1983). This syndrome highlights the power imbalance, the betrayal of trust and the bind of secrecy that render the child helpless and unable to resist the abuser. Psychological dissociation may be the only escape from the emotional and physical pain of CSA.

Anxiety

Ross et al. (1988) reported that among a sample of drug and alcohol treatment clients, women had a greater prevalence than men of anxiety disorders, especially phobia, panic disorder, agoraphobia, simple phobia and obsessive compulsive disorder. Research has also indicated an association between CSA and anxiety disorders (Pribor and Dinwiddie, 1992) including panic disorder (Walker et al., 1992), simple phobia (Fromuth, 1986; Burnam et al., 1988; Walker et al., 1992), obsessive-compulsive disorder (OCD) (Saunders et al., 1992), generalised anxiety disorder or anxiety symptoms (Briere and Runtz, 1988; Murphy et al., 1988; Bushnell et al., 1992; Elliott and Briere, 1992) and post-traumatic stress disorder (PTSD) (Lindberg and Distad, 1985; Edwards and Donaldson, 1989; O'Neill and Gupta, 1991). Briere and Runtz (1988) suggested that ". . . aspects of the assault become conditioned stimuli that evoke subsequent anxiety reactions in other situations" (p55).

The limited amount of research investigating both CSA and anxiety among substance misusers provides some confirmation that they are related. Kovach (1986) reported a relationship between CSA and PTSD among women attending AA. In their study of adolescent clients of a drug and alcohol program, Edwall et al. (1989) found that girls with a history of sexual abuse experienced nervousness and sleeplessness more often than other girls.

Sexual dysfunction

Although sexual dysfunction is a common problem for both men and women with substance misuse and can be related to the detrimental effects of substances, clinical studies show that women have a higher prevalence than men (Ross et al., 1988; Wilsnack, 1984). CSA might be one factor that contributes to this sex difference. Finkelhor and Browne (1986) argued that disruption to sexual development was a major feature of the trauma of CSA.

Most research findings have indicated that women with a history of CSA are more likely to experience sexual disorders (Briere and Runtz, 1987; Pribor and Dinwiddie, 1992; Saunders et al., 1992) or have higher ratings of sexual dysfunction (Elliott and Briere, 1992; Hunter, 1991) than women who have not experienced CSA. Some studies, however, have found no such evidence (Fromuth, 1986; Brown and

Anderson, 1991; Bushnell et al., 1992).

Self-esteem

The impaired self-esteem model proposed by Paone et al. (1992) to explain the relationship between CSA and substance misuse is supported by the research. Carson, Council and Volk (1988) found that a history of incest was associated with low self-esteem, particularly for women who were alcohol dependent. Studies of adolescent drug and alcohol treatment clients have found that girls with a history of sexual abuse have more shame and less pride (Edwall et al., 1989), more negative attitudes to their physical self and a weaker sense of identity (Cavaiola and Schiff, 1989) than other girls.

Feelings of alienation and social isolation are closely linked to poor self-esteem in women with substance abuse, according to Beckman (1978) and Carson et al. (1988). Gomberg (1988) has described how society's disapproval of female drinking and intoxication might isolate women from others as well as leading to self-rejection. O'Connor, Berry, Inaba, Weiss and Morrison (1994) reported that women in recovery from addiction were more prone to feelings of shame than their male counterparts. Given its taboo nature, it is not surprising if CSA adds to feelings of shame and stigma. Edwall et al. (1989) speculated that ". . . the pattern seems to be one of internalization: the abused female adolescent appears to be at risk for creating a picture of herself as bad or sick, while normalizing the situation around her" (p287).

The contribution of CSA to comorbidity

The various findings linking CSA with symptoms of psychological distress have important clinical implications for the field of alcohol and other drugs. The assessment and treatment of women with substance misuse who also have a history of CSA might be complicated by co-morbid symptoms that require specialist intervention. For women with substance misuse, the extent of the relationship between CSA and symptoms of psychological distress might also be aggravated or temporarily masked by the effects of the substance.

1.4 MEDIATING FACTORS

Explanations for the relationship between CSA and substance misuse usually imply a causal link between one and the other, with psychological distress as an important mediator. The research indicates, however, that there are several other important mediators that might influence the relationship. In particular, the research has highlighted the potential influence of characteristics of the CSA, family relationships, parental substance misuse, and other life experiences.

Characteristics of the CSA

Briere and Runtz (1988) showed that anxiety, dissociation and somatisation were most prevalent among women whose victimisation involved parental incest, older abusers, and a longer history of abuse. They argued that such co-variation between abuse characteristics and subsequent problems confirms that ". . . the abuse, itself, plays a role in later psychological disturbance" (p55). Nevertheless a review by Browne and Finkelhor (1986) found that no CSA characteristic has consistently been identified as a predictor of negative outcome. Characteristics that were most often associated with negative outcome were abuse by fathers or stepfathers, experiences involving genital contact, and the presence of force. Beitchman et al. (1992) updated and confirmed these findings.

Russell (1984) developed a model of abusive sexual behaviours with three categories of severity. The first category, defined as `very serious sexual abuse', including all forms of penetrative contact. The second, referred to as `serious' included digital penetration, unclothed breast contact or simulated intercourse. The `least serious' category comprised forced kissing, non-genital sexual touching and touching genitals through clothes. Browne and Finkelhor (1986) cited evidence that Russell's model distinguished between gradients of self-reported trauma. Fifty-nine percent of women whose CSA was very serious said they were extremely traumatised, compared with only 36% of those with serious CSA and 22% of those with the least serious type of abuse.

According to Browne and Finkelhor (1986), there is an on-going controversy about the influence of the age of CSA onset on long-term trauma. Most studies show no age effect. Some studies indicate greater trauma from pre-pubertal abuse (Courtois, 1979; Meiselman, 1978) and others from post-pubertal abuse (Sedney and Brooks, 1984; Murphy et al., 1988; Tsai, Feldman-Summers, and Edgar, 1979). Theoretically, both are feasible. The younger child is more vulnerable and dependent and less skilled, cognitively and linguistically whereas the older child is more aware of, and concerned about, societal norms. The relationship of the child's age with other characteristics such as the abuser's identity and conditions of disclosure demonstrates the complexity involved in trying to distinguish predictors of trauma. For example, younger children are more accessible to incestuous abusers than extrafamilial abusers.

Family relations and childhood experiences

Finkelhor and Browne (1986) have reframed the question about the impact of characteristics of the abuse. They argued that "The question is not `Was it more or less serious?' but `What are the specific injurious dynamics that were present?'" (p194). They have proposed four dynamics to account for the trauma of CSA: traumatic sexualisation, stigmatisation, betrayal and powerlessness.
According to their model, traumatic sexualisation arises from the imposition of developmentally and

interpersonally inappropriate behaviour on the child, leading to sexual dysfunctions, flashbacks during sex, and confusion of sex with affection. Paradoxically, it might result in either avoidance of, or compulsive attraction to, sex. Stigmatisation occurs when the child is blamed for the abuse or infers from the secrecy that the activities are shameful. The degree of stigma might determine later self-esteem impairment, suicidality, alienation and identification with other stigmatised groups, such as substance misusers or sex workers.

Betrayal is especially relevant when the abuser is a parent or when disclosure is not supported. It may impair the individual's ability to judge the trustworthiness of others, leading to hostility and anger as well as a vulnerability to further abuse. The experience of powerlessness during the abuse, particularly if the child was forced or tricked and disclosure was frustrated, could contribute to anxiety, somatisation, dissociation, depression, vulnerability to further abuse, delinquency, and aggression.

The traumagenic dynamics model is particularly useful in that it highlights the influence of family relations on the traumatic process. For example, Finkelhor and Browne (1986) suggested that family experiences of physical abuse or emotional neglect set a precedent of powerlessness that is then exacerbated by the sexual abuse. In contrast, a child who is valued in a healthy family environment might be able to recover more quickly from the impact of the CSA. Obviously, family responses to disclosure play an important role. Women's assessment of the impact of CSA is closely related to the degree of support received after disclosure (Wyatt and Mickey, 1988). Rejection, disbelief or blame from significant others would accentuate feelings of powerlessness, betrayal and stigmatisation.

Unfortunately, research indicates that CSA survivors have a higher risk of exposure to negative family experiences that could disrupt their recovery from the CSA. Finkelhor and Browne (1986) have suggested that parental absences, poor relationships with parents and conflict between parents might be risk factors for CSA although their review was based on retrospective studies where the direction of causality is unclear. Brown and Anderson (1991) reported that CSA survivors had a higher prevalence of childhood physical abuse and family psychiatric illness than other female psychiatric clients. Illicit drug use was almost twice as common among those who reported both physical and sexual abuse, compared with women who had experienced either physical or sexual abuse alone.

In their study of adolescent substance misusers, Harrison et al. (1989) reported that abused girls were more likely than non-abused girls to say that they used drugs to escape from their families, regardless of whether or not the abuse was intrafamilial. According to Edwall, et al. (1989), the experience of physical violence was more common among CSA survivors than other girls. For incest survivors, violence was typically perpetrated by family members but this was not the case for women who had experienced extrafamilial CSA.

Parental substance misuse

Research indicates that people whose parents misused substances have an increased risk of a range of childhood difficulties because of the negative impact of parental substance misuse on family relations (Velleman and Orford, 1993). In a study by Schilit and Gomberg (1987), alcohol-dependent women were more likely than other women to have had parents with alcohol problems. They also more often recalled conflict between their parents, maternal distance and feelings of being unloved.

As well as its impact on family relations, there are other ways that parental substance misuse might influence the risk of CSA and its relationship with women's substance misuse. Parental substance

misuse could increase the risk of CSA either as a disinhibiter used by the abuser (Araji and Finkelhor, 1986) or by disabling the parent's protection of the child. Parental substance misuse also provides a role model of substance misuse as a coping method and increases children's access to substances.

In a study of crack cocaine users, Paone et al. (1992) reported that 77% of CSA survivors had a family history of substance misuse, compared with 58% of non-abused women. Carson et al. (1988) found that women with a history of both incest and alcohol dependence were significantly more likely than women with either incest or alcohol dependence only to say that their parent or guardian had drinking problems. In contrast, Singer et al. (1989) found no differences between abused and non-abused groups of adolescents in parental substance misuse.

Rose et al. (1991) tested the relative influences of parental substance misuse and CSA on whether a client misused substances. In their sample of heavy users of acute inpatient and emergency psychiatric services, 50% of women reported having experienced CSA. Compared with other clients, adult children of alcoholics were more likely to have been sexually abused during childhood and more likely to misuse substances. Nevertheless, Rose et al. (1991) found that among clients with alcohol dependent parents, 83% of CSA survivors became substance misusers, compared with 58% of non-abused clients.

These results suggest that CSA might contribute to the variability in subsequent substance misuse, over and above the influence of parental substance misuse. A similar result was reported by Miller, Downs and Testa (1993) who found in a clinical study that rates of parent-to-child violence and childhood sexual abuse were significantly greater for women with alcohol problems than women without such problems, even when controlling for parental alcohol problems.

Other life experiences

Some research has indicated that women with a CSA history are not only more likely than other women to have been exposed to other forms of childhood abuse but they might also have an increased vulnerability to abuse in their adult years. Several community studies have reported higher rates of adult sexual abuse among groups of CSA survivors (Fromuth, 1986; Siegel et al., 1987; Walker et al., 1992) but this has been disputed by Mullen, et al. (1988). Russell (1986) reported that incest survivors not only had an increased risk of rape or attempted rape in later life, but were also more likely to be sexually and physically assaulted by their husbands.

The findings from clinical studies are less consistent. Briere and Runtz (1988) reported that CSA survivors had a higher chance of being battered as adults than other women in a clinical sample but no higher risk of being raped. In a study of psychiatric outpatients, Jacobson (1989) found that CSA was significantly related to adult sexual and physical abuse. No such relationships, however, were found in a larger study of inpatients by Jacobson and Richardson (1987).

Finkelhor (1979) suggested that CSA might increase vulnerability to further abuse by forcing children to leave home early and go into high-risk situations for violence or sexual abuse. For example, Simons and Whitbeck (1991) reported that childhood incest increased the probability of involvement in sex work among homeless women and runaway adolescent girls. Sex work was, in turn, a predictor of street victimisation (sexual abuse, physical abuse or threats and robbery). Two studies of women in treatment for substance misuse have noted the high prevalence of CSA among sex workers (Copeland

et al., 1993; Swift et al., in press).

Miller, Downs and Gondoli (1989) found that women in treatment for alcohol problems had a greater risk of spousal violence than women without such problems. Their study highlighted the difficulties in identifying causal relationships. Women with substance misuse might have an increased risk of domestic violence because their partners also misuse substances, their substance misuse leads to negative labelling and stigmatisation which might be used as justification for violence (Miller et al., (1989), or they misuse substances to cope with the violence.

Murphy et al. (1988) found that adult trauma compounded the long-term effects of childhood trauma. Women experiencing both child and adult sexual abuse had significantly higher levels of somatisation, OCD, depression, anxiety and hostility than women who had been abused either in childhood or during their adult years only. It seems that both CSA and substance misuse might predispose women to further physical or sexual abuse and this abuse during adulthood is likely to compound the trauma of CSA.

Implications for research

This review has presented evidence for a relationship between CSA and substance misuse that might, in part, arise because substance misuse is a response to the effects of childhood sexual trauma. The research also indicates that those women who have a history of CSA might have a more complex clinical picture because of the high risk of psychiatric comorbidity.

At the same time, the literature highlights the dangers of simple causal arguments to account for the relationship between CSA and substance misuse. The nature of the relationship might be modified by CSA characteristics, family relations, parental substance misuse and other life experiences. Therefore, it is important that research aimed at improving the outcome of substance misuse treatment for CSA survivors examines the relevance of these factors in the overall clinical picture.

2 METHOD

Introduction

This study aims to investigate the nature of the association between child sexual abuse and the subsequent misuse of alcohol or other drugs by women. In particular, it aims to examine those aspects of the substance use that are likely to be influenced by a history of CSA and assess the impact of CSA on psychiatric comorbidity. A combined quantitative and qualitative method of analysis was designed to enable an exploration of the influence of such mediating factors as CSA characteristics, family relations, parental substance misuse and other life experiences. The investigation aims to explore the implications of the relationships between these various factors for the treatment of substance misuse and dependence, the management of CSA disclosure and relapse prevention.

The study also aims to use a qualitative analysis to investigate the choices women make about primary help-seeking, particularly when they have both a history of CSA and current substance misuse. The analysis is designed to identify the barriers and catalysts to seeking help for either problem and generate hypotheses about women's needs in treatment or counselling.

Design of the study

A four group design was employed, in which all subjects were to have been involved in treatment services. Recruitment aimed to gather data from 50 women in each group.

Group 1: Women participating in treatment programs for the misuse of alcohol and other drugs and who have had experienced CSA.

Group 2: Women participating in treatment programs for the misuse of alcohol and other drugs and who have had no experience of CSA.

Group 3: Women participating in treatment for trauma related to CSA who also misused alcohol or other drugs.

Group 4: Women participating in treatment for trauma related to CSA who did not misuse alcohol or other drugs.

The main comparisons were between:

1) Groups 1 and 2 to test the hypothesis that a history of CSA will be predictive of earlier onset and greater severity of substance misuse. It was also hypothesised that a history of CSA will be predictive of a higher incidence of other symptoms of psychological distress, such as anxiety, depression and suicidality;

2) Groups 3 and 4 to test the hypothesis that the misuse of alcohol and other drugs will be correlated with greater severity of CSA characteristics; and
3) Groups 1 and 3 to qualitatively identify and describe the factors that influence women's

decisions about seeking help when they both have experienced CSA and are currently misusing substances.

So as not to confuse the four groups, each group will be referred to in a consistent way throughout this report. Group 1 will be referred to as the `drug and alcohol with CSA group', Group 2 as the `drug and alcohol only group', Group 3 as the `CSA with substance misuse group', and Group 4 as the `CSA only group'. The term `substance misuse' generally refers to excessive or self-destructive use of alcohol or other drugs. It was operationally defined in our criteria for the CSA with substance misuse group (see below).

Pilot study

The design of the questionnaire was tested and modified with information gathered from a pilot study of eight women from Jarrah House drug and alcohol treatment centre. Six of these women had a history of CSA.

Sample

Subjects were recruited in two ways. Groups of women were told about the study by the researchers during a visit to the agency and offered the opportunity to volunteer. Other women responded to standard advertisements explaining the conditions of the interview. Volunteers were then screened to assess their suitability in terms of the research group criteria.

The advertisement listed the areas on which questions would be based, including CSA and substance misuse but, to avoid imposing demand characteristics, there was no specific mention of the research question. Screening procedures were also designed to avoid the the risk of a self-fulfilling prophecy described by Silverman (1977) where research participants modify the emphasis in their testimonies to help confirm the research hypothesis. All subjects were debriefed at the end of the interview regarding the nature of the research question and the aims of the study. Interviewees were also reimbursed $20 for their time and travel expenses.

One hundred women in drug and alcohol treatment were recruited from a range of drug and alcohol agencies, including detoxification units, rehabilitation programs, outpatient counselling services and methadone maintenance units. The participating agencies were Jarrah House, We Help OurSelves (WHOS), Wistaria House, Parramatta Hospital, Rankin Court Methadone Clinic, Langton Dextoxification Unit, Langton outpatient counselling groups, Bourke Street outpatient counselling services, Detour House, Guthrie House and Herbert Street Clinic (moderation-oriented outpatient counselling). To avoid overlap with the CSA with substance misuse group, women who had attended counselling for CSA issues in the past 12 months were not included unless this had resulted from referral by their current drug and alcohol treatment program.

Fifty women were recruited for the CSA only group. The two main sources for women in CSA counselling programs were Dympna House, a specialist counselling agency for CSA survivors and the national newsletter of the Women's Incest Survivor's Network (WISN). Other sources of recruitment included *Beyond Survival* (a newsletter for ritual abuse survivors), clinicians at Redfern Community Health Centre, Royal Prince Alfred Sexual Assault Centre and Louisa Lawson House. The sample largely comprised Sydney women with some interstate recruitments through WISN. Although none of these women had current substance misuse, 21 (42%) reported past substance misuse.

Difficulties arose in the recruitment of women for the CSA with substance misuse group. `Substance misuse' was initially defined in terms of (a) regular use and (b) concerns or worries regarding use. The shortcomings of this criteria were evident early in the study. First, some women with low quantities and frequencies of use identified with this criteria because of their worry about using substances to cope and risks of escalating consumption. These women were not included in the 'substance misuse' group because their substance use did not currently constitute a behavioural risk.

Second, the recruitment of women with a behavioural risk was very slow. The substance misuse criteria was therefore reworded to include women who, for the last three months, had been either (a) drinking the equivalent of a bottle of wine per day; (b) smoking marijuana every day; or (c) injecting more than once a week.

It is also possible that this slow recruitment reflects an under-representation of women with alcohol and other drug problems in CSA counselling services. Some services advise clients not to attend groups if they are under the influence of substances and this might pose a barrier for moderately or severely dependent women. The treatment criteria in this study was therefore relaxed to include women outside CSA counselling, recruited through radio and local newspaper advertisements. The exclusion of people who had attended a drug and alcohol treatment program in the past 12 months remained to avoid overlap with the drug and alcohol with CSA group.

Due to time constraints, the recruitment of the CSA with substance misuse group was closed after 30 women had been interviewed. The final group included 16 (53%) women who were participating in CSA groups or counselling at the time of the interview or in the previous six months, and 14 (47%) who had not received help for CSA in the previous six months.

Screening for CSA was based on criteria derived from research findings. The definition used in the development of the Diagnostic Interview Schedule module for sexual assault (Burnam et al. 1988; Siegel et al., 1987) was modified in the current study to specifically ask about childhood experiences. Volunteers were asked: BEFORE you turned 16, did you ever have the experience where someone touched you in a sexual way or pressured you into having sexual contact, when you did not want to? This definition excluded non-contact abuse and avoided emphasising the use of force since this was considered to be misleading in the case of child victims who are vulnerable to other types of pressures. Although this definition was not based on the age gap between victim and abuser, 95% of the CSA survivors reported an age gap of at least five years.

Procedure

Informed consent was obtained from all participants. The Consent Form explained the content of the interview and the interviewee's entitlement to withdraw consent at any time (Appendix A). The interview was conducted in a semi-structured manner and, with each subject's permission, was audio-taped unobtrusively. The interviews were conducted at the drug and alcohol treatment agencies, Dympna House, the university or in the women's homes.
All interviewers were female. Quantitative interviews were conducted by the chief investigator, the senior research assistant, and a volunteer psychology graduate. Qualitative interviews were conducted by the chief investigator and the senior research assistant, both of whom were registered psychologists with clinical training.

All participants were asked quantitative questions (Appendix B) with slight modifications according to their group allocation. The quantitative interview typically lasted 90 minutes. Fifty-two participants (approximately 30% of each group) received an expanded version of the interview incorporating additional open-ended questions to gather data for the qualitative analysis. These questions are identified by the word `qualitative' in Appendix B. Sampling for qualitative interviews was based on convenience, recruiting women who had sufficient time to receive a longer interview. Qualitative interviews lasted 2-3 hours. The interview schedules were divided into three sections that are described below. The order of presentation of Sections B and C was alternated to control for demand characteristics.

Section A

All subjects participated in Section A which gathered data about relevant demographic factors, family history, help-seeking and other life experiences. This section was also designed to measure current psychological distress before women were exposed to potentially disturbing questions about CSA, in Section B.

The qualitative version of Section A explored the families of origin, including relationships with and between parents and the impact of parental substance misuse. Open-ended questions also explored past and current experiences of help-seeking. Those not in counselling were also asked about their future intentions of seeking help.

Section B

Since Section B focused on the the CSA, it was only given to those women who answered "yes" to the screening definition of CSA. Initially, quantitative data were gathered regarding the CSA history. Then participant's were asked to answer more detailed questions about "the experience that you think has had the MOST IMPACT on your life".

Multiple choice stimulus cards were used to assist each woman to disclose details of the abuser's category of identity and the sexual behaviours involved. Quantitative and qualitative questions also focused on the aftermath of the abuse, including disclosure and attributions about long-term effects. Section B was always closed with a debriefing discussion about personal strengths and women were given information regarding available sources of support.

Section C

Section C focused on the history of substance use, measures of substance consumption and dependence, and risk-taking behaviour. It was applied for all women who had current substance misuse and those women in the CSA only group who had a past history of substance misuse. The qualitative version of Section C explored women's reasons for using substances.

Measures

Psychological distress

The *General Health Questionnaire (GHQ)* (Goldberg and Williams, 1988) was chosen to measure

women's level of psychological distress, with four subscales measuring somatic symptoms, anxiety, social dysfunction and depression. Although the GHQ measures symptoms in the last two weeks an alternative scoring method suggested by Goodchild and Duncan-Jones (1985) allowed the detection of long-standing distress. The alternative method is produces more normally distributed data. It is referred to as the CGHQ.

Five additional items that were used by Briere and Runtz (1988) to measure dissociation were included using the scale of the CGHQ. The *Self-Esteem Inventory* (Coopersmith, 1970) was used to measure current levels of self-esteem.

It was expected that the scores for women undergoing current psychophysiological stress would be elevated and mightly unduly influence the results. Therefore, women who were currently withdrawing from substances, had an illness, or had very recently been traumatised were excluded from the analysis of CGHQ and its subscales and the scale for current dissociation.

Traumas

In addition to specific questions about sexual and physical abuse, Section A also included a list of other traumas based on the Diagnostic Interview Schedule module of traumas associated with Post-Traumatic Stress Disorder (Robins, Helzer, Croughan and Ratcliff, 1981). Childhood neglect was divided into `physical' and `emotional' neglect. An estimate of the number of life-time traumas was derived from a count of 11 traumas, including child and adult physical abuse and adult sexual abuse.

Severity of CSA

Each woman was shown multiple choice stimulus cards with a list of eight types of sexual behaviours (Appendix B, Section B) and asked whether she had experienced these behaviours during the CSA. For the purposes of this analysis, the behaviours were collapsed into two categories based on their frequency of occurrence. The cut-off point was 108 (60%), the median frequency for the sample of behaviours. The theoretical rationale for this grouping was that rarer types of behaviours might be more taboo and therefore have a more serious impact. Women's own ratings of the severity of abuse were used to validate this measure. Participants were asked to rate the trauma of the CSA on a five-point scale (Appendix B, Section B). The word `trauma' was later replaced by the more neutral term `effect'.

Alcohol and other drug consumption

Procedures for measuring substance consumption were designed to be comparable with the work of Swift et al. (in press). If the participant had used her main problem drug in the last two months, consumption levels were measured with the *Opiate Treatment Index* (*OTI)* (Darke, Hall, Heather, Wodak and Ward, 1992) and HIV risk taking, with the *HIV Risk-taking Behaviour Scale (HRBS)* (Ward, Darke and Hall, 1990). This extends the application of the*OTI* beyond its standardised application for use of substances in the previous month (Darke, Hall, Heather, Wodak and Ward, 1992) and therefore might alter its validity. Women who had last used their main problem drug more than two months ago were asked about typical substance use, quantity and frequency and risk taking behaviour when they last used.

Substance dependence
Standardised measures were used to measure the level of substance dependence. The *Impaired Control Questionnaire* (*ICQ*; Sitharthan etc.) and the *Severity of Alcohol Dependence Questionnaire — Form C* (*SADQ-C*; Stockwell etc.) were used to measure dependence on alcohol when alcohol was the main problem drug. The *Substance Dependence Scale* (*SDS)* (Gossop, Griffiths, Powis and Strang, 1992) was used to measure dependence on any other drugs identified as the main problem drug. For the first few interviews, a typographic error might have led to a slight underestimation of scores on this scale.

Data analyses

Quantitative method of analysis

Statistical analyses was conducted using the statistical package, *SPSS for Windows.* Descriptive analyses were conducted using the basic frequency and cross-tabulation procedures, with the exclusion of cases of missing data. For categorical data, odds ratios and their 95% confidence intervals were calculated to evaluate the degree of certainty around estimates of difference.

Normally distributed continuous data were reported with means, standard deviations and two-tailed t-tests for group differences. Where group variances were significantly different, t-test results are based on separate variance estimates. Where data were skewed, medians are also reported and t-test results verified using non-parametric procedures, such as the Mann-Whitney U test. The significance criteria for tests of group difference was $\alpha=.05$. No adjustment was made for the number of tests since the purposes of this study were exploratory. Testing was confined to variables that were relevant to the research questions.

Regression analyses were used to test the contribution of CSA to variation in measures of psychological distress and age of first intoxication. Significant covariates such as life traumas and parental substance misuse were also entered into the regression equations. Logistic regression analyses were used to test CSA's contribution to variability in suicidality and sex problems. Linear regression analyses was used to explore the contribution of CSA to women's current scores on theCGHQ and the dissociation scales. For each of these analyses, the CSA with substance misuse group was excluded and the drug and alcohol only group was used as a referent group. A linear regression analysis was used to examine the relationship of CSA to variability in the age of first intoxication, with the CSA only group excluded and the drug and alcohol only group used as a referent group.

In each of the regression analyses, variables were initially entered with the grouping variable and then all significant variables were entered together. The final model was reduced to include only those variables that met the criteria of $p<.05$ after adjustment for other variables. The reduced models of the five regression analyses are presented in Appendices E-I.

Qualitative method of analysis

Qualitative interviews were transcribed using a standardised format to suit the qualitative analysis package, *NUDIST*. The transcriptions were verbatim except for the exclusion of filler words such as "um". Markers were used to identify changes in emotion such as distress, laughter or pauses. Where

the interviewer's prompt might have cued the direction of the interviewee's response, the interviewer's comments were also transcribed. All identifying material was omitted from the transcripts. Although each participant is identified by a pseudonym in the table of excerpts from descriptions of the family system (Appendix C), the sources of quotes in the text are unidentified so as to preserve participants' anonymity.

The NUDIST package was used to identify the main themes in accounts of families of origin, help-seeking decisions, needs in treatment, high-impact CSA and reasons for using substances. The analysis of decisions about help-seeking initially focused on all four groups to identify the relative influences of CSA and substance misuse on decision-making processes. The models by Saunders (1993) and Herman (1992) were drawn from the literature because of their consistency with the themes emerging from the data. Emergent themes were then tested in the comparison between the drug and alcohol with CSA and CSA with substance misuse groups.

3.1 SAMPLE CHARACTERISTICS

Current treatment

Table 1 shows the various types of treatment programs from which women in the two drug and alcohol treatment groups were recruited. The groups were approximately equal in the proportion of clients from the detoxification unit, all-female residential programs and methadone maintenance clinic. The drug and alcohol only group included slightly more women from outpatient counselling services while the drug and alcohol with CSA group had more women attending the mixed-sex rehabilitation service.

Table 1: Number and percentage of women in drug and alcohol treatment programs

	Drug & alcohol with CSA		Drug & alcohol only	
Type of agency	N	%	N	%
Detoxification unit	9	18	8	16
Mixed-sex residential rehabilitation	8	16	3	6
All-female residential rehabilitation (short-term & therapeutic community)	10	20	12	24
Methadone maintenance	18	36	18	36
Outpatient counselling	5	10	9	18
TOTAL NUMBER	50	100	50	100

In addition to the detoxification unit at Langton Clinic, some residential rehabilitation services provided medication and support for detoxification. Some women in methadone maintenance were also withdrawing from other drugs. Forty percent of the drug and alcohol with CSA group were undergoing detoxification at the time of the interview, compared with 23% of the drug and alcohol only group. This was not a statistically significant difference.

Among the women outside drug and alcohol treatment, 50% of the CSA only group were recruited through the WISN newsletter. All of them were either currently receiving counselling or attending groups, or had been in the last six months. Due to the recruitment difficulties already discussed in Chapter 2, this was not the case for the CSA with substance misuse group. Thirty-six percent of the women in this group were recruited through local newspapers and radio and 47% of them had not been involved in counselling or groups in the last six months. One woman in this group was withdrawing from a substance without professional support at the time of the interview. Table 2 shows the treatment status of women in each of the two CSA groups.

Table 2: Number and percentage of women in CSA counselling or groups

Type of service	CSA with substance misuse		CSA only	
	N	%	N	%
CSA 1:1 counselling	8	27	30	60
CSA therapy group	1	3	11	22
Recently finished either counselling or group	6	20	1	2
Psychiatrist about CSA issues	1	3	8	16
No current treatment	14	47	—	—
TOTAL NUMBER	30	100	50	100

The majority of women in the CSA only group were involved in individual counselling with professionals other than psychiatrists. These included clinical psychologists, psychotherapists and other counsellors. Similar trends were evident among those women in the CSA with substance misuse group who were receiving or had recently received treatment.

Time since starting treatment

The length of time since starting drug and alcohol treatment varied considerably between different types of agencies. Time since starting methadone maintenance, for example, ranged from six days to seven years, with a median of 18 months. Since detoxification and rehabilitation programs are time-limited, it is not surprising that the time since starting treatment was much shorter for these programs. Excluding clients who attended WHOS (a long-term therapeutic community), the median time since starting detoxification or rehabilitation programs was seven days. The median time since arrival at WHOS was 21 days. Among clients of outpatient drug and alcohol counselling services, time since starting treatment ranged from seven days to two years, with a median of two months. There were no significant differences between the two drug and alcohol groups in time since starting treatment.

Among women in the CSA groups, time since starting individual counselling or therapy ranged from 18 days to seven years, with a median of one year. Median time since starting CSA group therapy was three months. There were no significant differences between the two CSA groups in the time since starting counselling or groups. For those seven women who had finished counselling or groups in the last six months, the median time since completion was two months.

Demographics

For the total sample of women, ages ranged from 16 to 69 years, with a mean of 32.6 years (sd=8.13) and a median of 32 years. Women in the CSA only group were significantly older than women in each of the other CSA groups ($p<.02$), with a mean of 35.7 years (sd=8.80) and a median of 34 years. Although the average age for this group was influenced by the outlying effect of a 69-year-old woman, these differences were robust when her age was not included in the tests.

There were no significant differences between the four groups in stability of residence in the past six months. Half or more than half of the women in each group had not moved residence at all in the last six months. However, among the drug and alcohol treatment groups, 8% of women with a CSA background and 12% of the drug and alcohol only group either had no fixed address or had been living in an institution.

Women in the drug and alcohol treatment groups were more likely than women in the other two groups to have spent time in prison ($\chi^2=27.16$, df=6, p=.000). Twenty-six percent of the drug and alcohol with CSA group and 32% of the drug and alcohol only group had spent longer than a night in prison, compared with only two (4%) women from the CSA only group and none of the CSA with substance misuse group.

Approximately 36% of the whole sample lived with a partner, either with or without children and 21% lived alone. Others lived alone with their children (16%), with friends or acquaintances (13%) or in an extended family situation (8%). Compared with other groups, more of the drug and alcohol with CSA group lived with their partners (44%) and fewer lived alone (12%).

Just under half of the women (48%) were in a relationship at the time of interview, with no group differences. The majority of women were heterosexual (76%). Compared with the drug and alcohol only group, more women in the drug and alcohol with CSA group were either bisexual or lesbian (27%). Although this trend was consistent with the findings of Swift et al. (in press), it was not a statistically significant difference.

There was, however, a significant difference between the drug and alcohol with CSA and CSA only groups ($\chi^2=7.15$, df=2, p=.028). Twenty percent of the drug and alcohol with CSA group said that they were bisexual and 6% said they were lesbian . Among the CSA only group, the pattern was reversed, with 8% saying they were bisexual and 22% lesbian. Since there was also a higher prevalence of sex work in the drug and alcohol with CSA group (see below), this difference probably indicates that they described their sexual preference according to behaviour rather than personal preference. This explanation was further supported by results indicating that people who had worked in the sex industry were more likely to define their preference as bisexual than people without this experience ($\chi^2=10.24$, df=2, p=.006).

The mean age of onset of consensual sex was 16.1 years (sd=4.09). Women in the drug and alcohol with CSA group were significantly younger (_=15.74 years, sd= 1.93) than the drug and alcohol only group (_=16.52 years, sd=2.07) when they first consented to sex (t=-1.95; df=97; p=.054). There were no differences between the drug and alcohol with CSA and either of the CSA counselling groups in age of first consensual sex. Age of first consensual sex was significantly correlated with the age of first

intoxication (r=.217, df=147, p=.008).
Approximately half of the women were mothers (49%). Fewer women in the CSA with substance misuse group had children (30%) compared with other groups. Of those who had children, 34% did not live with their children but there was not enough data to distinguish between loss of custody, children leaving home and other reasons for separation. Thirty-seven percent of women had never had a pregnancy. For those who had, the number of pregnancies (apart from children currently living) ranged from 1 to 10, with a median of one.

Education and employment

The mean age at which women left school was 15.96 (sd=1.54). On average, women in the drug and alcohol with CSA group left school one year earlier than other groups (_=15.2, sd=1.62, p=.000). This was a statistically significant trend (F=6.43; df=3,176; p=.000)

Approximately half of the women in the CSA only (46%) and CSA with substance misuse groups (57%) had been working in paid employment in the past 12 months. The majority of women in the two drug and alcohol treatment groups had not worked in paid employment in the previous 12 months (78%). Seventeen percent of the whole sample named household duties as their usual occupation.

The CSA only group were more likely than other groups to say that their usual occupation was professional or para-professional (according to the classification by Castles, 1986). Among that group, 48% said their usual occupation was professional, compared with 20% of the CSA with substance misuse group, 16% of the drug and alcohol only group and only 8% of the drug and alcohol with CSA group. Women from both drug and alcohol treatment groups were more likely than the two other groups to be working in clerical or sales and service jobs.

At the time of the interview, 74% of the drug and alcohol with CSA group and 78% of the drug and alcohol only group were recipients of social security. The types of social security included unemployment benefits, sickness and disability pensions, single parent support and other pensions. The main sources of income for the CSA with substance misuse group were employment (53%) and social security (33%). The main sources of income for the CSA only group were employment (44%), social security (38%) and partner's income (12%).

Sex work

These employment figures, however, may under-represent women's involvement in the sex industry because of the interviewees' discretion. The questions regarding employment were asked early in the interview, before rapport had been developed.

When asked directly about sex work, 66% of the drug and alcohol with CSA group and 38% of the drug and only group said they had worked in the sex industry. In contrast, only 17% of the CSA with substance misuse and 14% of the CSA only group had ever done sex work. Prevalence of sex work was significantly greater among the drug and alcohol with CSA group compared with either the drug and alcohol only group (χ^2=7.85; df=1; p=.005) or the CSA only group (χ^2=28.17; df=1; p=.000).

Women in the drug and alcohol with CSA group had three times the odds of working in the sex industry, compared with the drug and alcohol only group (OR=3.17, 95% CI=1.40; 7.17). Substance misuse might be associated with sex work because of economic and social factors. Most women in the drug and alcohol treatment groups who had worked in the sex industry (70%) said that they had done so to afford drugs. Nevertheless, these results also indicate that having a CSA background increases the strength of this association. The findings are consistent with those reported by Copeland et al. (1993) and Swift et al. (in press).

Some women described how the CSA had influenced their sexual development in a way that made sex work easier:

> *It just sort of seemed to come natural after that. And [pause] felt okay about it and like I said, I had to sort of live up to that name. And then it, so over the years, its just because I've had so many relationships and sexual experiences with different people and that, its made it easier for me to work because of my feeling of worthlessness [pause]. Just feels ah [pause] suppose it doesn't feel comfortable. But ah, because I DO feel like a piece of meat. From that* [CSA] *and those other experiences, its made it easier.* [Drug and alcohol with CSA]

Counselling that focuses on the CSA may challenge the woman's view of herself as a sexual commodity and thereby make sex work less tolerable:

> *That's why prostitution's so easy. And the last time I was out, it was very hard to do, 'Cos I started addressing the issues. And it just made me feel disgusted. But before that, it was like a duck to water. But this time, I just thought "Oh na, couldn't". Made me absolutely vomit.* [Drug and alcohol with CSA]

These findings lend some support to Finkelhor and Browne's (1986) concept of traumatic sexualisation. The CSA might lead to a distorted view of self as an object of exchange for sexual exploitation. There was no statistical relationship, however, between sex work and sexual dysfunction.

Concluding remarks

The statistics indicated that women in the CSA only group are older than the other groups. Women in the CSA counselling groups were more likely than women in drug and alcohol treatment programs to have been employed prior to counselling and to have been working as professionals or paraprofessionals. Women in the drug and alcohol with CSA group appear to have been educationally disadvantaged compared to other groups. They also began were more likely than others to have worked in the sex industry.

3.2 FAMILY OF ORIGIN

The majority of women (66%) had been raised by both biological parents for most of their childhood. The percentage was somewhat lower for women in the drug and alcohol with CSA group (52%). They were more likely than women in other groups to have been raised by adoptive or foster parents (14%, compared to 4% of women in the three other groups) or to have had step-parents (22%, compared to 12% of women in the other groups). There were, however, no significant differences between groups in the percentage of women who had been separated from a parent through either death or marital discord. Thirty-four percent of women had experienced separation from a parent before the age of 16.

Although there was a trend for the drug and alcohol with CSA group to include more only children (16%) than other groups (5%), there were no significant differences between groups in the gender of their siblings and order of birth in their families. Most women had siblings, and 41% had both brothers and sisters. Their distribution was evenly spread across the youngest, middle and oldest position in their families. There were three twins in the drug and alcohol only group.

The four groups reported similar sized families, with number of siblings ranging from zero to 11 and a median of two. Whereas American studies cited by Herman (1981) have found that incestuous families are typically larger than other families, our results showed no such differences for families in which either father-daughter incest or any other kind of incest took place.

Over half of the women (59%) said that their fathers had been born in Australia. The figure was slightly higher for mothers (65%). Two percent of Australian-born fathers and mothers were Aboriginal or Torres Strait Islanders. The next most common birth places of parents were countries within the UK and Ireland, and New Zealand. Thirteen percent of mothers and 18% of fathers were born in other places of the world, including Europe, USA, South America, Asia, Pacific Islands, the Middle East and Africa.

The sample had a predominantly Christian background with 37% of women being raised in the Roman Catholic religion and 37% raised in other Christian denominations. Twenty-one percent of the sample had no religious influence during their childhood. Only 6% of the sample were raised in religions other than Christian. The only major difference between the groups in their religious background was that four women in the CSA only group and two women in the CSA with substance misuse group said that they had been abused by ritually-abusive cults whereas none of the drug and alcohol treatment clients reported ritual abuse.

The groups were quite similar in the socio-economic status of families of origin, based on parents' usual occupation. The most common occupations for fathers were managerial/administrative (18%), professional (18%), trades (18%), and manual labour (13%). Around half (54%) of mothers had worked outside the home. They most commonly worked in professional (12%), clerical (12%), manual labour (10%) and sales and service (8%) jobs.

Among the drug and alcohol treatment clients, the CSA survivors had a less stable residence during childhood. They were significantly more likely to have runaway from home or been institutionalised before age 16 than other women (χ^2=5.89, df=1; p=.015). Overall, they experienced more changes of residence than the other women (U=621.5; p=.005). There were no other group differences in residential stability.

One woman linked her experiences of residential instability during early adolescence with incest:

> *I was abused by my foster father from eight to 10 years. I went into government institutions and I ran away heaps a times. And I used to sell me body for money to live on the streets.*[CSA with substance misuse]

She associated her alcohol problems with survival on the streets:

> *'Cos when I was a kid, workin' the streets, I was mad! I was drinkin' all the time! And, like, I was only a bit of a kid.*[CSA with substance misuse]

FAMILY POWER RELATIONS

The sub-sample of 52 women who received qualitative interviews was similar to the larger sample in families' ethnicity, socio-economic status, size and stability. The sub-sample also was representative of the larger sample's pattern of group differences in the parental unit.

In the qualitative analysis, families of origin were categorised according to the most prominent power relations that emerged from their descriptions of early family life. These categories are summarised using the women's own words in Appendix C. Overlap between the categories is not uncommon but the focus on prominent themes helps to highlight the impact of specific family patterns. The categories therefore represent broadly based `prototypes'.

The following section briefly summarises the main findings regarding women's experiences of different types of family relations. This analysis particularly focuses on any aspects of family life that might influence the risk of CSA or the parents' reactions to disclosure. That is not to say that the parents are to blame for the CSA except obviously where a parent was the abuser. Rather, the analysis focuses on aspects of family life that might reduce or increase the risk of CSA, moderate the support available for disclosure or influence the child's recovery from CSA.

A close parental relationship

Close relationships with either one or both parents were more frequently described by women who had not experienced CSA. Three women described their relationships with both parents as close and happy. Three said that they had distant relationships with their mothers but were close to fathers until adoloscence. Six women had close maternal relationships but distant relationships with their fathers, usually because fathers spent long hours away from home.

Just as with other families, women who had close parental relationships recalled disagreements and disciplinary problems, parental substance misuse, financial hardship, marital discord and family tragedies. The most prominent differences between these and other families were a lack of violence, a stable parental presence, reliable parental encouragement and affection, and a greater freedom for the child to express herself:

> *I think the three of us [siblings] grew up with the knowledge that you don't carry a grudge. You know, if you disagree with something you say so and sort it out. And that's basically how my parents sorted everything out.* [Drug and alcohol only]

> *Well, you know, we just used to give each other the shits, you know, sort a thing. But we've always got on. We've always got on. She's always been there.* [Drug and alcohol only]

> *You know, if I had a breakup with my boyfriend, I'd sit on the bed and talk to her.* [Drug and alcohol only]

He was sick. But he was always there. Whatever was in his pocket was mine and my sisters'. He always gave us money to buy our own stuff because he was too sick to do it. He sort of played the mother role and my Mum played the father role when he got sick.[Drug and alcoho

Despite positive relationships with one parent, some women were deeply affected by the lost opportunity for a positive relationship with the other parent and sometimes attributed their substance misuse to feelings of grief and anger about that parent:

Virtually the minute he died — he died at home — and I just thought well, you know, I'll never have a chance to sort of talk to this man, and that's when I started to question things. He died in September and I had my first drink in October and I continued to do so, since. I'm not blaming that but I think that was a big part of it.

[Drug and alcohol only]

Abandonment and being good

In many families, the women recalled having to be a certain way for their parents in order to be accepted. Typically, women spoke about the importance of being a "good girl". This meant doing what they were told and not challenging parental authority. Sometimes it also meant taking on adult responsibilities such as household chores, caring for siblings or emotionally supporting a parent. The theme of "good girl" was described as a response to parental preoccupation, maternal distance or maternal demands. In some families, however, the opportunity to win over the parents was not available and women from these families emphasised their feelings of abandonment and the necessity of early independence.

Preoccupied parents

Nine women reported that during their childhood, both parents seemed preoccupied and unavailable to their children. The main factors that preoccupied parents were physical and mental illness, substance misuse, economic survival and business enterprise and the marital relationship itself. It was as though parents and children occupied two separate worlds and intimate communication between them seemed impossible.

We never really interacted much with our parents. They would ship us off to a camp or something like that on the holidays. We didn't, we weren't close . . .

[CSA with substance misuse]

Sometimes, because they were remarried and I had younger brothers and they had a business, it was always fairly chaotic. I guess that's how you could describe my childhood, chaotic. So there wasn't really much time to really know how I was getting on with my mother. Other than when we were fighting, 'cos everyone was so busy.

[CSA only]

. . . basically we brought ourselves up. We learnt how to cook and clean and that. My grandmother would come over, occasionally do the washing.[Drug and alcohol with CSA]

One woman was institutionalised and separated from her siblings after her father died. She had few memories of closeness with her mother:

> *I didn't know my mother. I have no memories of my mother. At this, you know, up until . . . my memory begins of my mother, age 12 — apart from the glamorous lady who used to visit me once a month. That was all.* [CSA with substance misuse]

Another had chosen to be institutionalised because her parents' mental illness and substance misuse made them incapable of parenting:

> *. . . we had to show her what to wear, to go out, to go to school things or whatever and, yeah, we had to basically . . . I had to basically parent them. A lot of the time. Because he'd either be drunk or off his face on tablets or stuff.*[CSA with substance misuse]

Everyone in this category had experienced CSA. Some accounts indicated that parental distraction might have increased the risk of CSA in two ways. First, some women recalled that their mother's partners had exploited, and perhaps even engineered, the emotional distance between mother and child:

> *At the time, because I needed to feel special to someone and my Mum was worried about my brother and just how to survive, I guess it helped me feel special.*[CSA only]

> *. . . he was the sort of person that says "Children should be seen and not heard", and all that sort of stuff. And yeah, and it was pretty much like that. Like, I was in the way . . . I just remember feeling I was a bit of a non-being. And then at 12, suddenly I was related to him sexually and I felt worth something.*[Drug and alcohol with CSA]

Second, parental distraction might have increased the risk of CSA simply because children were left to cope alone or were abandoned at crucial times. One testimony of CSA demonstrated the gulf between parent and child that not only contributed to a rape but also delayed resolution of the trauma until adulthood. The woman was raped at age 12 while waiting for her father to pick her up after a school dance. He had apparently forgotten a prior arrangement to pick her up that evening. Since she did not know many people, she had not considered asking anyone else for a lift:

> *I was adamant, you know, my father was coming to pick me up and I went back to the hall and 'e wasn't there and then I went back to the shopping centre and walked around again. And I did the laps of the shop and went back and each time, he wasn't there.* [CSA with substance misuse]

She was lured away by the rapists and held until morning. Her father had arrived later to pick her up and when she wasn't there, he had assumed that she was staying at a friend's place. When she arrived home, he accused her of lying about the rape and insisted that she had stayed with a friend. As a child she had blamed herself for being enticed but in adulthood she came to believe that her father had contributed to her risk:

> *. . . you were left to look after yourself. You were in your own, had to fend for yourself and you made the wrong choice. But had there been a guardian, that choice might never have been mine to make — those mistakes.* [CSA with substance misuse]

Mother demanding, father peripheral

Five women described intense, demanding maternal relationships where they were required to meet high standards of responsibility and, at times, provide emotional solace for their mothers. Some fathers offered their daughters an alternative, less demanding parental relationship. Others were emotionally distant and left the parenting to the mother.

Mother's expectations of daughters were of two types. The first type was practical and directly related to the mother's role as homemaker. Daughters were expected to help with household duties and care for younger siblings:

> *. . . she was very demanding but only — I can see now, it was only because she had so much that she had to do. And she needed the help but at that time, it was very, very tiring for me because I had a lot of chores that I had to do, each day.*
> [Drug and alcohol with CSA]

> *I don't think she took a lot of things into account that I was a child . . . She just sort of treating me like an adult, that I should have all these duties as well as, sort of responsibilities and things.* [CSA with substance misuse]

The second type of expectation was emotional. In a way, the daughter was required to protect her mother, by maintaining the peace, being good or helping to mend the marital relationship:

> *I'd say I would have been in fear of her quite a bit. She's quite domineering. So I'd just keep the peace.* [CSA only]

> *I would describe that as [pause] as me trying very, very hard to make her happy. That I was in fact going to be the source of happiness.* [CSA only]

> *I think I was `therapist' for, oh, really as long as I can remember, tryin' a resolve arguments between the two of them.* [CSA only]

Barriers to CSA disclosure were sometimes described in terms of the child's duty towards her mother or both parents. Children who questioned the actions of adults were punished for making trouble and if the abuser was a member of the family, disclosure was a threat to the family integrity:

> *The way I'd been raised that you don't question. And that I wouldn't be believed anyway, which I wasn't. And I was just told "Making mountains out of molehills", "Its your problem, you know, you're just tryin' to make problems".* [CSA only]

> *I didn't want to tell and I didn't want to be found out because my family would have disintegrated if that happened. Or my mother — first of all, she wouldn't have been able to cope emotionally.* [CSA only]

Violence and denigration

In some families, the girls had been subjected to personal denigration, frequently associated with violence. The women learnt from an early age that they had no rights and little value within the family power relations. This experience of denigration was common among women who had been raised in a patriarchal family, by a rejecting foster parent, or where both parents were physically abusive. Most of the women whose families were categorised in this way had experienced CSA.

Patriarchal families

For the purposes of this study, the term `patriarchal' is used to refer to families where the main theme was the father's dominance over the mother and children, by verbal abuse and/or physical violence. Nine women described their families in this way. Five were in the drug and alcohol with CSA group and four in the CSA only group. In the extreme cases, the abuse was so pervasive that family life revolved around the father's dictatorship and children modified their own behaviour so as not to attract his wrath:

> *As soon as we heard 'im, you know, drive in the driveway, we'd sit up and you know, don't move, and do whatever he tells you to do, you know.* [CSA only]

> *. . . we'd never disagree. We were too scared. Its just . . . you were told "Go in your room", you go in your room and you sit on your bed. You don't move. You'll go and watch television because he thought — we hated television and I still do to this day — "Sit on the floor! Watch television!"— we were like robots. You didn't move. "Have dinner! Sit down!". You don't move.* [Drug and alcohol with CSA]

> *We were told to shut up. You never disagreed, you never challenged it. 'Cos you were just a child. He was God.* [CSA only]

Women from these families described their feelings about their fathers either with extreme ambivalence or complete loathing and fear. In the more violent families, women recalled hating their fathers and wishing they were gone:

> *. . . we used to pray all the time that he'd get killed in a truck accident or something, you know. So we hated him, really.* [CSA only]

> *In front of people, he try and force me to give 'im a kiss on the cheek and I wouldn't — no matter how much he hit me, I just wouldn't. And a course, he couldn't hit me in front of the people. They knew. They'd look at me and they'd say "She hates your guts". But he wouldn't be in that.* [Drug and alcohol with CSA]

Other women expressed sadness at the lost opportunity for a positive paternal relationship:

> *Well, it was a good relationship that went bad. Yeah, and when I realised he was lying and things. At that age [six years old], I realised that I lost respect for him.* [Drug and alcohol with CSA]

The mother's role was typically to placate the father by anticipating and meeting his needs and not

challenging his authority. The daughter was often expected to assist the mother in this role:

> *. . . as soon as he'd pull up in the car after work, we'd both jump. She'd get his dinner. I'd run and get his slippers and make his coffee, you know, I was six, from the age of six. Made his coffee after dinner [pause] so [pause] yeah, and a lot of nervousness. Our household was full of nerves.* [Drug and alcohol with CSA]

The ability of mothers to protect their children against fathers' abuses was variable. One woman reported that her mother had threatened to stab her father if he hit the children. Another said that her mother had been able to prevent the physical abuse but not the sexual abuse. Mothers were sometimes preoccupied with younger children or their own survival in a violent marriage or cut off from outside support because they did not speak English. Although women appreciated these constraints, there was often an expression of disappointment at the lack of maternal protection:

> *Mum is a very soft person. Like she wouldn't defy my father. He was too strong for her. I know that she loved me but she was a very weak woman. She couldn't even defend her own children.* [CSA only]

Even affectionate mothers were sometimes unable to provide adequate emotional solace in an environment of ongoing terror. A lack of warm attachment to the mother in the context of a violent father resulted in extreme feelings of isolation:

> *Didn't wanna live with my mother or my father. I hated the world. I didn't wanna live in it anymore. Nobody understood how I felt.* [CSA only]

> *You know, I wasn't part of them. I was just this . . . They were just people that were hurting me. And I just didn't say anything. I just used to hide.*
> [Drug and alcohol with CSA]

Sometimes children were able to form protective alliances with siblings:

> *Like if we knew someone was getting a hiding, they were about — like "Go to your room", and then Mum and Dad would be arguing because that person's done something wrong — we'd hurry up and run in and tell that person to put on heaps of jumpers 'cos we knew they were gonna get a hiding. Put on heaps of jumpers so you can't feel it [laughs].* [Drug and alcohol with CSA]

The patriarchal family structure placed children at risk of CSA in several ways. First, in three cases, the father had terrorised the family so much that he could sexually abuse his daughters without fear of resistance or disclosure. Each of these women had been threatened with death by their fathers in the context of CSA. The lack of a positive paternal relationship in the patriarchal family structure might also increase a child's risk of CSA when she seeks affection from other nearby trusted males. Sexual abusers included a trusted neighbour, a loved grandfather and a favourite uncle.

The threat of violence in the family also made it harder to disclose and led to unsupportive responses after disclosure. Parents acted to preserve family power relations, sometimes to avoid an escalation of

violence between members of the family rather than acting in the child's interests:

> *. . . we're frightened if it gets out, you know, all hell's gonna break loose between the family, and because we got a big family, we just don't need it [laughs].* [Drug and alcohol with CSA]

> *She asked me what happened. I told her what happened. She said "Have you told anybody else?" and I said "No." She said "Your father will kill 'im if he finds out about this. You can't tell him". And she said [pause] "Just forget about it".* [CSA only]

Another factor in patriarchal families that might have contributed to the risk of CSA was the personal denigration of the child. The daughter was often devalued by one or both parents, sometimes on the basis of her sex:

> *[Father] always put me down, like my mother, you know, "Women are sluts", so I got called a slut from a very young age, a slave.* [Drug and alcohol with CSA]

> *I could talk to him but it wasn't almost like "Oh you hurry up and say what you've got to say". It was like he never wanted to hear me really say anything [laughs]. And both my parents were really into this "Be seen and not heard". And always, always used to call me an idiot and a fool and a no-hoper and stuff like that.* [Drug and alcohol witl

This type of denigration probably discourages a warm parental relationship in which disclosure might take place. Ongoing denigration and abuse might also psychologically disarm the girl by lowering her self-esteem and contributing to feelings of culpability:

> *I was made to give other guys head jobs and stuff like that. And I've found out since that it is sexual abuse. Like for so long "Oh its alright, you know, that was my fault. I was there, sort a thing" . . .* [Drug and alcohol with CSA]

> *I know the parents were in the next room and I wanted to scream but was like "I'm gonna get into trouble for being in this room in the first place. I shouldna come in here" — I was kind of enticed to come in . . .* [Drug and alcohol with CSA]

Both parents physically abusive

Three women had grown up in families where both biological parents were physically violent towards them. Their families shared many of the characteristics of patriarchal families except that there were two abusive parents. This led to a particularly pervasive type of abuse from which there was no escape:

> *I would be left to look after the children and cook tea, clean the house. If I didn't do it — if everything wasn't done by the time they got back from the pub, I was flogged. That was it.* [Drug and alcohol with CSA]

> *I mean, I got abuse from all members of the family so — I didn't know how to cope with that — so I sort of withdraw into myself. And became very introverted and withdrawn.*

And so I didn't really notice what was going on around me, very much. [CSA only]

A prominent theme in these families was the suspected complicity of the mother in the father's acts of physical or sexual abuse:

> *Its just like me mother 'd get drunk and she'd say "I've had enough of these kids, you know — she's done nothin', you know, done nothin'". And she'd get 'im to the point where he'd bash me . . . And once he'd bash me she was happy.*
> [Drug and alcohol with CSA]

> *I was just sort of hanging around her. And she kept telling me to go inside, "Go and see ya father" and I said "No", I didn't want to. Because he had tried to touch me then . . . and she just kept telling' me to go back in. And I couldn't see any reason why. And so I just thought that she wants him to do it to me.* [CSA only]

All three women had been sexually abused by their fathers. The anticipated or actual consequence of disclosure was further violence from either parent:

> *. . . one thing he used to say was that Mum would get angry. Well that was, like, Mum getting angry was a really scary experience.* [CSA with substance misuse]

> *Scared. And I didn't know what me father'd do to me.* [Drug and alcohol with CSA]

> *I remember telling her and she belted me and told me I was a liar.* [CSA only]

Fostered but not favoured

Among women who had been raised by adopted, foster, or step-parents, five women described emotional and/or physical and sexual abuse by these parents. In three cases, the mother was the main abuser and in the other two cases, it was both parents. The most prominent theme was an unwillingness to bond with the child and sometimes parents openly favoured their biological children. The women recalled feeling rejected, scapegoated and unloved:

> *. . . you're a child, you've got no rights. You know, you're OWNED. These people own you.* [Drug and alcohol with CSA]

> *I'd win races, I was captain of teams. But hah! Na. My cousins didn't do that. I did! But they got praise for things they did. I never got any praise.*
> [Drug and alcohol with CSA]

> *They didn't like me 'cos I was Australian. They thought I had bad blood. That I was convict stock and it was a real comedown to their family now.*
> [CSA with substance misuse]

Psychological denigration was common in these families. Some women even recalled having been blamed for the circumstances that led to fostering. For example, a woman whose mother had died in childbirth was told that she was to blame for her mother's death. Another woman felt responsible for

her biological mother's departure from the family during her early childhood because she had inherited a dark complexion, reflecting her father's racial background.

Maternal mood swings

Another common family pattern emerging from the data was the detrimental impact of maternal mood swings. Six women described their mothers as having either a psychiatric illness or substance misuse that led to unpredictable emotional behaviour. Although this category included women from all four groups, it mostly comprised women with current substance misuse.

Whereas paternal violence followed a consistent pattern of domination, varying mainly in severity, maternal violence was often unpredictable and interspersed with affectionate behaviour. In contrast to the theme of denigration emerging in patriarchal families, maternal mood swings were associated with themes of emotional chaos. The maternal relationship was often described as a see-saw between rejection and affection:

> *The relationship was either loving or hating. It was never just normal. It was always [pause] You never knew how she was going to be — she was either sick or happy. I think she was manic-depressive. Don't know. She was either lovely or cruel. It was just a horr... it was a horrible, I remember hating my mother. Hated her.*
> [CSA with substance misuse]

> *. . . it would depend, her mood. If she was patient, she would listen and be okay and understand and that was great. If she got angry, then she would beating me. Or if she was depressed, she wouldn't care. So it was just like, different . . .*[CSA only]

> *I would sort of, walk up the stairs and I'd be listening to see whether she was drunk or not. So what sort of mood she's in. That was the fear part of it.*
> [Drug and alcohol with CSA]

The father was usually viewed ambivalently. Time spent alone with him was often valued but invariably he spent long hours away from the family and was unable to provide adequate parenting to compensate for the mother's erratic behaviour. In some cases, he withdrew deliberately, leaving the child to cope alone:

> *He was always travelling. Was never at home. But I basically have some good memories of him but it was never . . . I mean, basically, he was not there.* [CSA only]

> *I was resentful towards [father] because he took on a second job at night so that he didn't have to be home, because of her. So, which meant that Mum was at home all day on her own and I'd come home from school and I wouldn't know whether she was gonna be dead 'cos she was always saying she'd be dead by the time I got home from school.* [Drug and al

> *But I s'pose I look back now and I think, well, you know, he must a known what was going on. But he never stopped it.* [Drug and alcohol only]

Some of these families were also described as patriarchal. When the father was at home, he was

dictatorial and sometimes violent. Women described frightening power struggles between the mother and father. Other women recalled a `matriarchal' arrangement where the mother was the dominating partner. This arrangement, however, was often contradictory because in some of the same families, the mothers were also beaten by the fathers. This could reflect the child's perspective, where the father's power was seen as diminished because he seemed to be unable to intervene on her behalf:

> *He never had anything to do with me really. He was just there. He just did what he was told.* [CSA with substance misuse]

> *Frustrating. 'Cos he always took her side . . . Always take her advice. 'Cos she was sick, you see. So she was always right.* [Drug and alcohol only]

In the absence of a reliable paternal relationship, maternal mood swings contributed to feelings of being unloved and unworthy of love or respect. Two women, one of whom was sexually abused by her mother, attributed the CSA to their unmet needs for love and low self-esteem:

> *. . . sometimes when she would invite me to her bed, I knew that was going to happen and I knew that I didn't like it much but at the same time, I knew that I wanted to be close to her. So I felt like I was doing an election option — I was taking that option. And I didn't like it much but it was like "I have to choose and I choose to be with her". So I felt responsible.* [CSA only]

> *. . . my own mother didn't want me. She told me many, many times that to be pregnant at her age was just awful. And she didn't want me to be born. And she thought about giving me up but then she couldn't. I think if you've got that low a self-esteem, you attract negative things to you . . . You have no defense. That boundary isn't there — the boundary that says "People don't touch me. I'm worth something" isn't there. People feel they have the right to hurt you.* [CSA with substance misuse]

Changed view of parents

Three women who had recalled incestuous experiences for the first time during their adult years described a dramatic change in how they viewed their parents. One woman recalled being abused by her grandfather and now also suspected her father. A second woman had recalled abuse by her father and the third woman recalled abuse by both parents. They divided their memories of childhood into two parts — before and after their recollection of abuse:

> *. . . like I have two ways of describing it. The one is the way that I wanted it to be and that I believed it was, most of the time. And the other is the way that I'm finding out that it really was.* [CSA only]

> *I consciously thought I lived with these people who were perfect and I didn't understand why I had such mood swings.* [CSA v
> *I used to think he was a lovely man. But I could never remember anything . . .*
> [CSA only]

They expressed the view that their parents had been hiding behind a facade of normality and that the

only way to deal with the reality of abuse in the family was by dissociating:

> *Outward appearances were really good but underneath it all, there was serious dysfunction.* [CSA only]

> *I think it was because his behaviour was so extreme that I distanced myself from the sort of sadistic side of him and only saw the good stuff.* [CSA with substance misuse]

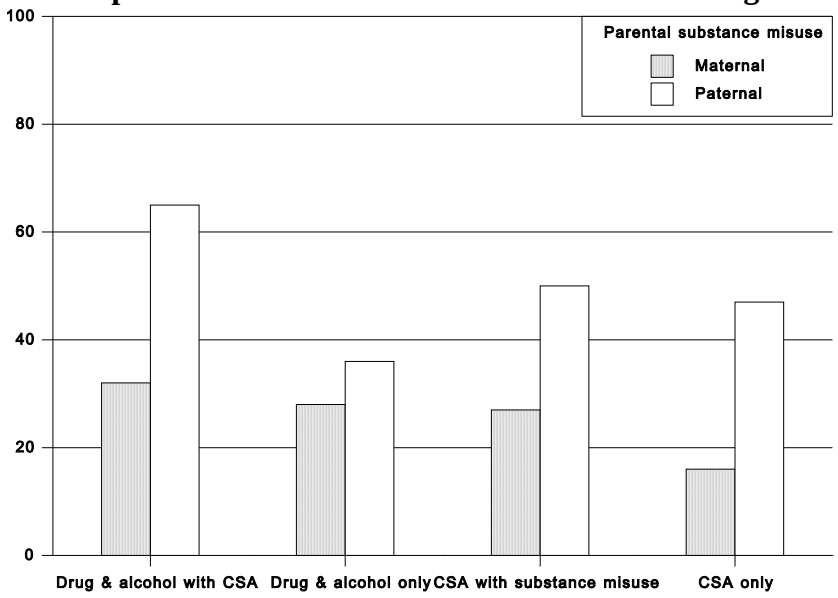
The struggles of women to reconstruct the past, particularly in the context of traumatic experiences, highlight an important qualification arising from the retrospective nature of this study. The pattern of group differences might be strongly influenced by CSA survivors' reconstruction of their family relationships in terms of their current feelings of anger and sadness about the CSA rather than accurately describing past events.

Nevertheless, this analysis identifies several factors that might influence the experience of CSA. In particular, this study indicates that violence, denigration or abandonment by parents not only increases the risk of CSA but might also pose a barrier to disclosure. Ongoing negative experiences in the family also impair children's self-esteem and probably magnify the traumatic effects of CSA. The findings highlight the child's dependence on the stability and goodwill of the parent.

3.3 PARENTAL SUBSTANCE MISUSE

Analysis of the full sample (N=180) revealed an interesting pattern of group differences in parents' substance misuse. Figure 1 shows that child sexual abuse was associated with paternal substance misuse, whereas current substance misuse appeared to be associated with maternal substance misuse. A summary of the frequencies is provided in Appendix D. These results highlight the importance of parental substance misuse as a potential modifier in the relationship between CSA and substance misuse during adulthood.

Figure 1: Prevalence of paternal and maternal substance misuse among the four study groups



Fathers of women in the drug and alcohol with CSA group were significantly more likely to have misused substances, compared with the drug and alcohol only group (χ^2=8.00, df=1, p=.005). The odds ratio was 0.31 (95% CI=0.13; 0.71). Since paternal substance misuse was unrelated to whether the father had perpetrated the CSA, the relationship between paternal substance misuse and CSA seems to be indicative of a broader effect on the safety of the child.

One factor may be the level of violence within the family. For example, women reporting paternal substance misuse were significantly more likely than other women to have experienced child physical abuse (χ^2=7.60, df=1, p=.006). The odds ratio was 0.43 (95% CI=0.23; 0.79). A significant relationship was also found between paternal substance misuse and emotional neglect during childhood (χ^2==4.88, df=1, p=.027), although the range of 95% confidence intervals for the odds ratio was broad and included the null value of one (OR=1.97, 95% CI=0.90; 4.32).

Twice as many women in the drug and alcohol with CSA group said that their mothers had misused substances, compared with the CSA only group. This just failed to achieve statistical significance (χ^2=3.31, df=1, p=.069) with an odds ratio close to one (OR=0.83, 95% CI=0.16; 1.09). Nevertheless, the consistent trend for greater reporting among the substance misuse groups, compared with the CSA only group suggests a potentially interesting area for further study. There was also a non-significant trend suggesting that maternal substance misuse might be associated with higher rates of emotional

neglect (χ^2=3.01, df=1, p=.082).

The majority of women who reported maternal substance misuse also said that their fathers misused substances (66%). This was not the case for paternal substance misuse where mothers also misused substances in only 33% of the cases. This is consistent with other findings that women with substance misuse are more likely than men to have partners who also misuse substances (Cronkite and Moos, 1984; Thom, 1986). It implies that the impact of maternal substance misuse may, in part, reflect the impact of both parents being substance misusers.

The results indicated that women who have both a history of CSA and substance misuse have a greater chance than other women of having a parent who misused substances. These results are consistent with those reported by Carson et al. (1988) and provide evidence for the idea that parental substance misuse mediates the relationship between CSA and subsequent misuse of substances.

Qualitative themes of parental substance misuse

In the qualitative interviews, half of the women (n=26) recalled that when they were children, their father, mother or both parents had misused substances. Table 3 summarises the frequencies of parental substance misuse across groups in the qualitative sample. The distribution of parental substance misuse across the groups grossly reflected the pattern observed in the larger sample.

Table 3: Frequencies and types of parental substance misuse across the four study groups

	Parent who misused substances			
Study group	Mother	Father	Both parents	Neither parent
Drug and alcohol with CSA	2	2	5	4
Drug and alcohol only	2	—	3	9
CSA with substance misuse	—	1	3	5
CSA only	1	6	—	8
TOTAL	5	9	12	26

Compared to other groups, a greater proportion of the drug and alcohol with CSA group reported that one or both parents had misused substances. The CSA only group typically reported paternal substance misuse whereas the CSA with substance misuse group mostly reported that both parents misused substances. A smaller percentage of the drug and alcohol only group reported either substance misuse by their mothers or both parents.

Women's descriptions of childhood revealed two main detrimental effects of parental substance misuse. These were (1) the exacerbation of negative aspects of family relations and (2) the learning of substance misuse as a method of coping. Each of these are summarised below.

Exacerbation of negative aspects of family relations.

Negative aspects of family relations such as violence, mood swings, parental preoccupation and marital discord were exacerbated when one or both parents misused substances. For example, in five of the nine patriarchal families, fathers misused substances and in two others, both parents misused substances. Violence within the family was strongly associated with parental substance misuse:

> *Dad used to come home from the pub really wasted and he'd just [pause] lash out at us for no reason.* [Drug and alcohol with CSA]

> *Well, we used to be scared of him all the time but more so when he was drinking. He was worse.* [CSA only]

> *. . . like, when my mother was sober, she was okay. As soon as she'd had a drink, she was a completely different person. She'd like to see violence, you know, like see me get bashed.* [Drug and alcohol with CSA]

The relationship between alcohol and violence was sometimes pervasive within the extended family and influenced women's later relationships:

> *I started going through the same things* [domestic violence] *with mine. My boyfriend. Because he drinks. And we're going sort of the same pattern as Mum and Dad and my Grandfather, you know. Like I said, its a hereditary thing and you get, you get used to it.* [Drug and alcohol with CSA]

Substance misuse also contributed to marital discord, both as a direct effect on mood and, indirectly, when one parent objected to the other parent's excessive use of substances:

> *. . . once they've come home, there was the loud music and talking and stuff. And almost very regularly, there was an argument which was just . . . you know, you'd hear people going "Oh, we've gotta go now, Bye". Cars driving off and then Mum and [Stepfather]'d just go for it. So. Yeah, I've always remembered it being pretty volatile. Lots of police coming round.* [CSA with substance misuse]

> *She made it happen. And a course, I used to always come and say "Look. Just leave him be". But she said "I can't 'cos he's too annoying. Anyway, then the bottles 'd be going out the front door, the pla... you know, then it'd be . . . oh, it was just full on. And I just remember, it was some nights I was just sittin on the stairs and just screaming for them stop.* [Drug and alcohol with CSA]

Mothers' mood swings were usually associated with either psychiatric disorders or substance misuse. Sometimes there was a dramatic contrast between sober and drunk behaviour:

> *Like when she wasn't drinking, she would, there was cuddles and sometimes when she*

was in a good mood, she'd give us, she'd praise us, tell us we're beautiful . . . But when she was drinking, ah, I hated her. And I was ashamed and frightened as well.
[Drug and alcohol with CSA]

The substance misuse also had more subtle detrimental effects on the child-parent relationship. Some interviewees felt that substance misuse had contributed to parental preoccupation. Parents were too distracted to share in the child's interests or observe her achievements:

She wouldn't turn up to things. She never turned up to any school things or anything like that. Never got involved in our lives. [Drug and alcohol with CSA]

. . . if I won an award at school, then he wouldn't be there and . . . he wasn't there to help me with my homework and . . . yeah, that kinda stuff. [Drug and alcohol with CSA]

The parental roles of setting limits and providing support for the child were often disrupted in families with substance misuse:

She was very vague. She'd ground us and then she'd forget about us, which was fine by us. We didn't mind her taking them at all. It was pretty much a secret but I knew where and what they were. [Drug and alcohol with CSA]

I would always, if I had a problem, I wouldn't go to them because I didn't want to cause more problems. You know, I was, I always felt like a burden. They've got enough to worry about, you know. Mum's too upset to go and see her. [Drug and alcohol with CSA]

The child was sometimes left by the other parent or other relatives to cope with their parent's intoxicated behaviour. Women recalled being sorely aware of the stigma associated with alcohol dependence and were sometimes extremely embarrassed about their parent's appearance:

I'd find her staggering around the shops, and I'd just walk past her. Like I wouldn't . . . I was ashamed of her. So there was no, there wasn't much, there was no relationship then, in that period of time. [Drug and alcohol only]

It effected my sister and I quite a lot in our teenage years because, I mean, it was difficult to bring friends home from school. [Drug and alcohol only]

There were also worries about the parent's safety. In one case, the father broke the mother's wrist but, partly because of substance misuse, the mother never sought help. The child eventually arranged for her mother to see a doctor. There were also other accounts of children's worries over their parent's safety:

I used to lie awake at night all the time, crying that one day my parents were gonna die.

I used to ring her up during the day sometimes and I'd say to her "Mum, what have you been drinking?". [Drug and alcohol with CSA]

Since substance misuse added to the unpredictability of parental behaviour, it contributed to an atmosphere of danger. Moreover, parental substance misuse increased the risk of CSA both directly and indirectly. It was sometimes directly linked to father-daughter incest:

I was too scared to sleep when he was in the house. Every time I knew he was drinkin', I'd try and stay at me friend's place or anywhere just to get away from him.
[Drug and alcohol with CSA]

More often, though, women highlighted the indirect risks of parental substance misuse where children were exposed to other dangerous adults:

. . . the music would just be blaring all hours of the morning and Dad's friend ... I 'member this man came up and gave me a kiss but he stuck his tongue in my mouth!

My parents were drinking quite a lot and they didn't have [pause] if they weren't drunk, they were up at the pub drinking. [Abuser] *would stay behind and look after us. He was the only adult around.* [Drug and alcohol with CSA]

The overall impact of parental substance misuse was disruptive, leading to an exacerbation of negative aspects of the family power relations. Sometimes sobriety was accompanied by effective and warm parenting and substance misuse appeared to dramatically change the outlook of the parent. Other times, it was difficult to separate the effects of substance misuse from ongoing violence within the family. Generally speaking, an increased risk to the child of violence or sexual abuse was particularly associated with substance misuse by the father. The negative aspects of parental substance misuse were qualitatively compounded when both parents misused substances. There were many accounts of the child being caught in the crossfire of parental substance misuse and marital discord:

. . . the memory of sitting there being terrified. Sitting on my bed, biting the sheet so I wouldn't scream. Because they were beating each other up.[CSA with substance misuse]

The qualitative analysis has also identified some factors that might hamper disclosure or restrict the parent's ability to empathise with the child's perspective if she did disclose. Although quantitative analysis indicates that neither paternal or maternal substance misuse was associated with lower rates of disclosure during childhood, 81% of women who disclosed reported that disclosure made no difference or made matters worse. Women who reported a negative or null disclosure outcome were significantly more likely to have experienced child physical abuse (χ^2=5.96, df=2, p=.051) and emotional neglect (χ^2=6.42, df=1, p=.040).

Learning substance misuse as a coping method

There were several ways that women thought parental substance misuse might have contributed to their own development of alcohol and other drug problems in adulthood. Obviously, it increased the access to substances and provided a powerful learning model:

It was only because it was, like, in the family. You go to one uncle's place, he's having a joint. You go to another one, there's a carton in the fridge. And it was just around us all the time. [Drug and alcohol with CSA]

. . . my Mum did it all the time so it was pretty normal in the house.

[CSA with substance misuse]

Some parents who encouraged their children to use substances at a young age:

> *I used to drink with my Dad. I mean I've got a photo of my brother in nappies. We had a . . . our glasses were little sherry glasses and we could have one of those, you know. So he was in nappies, so God knows. I remember drinking with my Dad when I was 11. And it was on a regular basis from the age of 11. So, their drug . . . their drinking allowed me to do it and feel okay about it. So yeah, it was always alright. Alcohol was always alright.* [Drug and alcohol with CSA]

> *. . . she was giving them to us to take. Because we were very — my sister and I — were very hyperactive. Not really though — we were excited and very, you know, gay and happy and we were always wanting to run around and play and Mum was always saying that we made too much noise and we had to sit still and she'd give us these pills to make us calm down.* [CSA with substance misuse]

One client in detoxification for benzodiazepine dependence recalled that her mother had been similarly dependent. She was first given a pill by her mother at age seven or eight because of disturbances in her sleeping patterns. Although her mother was secretive about the pills, her dependence led to carelessness in their storage:

> *So she had them all over the house. You know, and she was just out of it and she don't know where she was putting them. She wouldn't notice if 13 or 14 went missing. A day. And she just went back every day and got them from the chemist, you know . . . So I sort a collected them, one by one, you know. Packets and, then I went from there.*

[Drug and alcohol with CSA]

It is evident from each of these accounts that the women's own substance misuse is not only related to the parent's encouragement to use but also to inadequacies in the parenting relationship. It is as though the substances were used as a substitute for parental affection, patience and supervision.

Gender differences in parental substance misuse

The relationship identified in the quantitative analysis between maternal substance misuse and the women's own substance misuse might reflect several factors. First, women might be more inclined to identify with a female model of substance misuse. Women's accounts in this study cited occasions when they were encouraged to share their mother's role in the family more often than identification with the father. Access to the father's world outside the home, such as visits to the office, were described as exciting but typically infrequent. The mother was the primary role model.

Second, women's accounts reveal that traditional sex-typed roles of parenting modify the impact of maternal and paternal substance misuse. Descriptions of the main disruptions caused by paternal substance misuse have an indiscriminant quality. It is as though the father is pursuing his own interests and in doing so, incidentally increases the atmosphere of danger to all those present. Typically, most fathers misused substances (usually alcohol) outside the home and the disruption occurred after they

had become intoxicated.

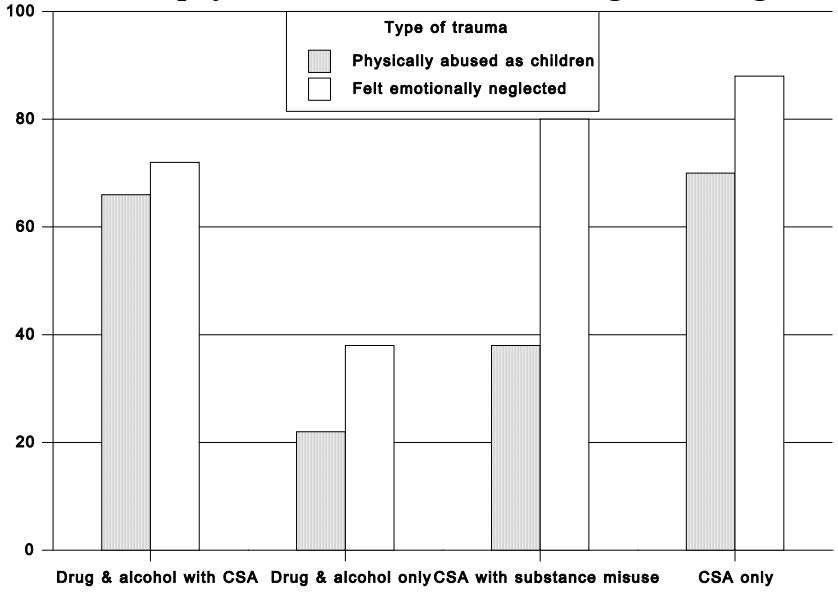
In contrast, maternal substance misuse was described in more personal terms, reflecting a more intense relationship with the mother, compared with the father. Usually, the father was absent from the home most of the time. All but one of those whose mothers, but not fathers, had misused substances described the maternal relationship in terms of trepidation about either personal attack towards them or having to deal with their mothers' self-destructive behaviours. In this, they were very similar to women whose mothers had chronic psychiatric problems.

3.4 HISTORY OF TRAUMA

Childhood traumas

The qualitative analysis of the accounts about families of origin have highlighted the inter-relationships between physical abuse, emotional neglect, CSA and subsequent misuse of substances among women. The quantitative analysis also provides evidence that the long-term effects associated with CSA might be mediated by a covariance of CSA with other forms of childhood abuse and neglect. The rates of child physical abuse and emotional neglect are illustrated in Figure 2 and summarised in Appendix D.

Figure 2: Prevalence of child physical abuse and emotional neglect among the four study groups



Women in the drug and alcohol with CSA group were considerably more likley than women in the drug and alcohol only group (OR=6.89; 95% CI=2.83; 16.74) to have experienced child physical abuse (χ^2=19.64, df=1, p=.000). There was also a significant difference between these two groups in their experience of emotional neglect (χ^2=11.68, df=1, p=.001) during childhood, with the CSA survivors having twice the risk of experiencing emotional neglect (OR=0.24; 95% CI=0.10; 0.55). These differences are illustrated in Figure 2.

Figure 2 also shows that the drug and alcohol with CSA group and the CSA only group were comparable in their rates of child physical abuse. Although women in the CSA only group were significantly more likely than those in the drug and alcohol with CSA group to say that they had experienced emotional neglect (χ^2=4.00, df=1, p=.046), 95% confidence intervals for the odds ratio just included the null of one (OR=2.85, CI=1.0; 8.17).

These results are consistent with the report by Brown and Anderson (1991) that CSA survivors have a higher prevalence of childhood physical abuse than other women. They also found that lifetime use of illicit drugs was twice as high for patients who had experienced both sexual and physical abuse than for those who had experienced either one alone.

The idea of a cumulative effect of childhood abuse is not supported in this study because of the similar

rates of child physical abuse among the drug and alcohol with CSA and CSA only groups. This is qualified, however, because the CSA only group included some women who had misused substances in the past and among those women, child physical abuse increased the odds of having used illicit substances (OR=9.17; 95% CI=1.15; 73.24). This result was statistically significant (χ^2=4.95, df=1, p=.026) although qualified by a small sub-sample size (n=21).

Other life traumas

In addition to emotional neglect and childhood physical abuse, women who had been sexually abused in childhood had also experienced more types of trauma throughout their lives than women without this background. The mean number of traumas for the drug and alcohol with CSA group was 5.65 (sd=2.36), compared with 3.62 (sd=2.63) for the drug and alcohol only group (t=4.64; df=98; p=.000). There were no significant differences between the drug and alcohol with CSA group and either of the CSA counselling groups. The trauma scale included child physical abuse and emotional neglect. It also included a range of other traumas and the main trends for each of these are discussed below.

Physical neglect: A higher proportion of women in the CSA groups had experienced physical neglect than in the drug and alcohol only group. For example, 36% of women in the drug and alcohol with CSA group said that they had been physically neglected in early childhood compared with 4% of the drug and alcohol only group. This was largely a childhood trauma, with the overall mean age of first occurrence as 4.98 years (sd=3.59, median = 4 yrs).

Significant other was threatened: Forty-one percent of women had seen a significant other threatened with physical harm. Women in the drug and alcohol only group were somewhat older (_=22.57, sd=11.19, median = 21 yrs) at the time they first saw someone threatened, compared with the drug and alcohol with CSA group (_=14.73, sd=8.25, median = 18 yrs).

The median ages of first seeing a significant other threatened were lower for the CSA counselling groups. The CSA with substance misuse group had a median age of ten years (_=13.33; sd=11.79). The CSA only group had a median age of six years (_=13.53; sd=15.67). Overall, these averages indicate that CSA survivors first saw a significant other being threatened during their childhood years whereas the drug and alcohol only group typically first experienced this trauma during adulthood.

Witnessed another person badly injured: The pattern of results for witnessing someone being badly injured was similar to those for seeing a significant other threatened. Forty-three percent of the whole sample had witnessed another person being badly injured sometime in their lives. The two drug and alcohol groups and the CSA with substance misuse group each reported median ages of first occurrence in adolescence whereas the CSA only had a median age of six years (_=10, sd=7.88).

A significant correlation between the ages of first witnessing another being badly injured and seeing a significant other threatened (r=0.71, df=44, p=.000) indicates that childhood witnessing might often have occurred in a domestic context where significant others were threatened with violence. This idea is supported by the qualitative analysis of women's descriptions of family power relations (Chapter 3.2).

Life threatening accident: Thirty-five percent of the sample had experienced a life-threatening accident. The drug and alcohol group was slightly older (_=19.94, sd=10.38, median = 22 yrs) than women in other groups when first experiencing a life threatening accident. In contrast, the median age for the drug and alcohol with CSA group was 16 years (_=15.18, sd=7.74).

Natural disaster: Thirty-one percent of the women had experienced a natural disaster, such as a flood or fire. The median age at which a disaster was first experienced was 12 years (_=15.05, sd=10.58) with no major trends of difference.

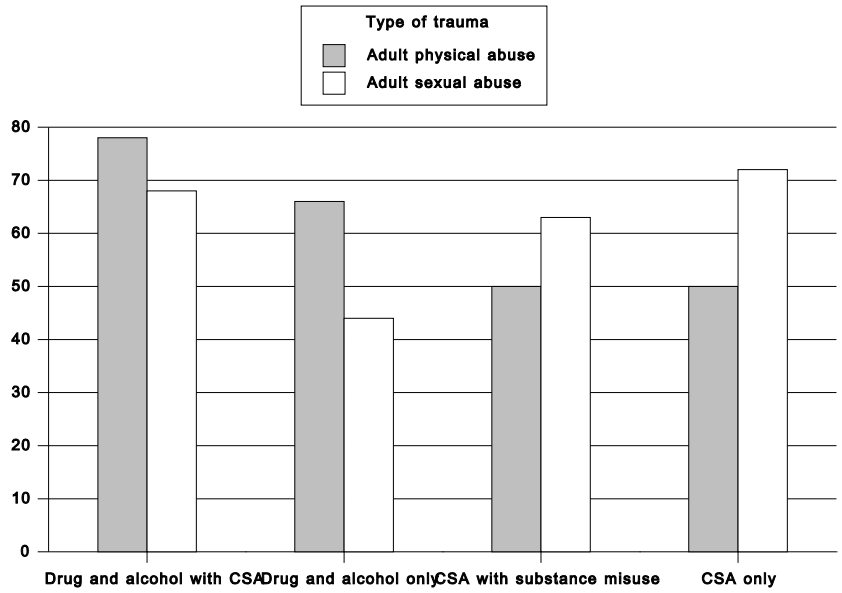
Threatened with a weapon or held captive: Women in the drug and alcohol with CSA group were more likely to have been threatened with a weapon or held captive (66%) than women in the drug and alcohol only group (40%), the CSA with substance misuse group (47%) or the CSA only group (40%) .

The first occurrence of this trauma was typically during adulthood for the two drug and alcohol treatment groups, whereas women in the CSA counselling groups reported an average first occurrence during childhood. For example, the drug and alcohol with CSA group had a median age of first occurrence of 20 years (_=19.39, sd=7.19) compared with five years (_=7.95, sd=9.26) for the CSA only group.

Injured during attack: Almost twice as many women in the drug and alcohol with CSA group (46%) had been injured during a physical attack compared with the CSA only group (24%) or the CSA with substance misuse group (23%). The trend of age differences was similar to that for being threatened with a weapon or held captive. Since these two variables were correlated (r=0.90, df=40, p=.000), there is a strong chance that first experiences of being held captive or threatened with a weapon resulted in physical injury.

Adult sexual abuse: Sixty-two percent of the interviewees had experienced sexual abuse during adulthood. The group differences for adult sexual abuse are illustrated in Figure 3 and summarised in Appendix D. The proportion of women experiencing adult sexual abuse was lowest in the drug and alcohol only group (44%). This was significantly lower, compared with 68% of the drug and alcohol with CSA group (χ^2=5.84, df=1, p=.016). The odds ratio was 2.70 (95% CI=1.20; 6.11). These results replicate the findings of Swift et al (in press) and support the idea that women who have been sexually abused in childhood are more vulnerable than other women to further abuse in adulthood (Fromuth, 1986; Russell, 1986; Siegel et al., 1987; Walker et al., 1992).

Figure 3: Prevalence of physical and sexual abuse during adulthood among the four study groups



Adult sexual abuse also was sometimes perpetrated by partners. Eighteen percent of the whole sample said that they had been repeatedly raped by their sexual partners:

> *. . . I had a husband that used to force me quite a few times, so I don't know. Its hard to put a number on something like that.* [CSA with substance misuse]

> *Even in the past few months, 'cos I was raped by a woman and she used to abuse me quite a bit . . . And I lived with a bloke who raped me constantly for five years 'cos I didn't realise that you could say "No" if you was livin' with someone or if you was married to someone.* [CSA only]

Adult physical abuse: The experience of physical abuse in adulthood was as common as adult sexual abuse (62%). However, Figure 3 (and Appendix D) shows the reverse pattern in group differences. The experience of physical abuse was more prevalent among the drug and alcohol treatment groups than the other groups. The drug and alcohol with CSA group was three and a half times more likely than the CSA only group (OR=3.54, 95% CI=1.49; 8.45) to have experienced physical abuse in adulthood (χ^2=8.51, df=1, p=.004). Figure 3 shows that whereas the experience of CSA increases women's vulnerability to adult sexual abuse, adult physical abuse is a risk that arises more from the substance dependent lifestyle. A summary of frequencies is provided in Appendix D.

Of the 112 women who had experienced adult physical abuse, 76% said that it was spousal violence. This high prevalence of spousal violence among women with substance dependence replicates the findings of Miller et al. (1989). Most women (66%) reported that they had experienced ongoing violence which ranged from one month or less to longer than eight years. The median duration was two years. There was a noticeable pattern of difference between the drug and alcohol with CSA and CSA only groups in the involvement of alcohol in spousal violence. In the drug and alcohol with CSA group, 88% of domestic violence survivors said that the perpetrator had always or sometimes been intoxicated when violent and 75% said that they had always or sometimes been intoxicated at the time of the abuse. In contrast, the percentages for the CSA only group were 42% and 32% respectively.

One woman had sought help after being beaten and thrown out of home by her husband after he discovered that she was still using drugs. Ironically, she said that one motivation for her substance misuse was to help her maintain the home in the face of domestic violence:

> *Well, it gives me motivation which I lack, due to my husband. Like someone who bashes you and makes it hard for you, takes away all the motivation that you have. Like motivation just to do the housework. Like I've really gotta push myself. REALLY gotta push myself.* [Drug and alcohol with CSA]

Simons and Whitbeck (1991) found an association between childhood incest, sex work and adult abuse, both physical and sexual. In the current study, sex work was not associated with higher rates of adult sexual abuse but was significantly associated with adult physical abuse (χ^2=8.69, df=1, p=.003). Women who had worked in the sex industry had more than three times the odds (OR=0.36; 95% CI=0.18; 0.72) of having been physical abused in adulthood, compared with other women.

Trauma as a mediating factor

These results indicate that women who have experienced CSA had a greater risk of experiencing child physical abuse and emotional neglect, regardless of whether they misused substances. If other childhood traumas mediate the relationship between CSA and substance misuse, the effect of that mediation is not clear from these results. All CSA groups also had a greater risk of adult sexual abuse, confirming other research that suggests that early sexual trauma increases one's vulnerability to later victimisation.

Women who misused substances had a greater risk of adult physical abuse, regardless of whether they had experienced CSA. Women in the drug and alcohol with CSA group were therefore more likely than other women to have experienced a range of traumas throughout their lives. The cumulative

effects of these traumas might have important clinical implications.

3.5 SUBSTANCE MISUSE

Information was gathered from the three substance misuse groups regarding their past and recent use of alcohol and other drugs. Similar information was collected for 21 (42%) of the CSA only group who had misused substances some time in the past. Only seven of these women had received treatment for their past problems and their substance use history was comparable to that of the CSA with substance misuse group.

Ritual abuse survivors, four of whom were in the CSA only group and two of whom were in the CSA with substance misuse group reported earlier ages of drug use because cult activities included the administration of benzodiazepine to them during early years of childhood. Only three of the six ritual abuse survivors, however, had misused substances in adulthood.

The drug and alcohol with CSA and CSA with substance misuse groups are specifically compared in Chapter 4 of this report. That comparison provides an understanding of how different degrees of substance misuse interact with CSA to produce different patterns of help-seeking.

The following analysis focuses on the comparison between the drug and alcohol with CSA and drug and alcohol only groups. To investigate the hypothesis that CSA will be associated with an earlier onset and greater severity of substance misuse, these two drug and alcohol treatment groups were compared in their history of substance misuse, levels of dependence, consumption and risk-taking behaviour.

History of substance use

There was no significant difference between the two drug and alcohol treatment groups in the number of different types of substances that women had ever used. The mean number of substances ever used by women in both groups was 7.83 (sd=2.27, median=8). There was no significant difference in the number of substances regularly used by the drug and alcohol with CSA group (_=5.82, sd=1.99) compared with the drug and alcohol only group (_=5.12, sd=2.12).

As shown in Table 4, the two groups were similar in the types of substances they had used in the past. The most commonly used substances included tobacco, alcohol and marijuana. The least used substances were barbiturates, analgesics and inhalants.

There was a trend of difference suggesting that more women in the drug and alcohol with CSA group had tried inhalants but this was not significant. There was, however, a significant difference between the two groups in the age at which people first tried inhalants (t=-2.12, df=24.67, p=.044). Typically, inhalants use began in early adolescence among the drug and alcohol with CSA group (_=15.04, sd=4.26) and late adolescence among the drug and alcohol only group (_=18.69, sd=5.99). It is noteworthy that the mean age of first use for the CSA with substance misuse group was also in late adolescence (_=17.38, sd=3.14).

Table 4: Substances ever used by women in the two drug and alcohol treatment groups

	Drug & alcohol with CSA		Drug & alcohol only	
Type of substance	N	%	N	%
Alcohol	49	98	48	96
Tobacco	50	100	50	100
Heroin and other opiates	40	80	40	80
Marijuana	50	100	46	92
Hallucinogens	35	70	36	72
Amphetamines	42	84	43	86
Cocaine	34	68	36	72
Tranquillisers	37	74	39	78
Barbiturates	15	30	19	39
Analgesics	19	39	14	28
Inhalants	25	50	16	32

Contrary to the findings of Harrison et al. (1989), this study found no difference between the drug and alcohol treatment groups their mean age of first alcohol use. The mean age for the two groups combined was 13.42 (sd=3.84, median=14). The sample included two women in the drug and alcohol with CSA group and one in the drug and alcohol only group who had never used alcohol.

There were also no significant differences between the two drug and alcohol treatment groups in their age of first use and first regular use of their main problem drugs. For the two groups, the mean age of first use of main problem drug was 17.8 years (sd=5.21, median=17) and first regular use of main problem drug was 20.83 years (sd=7.13, median=20). In contrast to the findings of Singer et al. (1989), there were no differences between the two groups in the rates of regular use of cocaine and amphetamines, nor was there any difference in age of first use of these stimulants.

The two groups were also similar in their age of first awareness of problems related to substance misuse or age of first treatment entry. The mean age of first awareness for the two groups was 23.32 years (sd=6.65, median=22.5). The distribution of women's estimates of the time lag between their first awareness of drug-related problems and first treatment entry was heavily skewed, with 41% of women seeking help in the same year that they became aware of their problems. Other women's estimates ranged up to 18 years time lag. Since there were no group differences in the time lag, there is no evidence that CSA plays a role in the acceleration of symptoms towards dependence known as telescoping (Piazzo et al., 1989).

Age of first intoxication

There was a difference between the two groups in their age of first intoxication. The mean age of first intoxication was 13.8 years (sd=3.23) for the drug and alcohol with CSA group and this was significantly younger than the mean age of 15.8 years (sd=3.06) for the drug and alcohol only group (t=-3.18, df=98, p=.002) This result is consistent with the findings from adolescent studies (Flanigan et al., 1988; Singer et al., 1989).

A linear regression analysis was used to account for the contribution of CSA to the variance in age of first intoxication, relative to six covariates. An earlier age of intoxication was significantly associated with a younger age group (r=0.53, df=148, p=.000), an earlier age of first consensual sex (r=0.22, df=147, p=.008) and a greater number of traumas (r=-0.23, df=148, p=.004). An earlier age of intoxication was also significantly related to paternal substance misuse (t=3.14; df=144, p=.002), maternal substance misuse (t=2.47, df=146, p=.015) and child physical abuse (t=2.13, df=146, p=.035).

There were two alternative linear regression models that accounted for the variance in age of first intoxication (Appendix E). The simplest model showed that the drug and alcohol with CSA group had a significantly earlier age of first intoxication compared with the drug and alcohol only group, after adjustment for the effects of age and maternal substance misuse (F=12.05, p=.000). This model accounted for approximately one-third of the variance in age of first intoxication (Adjusted r^2=.34). The CSA with substance misuse showed no difference from the drug and alcohol only group.

An alternative model adjusted the equation further, taking into account the effect of the number of traumas. This was also a highly significant model (F=11.05, p=.000), accounting for slightly more of the variance in age of first intoxication (Adjusted r^2=.35) than the simpler model.

The pattern of results resembles that reported by Rose et al. (1991) who found that after controlling for the influence of parental substance misuse, people who had experienced CSA were still more likely than others to misuse substances. The relationship between CSA and first age of intoxication found in this study is robust even after controlling for the influence of maternal substance misuse and other traumas.
The qualitative data reveal that any causality in this relationship is two-directional. Some women reported that they had started misusing substances because of the CSA while several other women said that they had first experienced CSA while they were intoxicated. For some women, self-medication began at a very young age and was framed as a form of survival:

> *I just always had to be out of it. To deal with going to school and dealing with everyday life. Because at that age, I didn't know about suicide.*
>
> [Drug and alcohol with CSA]

> *Yeah, would've been around 8, 9 years old or something like that. 'Cos I loved it. Soon as I first had it, I loved it. 'Cos it numbs you. You could put up with anythink.*
>
> [Drug and alcohol with CSA]

> *. . . when I was 12, I used to smother my pillow with thinner and breath it in. That's how I went to sleep, you know.* [Drug and alcohol with CSA]

Eighteen percent of women in this study reported that first intoxication had occurred during the same year or preceded the CSA. Moore and Fleming (1989) argued that intoxication might increase a girl's

vulnerability to CSA. One woman recalled her experience of rape at a teenage party:

> *I didn't have much choice, it was just the way he did it. Like I was sitting on the lounge, like really smashed, on the nod sort a thing . . .* [Drug and alcohol with CSA]

The girl might then become caught in a viscious cycle where she is blamed for the CSA and branded with a stigma that isolates her from her peer group. Both Moore and Fleming (1989) and Finkelhor and Browne (1986) argued that CSA might lead the adolescent to drift into alternative peer groups where substance misuse and intoxicated sexual behaviour are the norm.

> *. . . after a while, I lived up to other people's expectations, like, 'cos people thought I had a bad name and I just had to, I wanted to live up to that. Yeah, I liked being a non-conformist from society.* [Drug and alcohol with CSA]

Main problem drug

Table 5 shows the substances that women said were their main problem drugs at the time of the interview. Heroin and alcohol were most prevalent as the main problem drugs for both groups.

Table 5: Main problems drugs reported by women in the drug and alcohol treatment groups

	Drug & alcohol with CSA		Drug & alcohol only	
Main problem drug	N	%	N	%
Heroin and other opiates	20	40	26	52
Alcohol	11	22	14	28
Tranquillisers	6	12	5	10
Amphetamines or cocaine	11	22	4	8
Marijuana	2	4	1	2

Slightly more women in the drug and alcohol only group said their main problem drug was heroin or other opiates (methadone or codeine) but this was not a significant trend. There was a significant group difference in the number of women who had amphetamines or cocaine as their main problem drug (χ^2=3.84, df=1, p=.05). Women in the drug and alcohol with CSA group had three times the odds of the drug and alcohol only group but confidence intervals narrowly included the null of 1 (OR=3.08; 95% CI=0.09; 1.05).

This finding of drug preference is consistent with the report by Singer et al. (1989) that highlighted

higher rates of cocaine and stimulant use among adolescents. The direction of group differences supports the suggestion by Harrison et al. (1989) that these stimulants might be used to enhance self-protective vigilance because of CSA.

Levels of dependence

The dependence levels were measured for each woman's main problem drug. Since only a small number of women named alcohol as their main problem drug (n=23), any conclusions regarding severity of alcohol dependence may be limited. There were no significant differences between the two groups in alcohol dependence. The mean scores on the SADQ-C were 33.22 (sd=15.71, median=35) for the drug and alcohol with CSA group and 26.43 (sd=14.58 median=24) for the drug and alcohol only group. Six (67%) of women in the drug and alcohol with CSA group and five (36%) of the women in the drug and alcohol only group had a score equal or greater than 31, indicating severe alcohol dependence (Stockwell and Sitharthan, 1991).

Similar results were found for other drugs. Among those women whose main problem drug was something other than alcohol (n=76), the mean scores on the SDS were 10.24 (sd=3.83, median=11) for the drug and alcohol with CSA group and 10.56 (sd=3.31, median=11) for the drug and alcohol only group. Taken together with the results for alcohol, there is no evidence that CSA contributes to a greater level of dependence on the main problem drug.

These results may have been restricted by a `floor effect' due to the exclusive sampling of women who were highly dependent on their main problem drugs. For example, the distributions of the SDS scores for the two groups were skewed to the more severe end of the scale, with medians of 11. This was high compared with the medians reported by Gossop, Griffiths, Powis and Strang (1992) for heroin users (median=9) and amphetamine users (median=0) from a non-clinical sample.

Consumption levels

Since 80% of the drug and alcohol with CSA group and 76% of the drug and alcohol only group had used their main problem drug in the previous two months, the analysis of consumption levels mainly focussed on results from the OTI. There was no difference between the drug and alcohol with CSA group (_=3.86, sd=1.71) and the drug and alcohol only (_==3.5, sd=1.22) group in the diversity of substances used in the target month.

Trends of group difference in the type of substances consumed by women during the target month tended to reflect the pattern of differences in the main problem drug. The drug and alcohol with CSA group tended to use more marijuana and amphetamines than the drug and alcohol only group but these trends were not significant. The average number of heroin use episodes was higher for the drug and alcohol only group (_=0.87 (sd=1.36), compared with the drug and alcohol with CSA group (_=0.29, sd=0.66). This was a significant difference (t=-2.45, df=52.15, p=.018).

Among those who used alcohol during the target month, the drug and alcohol with CSA group had a higher average number of use episodes (_=10.56, sd=10.5), compared with the drug and alcohol only group (_=4.97, sd=6.88). This difference (t=2.15, df=37.74, p=.038) was significant. There were no

other group differences in consumption.

Relapses

The two groups were similar in the number of times they had managed to stay sober or straight for at least two months. Among those who had stayed straight at least once, the number of sober times ranged from one to 12 times, with a median of two for both groups. The reasons for relapse reported by women with substance misuse included changes in lifestyle, (such as not being pregnant anymore or having more leisure time), social pressure from friends, partners or special celebrations, getting a normal liver function test result, emotional reasons (such as loneliness, agitation, work stress or thinking about past traumas), and domestic violence.

Risk-taking behaviour

The mean HIV Risk-taking Behaviour Scale (HRBS) score was similar for both groups, indicating an equal level of risk-taking. The drug and alcohol with CSA group had a median score of seven (_=7.7, sd=6.42) and the drug and alcohol only group had a median score of six (_=7.83, sd=7.39). These scores correspond with the average range derived from a group of opiate users interviewed by Darke et al. (1991). The drug and alcohol only group had a slightly elevated level of risk due to injecting behaviour (_=4.14, sd=5.44, median=2), compared with the drug and alcohol with CSA group (_=2.9, sd=3.41, median=1). The two groups had a similar risk score for sexual behaviour with a median of six.

Prevalence of hepatitis across the two groups was similar with 55% of women in drug and alcohol treatment reporting either Hepatitis B or C. Ninety-one percent of women in the two groups had been tested for HIV. Only one woman in the drug and alcohol with CSA group was HIV positive.

Substance misuse to cope with CSA

Women's accounts of the relationship between their experiences of CSA and substance misuse support both the self-medication and impaired self-esteem models described by Paone et al. (1992). For some women, the substance misuse was one of several methods of dissociation:

> *When you're dead drunk, you don't feel anything. When I was working, I used to work 12 hours a day, so I wouldn't have to think. And I don't like sleepin' much 'cos that's when ya think. I dunno, I just used to be able to block it out. Just put a screen up and say "Well, its gone." Still has a habit of coming back.* [Drug and alcohol with CSA]

Although women from all groups used substances to build their confidence in social situations, there were some differences in the way that women conceptualised this lack of confidence. Whereas a common attribution was that substance misuse helped to counteract `shyness', some CSA survivors described the need for confidence in terms of their own lack of worthiness or their desire for power:

> *Inadequacy. Just thought I was ugly and dirty and all those feelings, and rejection of*

my own self. And I just wasn't happy with myself. And when I had a drink, I felt great! Took everything away. Took all those feelings away. [Drug and alcohol with CSA]

Puts my mind at ease and I feel safe and secure and I feel like a big woman [laughs]. I can say anything I like at any time I like, in front a anybody. Be cheeky.
[Drug and alcohol with CSA]

These comments give some insight into substance misuse not only among women, but also among adolescents who have experienced CSA. The need for social confidence is a particularly salient need in adolescence and the pressure to use substances to fit in with the peer group was an often cited reason for starting to use. As Finkelhor and Browne (1986) argued, CSA seems to amplify this need because it stigmatises and disempowers the girl.

3.7 CHARACTERISTICS OF CHILD SEXUAL ABUSE

The following section describes the CSA experiences reported by women in this study. Initially, the analysis focuses on descriptive data from all three CSA groups. Then, to investigate the hypothesis that substance misuse in adulthood is associated with a more severe type of child sexual abuse, the CSA with substance misuse and CSA only groups are compared in the type and extent of their abusive experiences.

Overall experience of CSA

Characteristics of the abusers

Multiple experiences of abuse were common. The number of different people by whom women had been abused during childhood ranged from one to 25. Five women said that there had been too many abusers to count, four of whom were ritual abuse survivors. Women who had not been ritually abused reported a range from one to 10 abusers, with a median of two (_=2.67, sd=1.76). Twenty-nine percent of the sample (including ritual abuse survivors) said that they had been abused by more than one person at the same time. Table 6 provides a summary of the abusers reported in this study.

Table 6: Prevalence of extrafamilial and incestuous abusers

Extrafamilial abuser's relationship to victim	No.	%	Incestuous abuser's relationship to victim	No.	%
Neighbour/trusted family	51	39%	Biological/adopted father	52	40%
friend	38	29%	Stepfather	8	6%
Stranger	30	23%	Biological/adopted mother	9	7%
Acquaintance	17	13%	Stepmother	2	2%
Mother's boyfriend	12	9%	Uncle	25	19%
Friend	6	5%	Brother	26	20%
Lover	9	7%	Grandfather	11	9%
Other extrafamilial[1]			Cousin	11	9%
			Brother-in-law	8	6%
			Other incestuous[2]	3	2%

Note: Figures do not add up to total sample size because some women were abused by more than one person.
[1] Other extrafamilial abusers included father's acquaintance, baby-sitter, priest, employer, sister's boyfriend and cult leaders.
[2] Other incestuous abusers included half-brothers and an aunt.

Table 6 shows that most of the abusers were male. Eighty-nine percent of women said that they had only been abused by males. Two percent had been abused by females only and 9% had been abused by both sexes. Seventy-three percent of women had been incestuously abused and the same percentage had been abused by people outside the family. A large number of the women reported abuse by their biological or adopted fathers (40%). Stepfathers were far less prevalent (8%). Nine women said that they were abused by their biological or adopted mothers (7%) and two women said that their stepmothers had abused them (2%). The most common extrafamilial abuser was a neighbour or trusted

family friend (39%).

Types of sexual behaviour and coercion

Almost half of the women (47%) in this study had been physically forced or threatened with force during CSA. All women had experienced CSA involving physical contact. The first category of `most frequent' behaviours is similar to Russell's (1984)`serious behaviours' category, including fondling, forced touch and frotage. Unlike Russell's (1984) model, attempted intercourse is also included in this group. Most women said that someone had fondled or touched their breasts or genitals (98%) or rubbed genitals against them (82%). Being forced to touch someone in a sexual way was also a common form of abuse (77%). Sixty-eight percent had experienced attempted intercourse.

The second category of `least frequent' behaviours is equivalent to Russell's (1984) `very serious behaviours' category except for the exclusion of attempted intercourse. It includes cunnilingus, fellatio, and vaginal and anal intercourse. Cunnilingus (34%) was less common than fellatio (48%). More than half of the sample (52%) said that someone had imposed vaginal intercourse on them while 23% said that the abuse had involved anal intercourse. The classification of the least frequent behaviours as `very serious' was validated by a significant relationship with women's perceived severity of impact ($t=-4.33$, $df=128$, $p=.000$). Women who had experienced these behaviours rated the severity of the CSA higher.

Some descriptions of the behaviours on the multiple choice stimulus cards lacked specificity and therefore the meaning of women's responses is not always clear, especially with respect to lesbian CSA. For example, vaginal and anal penetration by lesbian abusers probably included digital penetration whereas heterosexual digital penetration might have been classified as fondling.

Aftermath of CSA

A small number of women in the study said that they had become pregnant as a result of the CSA (8%). This included three ritual abuse survivors who said that pregnancy and subsequent infanticide comprised a part of cult activities. The other seven women who became pregnant as a result of non-ritual abuse either had terminations or adopted their children out. One woman's baby died in hospital while awaiting adoption.

Only 39% of women had disclosed the CSA before age 16. Another 2% said that they had hinted to an adult about what was happening and 3% said that someone found out. The majority of women who had disclosed before age 16 said that disclosure made things worse (58%) or made no difference (23%).

High-impact CSA experience

Each woman was asked to choose an experience of CSA that she thought had had the *most impact* on her life. Comprehensive data was then gathered regarding the nature of this experience.

Characteristics of the high-impact abusers

Sixty-two percent of high-impact CSA experiences were incestuous. Women tended to choose incestuous experiences as being more traumatic than other experiences. A quarter of all the women reported that the high-impact CSA was father-daughter incest (25%). Another 5% said that the abuser was their step- or foster-father. Two percent of women said the abuser was their mother. The next most frequently reported abusers were neighbours or trusted family friends (21%), brothers (10%) and uncles (10%). Other relatives included cousins and grandfathers or other elderly male relatives. Other non-family members included strangers, acquaintances, friends, a lover, and an employer.

Some women said that they were abused by more than one person at the same time. These experiences involved trusted family friends, acquaintances, cult members or fathers with other men. The six ritual abuse survivors reported that they had been taken to cult meetings by one or both parents and had been multiply abused by cult members. Aside from the ritual abuse survivors, four other women said that a father or caretaker had arranged for another person or people to abuse them.

Age and duration

In 22% of cases, the high impact CSA was either a solitary incident or lasted less than 12 months. Ongoing incidents lasted from one to 22 years, with a median duration of two years (_=3.47, sd=4.25). The distribution of duration was skewed by the presence of ritual abuse survivors who reported a higher median of 8.5 years (_=11.17, sd=8.66), compared to other women.

The mean age at the time that the abuse started was 8.29 years (sd=3.93, median=8). The six ritual abuse survivors reported a younger mean age than the rest of the sample (_=4.33, sd=3.78, median=3.5). The mean age of the perpetrator of the high-impact CSA was 32 years (sd=13.54). Abuser's ages ranged from nine to 80 years. Ritual abuse survivors reported a higher mean age of 38.6 years (sd=7.40), compared with other women.

Types of sexual behaviour and coercion

The types of behaviour in the high-impact CSA had a similar pattern to women's overall experiences of CSA. The majority of high-impact experiences involved fondling (93%), frotage (70%) and being forced to touch the abuser in a sexual way (64%). More than half (55%) of the high-impact incidents involved attempted intercourse. Fellatio and vaginal intercourse were almost as common (42%). Less common were cunnilingus (27%) and anal intercourse (17%).

Occasionally women chose apparently less serious behaviours as the high-impact abuse and two women chose experiences that had not involved physical contact. Typically these decisions were based on the abuser's identity or the age of onset, particularly with respect to the power imbalance between abuser and victim:

'Cos I was quite a bit older when the next one happened. I was practically a woman, you know, and I sort of . . . now I think about it then, it was like that, an assault, like, but I was a bit more in control of it . . . the younger one — I was very confused and didn't really know what was going on . . . [Drug and alcohol with CSA]

Abusers used a variety of coercive methods, which are summarised in Table 7. The types of coercion can be roughly divided into the use of psychological manipulation and the threat of physical harm and immobilisation of the child. Many women recalled being afraid that the abuser might not like or love them anymore if they did not cooperate. Trickery and deception were also common forms of psychological manipulation. Threat of physical harm sprang naturally from the size discrepancy between victim and abuser. Fear of the abuser's size and strength was the most common way by which women recalled being coerced (67%). Many women had also been physically pushed or held down. One quarter of the women had also experienced physical injury during the CSA. The use of weapons were less common than other forms of physical threat.

Table 7: Prevalence of types of coercion by abuser to involve child in CSA

Method of coercion used against the child		No.	%
Psychological manipulation			
Fear of losing abuser's love		56	43%
Trickery or deception	56	43%	
Verbal persuasion		49	38%
Bribery or offer of reward		33	25%
Fear of losing someone else's love		32	25%
Physical threat and immobilisation			
Fear of abuser's size and strength		87	67%
Physical restraint		57	44%
Threat of physical harm		44	34%
Fear of someone else being hurt		38	29%
Physical harm		32	25%
Threat with a weapon		23	18%
Intoxication		19	15%
Threat that abuser would hurt himself		7	5%
Other types of coercion[1]		13	10%

Note: Figures do not add up to total sample size because some women were coerced in more than one way.

[1] Other types of coercion included psychological programming, fear of punishment, parental coercion, assault during sleep, reassurance of no harm, employee harassment, pretence of affection, taking by surprise and a threat that the abuser might marry mother.

Disclosure of the high-impact abuse

The median age at which women first disclosed regarding the high-impact CSA experience was 18.5 years, with a range from 3 to 64 years. Women typically had disclosed to either their counsellors or agency staff (n=29; 22%), their mothers (n=20; 15%), or their friends (n=27; 21%). Other common disclosees included sexual partners (n=16; 12%) and siblings (n=7; 5%). Eight women (6%) disclosed this experience for the first time to the researcher during the interview. Four women (3%) had disclosed first to the police, usually during childhood. Women had also disclosed to other relatives, teachers and school counsellors, the clergy, health workers and acquaintances.

Very few women were satisfied with adults' responses to their childhood disclosure. The act of disclosure was described as painful and difficult even when supportive adults were present. Negative responses by adults were common, including rejection and punishment and warnings against further disclosure:

> *I told* [nun] *and she said I was disgusting and that I was tellin' lies and you know, she knew the family, knew that nothin' like that would ever happen . . .she got the priest in and told the priest that I'd lied. And the priest made me apologise.* [Drug and alcohol with CSA]

Disclosure during adulthood was usually a more positive experience, particularly when the disclosee was an empathic counsellor or a sibling who confirmed that the abuse had occurred.

Few women reported that the abuser had been legally charged. Among the qualitative interviewees, nine women, (24%) had been interviewed by the police but only four abusers had been convicted. One women had been asked to act as a decoy to lure the abuser into attempted CSA in front of concealed police witnesses. Another women recalled that her father had been convicted but never went to jail because of a good behaviour bond. She and her mother had since become estranged because her mother had continued to live with him. Some women had decided to lay charges during adulthood. In the process of preparing a case, one woman contacted a relative of the abuser who disclosed that she had also been abused and was prepared to lay charges against the same abuser.

Pattern of group differences

The two CSA counselling groups were compared to test the hypothesis that women with substance misuse would have a more severely traumatic type of abuse than women without substance misuse. Four women in the CSA only group and two in the CSA with substance misuse group reported being ritually abused by cult members during their childhood. Ritual abuse survivors were not included in tests for significance since their CSA characteristics were extreme compared with other women. For example, whereas the mean number of abusers for other women in these two groups was 3 (sd=1.94), the number of abusers reported by the six ritual abuse survivors included, 18, 25 and, for four women, too many to count. They were also more likely to report abuse by all members of the family, including their mothers.

Characteristics of the abusers

There was no difference between the two groups in the number of abusers. The CSA only group had a significantly higher prevalence of incestuous CSA (χ^2=5.06, df=1, p=.025). Ninety-one percent of this group had experienced incest, compared with 71% of the CSA with substance misuse group (OR=4.2; 95% CI=1.13; 15.61). The groups were similar in their prevalence of incest by biological or adopted fathers (57%). One woman in the CSA with substance misuse group and two in the CSA only group had been sexually abused by a biological or adopted mother.

There was a significant difference between the two groups in their experience of extrafamilial abuse (χ^2=3.68, df=1, p=.055). Almost all (82%) of the CSA with substance misuse group had been abused by people outside the family, compared with 61% of the CSA only group (OR=2.96; 95% CI=0.95; 9.19).

Age and duration of CSA

Table 8 summarises characteristics of the high-impact CSA and shows the group comparison. For the CSA only group, the high impact CSA began in early childhood, with a mean duration of 4.59 years (median= 4 years). There was a large mean age gap of 28 years (median=27) between victim and abuser. In contrast, the CSA with substance misuse group typically experienced the high-impact abuse during later childhood, with a mean duration of 2.75 years (median=1 year), and were somewhat closer in age to their abusers. The difference in age gap was mainly due to the child's age of onset as there was no difference between the groups in the age of the abuser. The average abuser was in his (or her) early '30s.

Table 8: High-impact abuse statistics and differences between the CSA counselling groups

Feature of the CSA	CSA with substance misuse	CSA only	t_{df}	*p*
Mean age at the time CSA began	10 yrs (sd=4.41)	6.52 yrs (sd=3.44)	$3.78_{(72)}$	.000
Mean age difference between child and abuser	20.21 yrs (sd=13.54)	28.11 (sd=14.85)	$-2.29_{(72)}$	.025
Mean age of abuser	30.21 yrs (sd=11.96)	34.63 yrs (sd=14.48)	$-1.36_{(72)}$	*ns*
Mean duration of abuse	2.75 yrs (sd=3.42)	4.59 yrs (sd=3.97)	$-2.03_{(72)}$	.046

Types of sexual behaviour and coercion

The two groups were similar in their experience of the eight sexual behaviours listed on the stimulus cards and there was no significant difference in their experience of the two study categories. Everyone had experienced serious types of behaviours and 86% of the CSA with substance misuse group and 78% of the CSA only group had experienced at least one of the very serious types of behaviour.

Although there was a slight trend for more of the CSA with substance misuse group (28%) to report that they had been drugged during the CSA, this was not a statistically significant difference (χ^2=4.92, df=2, p=.086). Any connection with later substance misuse was contradicted because the rates of coercion by drugs for the drug and alcohol with CSA group (10%) were the same as for the CSA only group (12%).

Disclosure of CSA

There was no difference between the two groups in the percentage of women who disclosed before age 16. Over half (53%) of the CSA only group and 41% of the CSA with substance misuse group disclosed during childhood. Among those who disclosed before 16, only about 20% of each group thought that disclosure made things better.

The mean age when women disclosed the high-impact CSA was 17 years (sd=6.84) for the CSA with substance misuse group and 21 years (sd=12.68) for the CSA only group. The groups had a similar pattern in their choice of first disclosees, with more of the CSA only group disclosing to sexual partners (16%) and fewer disclosing to friends (14%), compared with the CSA with substance misuse group (3% and 30% respectively).

Maturity of the victim

In summary, the two groups differed in their age of high-impact CSA, and, related to that, the duration of the abuse and the age difference between abuser and victim. The CSA with substance misuse group were also more likely to have been abused outside the family whereas the CSA only group were more likely to have experienced incestuous CSA. A similarity between the CSA with substance misuse and the drug and alcohol with CSA groups in their CSA characteristics further reinforces the idea that these characteristics are related to the development of substance misuse.

Children who are first abused at an age close to adolescence might be more inclined than children abused at a younger age to turn to substances as a way of coping. Alternatively, some girls might have been abused because their substance misuse increased their vulnerability, particularly outside the family.

There was no correlation between the age of the high-impact CSA and age of first intoxication (r=-0.15, df=98, p=0.14). Regardless of what age they experienced the high-impact abuse, CSA survivors started experimenting with excessive substance use earlier than other women. Perhaps women who were abused at a younger age had adopted other methods of coping with the trauma by the time that they began to experiment, whereas, women who were abused at a later age learned to view substance misuse as a primary method of coping.
It is also important to take into consideration the different meanings that CSA might have at

different ages. For the adolescent who is particularly focused on peer group acceptance and more aware than the younger child of society's norms, substance misuse might become a way of boosting social confidence, particularly in male-dominated groups. This idea is consistent with the model proposed by Paone et al. (1992) to account for the high prevalence of CSA among crack cocaine users. Since the CSA with substance misuse group had more experience of extrafamilial abuse, they might be more fearful of a recurrence of the abuse whereas incest survivors might feel safer once they have left the family. Substance misuse might be one way to bolster confidence against this anxiety about the potential for further sexual attacks.

These findings are confounded because 21 (42%) of the women in the CSA only group said that they had, at some time in their lives, misused substances although only four had received treatment. Retrospective self-reports indicated that their levels of dependence had been similar to those reported by the CSA with substance misuse group. A comparison of these people with the rest of the group showed only one difference in CSA characteristics. A greater proportion of those who had a past problem with substances had experienced very serious sexual behaviours, compared with those who had never misused substances (χ^2=4.02, df=1, p=.05). Since the 95% confidence intervals for the odds ratio included the null of one (OR=0.13; 95% CI=.01; 1.21), this difference might have arisen by chance.

3.6 PSYCHOLOGICAL DISTRESS

Regardless of a background of CSA, the qualitative interviews indicated that substance misuse was a coping method used to build social confidence, anaesthetise negative emotions, such as grief, anxiety and sadness, dissociate negative memories, tolerate domestic violence and unwanted sexual contact (including sex work), facilitate the expression of anger and, for some women, refusal of unwanted sex. The qualitative data revealed how CSA adds complexity to this range of functions because of its strong impact on women's memories, emotions, self-esteem, relationships and sexual function. It appears to have a specific legacy with respect to psychological distress. The data also showed that substance misuse was one among several ways of coping and other methods included dissociation, self-destructive acts, long working hours and eating disorders.

To test the hypothesis that CSA will be associated with symptoms of psychological distress, the two drug and alcohol treatment groups were compared on measures of current distress and past psychological symptoms. The results of this analysis are presented below, together with other relevant group differences.

Psychiatric hospitalisation

The drug and alcohol with CSA group had the highest rate of psychiatric hospitalisation (44%) but this was not significantly different from that of the drug and alcohol only group (28%). Similar rates were reported by the CSA only group (32%) and somewhat lower rates were reported by the CSA with substance misuse group (23%).

The main reasons for hospitalisation were drug overdoses and other suicide attempts, depression, "nervous breakdowns" and drug-related seizures. A few women reported psychotic episodes, postnatal problems and other psychiatric disorders such as obsessive-compulsive disorder and anorexia nervosa.

General Health Questionnaire (CGHQ)

The mean CGHQ score for those women who were not excluded from the analysis because of detoxification, illness or recent trauma was 17.27 (sd=7.10, median=18). The main group differences were between the two drug and alcohol treatment groups. Table 9 summarises the comparison between these two groups on each of the four diagnostic subscales: somatisation, anxiety, social dysfunction and depression.

Somatisation

As shown in Table 9, the drug and alcohol with CSA group were experiencing significantly more somatic symptoms, compared with the drug and alcohol only group. This finding is consistent with results reported by other studies (Bushnell, et al., 1992; Pribor and Dinwiddie, 1992; Walker et al., 1992; Briere and Runtz, 1988).

Table 9: General Health Questionnaire (CGHQ) Scale and subscale statistics and differences between the drug and alcohol treatment groups

CGHQ subscale	Drug & alcohol with CSA		Drug & alcohol only			
	_	sd	_	sd	t_{df}	*p*
Somatisation	4.83	1.72	3.30	2.13	3.19_{65}	.002
Anxiety	5.83	1.29	4.38	2.24	3.33_{59}	.002
Social dysfunction	3.33	2.28	2.70	2.26	1.13_{65}	*ns*
Depression	3.47	2.46	2.32	2.51	1.87_{65}	*ns*
TOTAL CGHQ	17.53	6.23	12.73	7.48	2.81_{65}	.006

Note: The CGHQ measures symptoms experienced in the previous two weeks. Scoring was according to Goodchild and Duncan-Jones (1985).

Anxiety

Table 9 indicates that women in the drug and alcohol with CSA group were significantly more anxious than those in the drug and alcohol only group. This relationship between CSA and anxiety symptoms is consistent with studies of other populations (Briere and Runtz, 1988; Murphy et al., 1988; Bushnell et al., 1992; Elliott and Briere, 1992).

Social dysfunction

There was a marginally insignificant trend for the drug and alcohol with CSA group to have higher degree of social dysfunction, compared with the drug and alcohol only group (p=.066). The CSA with substance misuse group had a higher mean level of social dysfunction (_=4.97; sd=2.37) than the drug and alcohol with CSA group. This was a statistically significant difference (t=-2.70, df=57, p=.009). This difference might reflect the impact of treatment. Women in drug and alcohol treatment sometimes commented that their social functioning had improved since they entered the therapeutic residential environment and ceased their substance misuse.

The CSA with substance misuse group also had a higher social dysfunction score than the CSA only group (_=3.50; sd=2.30). This significant difference (t=2.92, df=72, p=.005) between the two CSA counselling groups indicates a relationship between substance misuse and impaired social functioning.

Depression

Although the drug and alcohol with CSA group was more depressed than the drug and alcohol only group, this trend was marginally insignificant (p=.066). The trend is not as strong as trends reported in the literature (Walker et al., 1992).

Regression analysis

The total CGHQ score was significantly correlated with age of first intoxication (r=-0.31, df=118, p=.001) and number of traumas (r= 0.28, df=150, p=.001). It was also significantly higher for women who reported paternal substance misuse (t=-2.51, df=142.98, p=.013), emotional neglect (t=-3.59, df=148, p=.000), adult sexual abuse (t=-3, df=148, p=.003), and adult physical abuse (t=-2.43, df=148, p=.016).

A linear regression analysis was used to explore the contributions of these life experiences to the variance in the CGHQ scores. The final model is summarised in Appendix F. The effects of having a history of CSA, or a history of both CSA and substance dependence were significantly related to the CGHQ after adjusting for each other, adult physical abuse and emotional neglect (F=6.87, p=.000). This model accounted for 14% of the variance in CGHQ scores (Adjusted r^2=.14).

Dissociation

On a scale of five, the group had a mean dissociation score of 2.69 (sd=1.98) and a median of three. The drug and alcohol with CSA group had a higher mean dissociation score (_=2.57, sd=1.81) than the drug and alcohol only group (_=1.57, sd=1.89). This was a significant difference (t=2.19, df=65, p=.032), indicating that the CSA survivors had experienced more symptoms of dissociation in the two weeks before the interview.

The CSA only group (_=3.30, sd=1.82) and the CSA with substance misuse group (_=3.38, sd=1.88) reported still higher scores of dissociation but there were no other significant group differences. These results are consistent with the relationship between CSA and dissociation identified in other studies (Briere and Runtz, 1987; Briere and Runtz, 1988; Elliott and Briere, 1992).

Regression analysis

High levels of dissociation were associated with emotional neglect (t=-2.98, df=98.73, p=.005), adult sexual abuse (t=-2.43, df=131.47, p=.02) and paternal substance misuse (t=-2.56, df=175, p=.011). High levels of dissociation were also correlated with a higher number of traumas (r=.21, df=180, p=.004) and an earlier age of first intoxication (r=-.24, df=148, p=.004).

A linear regression analysis was used to explore the contributions of these life experiences to the variance in the dissociation scores. The final model is summarised in Appendix G. The effects of having a history of CSA, or a history of both CSA and substance dependence were significantly related to dissociation after adjusting for each other and emotional neglect. (F=6.46, p=.000). The reduced model only accounted for 10% of the variance in dissociation scores (Adjusted r^2=.10).

Self-Esteem

The mean score on the self-esteem inventory (SEI) for the whole sample was 44.24 (sd=21.83) with a median of 40, out of a total possible score of 100. This corresponds to the lowest quartile of the scores from an adult sample reported by Coopersmith (1970). Whereas the normative sample was skewed towards higher scores, the sample of scores from this study were skewed towards the lower end of the scale.

Although not significant, the pattern of group differences in self-esteem was similar to that reported by Carson et al. (1988) where a history of incest was associated with low self-esteem, particularly for women who were alcohol dependent. In the current study, the drug and alcohol only group reported the highest self-esteem (_=48.32; sd=26.40; median=42). The CSA only group (_=44.46; sd=22.54; median=42) and the CSA with substance misuse (_=42.53; sd=18.30; median=42) had similar results. The drug and alcohol with CSA group had the lowest self-esteem (_=40.96; sd=17.53 median=40).

Women who had experienced CSA were asked how it had changed or influenced their feelings about themselves. The most prominent theme in their responses was one of shameful devaluation:

> *Feeling about myself? That I'm not worthy of a lot, not deserving, not and just have to put up.* [CSA only]

> *I felt dirty. Just didn't feel like a normal human being. I felt like I'd done something wrong that can never be . . . that can never change.* [Drug and alcohol with CS

> *The general feeling after you've been sexually assaulted is feeling filthy. As if you are not worth anything. Not even . . . you have absolutely no worth, you know? Everyone in the world is better than you. And if you actually felt anything - any enjoyment out of it - you'd even feel worse about yourself.* [CSA with substance misus

Feelings of shame and stigma sometimes led to a self-imposed exile from social contact:

> *Well, I feel sort of worthless. Like I feel like sometimes people can see what sort of person I am. And what I've done. What was done to me. And I've got no trust for anybody, 'cept my kids, course. I don't mix well with people.* [Drug and alcohol with CSA]

Without a personal sense of self-esteem, some women measured their own worth by trying to please others:

> *I don't know if thats the sole thing but probably made me feel worthless. Because, like I said, the only time I can get approval if I, or get self-approval is if I get approval — bullshit approval — by the people.* [Drug and alcohol with CSA]

> *. . . just made me feel like I was worthless. That I didn't really have any rights. Yeah. Just made me feel like I wasn't important. I didn't matter. You were there to please everybody else.* [CSA only]

For one woman, this process of devaluation through sexual abuse was compounded by

experiences of racist exploitation that added to her vulnerability:

> *Because I've . . . it made me feel like I was worthless. Even when I was growing up, the sexual relationships I had were always when I was drunk and, I dunno. Its just like this hidden thing. Like don't meet anybody whenever you're going out with the girls. Like Aboriginal girls or women were just there to have sex with.* [Drug and alcohol with CSA]

At times the person's self-esteem was so wounded that genuine social reassurance felt unreal:

> *You're never as good. You never feel good about yourself. I don't feel good about myself. Whatever I feel, its pretend. Every person in the world could tell me that I was a wonderful person, intelligent and lovely and all the rest of it and I would think I was pretending. 'Cos the real me is really horrible. I'm not worth anything.*
>
> [CSA with substance misuse]

These feelings of worthlessness can often lead to self-destructive behaviour, such as substance misuse, poor relationship choices or suicide attempts:

> *Self-worthless. [pause] Yeah.Worthless. Self-destruct. Self-hate. Ah, like a slut.*

> *One of the things that is really difficult is a real powerful self hatred that comes out as a self-destructive feeling.* [CSA only]

> *I would probably have felt much more worthwhile a person. You know, I wouldn't continually get into relationships which were dysfunctional or relationships that I got hurt in.* [Drug and alcohol with CSA]

A prominent theme among women in the CSA counselling groups was the disconnection from deeper sources of motivation that frustrated endeavours to achieve:

> *It made it almost impossible for me to cope at school because I couldn't attend to what was going on because of the pressure . . . I'd go to bed in a very charged emotional state, I couldn't settle and I also didn't sleep at all well. So quite often through the day, I was just extremely tired and eventually became, you know, aggressive as well. And then there was depression . . . I guess I actually lost that connection to my will. You know, feeling that what I did was an impulse from inside me. Even as a child, I lost that. And that I cut off from my energy.* [CSA only]

> *Well I don't have a job. And thats because I can't concentrate to study, etcetera. I know that what I came into the world with, like, my brain worked okay, my body worked okay — there's no reason, I didn't have to be — I see myself as being like a disabled person in that I don't have the ability to function as I should.*
>
> [CSA with substance misuse]

Often when women did experience academic or work achievements, their confidence was so disrupted that they were never satisfied with their own performance:

I was shy, I was stupid, I didn't do anything well. There was a lot of over-achiever but I never was happy with it. [CSA only]

I find it hard to believe in myself. I'm going to uni — done one year of uni — and previous years of TAFE, and 99% of the time, it'll be A grade or Distinction, High Distinction areas. And to me its still not proof enough that I can actually do things. [CSA only]

Yeah. And I should feel "Oh gee, you've done well" but at times, I think "Oh you know, life sucks." [Laughs] [CSA only]

Some women emphasised the changes they were experiencing since they began to receive counselling for the CSA. In particular, counselling can provide a new perspective about who was responsible for the CSA:

Well, I think I've gone through many years of blaming myself for it. And now, I'm changing and I'm starting to believe that its not me to blame. Its him to blame.

[CSA with substance misuse]

Counselling can also help women to value their own feelings:

I guess I'd have to say looking at the childhood I had, I would now be more compassionate towards myself and much more caring about myself, in terms of actually being able to look after myself when I AM emotionally upset. [CSA only]

There was a transition phase, however, in which these new, more empowering discourses, competed with old self-denigrating discourses:

I still feel worthless a lot. Still feel very . . . still feel a lot of shame about certain incidences that happened. Its really hard to describe because there's a lot of ambivalence there. Because at the same time, I also know that I don't have to be ashamed for what has happened even though . . . So yeah, I've sort of got the problem of the two emotions at once and I'm still going through that. [CSA only]

There's a large gap between what I feel and what I know. I know through my reading and my therapy that I'm not responsible. I know that life isn't completely hopeless. I know that I can get better. But my feelings about it are probably still very much that I'll never get out of this mess. My life will go on this way forever. I will never have any power. That life is to be got through. [CSA only]

Suicidality

Almost half (49%) of the women had attempted suicide some time in their lives. A greater percentage of the drug and alcohol with CSA group had attempted suicide than any other group. Seventy percent of women in this group had tried suicide, compared with 36% of the drug and alcohol only group (χ^2=11.60, df=1, p=.001) and 38% of the CSA only group (χ^2=10.31, df=1, p=.001). Women in the drug and alcohol with CSA group had four times the odds of attempting suicide than either the drug and alcohol only group (OR=4.15, 95 CI=1.80; 9.57) or the CSA only group (OR=3.81, 95% CI=1.66; 8.75). The CSA with substance misuse group also reported a relatively high rate of attempted suicide (57%) which was not significantly different from that of the drug and alcohol with CSA group.

These results are consistent with the findings of Edwall et al. (1989) and Swift et al. (submitted) who reported a relationship between CSA and suicidality among female drug and alcohol treatment clients. The results of the current study indicate that the high risk of suicidality among women in the drug and alcohol with CSA group reflects the combined effects of past trauma and current access to substances.

This idea is supported by figures indicating that the most common method of suicide for all groups was drug overdose. Of those women who had attempted suicide, 89% had attempted a drug overdose and 30% had cut their wrists. Women reported a diversity of other methods, including gas, jumping from a height, trying to get run over and hanging. There were no significant group differences in the methods used or the number of suicide attempts, with an overall mean of 1.74 (sd=3.47) attempts.

Childhood experiences associated with CSA that increased the odds of attempted suicide included paternal substance misuse (OR=1.69; 95% CI=0.93; 3.06), emotional neglect (OR=1.9; 95% CI=1; 3.61) and a younger age of first intoxication (t=2.63, df=146, p=.009). It is noteworthy that several women recalled childhood suicide attempts. These women were from CSA groups:

> *I was about 12 or 13 and we were out for a picnic and we were along the railway track and I just walked into a tunnel which was up the road. And just sort of got into the middle of the tunnel, sat down in the middle of the tunnel. And thought well, you know, I wanted to get into the middle of it so that I couldn't — you know, the train — I couldn't get out of it.* [Drug and a

> *Yeah, well I wasn't so conscious about thinkin' about suicide. I mean, I was just thinkin' "Oh well, I may fell down. If I go a little bit farther, I may fell down". And I did it until I fell down and then I had just a feeling of such an idiot. "Why you didn't do it two floors more!", you know.* [CSA only]

The odds for suicide attempts were also greater if the woman had experienced adult physical abuse (OR=1.88; 95% CI=1.02; 3.48) or had experienced a larger number of traumas (t=-3.82, df=178, p=.000). Surprisingly, it was these variables, rather than the childhood variables that fitted in a logistic regression model accounting for the variance in attempted suicide (Appendix H). The regression showed that the difference between the two drug and alcohol treatment groups in rates of attempted suicide was significant after adjusting for the effects of the number of traumas and adult physical abuse (χ^2=22.63, df=4, p=.000).

Attempted suicide was also related to the women's levels of psychological distress at the time of the interview. Women who had attempted suicide had higher scores on the CGHQ than those without a suicide history (t=-4.35, df=178, p=.000). High rates of attempted suicide were also significantly related to high levels of dissociation (t=2.92, df=178, p=.004) and low self-esteem (t=-3.54, df=178, p=.001).

Self-mutilation

The percentage of women who had cut or deliberately hurt themselves was higher among women with a CSA background. Over half (54%) of the drug and alcohol with CSA group, compared with 30% of the drug and alcohol only group had harmed themselves deliberately (χ^2=5.91, df=1, p=.015). The odds ratio was 2.74 (95% CI=1.20; 6.23). The association between CSA and self-mutilation observed by Rose et al. (1991) was supported in this study. The CSA only group (59%; N=29) and the CSA with substance misuse group (63%) had similar rates of self-mutilation to that of the drug and alcohol with CSA group. Unlike the study by Rose et al. (1991), there was no relationship between self-mutilation and parental substance misuse.

The relationships found between rates of self-mutilation and high scores on all four CGHQ subscales, greater dissociation and low self-esteem were similar to those reported for suicide. High rates of self-mutilation were also related to an earlier age of first intoxication (t=-2.52, df=145, p=.013) and first alcohol use (t=-3.47, df=124.22, p=.001).

Eating disorders

A pattern similar to that of self-mutilation was observed for eating disorders. Over half (54%) of the drug and alcohol with CSA group, compared with 36% of the drug and alcohol only group had experienced trouble with eating or food (χ^2=5.93, df=2, p=.052). The odds ratio was 2.56 (95% CI=1.1; 5.96). Since the CSA only group (68%) and the CSA with substance misuse group (60%) also had a high prevalence of eating disorders, these results support other findings (Bushnell et al., 1992; Smolak et al., 1990) that CSA is associated with eating disorders.

High rates of eating disorders were associated with greater somatisation (t=2.68, df=163, p=.008) and anxiety (t=2, df=110.34, p=.048). They were also associated with an earlier age of first intoxication (-2.02, df=81.28, p=.047) and first alcohol use (t=-2, df=132, .048), suggesting that eating problems and substance misuse might have similar functions as methods of coping with trauma. The types of eating problems that women encountered included loss of appetite, compulsive or over-eating, eating or not eating to deal with emotions, anorexia, bingeing and bulimia. Another 8% of women said that they were dissatisfied with their weight and some women attributed weight gain to safety needs:

> *I feel more comfortable being the weight I am now rather than — there's times when I've been quite skinny and I feel too exposed — I like to hide behind a bit of weight.*
>
> [CSA only]

Sexual dysfunction

A striking pattern associated with CSA was found for sexual dysfunction. The majority of

women in the CSA groups had experienced problems with their sex life some time in adulthood. This was the case for 90% of the CSA with substance misuse group, 86% of the CSA only group, and 76% of the drug and alcohol with CSA group. In contrast less than half of the drug and alcohol only group (44%) had experienced problems with their adult sex life.

Among the drug and alcohol treatment groups, women with a CSA history were four times as likely as other women (OR=4.03, 95% CI=1.71; 9.49) to have experienced sexual problems (χ^2=10.67, df=1, p=.001). Although these findings support Wilsnack's (1984) assertion of high rates of sex problems among women with substance misuse, they are also consistent with other studies that have reported an association between CSA and adult sex problems (Briere and Runtz, 1987; Pribor and Dinwiddie, 1993; Saunders et al., 1992).

Regression analysis

A logistic regression was used to explore the contribution of life experiences to the variance in adult sexual dysfunction. Sex problems were significantly associated with a high number of traumas (t=-3.37, df=177, p=.001). The odds for sexual dysfunction were greater if the woman had experienced child physical abuse (OR=0.51; 95% CI=0.26; 0.98), she had experienced emotional neglect (OR=0.29; 95% CI=0.15; 0.58) or adult sexual abuse (OR=0.46; 95% CI=0.24; 0.9).

The final model is summarised in Appendix I. It showed that the drug and alcohol with CSA and CSA only groups were significantly different from the drug and alcohol only group in sexual dysfunction after adjusting for the effects of each other and the number of traumas (χ^2=27.82, df=3, p=.000).

Qualitative analysis

Finkelhor and Browne (1986) proposed a model of traumatic sexualisation by the imposition of a developmentally and socially inappropriate sexuality on the child, increasing the salience of sexual issues and leading to a variety of psychological and behavioural symptoms. This study highlights a number of sex problems that are consistent with that model. They are dissatisfaction and avoidance, problems with intimacy and trust, negative emotions during sex, use of substances to cope, feeling obligated to have unwanted sex and having unwanted attractions or compulsivity.

Dissatisfaction and avoidance

Women who had experienced dissatisfaction or difficulties in their sex life were asked to describe the nature of these difficulties. The most common problems for all groups were an aversion to, or dissatisfaction with, sex. Forty-five percent of the women with sex problems said that they disliked sex and/or avoided it and 22% said that they did not feel satisfied when having sex.

> *I've never been comfortable with it. I think of it as being dirty. I never get past the stage of, you know, I mean, I go out to dinner and then a couple of weeks down the track, they expect something, and that's when I run, you know. Scares me.*
>
> [Drug and alcohol with CSA]
>
> *Lack of satisfying, satisfactory sex.* [Drug and alcohol only]
>
> *. . . just sort of being sexual with people doesn't feel good to me. It just feels —*

sometimes it feels good — but usually it just feels awful so I thought I'd give it a miss for a while. [CSA with substance misuse]

I've just basically always avoided it and sort of switched off. [CSA only]

Two other problems that were common to all groups were women's lack of confidence in their own attractiveness or performance, and problems in their relationships:

. . . my husband wasn't really interested in sex. And I sort of took that on that it was my fault. There was something wrong with me. That it was, you know, something that I was doing wrong. [Drug and alcohol with CSA]

Intimacy and trust

Some sexual problems seemed to be more common among women who had experienced CSA. For example, those who had experienced CSA often related their sexual problems to fears about being close or intimate with others:

Not trusting. That's always been a big one for me. I very, very rarely trust anybody. And like giving parts of yourself, which you know that whoever you're in the relationship with actually want, I don't do. [CSA only]

But yeah, my adult sex life, scared of it, scared of intimacy. Emotional intimacy and physical. [Drug and alcohol with CSA]

Some women who had experienced incest found that sex became more difficult as the relationship with their partner became closer:

Relationships usually are very short. There'd be sex at the beginning and then there'd be a fear of sex after that. And then I don't want anything — the relationship or anything. [CSA only]

. . . after getting to a certain point in intimacy, then I stop wanting to have sex. Like I find that I don't want to have sex with people that I'm emotionally intimate with.

[CSA only]

Sometimes the desire to have the sex while keeping away from emotional intimacy resulted in mutually exploitative situations:

I mean even now, my casual partner is a married man. Which has been convenient for me . . . but its wrong, you know, I'm trying to - like smoking pot - I'm trying to distance myself from something that's sort of comfortable but it doesn't fulfil your needs and its still the same sort of set up where you are being used. [CSA with substance misuse]

CSA and negative emotions

There was strong evidence that sex problems were associated with negative affect. Women with sex problems had higher scores on the CGHQ subscales of somatisation ($t=3.6$, $df=177$, $p=.000$),

anxiety (t=3.53, df=177, p=.001) and depression (t=2.27, df=177, p=.024). A common sex problem identified by women in the CSA with substance misuse (42%) and CSA only groups (23%) was the occurrence of unpleasant emotions during sex. The emotions mentioned included anxiety, anger, confusion, sadness and terror:

> *Well, I find that when I am in a relationship and I was sexually active, I don't know, every time after love-making, I seem to get really depressed and I cry and just don't wanna be touched.* [CSA only]

> *Because what happened with me was that my sexual feelings and anger were entwined. And it meant that I need to be able to separate my anger from sexual energy, so to speak. Because if I felt sexual, I often just [snaps fingers] went into anger.* [CSA only]

> *I think what it then does is link sexual feelings with awful feelings and that is what destroys people's sex life. Because every time you feel sexual, you just feel scared or you feel [pause] just awful. So then you can never have — or until you work on it — you can't have a sexuality that's free of bad feelings.* [CSA with substance misus

Negative emotions were sometimes related to flashbacks or unpleasant thoughts during sex:

> *I remembered that at the beginning, I had a lot of flashbacks but I said "I don't want this to affect me" so I just kept going. And what happens was that most of the time, when I had sex, I had a strong need to do it as quick as possible and just feeling like I have to run away from it.* [CSA only]

> *Well, all I can put it down to is the sexual abuse and I think sometimes, just the way you might be touched might set off a memory of, you know, the way it was when I was a child or, just even really maybe a look, or anything. Just then you start getting flashbacks, you know.* [CSA only]

Women frequently avoided behaviours that specifically reminded them of the abuse:

> *I'm very, very, very, very nervous about anything except sort of plain, ordinary run of the mill sex. The idea of having anal sex would completely and utterly freak me out. Oral sex would make me sick. I couldn't cope, I just couldn't cope with it. Even . . . it just panics me, the thought of it.* [Drug and alcohol with CS

<u>Using substances to cope</u>

If a CSA history prompts negative emotions at the time of sex, how is it that only one of the women in the drug and alcohol with CSA group specifically reported this problem? Similarly, people in this group were less likely than women in the other CSA groups to say that they felt vulnerable or had problems with intimacy. Perhaps one explanation is that their substance misuse acted as a buffer to these feelings:

> *Well in the past, I've been pretty promiscuous. Now that the drugs aren't - the pills have gone and the alcohol's gone - I'm not able to sleep with anybody and it has to be someone I really care about for me to be able to have sex with them . . . even then I feel vulnerable and I don't like to be touched and stuff . . .* [Drug and alcohol with CSA]

I just don't like it. I just . . . it makes me feel ill. Even to think of sex either with men or with women. I just - unless I'm really drunk, I can't go through with it.

[Drug and alcohol with CSA]

Oh, it depended. You know, like maybe, very small amount of time that things were okay and I didn't need anything. But nearly always, to make it more palatable, I guess [laughing]. Yeah, I, be better, definitely better if I had something. Definitely.

[Drug and alcohol with CSA]

Although there was a trend of association between sex problems and earlier onset of alcohol use, this was not significant (t=-1.91, df=144, p=.059). The drug and alcohol with CSA group were more likely to say they had used drugs to overcome sexual difficulties (52%) than the drug and alcohol only group (32%) and this difference was significant (χ^2=4.11; df=1; p=.043). More women in the drug and alcohol with CSA group had used drugs to make sex easier than the CSA only group (35%) but this trend was not significant (χ^2=3.02; df=1; p=.082). The drug and alcohol with CSA group and the CSA with substance misuse group (57%) were equally likely to have used substances to cope with sex problems.
An alternative buffer to negative feelings during sex might be dissociation. Women with sex problems had higher mean scores of dissociation than other women (t=3.3, df=177, p=.001). In the qualitative interviews women in the CSA only group described feelings of detachment and dissociation:

I was just aware that there was someone there, kind a thing, and I would dissociate entirely from the entireness of the experience to the point of physically not even feeling anything that's happening. Like "Oh is it over yet? No we're still going" kind a thing. [CSA only]

Sexual duty

Gavey (1993) has demonstrated the role of heterosexist discourses in the prescription of certain forms of sex, particularly coitus. In this study, the obligation to have sex even without desire was particularly highlighted by women in the CSA groups. In fact, so many women responded to our question about unwanted sex during adulthood with examples of consent without desire that the interview question was made more specific to distinguish "those situations where you said `no' or indicated `no' and the person persisted anyway". The examples of sex without desire were characterised by a kind of passive acquiescence:

I just would say nothing. I would be passive. So [pause] I wasn't giving consent but I wasn't saying "no" either [CSA only]

No, well I've [pause], well I sort of haven't wanted to but sort of have gone along.

[Drug and alcohol only]

Its just as though "Oh yeah, get it over and done with". [Drug and alcohol with CSA]

[Friends] were saying its so good, you know, and I hated it. I just thought it was just something that ya had to do. It was part of life. You had to do it. [CSA only]

It was difficult to negotiate the kind of sex they wanted or did not want:

. . . it was like, things that I didn't like, I would never say "Don't do" because I was ... I didn't think I had the right to. [CSA only]

Women also consented to sex without desire in exchange for affection, to please their partner or because they thought it was their duty:

And sometimes I've used sex in a form of caring, rather than other stuff. You know, you get to that thing "Oh, if you sleep with someone, they're bound to love you" — that kind of stuff. [CSA only]

It was a real grit my teeth affair. I didn't like touching him. It certainly wasn't a prolonged or pleasurable experience. It was something — you know, I'd just count the days, you know, normal people did it once in three or four days and once every three or four days I'd get a bit anxious and think "Well, now its my job and its my duty, and I'd better. Tonight's the night." [CSA only]

Caused me to lie, 'cos I'd fake orgasms constantly. Because I felt that it is important that he felt that he was doing a good job. [CSA only]

<u>Unwanted attractions</u>

Another problem that was only experienced by women in the CSA counselling groups was the problem of unwanted attractions. For example, one woman was attracted to older men and attributed this to her experience of abuse by her father. This attraction interfered with her work performance because many of the clients in her business were older men. Other unwanted attractions included promiscuity or infidelity:

I got mixed up with this fellow and I'm very sorry that I did. And since that, and thinking about it since then, that's brought up it all and why am I doing this? [CSA with substance misuse]

Some women described a sense of compulsion tied in with other compulsive behaviours.

I think I just, I go overboard on everything. On the eating, the drinking, sex, love, everything. Its just overboard. Its a binge thing if I'm being ho..., absolutely honest. [CSA with substance misuse]

If I pick up a relationship, ah, to me its a bust. 'Cos its all about why I use drugs. To make me feel comfortable. And when I'm not using drugs, I'm with someone. So, they're my drug at that time. [Drug and alcohol with CSA]

Attributions about sexual problems

Some of the women made attributions about the origins of their sexual problems. Substance misuse was cited as a cause of sex problems by 41% of the drug and alcohol only group and 24% of the drug and alcohol with CSA group. For example a woman who had been on methadone for 18 years believed that it had dampened her senses and taken away her motivation to do most things, including sex:

> *Well, I went without for six years. Didn't wanna know about it, literally. Rather read my book. I just read my books all these years. You know, and vegied out at home. And that's all I did.* [Drug and alcohol only]

None of the CSA with substance misuse and only one person (2%) in the CSA only group cited substance misuse as a cause of past sex problems. Women in the CSA counselling groups were more likely to attribute their sexual problems to CSA than women in the drug and alcohol with CSA group. For example, 28% of women with sex problems in the CSA only group made this attribution, compared with only 8% of the drug and alcohol with CSA group.

When asked specifically whether or not they thought that the CSA had affected their adult sex lives, almost all of the CSA only group (92%) said that it had, compared with 76% of the drug and alcohol with CSA group (χ^2=4.76; df=1; p=.029). In particular, 80% of the CSA only group said that the CSA had led them to feel frightened of sex or some aspect of sex, compared with only 51% of the drug and alcohol with CSA group (χ^2=9.22; df=1; p=.002). It seems likely CSA counselling made an important contribution to these group differences in attribution.

Women also attributed their sexual difficulties to other causes, such as their experiences of pregnancy, childbirth, illness or physical discomfort or their partner's sexual problems. Some women attributed their difficulties to a strict upbringing regarding sex:

> *. . . I was brought up to believe that it is was dirty. You know, nice girls didn't do that sort a thing, and then when you got married, it was just to have children.*
>
> [Drug and alcohol only]

The legacy of CSA

Both the quantitative and qualitative analyses of psychological distress among CSA survivors reveal a legacy of emotional, physical and behavioural symptoms that are likely to play an important role in drug and alcohol treatment and relapse prevention. These symptoms could be further aggravated by substance misuse and a combination of CSA and substance misuse places women at risk of suicide. Other risk factors that mediate the relationship between CSA and long-term distress include emotional neglect, adult physical abuse and the number of lifetime traumas.

4.1 HELP-SEEKING: RESEARCH AND THEORY

Seeking help for substance misuse

According to Saunders (1993), the most difficult step for people seeking psychotherapy is their initial recognition that they have a problem. His evidence indicates that a person's achievement of this step is unrelated to previous therapy experiences. Moreover, people with both the least and the most severe symptoms had trouble recognising their problems.

After problem recognition, Saunders (1993) argued, there are three other steps. The person decides that therapy might help, decides to seek therapy, and then contacts the agency. Saunders' (1993) model proposes a kind of impetus in which each step becomes easier than the last. Factors such as social support may intervene, either in a positive way as the person receives assistance from significant others, or in a negative way in which the person is discouraged from the idea of professional help.

A similar process is evident in the model of the Process of Change by Prochorska and DiClemente (1986). Since the `pre-contemplator' is unaware of the problematic nature of his or her substance misuse, the shift from pre-contemplation to contemplation is a shift in awareness about the problem. Studies have shown that this step of recognition is just as difficult in the case of substance misuse as for other psychological symptoms. (Thom, 1986; Cunningham, Sobell, Sobell , Agrawal and Toneatto, 1993). Similarly, the last three steps of Saunders' (1993) model seem to parallel early stages in the Process of Change model where the person moves from ambivalent contemplation into preparation and then action.

In a community study, Kessler, Brown and Broman (1981) found that women are generally more ready than men to translate non-specific feelings of psychiatric symptoms into conscious problem recognition. The discovery by Thom (1986) that women entering treatment were less likely than men to see alcohol as their main problem, seems to suggest that the opposite is true for substance misuse. Thom (1986) also reported, however, that these women were more likely than their male counterparts to attribute their drinking to a crisis or daily stress. They may have recognised the existence of a problem but conceptualised it in terms other than substance misuse.

This idea is supported by findings that women with substance misuse tend to seek medical treatment for interpersonal or psychological problems or contact psychiatric services without informing these professionals about their alcohol or other drug problems (Beckman and Amaro, 1982; Dahlgren and Myrhed, 1977). Ironically, there is evidence that women are less likely than men to be diagnosed and referred by physicians for drug and alcohol treatment (Beckman, 1994).

The decision to seek help for problems other than substance misuse might also be reinforced by a fear of social stigma. People with alcohol problems delay seeking help because of the stigma attached to the `alcoholic' or `addict' label (Thom, 1986; Cunningham et al., 1993; Copeland et al., 1993).

Beckman (1994) emphasised that treatment for women should focus especially on building satisfying and supportive social relationships in women's lives. She based this conclusion on research demonstrating the importance of social influences on women's help-seeking. Although women cite social pressure as a reason for seeking help (Thom, 1987), they are also more likely than men to encounter social opposition, particularly from their sexual partners (Beckman and Amaro, 1986; Thom, 1987). Spousal opposition is partially explained by women's higher chance of having a heavy drinking partner (Thom, 1986). Women entering treatment are more likely than men to have problems with spousal violence and feelings of powerlessness (Thom, 1987). There is also evidence that they delay seeking help because of their family responsibilities and financial dependence (Beckman, 1984; Walker et al., 1982).

Seeking help for CSA

Alcohol treatment outcome studies indicate that women have special needs that might not be addressed in programs that have been designed primarily for men (Jarvis, 1992). Copeland and Hall, 1992a, 1992b) found that a gender sensitive treatment program had higher rates of recruitment and lower rates of drop-out among lesbian women, mothers of dependent children and women with a history of CSA, than a traditional mixed-sex program. Their findings support the view that CSA survivors have an increased need for a physically and emotionally safe environment because their trust has been seriously violated during early life (Gelinas, 1983).

Safety has also been strongly emphasised as a treatment need of trauma survivors by Herman (1992). She proposed a three stage model for assisting trauma recovery. The central task of the first stage is the establishment of safety. Physical safety would include learning self-care and the management of self-destructive behaviours (including substance misuse) and finding refuge from dangerous others. Herman (1992) also emphasised emotional safety. She maintained: ". . . the second most common error is premature or precipitate engagement in exploratory work, without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance" (p172).

This helps to explain a finding reported by Copeland et al. (1993) that among women with a CSA history, those who had attended a gender-sensitive drug and alcohol treatment program were more likely than other women to have relapsed in the six months following treatment. On the basis of these results, Copeland et al. (1993) cautioned that women should not be pressured into prolonged descriptions of their experiences by treatment staff, especially where staff are not trained to deal with CSA issues and are unable to provide long-term psychological support.

Nevertheless, according to Herman (1992), the most common therapeutic error is avoidance of the traumatic material. Research demonstrates that a combination of client timidity and professional reluctance obstructs women's disclosures of CSA to help-providers. Rose (1991) reported that none of the abused clients in her sample from emergency psychiatric services had ever been asked about their experiences of abuse and few received a response if they raised the issue in a clinical setting. Despite a high prevalence of abuse among those with substance misuse, none of these clients had ever participated in a service where a connection had been made between abuse and substance misuse. Pribor and Dinwiddie (1992) also found that many women had never told their psychiatrists about the abuse, nor were they asked.

Briere and Runtz (1987) argued that ". . . mental health practitioners are unlikely to ask about sexual abuse routinely and, when they are told of such a history, may discount or even disbelieve their clients. This tendency to avoid abuse issues during the assessment phase of treatment may have serious consequences, since many clients will not volunteer victimization experiences unless specifically asked" (p375). In their study, only 39% of former abuse victims identified themselves as such prior to direct questioning by the intake clinician.

Golding, Stein, Siegel, Burnam and Sorensen (1988) found that people with a history of sexual abuse were significantly more likely than non-abused people to use both mental health and medical services, especially CSA survivors. Having a psychiatric diagnosis and disablement from physical health problems increased the likelihood that women would seek help even if they had no health insurance. Golding et al. (1988) concluded that ". . . the need for care associated with assault overwhelms the financial barrier of lacking insurance" (p640).

Silver, Boon and Stones (1983) have argued that this need is an active search for meaning about the CSA experience. They found that incest survivors who were still trying to understand the meaning of their experiences had more current psychological distress, impairment, lower self-esteem and less resolution of the experience than those who had found an explanation for the assault. The opportunity to ventilate feelings about the victimisation assisted women to make meaning out of an abusive experience.

This finding is consistent with the second stage of Herman's (1992) model of trauma recovery. She describes this stage as a process of validation in which the therapist normalises the client's responses to the trauma, facilitates its conceptualisation and shares the emotional burden while affirming the survivor's dignity and value. The client is able to speak the unspeakable and experience the grief.

Unfortunately, according to Silver et al. (1983), women who successfully resolve the meaning of the abuse are no more likely than others to have had professional assistance, either specifically about the abuse or for emotional problems. Professional assistance does not seem to guarantee a resolution. Of course, the value of such assistance will depend on its quality or relevance for the help-seeker. Pribor and Dinwiddie (1992) reported that 83% of women seeking help for incest had not found their previous therapist to be helpful.

The final stage of Herman's (1992) model is reconnection at a point when the client is ready to engage more actively in the world. She no longer feels possessed by the past and is starting to develop new aspirations. This is a stage of major changes in which the client chooses new behaviours and learns how to relate differently to others. She might begin to take more control in sexual relationships and to redefine her sexual needs. According to Herman (1992) the tasks of this final stage include relapse prevention, based on the recognition that traumatic symptoms will return at times of stress.

The need to address CSA issues in substance misuse treatment has been highlighted by Young's (1990) suggestion that incest material might precipitate relapse when abstinence triggers the return of traumatic memories. This raises the somewhat contentious question about whether CSA counselling should come after abstinence has been achieved or be provided concurrently to substance misuse treatment.

Implications of CSA for substance misuse treatment

The research into help-seeking suggests that women often attribute their substance misuse to underlying psychological stress and are therefore inclined to seek help initially from physicians or psychiatrists. Although women's stress might be partially a response to CSA trauma, they are unlikely to disclose to professionals unless specifically asked.

Routine inquiry could address this problem but researchers have warned against intense exploration unless there are trained personnel available to offer specialist care. CSA increases women's needs for safety within the treatment setting and without proper resolution, CSA trauma could contribute to relapse to substance misuse.

The four step model proposed by Saunders (1993) is a useful framework with which to explore the decisions women make about seeking help for either CSA, substance misuse or both, and the social factors that influence these decisions. Herman's (1992) model of trauma recovery highlights the needs of the CSA survivor and raises the possibility that poor outcome might be related to a mismatch between the client's stage of recovery and the service provider's approach to CSA.

4.2 PATTERNS OF HELP-SEEKING

To provide a context for the qualitative analysis on help-seeking, the history of help-seeking is initially described for each of the four groups. The data reveal patterns of help-seeking that distinguish the drug and alcohol treatment clients from the CSA counselling groups.

History of help-seeking

Most people in the study had sought help before for their current presenting problem. Of those in drug and alcohol treatment, 90% of women with a CSA history and 98% of other women had previously sought help because of substance misuse. The CSA counselling groups differed in their history of counselling. Whereas 84% of the CSA only group had previously sought help because of the CSA, only 57% of the CSA with substance misuse group had done so. Although this difference reflects the recruitment of 47% of that group from outside treatment services, it might also support the idea that substance misuse could be a barrier to help-seeking for CSA survivors. Except where indicated, the following statistics on past help-seeking are based only on the reports of those women who had sought help before for their current presenting problem.

Over one-third of drug and alcohol clients were revisiting their current treatment agency. This was true for 38% of the drug and alcohol with CSA group and 31% of the drug and alcohol only group. In contrast, only 7% of the two CSA counselling groups had returned to the same agency for CSA counselling.

There are two factors that are probably contributing to this difference. First, clients of individual counselling, such as CSA counselling typically would only visit the counsellor for one or two periods of continuous counselling whereas clients of drug and alcohol agencies might return several times to the same rehabilitation program. Second, the difference reflects the organisation of area health services where one drug and alcohol program caters for a specific geographical area. A person who repeatedly seeks help for drug and alcohol problems in the same geographical area is therefore highly likely to return to the same agency.

The difference might also reflect the different pattern of help-seeking in the two groups. Drug and alcohol clients are likely to have repeated attempts at dealing with the same problem in the same program, attributing their initial lack of success to their own actions:

> *It was me. It was just, I chose to look at things in a really sick way. That's another thing about the program. Its up to you. If you wanna get well, you have to want to get well. If you choose to look at things in a sick way, there's nothing here for you.*
>
> [Drug and alcohol with CSA]

In contrast, CSA clients showed more of a searching pattern of help-seeking, to find the ideal therapist for their personal needs. When they found that person, or group, they were then likely to see therapy through to completion. If treatment was unsuccessful, they attributed the responsibility to the therapist or group and looked elsewhere for better help. For many women, this pattern of searching was complicated by a lack of specific CSA services:

> *. . . what I say to my girlfriends now that are having the same trouble. I say*

"Well don't give up. Don't be put off just because of one person. Just keep looking" . . . [CSA only]

Most women in the drug and alcohol with CSA group had, at some stage, left treatment before program completion (77%). Compared with the drug and alcohol only group (41%), they were significantly more at risk of leaving treatment before completion (χ^2=12.03, df=1, p=.001; OR=4.91, 95% CI=1.95; 12.4). Findings by Copeland and Hall (1992b) have suggested that this drop-out rate might be reduced in a gender-sensitive treatment program.

More than half of the CSA with substance misuse group (59%) and 49% of the CSA only group had left counselling or groups before expected completion. These figures, however, could have been inflated due to a lack of distinction between the woman's choice to leave and having to leave because of changes in the therapist's situation.

Women in drug and alcohol treatment

For drug and alcohol clients who had attended treatment programs before, the number of previous programs ranged from one to 38. There was no significant difference in the average number of previous programs for the drug and alcohol with CSA group (median=5, _=7.04, sd=7.1) and the drug and alcohol only group (median=3, _=6.48, sd=8.39).

Types of drug and alcohol programs

Detoxification: Previous help-seeking typically included detoxification, with 76% of the drug and alcohol with CSA group and 82% of the drug and alcohol only group having previously had supervised detoxification. The median number of previous detoxification programs ranged from one to 20, and was higher for the drug and alcohol with CSA group (_=4.27, sd=4.27, median=3) than for the drug and alcohol only group (_=3.08, sd=3.22, median=2). This was a marginally significant difference (U=492.5, p=.052).

Residential rehabilitation programs: In contrast to detoxification, few of the women had previously attended short-term residential rehabilitation programs. Only 36% of women in the drug and alcohol with CSA group and 22% of the drug and alcohol only group had previously been in short-term rehabilitation programs. The number of previous rehabilitation programs ranged from one to 30 with no significant differences between the drug and alcohol with CSA group (median=3) and the drug and alcohol only group (median=1).

Methadone maintenance: Previous experience of methadone maintenance was common for both the drug and alcohol with CSA group (60%) and the drug and alcohol only group (57%). the median number of previous methadone maintenance programs for both groups was two, with estimates ranging from one to 10.

Therapeutic communities: Past participation in long-term therapeutic communities was reported by 40% of women with a CSA history and 35% of women in the drug and alcohol only group. The median number of therapeutic communities was one for both groups.
Outpatient drug & alcohol counselling: Just over half of the drug and alcohol CSA group (51%)

and 43% of the drug and alcohol only group had received outpatient counselling for substance misuse in the past. The median number of counselling experiences reported by each group was one.

Other sources of help: Among the drug and alcohol clients, four women had received help from their GP's for their substance misuse and one woman had received acupuncture. These figures, however, may under-estimate the number of people who initially sought help from their GP and were then referred to specialist programs.

Child sexual abuse counselling: Regardless of whether or not they had previously sought help for drug and alcohol problems, only four women in the drug and alcohol with CSA group had ever received specialist CSA counselling. This low figure was partly due to the selection process in this study, which excluded women in drug and alcohol treatment who had received CSA counselling in the 12 months prior to entering their current drug and alcohol treatment program.

Women in CSA counselling

Among the 17 women in the CSA with substance misuse and the 41 women from the CSA only group who had sought help before because of CSA, the number of previous programs ranged from one to 16. The median number of previous counselling experiences was two (_=3.41, sd=3.61) for the CSA with substance misuse group and three (_=3.56, sd=2.82) for the CSA only group. This was not a significant difference.

Type of counselling program

Outpatient counselling for CSA: It is not surprising that outpatient counselling was the most common form of CSA therapy for both the CSA with substance misuse group (71%) and the CSA only group (80%). Outpatient counselling was defined broadly, including specialist agencies such as Dympna House or sexual assault units as well as clinical psychologists, psychotherapists and other counsellors. The number of previous outpatient counselling episodes ranged from one to 13, with no difference between the CSA with substance misuse group (_=2.33, sd=2.54, median=1.5) and the CSA only group (_=2.39, sd=2.32, median=2).

CSA group work: Over half (59%) of both CSA counselling groups had previously attended group therapy focusing on CSA. The number of groups previously attended ranged from one to four, with a median of one for both groups.

Psychiatric treatment: Some women sought help from psychiatrists specifically because of the CSA. Other women initially sought psychiatric help for some other reason and the CSA issues unfolded during the course of treatment. Psychiatric treatment for CSA had been previously received by 29% of the CSA with substance misuse group and 24% of the CSA only group. The number of episodes of psychiatric treatment ranged from one to five, with a median of one.

Rape Crisis telephone counselling: The Rape Crisis Centre offers 24 hour telephone counselling and referral advice. The service is primarily set up to deal with adult sexual abuse.

Nevertheless, among women who had previously sought help for CSA, the Rape Crisis phone service was used by 29% of the CSA with substance misuse group and 34% of the CSA only group. Use of the Rape Crisis line was sometimes prompted by the lack of access to specialist CSA services. For instance, Dympna House only has the resources to operate a telephone service from 2-5pm on weekdays. Some women emphasised the need for telephone counselling outside working hours:

> *I've had periods in which I've been really having bad times like thinking suicide and, you know, you only can phone them during the week days and things like that.* [CSA only]

Drug and alcohol treatment programs*:* Regardless of whether or not they had previously sought help for CSA, previous experiences of drug and alcohol treatment programs among CSA counselling groups were rare. Only two women in the CSA with substance misuse group had ever sought help for their substance misuse. This was partially influenced by the study criteria excluding women who had been in drug and alcohol treatment in the 12 months prior to the interview. Of the 21 women in the CSA only group who had experienced past problems with substance misuse, four had attended drug and alcohol treatment programs.

Other types of help

Regardless of whether or not they had previously sought help for their current presenting problem, all women were asked about other types of counselling or treatment programs they had attended. More women in the CSA counselling groups had sought help in the past for psychological or social problems other than substance misuse or CSA, compared with the drug and alcohol treatment groups. Seventy-three percent of women in the CSA with substance misuse group had tried a median of two different types of services. The CSA only group had more experience with 90% of women having tried a median of three different types of services.

By contrast, 56% of the drug and alcohol with CSA group and 46% of the drug and alcohol only group had tried a median of one type of service. The difference between the drug and alcohol with CSA and the CSA with substance misuse groups was significant ($U=481.0$, $p=.005$).

Psychiatric and general outpatient counselling services (including psychologists and other mental health professionals) were the most commonly sought services for all groups. Compared with other groups (38-39%), a greater percentage of the drug and alcohol with CSA group (54%) had sought psychiatric help. This relates to that group's greater risk of being hospitalised in a psychiatric unit, usually because of overdose. Outpatient visits to a psychiatrist were sometimes reported as a follow-up to such hospitalisation. Although the differences between the drug and alcohol with CSA and drug and alcohol only groups in psychiatric counselling were not significant, the trend was consistent with that reported by Golding et al. (1988) in their community study. In contrast there were no group differences for general outpatient counselling, with rates of attendance around 50% .

Twenty-four percent of the CSA only group had received school counselling or visited a psychiatrist during their childhood. This was also the case for 15% of the drug and alcohol with CSA group. In contrast, only 9% of the drug and alcohol only group and 5% of the CSA with

substance misuse group had received childhood mental health intervention.
More women in the CSA with substance misuse group (30%) had sought help from general practitioners, compared with the drug and alcohol with CSA group (7%). This result seems a little surprising since more of the latter group misused prescription drugs. Other types of services experienced by women in the past included group therapy, adult sexual abuse counselling, relationship and family counselling, pastoral counselling, behavioural workshops, somatic therapy and rebirthing.

Self-help

There was a significant pattern of difference across the groups in the percentage of women who had participated in self-help groups. Given the wide accessibility of AA and NA and the cooperation between self-help groups and treatment programs, it is not surprising that a high percentage of the drug and alcohol with CSA (90%) and drug and alcohol only (78%) groups had attended a self-help meeting. Women attending Wisteria House drug and alcohol treatment unit had all attended Gamblers Anonymous (GA) in addition to AA and NA as part of the treatment program.

In contrast, only 30% of the CSA with substance misuse group and 58% of the CSA only group had attended self-help groups (χ^2=35.49, df=3, p=.000). The most common self-help groups attended by women from the CSA counselling groups were AA, Incest Survivors Anonymous (ISA) and Overeaters Anonymous (OA).

General trends

Women in the drug and alcohol treatment programs had typically sought help before this occasion, usually for detoxification. Many women had previously attended their current treatment agency. Women with a history of CSA were more likely than other women to have dropped out of drug and alcohol treatment before program completion. Women who were currently receiving CSA counselling also had a history of seeking help, typically from outpatient counsellors. Their style of help-seeking was more investigative than the drug and alcohol treatment clients, partly because of the difficulty of finding people with specialist skills. CSA survivors also sought help from psychiatrists, often initially for psychological distress. Women in the drug and alcohol with CSA group were particularly likely to have sought psychiatric help for a reason other than CSA.

4. 3 A MODEL OF HELP-SEEKING

Saunder's (1993) four-step model of help-seeking was chosen from the literature because it provided a useful structure for understanding the factors identified by women as catalysts and barriers to help-seeking. Although the four steps will be explored separately below, it can be seen from the data that they are neither mutually exclusive nor linearly progressive. The statistics on the number of programs in which women have participated demonstrate that women move in and out of treatment at different stages in their lives. During these stages, they have varying degrees of problem recognition and ambivalence about the potential helpfulness of treatment or therapy.

The following content analysis was developed from the transcripts of women from all four groups to initially discern commonalities and differences in patterns of help-seeking for substance misuse and CSA. Prominent themes were identified and their validity tested by specifically comparing the two groups who had both current substance misuse and a history of CSA. The aim was to account for factors leading to the different choices these women made between drug and alcohol treatment, CSA counselling or groups, or not seeking help at all. Although the analysis centres on the qualitative interviews, reports of group statistics refer to the whole sample.

STEP 1: PROBLEM RECOGNITION

The women's experiences of help-seeking were consistent with the research findings that problem recognition is the most difficult step to overcome (Saunders 1993). Our data revealed that women were aware of their own distress or instability but lacked the language or discourse to account for it. Counselling and treatment services seemed to offer a rational explanation for experiences that had felt out of control:

> *I just saw it on tele. And he described the features of depression and I didn't realise that I was — I knew I was unhappy — but I didn't realise I was suffering from anything. But what he said fitted into everything that I was feeling and doing.* [CSA only]

> *. . . the fact that they have identified me. You know, its wonderful to know that I'm just your average alcoholic. You know, there's nothing — they've worked out the problem and they've got the solution. And its just up to me to work on it. That was a relief to me.* [Drug and alcohol only]

This naming process may be particularly hampered in the case of substance misuse or CSA because of the social taboos associated with these problems. Women often had felt isolated and unable to speak to others about their experiences. They lacked the words to name, and make sense of their distress.

Naming the substance misuse

Women with alcohol problems often found it difficult to acknowledge the problematic side of their alcohol use because others around them were drinking as much as they were. They described a culture of drinking in their families or communities:

> *You're bought up with a drinking family. You're friends are all drinkers. My ex-husband was a drinker. [Current husband] was a drinker. My kids drink. We're all in that environment. And so if you've got a weakness there . . .* [Drug and alcohol only]

> *'Cos I didn't think I was an alcoholic. Everybody else was drinking. And it didn't occur to me that . . . I mean I wasn't drinking anymore than anyone else but it was, it wasn't destroying them and it was, but it was me.* [Drug and alcohol only]

This sometimes led to subtle social pressures to continue using the alcohol even though it was causing problems:

> *I've got to move away from Mum and Dad. Otherwise I'm just going to get back into the drinking habit again because they do it ALL the time, you know. Its sort of life with my family . . . "Well how can you be an alcoholic if I drink more than you?" [Laughing].* [Drug and alcohol with CSA]

Typically, women spoke about the substance misuse as only part of the problem. Even women without a CSA history thought that the substance misuse was closely connected to emotional distress:

> *And it wasn't just . . . I mean, not the drinking part. You know, things that I've been going through — harbouring this guilt, this shame, this grief — and these common traits of an alcoholic. I didn't recognise that fact* [Drug and alcohol only]

> *You need balance of the physical, spiritual, emotional and mental, in order to really function properly as a person, I think. And need to be aware that these things need just as much love and care as you, as you do need to take care of the addiction problem.* [Drug and alcohol only]

Naming the CSA

Half of the women in the CSA counselling groups said that they had help for symptoms of psychological distress. The most common symptoms were feelings of unhappiness or depression, anxiety and desperation. Usually, the women had responded to signs of distress without any certainty about the relative impact of the CSA:

> *I always felt that there wasn't something right. But I didn't really know where to go. And I couldn't isolate it to that. It was, it sort of blended in with my father dieing and the fairly chaotic lifestyle we had. So I couldn't really isolate it.* [CSA only]
> *Well, I'd been blocking it out for such a long time and I knew that there was a reason why I was behaving the way I had been behaving. I'd been a very*

promiscuous person for some years, at that stage, and never really fully understood why . . . But I knew that it wasn't making me feel good. [CSA only]

The majority of women in all three CSA groups had experienced unwanted memory flashbacks of the abuse at some time in their lives (83%). A greater percentage of the CSA only group (84%) had experienced a memory block regarding some of the details of the abuse, compared with around half of the CSA with substance misuse group (50%) and the drug and alcohol with CSA group (59%). This was a rather gross measure of memory loss, however, since it not only included those women who had recalled the abuse after having no memory at all, but also those who had forgotten circumstantial details, such as who else was there or the events immediately preceding or following the abuse.

Of the 37 women who gave qualitative interviews, 11 (30%) had recalled an abusive experience after having no previous memory. Reported triggers to recall included therapy (n=6), seeing something with incidental resemblance (n=2), meeting someone who had also been abused (n=1), feeling very relaxed after meditation (n=1), and the death of the abuser (n=1). Recollection of lost memories of the abuse were typically associated with mixed feelings of shock and relief. The memories made sense of chaotic and frightening emotions or behaviours:

I mean, you have that desire of saying "I'm really crazy and this is not true" but as the time goes and you get more convinced and things start to fit together. In some ways, that's painful too, you know, because it means there is no way to escape . . . its funny because at the same time, its a release because you find a place where you feel like your life has a sense after all. [CSA only]

I went into shock. And also, it was a mixture of shock and relief, because it was, I was really shocked to think that that could have happened and I was relieved because it just made sense of so many things. [CSA only]

Even women who had always had some memory of the abuse reported that they had re-discovered its significance while trying to solve other problems:

. . . something finally happened because I went to our bookshop because I was looking for a book of food addictions and things like that. And exactly next to the shelf, there was the books about incest. So I started looking. I mean, and I felt something, you know, like "Oh God, there is something here". I knew about my abuse but I would never call it incest anyway so I just started thinking where I can get some information about this. [CSA only]

I just didn't know what my problem was, considering there seemed to be so many. And he said, I walked in and went flick, flick, flick, flick, I had all these cards and we just had to work out which one seemed to be the crux of it. [CSA with substance misuse]

Women in the drug and alcohol with CSA group often minimised the CSA in their attributions about its long-term impact. Some women felt that it was just one trauma among many negative experiences. Some compared themselves favourably with other clients who had been more

severely abused. Discourses about heterosexuality, such as the equivocation of sex and coitus also tended to conceal the abusive nature of some CSA experiences:

> *. . . it wasn't sexual intercourse and I didn't think it was anything to worry about. And he was our friend, you know. And, yeah, I just blocked it out.*
> [Drug and alcohol with CSA]

The taboo nature of CSA means that such early formulations of the experience remained unchallenged. The child is isolated and unable to articulate or process the trauma. She tries to forget it happened. This obstruction to the processing of the trauma was also relevant for incestuous experiences where the CSA has been defined by the abuser within the isolated context of the family:

> *I never addressed any of this, I never . . . I just thought it was extremely normal, my family life. And now, I'm startin' to believe that its not normal for a stepfather to start touching up his stepdaughter. And even though it might be common, doesn't mean its normal. And I'm startin' to realise why I act in certain ways and why I need male approval.* [Drug and alcohol with CSA]

> *Yeah, I mean, basically she was my mother. I mean, she would tell me what to and what not to do. So if she was telling me to do it or not telling me actually but if she was doing it, I felt that it should be right, you know. I hadn't any other way to compare . . .* [CSA only]

A frequently identified benefit of therapy was its facilitation of the development of new discourses that enable the client to name the abusive nature of CSA and thereby make sense of the experience and its after-effects. For example, one woman was particularly traumatised by exposure to her father's pornography and exhibitionism. She had been searching for a way to define the `essence' of her experience, coining the term `mental rape'. She derived some relief from youth services when they helped her to further define the problem:

> *And for some reason, I felt really ashamed of what I'd done. And they just said oh it was a form of sexual harassment. So I thought, oh okay, two magical words and that was it. You know, I thought, sexual harassment. And then someone said sexual suggestion. So I thought, oh well, okay, fine.* [CSA only]

Pathways to problem recognition

The women described four pathways to problem recognition. These were (1) a frustrating sense of inertia, (2) an escalation of substance misuse leading to loss of control over important parts of life, (3) a break-down of previously effective methods of coping, and/or (4) a crisis or problem in the women's relationships.

Inertia

Women with substance misuse sometimes reached a turning point where they were just tired of being drug-dependent or doing sex-work. This was a particularly prominent theme for the drug

and alcohol only group, 32% of whom said that they had sought help because they wanted to change their lifestyle:

> *Hanging out too many times. Being on the street, I s'pose. Not getting anywhere . . . Oh, never had any money. I never had anythink.* [Drug and alcohol only]

> *I'd wake up in the morning with the shakes and I'd have to have a drink to stop the shakes and that one drink would set off the compulsion. Then I'd drink all day. And I just wanted to get off the merry-go-round.* [Drug and alcohol only]

Women without substance misuse sometimes expressed a similar sentiment. They found themselves locked into a pattern of self-defeating behaviour:

> *. . . things weren't going well. I had a really sort of disrupted, sort of . . . I'd do a year of study and then I'd leave and . . . Like I did a year of psychology. Then I left. Then I did about 20 million jobs. Then I did a year of naturopathy. I just couldn't, I didn't have, I can't . . . I always had difficulty concentrating and all that sort of stuff.* [CSA only]

> *I felt that I would work so hard to get somewhere and then it would be like self-sabotaging and just bring myself back down again. And no matter how hard I tried, I couldn't get, I couldn't get sort of something to just find a smooth run.*

Loss of control

For many women, increasingly severe substance dependence meant a progressive erosion of their ability to control their lives. They eventually had reached a crisis in which the essentials of life were threatened:

> *I was losing my job. I didn't know anything about NA or anything. I was losing my job . . . Everyone knew I was on heroin even though I didn't believe they did. And then it got to the final stage where I had to work as a prostitute at night and work there during the day and the only part of normality in my life was that day job. I was scared of losing it.* [Drug and alcohol with CSA]

> *For alcohol? Well I was drinking a bottle a scotch a day, plus port. Blacking out. I was suicidal. And I was gettin worse and worse. And I went to the doctor and my liver was enlarged, my cholesterol was up, my blood pressure was high.*

Breakdown of coping methods

Whereas some women has recognised their problem because of a progressive loss of control in which their lifestyle was threatened, others experienced a breakdown in the effectiveness of their usual coping strategies and became depressed or anxious. For women with substance misuse, the breakdown was typically associated with a relapse or fear of relapse after a period of abstinence:

I had had some sobriety through AA and I was really starting to enjoy life and then I had a bust. And I had several busts since then and they were forming a pattern. Every time I'd have the . . . the bust only lasted one day, each time. About six busts I had after nine months of sobriety. [Drug and alcohol only]

Well I was, I had given up smoking and drinking for about two months and I'd done it a lot of times before. And I was just feeling really miserable and I just felt like I wanted to start smoking again. I felt like I wanted to ring up this guy and get him to bring something over for me. [Drug and alcohol with CSA]

A similar breakdown of coping was commonly mentioned by women in the CSA counselling groups, where they could no longer fend off anxiety or depression related to the abuse:

I mean, maybe through overworking or whatever, but I felt in control. But at that point, I didn't feel that I could control things anymore. I mean, nothing seems to be enough at that stage. All the old things didn't work. [CSA only]

Just the way I was feeling. I dunno. I was crying all the time. I didn't wanna get out of bed to go to work. You know, just feeling really, really depressed. And I thought, "I've gotta do something. I can't snap myself out of this". [CSA only]

This type of breakdown was sometimes precipitated by a change in circumstances. For example, one woman began to experience her problems just after migrating to Australia:

You have all this break in your life — I mean, everything just fell down and you have to start from nothing. And that means that your emotional life — in my case, was the abuse, you know, I had the abuse there, unresolved and it started exploding. So the immigration itself was a process in which I had to find what was wrong with me. [CSA only]

Relationships

The most powerful social influences on problem recognition were the women's relationships with their children and their sexual partners. Feelings of protectiveness towards their children often prompted them to re-assess their own unsafe behaviour:

[My son]. I knew I was about to lash at him. And I could see myself going down hill. And I said "I've had enough. I've got to stop". [Drug and alcohol with CSA]

. . . about 12 months ago, I realised that there was no turning back anymore. I had to do something about it. 'Cos otherwise I was gonna destroy my life and I was gonna destroy my own son's life. [CSA only]

I started fittin' and seizures from Serepax. And that really scared me. I was alone with me kids. And me daughter — she's nine, she's been through a lot — and I just didn't want her to see things like that happening around her.

This concern may have been magnified by women's fears about repeating abusive family patterns. Several women stressed the importance of "breaking the cycle":

> *. . . I owe him at least enough to try and deal with my problems so I don't put my hangups onto him like my parents did to me.* [CSA only]

Women also experienced problems with their adult relationships. Women with CSA backgrounds often began to confront the CSA for the first time because of its effects on their sexual enjoyment or its threat to valued relationships with sexual partners. For example, one woman had experienced unsafe feelings and an aversion to sex as soon as any of her relationships had become close. Her usual response was to break off the relationship:

> *I find it very hard to believe in people that are genuine and caring and loving and, I have great difficulty actually thinking that's real. I'm always waiting for the sting in the tail. I have real difficulty feelin' safe with people.* [CSA only]

She began to confront this problem after starting a new relationship:

> *This time I'm with a partner whose very . . . I have a lot of trust with and who I'm able to work through things with and he's also committed to working on his own issues. And I reached that stage in the relationship where I stopped wanting to have sex and I knew that this was an old pattern of mine, and I decided that this time, I would stay with him and see what comes out of staying.* [CSA only]

Another problem of safety in relationships was described by women who had experienced unwanted attractions to abusive partners:

> *I end up seeming to pick men that are abusive of me. Whether I'm actually looking for that father figure or not, I'm not quite sure. And I don't know, I just seem to be meeting all the wrong men all the time, so I've discovered — only in the past few months — my inner self is virtually telling me that I need to get counselling to get rid of this, oh what would you call it — this, this thing that I'm carrying with me that I can never forget.* [CSA with substance misuse]

Group differences in prioritising

The two groups who both had current substance misuse and a history of CSA were quite different in the way that they had defined their problems. These differences may have been influenced by three factors arising from the design of this study. These were the levels of dependence in each group, the definition of substance misuse, and the range of treatment experiences.

The groups differences were related to levels of substance dependence in each group. Although the average levels of impaired control of alcohol were just as high for the CSA with substance misuse group (_=9.19, sd=3.29) as for the drug and alcohol with CSA group (_=10.33, sd=3.54), the severity of alcohol dependence was significantly different (t=3.74, df=9.38, p=.004). The

average SADQ-C was in the severe range for the drug and alcohol with CSA group (_=33.22, sd=15.71) but in the low-moderate range for the CSA with substance misuse group (_=12.81, sd=6.11). Similarly, levels of dependence on substances other than alcohol were significantly higher (t=2.05, df=52, p=.045) for the drug and alcohol with CSA group (_=10.24, sd=3.83) compared with the CSA with substance misuse group (_=7.86, sd=3.44).

The two groups were selected into the sample by different definitions of substance misuse. Women in the drug and alcohol with CSA group had necessarily recognised their substance misuse as a problem because they had chosen to seek treatment. The selection criteria for the CSA with substance misuse group was designed to match this by including women who were concerned or worried about their substance misuse. Due to recruitment difficulties, however, this criteria was later replaced with a behavioural definition of quantity and frequency of substance use.

The two groups also had a distinctively different pattern of drug use that is evident in the main problem drugs listed in Table 10. Women in the CSA with substance misuse group predominantly misused alcohol or marijuana whereas the drug and alcohol with CSA group were more likely to say they had a problem with heroin or other illicit substances.

Table 10: Main problems drugs reported by women in the drug and alcohol with CSA and CSA with substance misuse groups

	Drug & alcohol with CSA		CSA with substance misuse	
Main problem drug	N	%	N	%
Heroin and other opiates	20	40	—	—
Alcohol	11	22	16	53
Tranquillisers	6	12	2	7
Amphetamines or cocaine	11	22	—	—
Marijuana	2	4	11	37
LSD	—	—	1	3

The greater accessibility of alcohol and marijuana probably accounts for the significantly earlier use of main problem drug (t=2.55, df=78, p=.013) by the CSA with substance misuse group (_=14.1 years, sd=4.29), compared with the drug and alcohol only group (_=17.26 years, sd=5.9). There were no significant differences between the two groups in their ages of first alcohol use, intoxication, problem awareness or treatment entry.

Recruitment difficulties also contributed to a diversity in the history of help-seeking among women in the CSA with substance misuse group. Just under half (47%) of that group were not currently receiving therapy for CSA. In the qualitative sub-sample of that group, six of the ten

women were not currently receiving help and three had never received help for CSA.

Not surprisingly, those in drug and alcohol treatment saw the substance misuse as the main presenting problem. Loss of control through escalating dependence was a prominent pathway to recognising that the substance misuse was problematic. In contrast, women in the CSA with substance misuse group were less concerned about their substance misuse. Some women who were recruited via the behavioural criteria did not view their substance misuse as a problem:

> *I'd be unlikely to seek help for my drug use 'cos I've never really viewed it as something I haven't been able to control or something I'd have to seek help for.*

Women in the CSA with substance misuse group typically made a connection between the CSA and the substance misuse. The substance misuse was viewed as a symptom that could be brought under control if necessary. In contrast, the CSA was seen as a more entrenched problem, underlying the substance misuse and other behaviours:

> *The alcohol, I don't classify as a problem. I can . . . I can. I know I can. Its like my smoking. I can stop. If I want to. Its just that I don't want to. This thing that's going on with my father, I can't stop on my own. So.*
> [CSA with substance misuse]

> *. . . my problem stems from the, my childhood — that's what I have always thought.* [CSA with substance misuse]

> *. . . the alcohol problem, as I call it, for me is wound up with those sexual assault issues. So I can't go and legitimately seek help from a drug and alcohol counsellor whose aim is to help me kick this physical thing that I have. Its more a mental thing that I feel and I do think that I could probably benefit from some sort of counselling that encompasses both of them but at the moment, I'm still floundering, looking for what's right.* [CSA with substance misuse]

The most prominent pathways to problem recognition for women in this group were inertia and the breakdown of usual coping methods. In particular, women in this group described recent experiences of intrusive moods or behaviours that they related to the CSA:

> *Well, I've never really dug it up much at all. Its just stayed down there, but . . . I got mixed up with this fellow and I've very sorry that I did. And since that, and thinking about it since then, that's brought up it all and why am I doing this?*
> [CSA with substance misuse]
> *I knew that I had a lot of stuff that was sort of upsetting me and I was having nightmares and . . . I knew that it was all related somehow.*
> [CSA with substance misuse]

These intrusive experiences were sometimes disinhibited by substance use:

> *I suppose its just recently dawning on me that a lot of things that I've never faced — possibly is the word to use there — that I can now see that when I drink and I meet up with the wrong person, somebody — usually male — that antagonises*

me, I don't even hesitate. This anger from deep down — I think I'd describe it as being a rage. When I lose it in that sort of circumstance, I really let that person know. It doesn't matter where I am or whose around or . . . So that's how I sort of sat back and thought "Right. You've got a problem, there".

[CSA with substance misuse]

Compared with the drug and alcohol with CSA group, women in the CSA with substance misuse group seemed to have spent more time processing the CSA. This is evident in the patterns of disclosure for each group. Although there were no significant differences between the two groups in the mean age of first disclosure or the outcome of childhood disclosure, qualitative analysis showed a theme of validating adult disclosures among the CSA with substance misuse group.

Validation through adult disclosure was not easy because partners, family members and friends were ambivalent, shocked, and controlling in their response. On the other hand, after disclosure, they could also be accommodating about sexual difficulties, more protective of the woman, and some even disclosed their own experiences of abuse. For the CSA with substance misuse group, contact with other women who had been sexually abused by the same abuser was a source of further validation.

In contrast, adult disclosure of CSA outside therapy was less prominent and more negative in the accounts of women from the drug and alcohol with CSA group. Negative experiences of adult disclosure included rejection and demands for no further disclosure or discussion about the abuse. The most common experiences in this group, however, was minimal disclosure during adulthood. Even in treatment, CSA disclosure was limited. Statistics for the whole group showed that 12% had never disclosed about the high-impact CSA prior to the interview, compared with only one person in the CSA with substance misuse group:

Whereas in all the rehabs I went to, nobody really ever asked me anythink like that. So I never talked about stuff like that 'cos I didn't really want to.

[Drug and alcohol with CSA]

The qualitative analysis indicated that women in the CSA with substance misuse group were focused on the CSA as the main problem from which the substance misuse stemmed. Women in the drug and alcohol with CSA group focussed on the loss of control over their lifestyle because of their substance misuse and had spent less time processing the CSA as a traumatic stressor.

STEP 2: DECIDING THAT THERAPY OR TREATMENT MIGHT HELP

There were three factors that influenced women's decisions about whether therapy or treatment might be helpful. One factor that was relevant for women starting treatment or attending counselling for the first time was their lack of awareness about available services. This was more prominent for women seeking drug and alcohol treatment than for women seeking CSA counselling because the latter group were informed about the availability of services by telephone counsellors, or received therapy for the CSA in the process of general outpatient counselling.

The second factor influencing how women viewed therapy or treatment was their readiness to tolerate the discomfort involved in changing, the embarrassment of asking for help and the potentially overwhelming emotions stirred up in therapy. Women from all groups indicated that their state of readiness to change their substance misuse or deal with the CSA was the key to whether or not they viewed help-seeking as potentially beneficial.

Third, women from the CSA substance misuse group highlighted the limitations of choice available in drug and alcohol treatment services. With low levels of dependence, some of these women were willing candidates for controlled drinking programs and frustrated by the lack of choice in services.

Lack of awareness

Lack of awareness about the available services is an important barrier to seeking help for substance misuse. Some women struggled with the problem for some time before getting the information they needed:

> *I didn't know there was any help. Its not advertised or anything like that. I didn't know. Like, people'll say to me, "Oh you drink too much. You got a drinking problem". I says "Yes, I know that. Know for a long time". "Oh you should just stop" — just like that - "You just don't have another drink". I tried that but it made me very sick.* [Drug and alcohol with CSA]

In the absence of other information, women formed ideas about treatment or self-help based on stereotypes that did not fit their own situations:

> *I heard about [AA] but I thought it was only for old man, layin' in parks with their metho bottles. I didn't . . . "Oh no, it couldn't possibly be ME" [Laughs].*
>
> *But I always thought it was plac . . . there wasn't any help and the only places that were helpful, like, you know, I'd be allocated to a bed in a room of 20 women and they'd feed and clothe me and I just didn't, you know, I didn't, I wasn't a derelict on the street, you know, and I thought that's what it was for.* [Drug and alcohol with CSA]

Contact with others who had received help through self-help groups gave women an opportunity to seek information about the potential benefits of help-seeking:

At AA meetings, I'd heard people — expatients of Wisteria House — speaking and I thought well they all seem to — or the great majority of them seem to — just come along in leaps and bounds. Heard a lot of good things about the counsellors.

Readiness to seek help for dependence

Not everyone, however, was able to benefit from these contacts, every time. The women who benefited were already focused on the need for change and were looking to others for an example of how this might be achieved. For this to happen, they had to have reached a stage of readiness where they wanted to hear the message. Without this motivated state of mind, treatment seemed to offer no benefits:

I sort of, I appreciated the information and that they were giving me but because I didn't really do it anything much myself, well it wasn't helpful. [Drug and alcohol only]

Women's accounts about readiness are consistent with the stage of precontemplation described by Prochorska and DiClemente (1986). In fact women in their early stages of problem recognition tended to opt for isolation in preference to seeking help. In hindsight, women in the drug and alcohol treatment programs described help-seeking as a threat to independence. This theme was similar to men's reluctance to admit loss of control in the study by Thom (1986). Its prominence in this study challenges the idea that it is solely linked to masculine stereotypes.

You've worked it out yaself. You don't tell nobody you've got a problem. [Drug and alcohol with CSA]

Stubborn would be the word, maybe. Or independent. I'm not too sure but when the mood swings come, they come. And I can't get on the phone and say "Help me!" I'm just not like that. [Drug and alcohol with CSA]

The old, sort of attitude that I can do it by myself. That I'd be abnormal to go out there and seek professional help. That I should learn to take care of myself. Its very ingrained in your upbringing too. To sort of, look after your own, look after your own problems. [Drug and alcohol only]

These women decided that treatment might be helpful when they realised the extent of their own dependence on the substance and their inability to manage it alone:

And looking back and seeing that each time I tried to set it up for myself and do it myself, I'd fail. And so it came to the stage where life was too unmanageable. This is a myth. I really do need help or I'm going to end up killing myself accidentally or something. [Drug and alcohol only]

Its a very lonely existence, willpower. 'Cos you're determined not to have a drink, and in front of everybody else, and it gets harder — you don't — and its harder and harder and harder and finally you break. [Drug and alcohol only]

Typically they had anticipated that treatment would provide a safe haven from the temptations of their substance using culture and education about how to manage dependence. A decision that treatment might help was sometimes described as a new glimmer of hope:

> *There has to be some organisation somewhere that can show me, you know, give me the weapons to deal with this.* [Drug and alcohol only]

> *And [pause] and then it came to me one day, that as a child, I'd had visions of a beautiful life. 'Cos that's sort of like, I remembered that once upon a time, I'd had dreams and stuff. And somehow in all of this madness, I got hope.* [Drug and alcohol with CSA]

Lack of choice

Women in the CSA with substance misuse group generally had not defined drug and alcohol treatment programs as potentially helpful. Typically, those who did see their substance misuse as problematic or in need of control were not attracted to the disease model of substance misuse or the goal of abstinence. Since they linked their substance misuse to underlying emotional problems, they felt that addressing these underlying issues would enable them to moderate their substance use to less risky levels:

> *But I'm a bit of a problem maker of me own accord 'cos I don't like 12 steps programs. I don't really think I should have to give up alcohol completely. I'd just like to develop a talent for not depending on it when I'm feelin' a bit low.* [CSA with substance misuse]

> *I think the trouble is with the 12 step stuff is that they believe and they think that for their recovery to be successful, they believe that abstinence is the only way. They believe that the 12 steps are the only way. That nothing else could work. And that the mere notion that something else could work is threatening to the recovery and I was actually into the idea that if I worked on this stuff, I wouldn't need to get blotto every night [laughs]. If I actually looked at the issues of, you know, my life. And its also, I think its silly if you've been using one coping method for many years to just take it away, with no support.* [CSA with substance misuse]

Readiness to seek help for CSA

A common barrier to seeking CSA counselling was the unpleasantness of reviving memories and emotions associated with the original trauma. Women in the drug and alcohol with CSA group had rarely considered seeking help for the CSA prior to being offered help in their current drug and alcohol treatment program. Even when the opportunity arose, women sometimes felt unready to disclose about CSA:

> *Maybe if they just gave you time to settle in first. On the first day. 'Cos I came in the afternoon. And, like, I waited for her and next minute everything hit me all at once. All these questions, and I just went "no, no, no" 'cos I wanted to*

hurry up and get it over and done with so I could just go to bed 'cos I was that tired, you know. [Drug and alcohol with CSA]

Well, I didn't — with the psychiatrist — I didn't feel like we were getting anywhere, like we were just getting in there and just talking about basic things. I guess I wasn't prepared to let her in on a lot of things. [Drug and alcohol with CSA]

Herman's (1992) assertion that premature exploration without sufficient attention to the establishment of emotional safety can be counterproductive is borne out in this study:

Thats what scared me, too. 'Cos it was a full-on, you know? All the details, all the — straight out. No. You've gotta do it slowly and its gotta come out from yaself. Don't push it out. 'Cos the more you push it out, the more you press it down. You only push out the things that you wanna hear. And all the other stuff, you push that down further. [Drug and alcohol with CSA]

Even women who had sought help for CSA reported ambivalence about the helpfulness of therapy:

It was just [pause] it was really DEEP stuff. You know. And he said "Come back next week", well I haven't been back. And I find I do that. And I just don't go back. I avoid it. Its traumatic. [CSA with substance misuse]

I was very naive about what would actually happen. If I had 've known then what it would be like, I'm not sure I would 've embarked on it. [Laughs] [CSA with substance misuse]

This ambivalence typically arose from the threat of being overwhelmed by powerful emotions associated with the trauma:

It just overwhelms me. There's something there that terrifies the life out of me. I don't, I don't know. I mean, its probably nothing. But I can't, I get so sad and I get so upset. [CSA with substance misuse]

. . . its like I can go out into the world and everyone thinks "My gosh, she's looking fantastic. You know, on top of the world!" You know, you can present a very happy facade. But yet I knew as soon as I walked into that room, I would crumble. I just had no emotional strength whatsoever and I'd just be a basket case within two minutes! "I don't know what's wrong with me!" and I'd be crying again. [CSA with substance misuse]

And just because I was with uni, I just thought no not at the moment, I won't [seek help] *— it'll just take over me, consume me — and I won't get through uni.* [CSA only]

STEP 3: DECIDING TO SEEK HELP

Pathways to the decision

There were three pathways by which women decided to seek help. They made the decision 1) in the process of searching for an answer to their problem; 2) in a state of crisis; or 3) as part of a pragmatic plan.

Searching for an answer

A persistent, search for the source of the problem was a common pathway into CSA counselling. Typically `searchers' received help from a variety of services for a diversity of symptoms before seeking help specifically for the CSA. For example, one woman initially sought help for postnatal depression. She then received help from a variety of services available to assist mothers in the care of their infants. When the depression persisted, she was prescribed anti-depressant medication by a psychiatrist. With repeated visits, she developed trust in the psychiatrist, began to explore family issues and eventually disclosed about the CSA. For other women, identification of CSA as the primary problem meant a further search for the "right" person:

> *So I s'pose it was a combination of having worked out a number of major core problems in my life before I got to the real thing. And then a complete dissatisfaction with the counselling services available.* [CSA only]

This searching theme was less prominent in women's decisions to seek help for substance misuse. The comorbidity of substance misuse with other symptoms of psychological distress such as anxiety or depression sometimes produced a search for priorities:

> *. . . here they're more aware of, you know, the alcohol and that's the main problem. And then — or could be the depression, I dunno, its sort of like a cycle, a circle, like once I get on, I can't get off so if I can control the alcohol, then I don't get as depressed.* [Drug and alcohol with CSA]

In a state of crisis

A prominent pathway into treatment for women in the drug and alcohol with CSA group was in response to a crisis. Crises typically involved some threat of physical harm, such as self-harm, domestic violence, rape or homelessness. For example, women sought help in response to life-threatening thoughts or behaviours:

> *It got to the stage where I started thinking "Well Mum'll get over it if I OD. And thats what scared me because I'd never really . . . I'd always thought about suicide from a really young age. But I never did it because I was worried about how it would affect my family. So I - and like, two weeks before I put myself in detox - it was "Well, they'll get over it". So thats what really . . . I was just in such despair.* [Drug and alcohol with CSA]
> *I want to get help because I nearly died. And I nearly died the week before. And*

I wanted to know why I keep taking 'em. [Drug and alcohol with CSA]

Part of a pragmatic plan

In contrast to the crisis-driven decision to seek help, some women described a more calm, pragmatic approach in which they identified a need and responded by seeking help:

> *I mean, when I thought that it was necessary, I went straight for it. I mean I, you know, if I've felt, you know, going round in circles, that was time to do something.* [CSA with substance misuse]

The pragmatic approach involved an evaluation of the options available and the development of a plan for the future.

> *I've just left it until about a month ago where I just had to - just about finished uni, only a couple a weeks to go - but I thought six weeks, I should hopefully be able to do the two, 'cos it just became such a strong thing I needed to deal with.*

> *I liked the fact that it was only four weeks, with the understanding that I would go onto then another rehab - more half-way house - which I do on Tuesday. Because I'm itching to get back into work now. I don't like sitting. I'm not the kind of person that can sit around and do nothing.* [Drug and alcohol only]

> *I thought, "Right, well if I'm going to go to uni, I'd better get myself straightened out". And that was what prompted my decision.* [CSA with substance misuse]

The pragmatic approach was also evident in decisions not to seek help by some women in the CSA with substance misuse group:

> *. . . but I think if I started to feel that my drug use was really out of control, I think I would go and get help the same, just the same as I would get help if I felt my life was getting out of control. I think I've got to the point, now where its a lot easier just to stop and face something — whatever it might be. Like that's something I've learnt to do.* [CSA with substance misuse]

> *I'm really sure that I can do it myself. And, well, I've stopped the alcohol now so that's one thing. So the drugs are next. So what I'd sort of said to myself was "I'll give it a go and see if I can do it". And I've given myself two years to try and do it. If I can't do it in the two year time, then I'm going to go to somebody.*

Social influences on decision-making

The factors that either delayed or prompted help-seeking after recognition of the problem and a decision that treatment or therapy could help were similar for all groups. The barriers and catalysts to making this decision were typically social influences. Among the whole sample, 22% of women cited social influences in their reasons for help-seeking.

Family priorities as barriers to help-seeking

Walker et al. (1992) found that women's decisions to seek help for substance misuse were strongly influenced by family priorities. This finding was supported in the current study and also applied to seeking help for CSA. For example, women sometimes put their own needs aside so that others in the family could get assistance:

> *. . . when I started working, I started paying my mother's psychiatric . . . And there was not enough money left for me. I mean, thats very expensive so I basically said that there was not money enough. I mean, I had money enough to pay for me but not for two. Also because my brother needed help and I thought that the best way was help my mother.* [CSA only]

> *. . . there were always a lot of problems in the family and I was the mediator, so I was thinking about them. From a very young age, since my father died, I took on a lot of responsibility plus my Mum was fairly emotional. So I sort of, I guess in some ways, I was probably looking after her without realising it. And then, I - my brother had a lot of problems with drugs and alcohol - and I was always the go-between with that.* [CSA only]

Decisions about seeking help were strongly influenced by the needs of children:

> *I really couldn't afford the time and, again, its always, I've had this huge fear of somebody uncovering things that I don't remember. And if that happened, who would look after my children? It was me and them.* [CSA with substance misuse]

> *. . . And I just can't put [daughter] through it . . . like I'll get on a dose* [of methadone] *and taper so I won't have to go through withdrawal. And also I didn't wanna lose my job. I wanted to keep working. So I couldn't have, you know, a month or two time out to dry out. And plus I still had to sort of be a mother and do things around here and I could'nt do it otherwise.* [Drug and alcohol with CSA]

One drug and alcohol treatment client with a history of CSA was uneasy about leaving her teenage daughter with her husband's parents while she sought residential treatment because on a previous separation, her daughter had been sexually abused at their house by her brother-in-law. She felt that the rest of the family had "swept it under the carpet, like it didn't happen".

Over half of the drug and alcohol clients had told their family about seeking help and received a mainly supportive reaction from relatives. This was the case for 63% of the drug and alcohol with CSA group and 54% of the drug and alcohol only group. Of these two groups combined,

20% had received an unsupportive or mixed reaction and 16% had not told their families. In contrast, only 24% of the CSA only group reported a mainly supportive reaction by family members and 54% had received either a negative or mixed reaction. A similar pattern, but less pronounced pattern was observed among help-seekers in the CSA with substance misuse group with 44% reporting supportive family reactions, 31% mixed or unsupportive and 25% unaware.

The quantitative pattern of results reflects the difficulties of CSA disclosure. For incest survivors, disclosure to family members about help-seeking was fraught with potential confrontations and fear of family reactions was sometimes a barrier to help-seeking:

> *Mum knows. I told her about three weeks ago. And she thought that was good. But she doesn't really want to get too much more involved with it, I think. And certainly no legal aspects. 'Cos I have mentioned that, that because I know he's still around, I think he should be brought into line, and she just totally freaks out at the idea.* [CSA only]

> *I decided I had to have counselling. But I thought, its like, its so difficult. I like to visit my mother. But my father's there at the same time. And I don't want to associate with him anymore. And the only, the only way I can dis-associate with him is to tell my mother what was going on . . . I think the fear of hurting my mother.* [CSA with substance misuse]

Even when the CSA occurred outside the family and family relations were congenial, parents and relatives sometimes found it hard to appreciate the changes that women were experiencing through counselling. There was a tendency to wish the problem away:

> *They only learned of it after I'd gone into counselling — that it occurred. So the whole thing freaked them out. But overall, yeah, they are glad that I have gone and gotten help. Even though, at the time I was being counselled, I . . . they thought I'd gone totally crazy. They didn't understand the healing process. They weren't able to understand why I couldn't work, I couldn't be normal for that time . . . All they wanted me to do was go back to work, put it behind me, get on with my life.*
>
> [CSA with substance misuse]

Partner's mixed feelings

Almost all CSA survivors had received support from their sexual partners when they decided to seek help. This was less so for the drug and alcohol treatment groups, particularly the drug and alcohol with CSA group (72%). Women who said that their partners had mixed feelings about their decision to seek help highlighted some important implications for clinical outcome. Regardless of the presenting problem, help-seeking can unsettle a close relationship because any major changes in the woman's lifestyle will require adjustment from her partner.

Consistent with other studies (Cronkite and Moos, 1984; Thom, 1986; Swift et al., submitted) 65% of drug and alcohol treatment clients with partners reported that their partners misused substances. In contrast, only 39% of women in the CSA with substance misuse group and none

of the women in the CSA only group reported that their partner's misused substances. There was a significant difference (χ^2=6.49, df=1, p=.011) between the drug and alcohol with CSA and CSA with substance misuse groups (OR=5.24; 95% CI= 1.41; 19.52).

The partner's substance misuse may be an important relapse trigger that needs to be addressed in treatment. For example, a woman attending an alcohol rehabilitation program expressed a kind of `catch-22' about her decision to change her drinking. Her drinking problems were threatening her marriage but she and her husband shared a lifestyle that included regular visits to the hotel together. Her husband was regretful that she could not drink with him without the danger of a relapse to compulsive drinking:

> *[Husband] said "You know, what I wanna do is go out and have a drink with ya" — 'cos we always, when we do that, we're always together. And he said "But ya can't stop and just have the couple a drinks" . . .* [Drug and alcohol with CSA]

Although her husband wanted the problems to stop, she was apprehensive about whether he would support her decision to be abstinent:

> *I mean, I can go in there and have a Clayton's, whatever or . . . and he can still have his beer. I'm not gonna, you know, deprive him of having a beer. And I think that HE should try and understand that do I also have to have a beer? or an alcohol, just because he's having one. Still enjoy each other's company or whatsever going on.* [Drug and alcohol with CSA]

Help-seeking for CSA issues also prompted important changes in lifestyle that petitioned partner adjustment. Typically, this included renegotiations around the women's new motivation to take time out for therapy and reflection, and their need to take more control over the sexual relationship:

> *It has affected a lot our relationship - in the sexual way, obviously — but also myself. I mean, I've been changing during the whole process and things like, for example, I take a lot of time for myself, sometimes. Especially if I had a hard week, I would write a lot. That means that we would basically be each one in different rooms and he needs that sense of, you know, being together.* [CSA only]

> *My husband and I have been celibate now for about 18 months. We're just starting to re-establish that although I'm still not sure whether that's something I can set limits on and so its very tentative.* [CSA only]

In some cases, partners disclosed that they too had experienced sexual abuse:

> *But we're still blundering. Still sort of get a bit freaked out. She does too, 'cos she's also a sexual abuse victim.* [CSA with substance misuse]

> *. . . after I started going to counselling, he also remembered experiences of having been sexually assaulted which neither of us were prepared for. So, of course, then it doubly affected our relationship.* [CSA with substance misuse]

Assistance in seeking help

Saunders (1993) found that the third step of help-seeking was achieved faster by those people who had talked with others about seeking help. This finding was supported by women's comments about the assistance they received from others at the time of help-seeking. For example, one woman sought help after her girlfriend witnessed her drug-related seizure. Her girlfriend acted promptly to seek information on her behalf:

> *And my girlfriend rang up and said "Look, there's help out there!" and I said "Well, is there?". And she said "Here's the number. Call it and go." And I called her, and I went. And thats how I got in here.* [Drug and alcohol with CSA]

Her friend's discovery not only brought her into contact with a treatment referral agency but also influenced her own readiness to seek help because it ended her isolation:

> *And its been a secret, 14, 15 years. And finally it came out. And I felt good about it coming out. She said "Do you need help?" And I thought, well I think I do, you know.* [Drug and alcohol with CSA]

This kind of problem sharing was particularly important for CSA survivors. Sometimes help-seeking was prompted after siblings compared their memories of abuse within the family:

> *Mainly because my sister was* [in the treatment program] *and told me how good it was. And gave me a little bit of, and also my sister had been giving me a little bit of insight into what had happened in our childhood . . . like talked to me a bit and I realised how fresh everything still was in my mind.*
> [Drug and alcohol with CSA]

> *Until about 18 months ago, my sister approached me and said that she'd had these shocking memories of being sexually abused. And I immediately said "Well, yes it was Dad. Don't you remember?" And she had no memory . . . And she started saying to me "Well, why haven't you been to see anybody about this?" and I started say . . . And I was saying "Well, why? Everything was alright" [Laughs] I was still trying to keep along with that thing that had, you know, kept life normal for me. But she helped me to see that I couldn't keep on with this particular facade and that I had to confront it. And I realised I had to go and get help to do that.* [CSA with subs

Social stigma

Consistent with reports from other studies (Thom, 1986; Cunningham et al., 1993; Copeland et al., 1993), this studies shows that social stigma is a barrier to help-seeking, even when the woman has decided that she needs help. This is illustrated by the example of one drug and alcohol client who had initially sought help for psychological and family problems. In the two years, she had received counselling, she had never mentioned her alcohol problems. She explained how the psychological problems could be viewed as a product of external

circumstances but the alcohol problems seemed to detract from her sense of adequacy as a person:

> *To seek help to me was a very demeaning — as far as my alcohol problem — I could seek help as far as psychological problems are concerned, you know, with my family and things like that because that was outside my sphere of influence. That wasn't — I mean, it was part of me — but it wasn't a defect. You know?* [Drug and alcohol with CSA]

There was considerable stigma attached to being `out of control':

> *You know, I always sort of have this wonderful front to the world that I'm very confident. I know what I'm doin'. I've got my life together. And I didn't want anybody to know that I hadn't.* [Drug and alcohol with CSA]

> *I can't believe this has happened to me in my life. I don't need that. I should be all organised and settled and that. You know, just a lot of things, I thought "No, I'll be right, I'll be right". You know . . . I really needed that help but I was on the outside, saying "Na, I don't need that". But inside I was screaming for it.* [Drug and alcohol with CSA]

The woman's own fears about stigma were reinforced by a taboo against speaking openly even to significant others:

> *. . . people knew the problem I had on the outside but wouldn't say anything about it. We wouldn't talk about it. You know. Even my Mum's, like, thinking that she knew I had a problem but because I wasn't doing it in front of her or anythink, she thought I had it under control.* [Drug and alcohol with CSA]

Not surprisingly, help-seeking for CSA appears to be similarly stigmatised. Women spoke about their own feelings of shame and their fears of disbelief or punishment from others:

> *Like they've found me out. They know that there's something wrong with me.* [Drug and alcohol with CSA]

> *. . . what's the point because nobody would really believe what my story is anyway.* [CSA only]

> *How I feel at the moment is the fear of backlash. The fear of being found out that I'm breaking the silence. You know, that I'm actually saying what I'm saying to you. The fear that, you know, that something terrible's gonna happen.* [CSA only]

Group differences in deciding to seek help

The most striking difference between the two groups with both current substance misuse and a history of CSA was in their pathways to seeking help. Crises that prompted help-seeking were more common and more potentially dangerous for the drug and alcohol with CSA group. In contrast, decisions about help-seeking were made by women in the CSA with substance misuse usually in a pragmatic way or as part of a search for the source of the problem.

Analysis of the social influences on help-seeking indicate different barriers depending on the presenting problem. The trends indicated that women with higher levels of substance dependence are more likely to have sexual partners who also misuse substances and slightly more likely to receive an unsupportive response from their partner about seeking help for substance misuse. Women seeking help for CSA, on the other hand, received support from partners but were less likely to tell their families about help-seeking and slightly more likely to report negative or mixed reactions.

STEP 4: MAKING CONTACT WITH SERVICES

There were a number of obstacles that women encountered once they had decided to seek help. The most commonly mentioned obstacles included factors that limited women's access to appropriate services, the reluctance of service providers to address the clients' concerns, and interruptions to the process of therapy.

Reliance on referral

Women seeking help because of either CSA or substance misuse relied heavily on referral agencies. Around half of all the women (53%) had been referred from one place to another or been offered aftercare services. Referral agencies included general practitioners, outpatient drug and alcohol counsellors, telephone counselling services and other counselling services. These statistics probably understated the most common referrals by telephone to CSA counselling and from GP's to drug and alcohol treatment. Referrals were considered helpful by 74% of the drug and alcohol with CSA group and the CSA only group. In contrast, only 56% of the CSA with substance misuse group had found referrals to be helpful.

Around half of the women had been screened for the alternative presenting problem. While receiving drug and alcohol treatment, 40% of those with CSA and 50% of those without had at some stage been asked whether they had a history of CSA. Similarly, while receiving CSA counselling, 48% of the CSA with substance misuse group and 50% of the CSA only group had been asked about their current substance use.

Views about the way these issues were handled tended to favour a medium intensity approach. Women in the drug and alcohol with CSA group described the most positive experiences as group discussions about CSA where there was no pressure to disclose and a facilitator who could contain the level of emotion that was aroused. The most negative experiences that women described included being pressured to disclose, even when they had no experience of CSA. Important features of these experiences are further discussed in the next chapter.

For women in CSA counselling, there was a similar pattern. The most positive experiences of discussing substance misuse allowed the woman to explore her own substance use without fear of a judgemental or dictatorial reaction. Women were interested in discussing their substance use but reserved the right to decide about their own future behaviour:

> *I think even when I was seeing her, I did occasionally shoot up. And I just never told her about it because she'd just be condescending. Judgemental.*
>
> [CSA with substance misuse]

> *I used to discuss it as an issue for myself, in amongst all my other issues and I'd tell her what sort of behaviour I was doing, you know, like "Oh God, I got pissed again last night. I'm really panicked. I can't live like this. My body won't take it", you know, whinge, moan, complain and she was pretty helpful in sort a suggesting other things I could do like instead a drinkin' two or three glasses of wine in a row, to alternate with water and stuff like that. She never sort a pushed don't drink at all but she always wanted me to at least acknowledge that*

it was becoming a problem. And I was glad a that 'cos I was a bit sort of in denial at the time so I appreciated her bein' able to mention it without attacking me.

[CSA with substance misuse]

Reluctance to address deeper concerns

One of the most difficult problems women faced when seeking help was the reluctance of service providers to address what the client saw as the underlying problem. The higher risk of suicidality among women in the drug and alcohol with CSA group increased their chances of contact with primary health care services. This offers an opportunity for brief intervention, not only because of substance misuse but also to identify any needs for specialist care. Unfortunately, women who were hospitalised because of overdose sometimes encountered a reluctance on the part of service providers to acknowledge the overdose as a symptom of emotional distress and this appeared to be related to stigma about substance misuse:

. . . anytime, you know if I've been taken to hospital or anything like that, you know, with overdose and they realise there was alcohol involved, there was never any sort of question. You know, it was just sort of "Oh you're not good enough. You're an idiot". There wasn't any sort of . . . Maybe they're just too busy. They just don't try and get underneath to find out what happened, what makes it.

[Drug and alcohol with CSA]

Some women had benefited from drug treatment during acute phases of depression or anxiety. Others believed that their problems had been aggravated because drug treatment was used in preference to screening and referral for therapy or treatment:

I'd been very sick, I s'pose, for years, you know. And every time I went to a doctor, they just prescribed me antidepressants. And you know, we won't look at the feelings, we won't look at what's going on for you, we just . . . And this just kept going on for years and years and years. [CSA only]

Nobody told me I was a drug addict until I had a problem with speed. And yet for 10 years I had a problem with prescription drugs. Since I was like 11 years old, I've been taking Valium and stuff. I was that age and they started prescribing things for me 'cos of my anxiety and my sleep problems.

[Drug and alcohol only]

I'd go back and say "Well they're not working". So he'd say "Oh well, we'll try Serepax". And obviously because I was drinking, naturally they weren't working, 'cos my depression was coming from the booze . . . [Drug and alcohol only]

Although GP's were a common source of referral to drug and alcohol treatment programs, some women had difficulty persuading medical practitioners that their alcohol problems warranted clinical attention. This observation raises the possibility that women with less severe symptoms of dependence and, possibly from more middle-class backgrounds, are less likely to receive intervention for substance misuse:

I went to doctors — I went to my husband's family doctor and I went to my mother's doctor. And I said "Look, I think I could be an alcoholic" and both of them asked me a series of questions and said "Oh no, I think you're just, you know, you've got to be a strong person. And, you know, just sort of chin up and off you go". Both of them. I was sitting there saying "I think I've got an alcoholic problem" , they're saying "No, no. Just get on with life".

[Drug and alcohol only]

All these doctors told me I wasn't alcoholic and I said "But I am alcoholic. I don't wanna drink like this." You know, I don't wanna have, I don't wanna do the things I do. I don't wanna have blackouts. I don't wanna get drunk.

[CSA with substance misuse]

I left hospital with a CASUAL suggestion I might like to try AA. But that was it . . . They fixed me up physically but gave me no weapons to deal with the outside world again and I didn't even know there were such things as rehab or detoxing.

[Drug and alcohol only]

Women seeking help because of CSA also encountered reluctance from general counsellors to acknowledge the CSA. After recalling memories of extrafamilial CSA, one woman disclosed to several counsellors before finding someone who believed her. Her history of adolescent substance misuse compounded the problem:

I said "Oh look, you know, there's something really weird but I was driving along the other day and I had this picture of a friend of a family's in my head and I nearly chucked. I had to stop, get out a the car and stop the panic attack that was building up. "Oh dear, drugs move in mysterious ways". "Yes, but I haven't had drugs for about a year. That's why I've been here". "Oh year, but they still have an effect for a while . . . " And like what crap!

[CSA with substance misuse]

She felt that counsellors have an obligation to empathise with the client's emotion, even if they doubt the validity of the memories:

Somebody needs to be there with me for two seconds, just to, like, acknowledge that the emotion is there — irrespective of whether everything else is rubbish — and then just letting me deal with that emotion and I'm sure everything else would fit in nicely afterwards. [CSA with substance misuse]

Financial hardship and limited access

Copeland et al. (1993) argued that intensive screening for CSA may be counterproductive if there are limited specialist services available for referral. A prominent theme voiced by women seeking CSA counselling was the frustration of limited access to government-funded services and financial hardship due to private counselling fees.

At the time of this study, Dympna House is the only specialist CSA service in NSW. Those women who had accessed this service emphasised its benefits, including a daytime hotline, ten-week groups and a network of counsellors. Other specialist services available included the Rape Crisis Centre hotline and counselling services, sexual assault units in major hospitals and specialist CSA groups facilitated by community health professionals. Nevertheless, the demand for such services appeared to outweigh the supply:

> *I had to wait a year to see somebody so even if they refer you, what can you do?* [CSA only]

> *I mean, if I get through its like "Oh God, I won the Lotto" or something because its so difficult.* [CSA only]

> *Because their hours do not suit my work, so I was having a lot of time off work and going there and then it just got a bit much and my supervisor was saying, you know "You've gotta stop this having this time off".* [CSA only]

Despite Medicare rebates for psychiatric services, women found that help-seeking outside government-funded agencies was financially difficult:

> *I haven't given up. Kept looking. There just isn't help. Or usually it costs money and I don't have the money.* [CSA only]

> *. . . originally my doctor recommended the psychiatrist because she said to me "Look, they're very expensive — psychologists. I recommend you see a psychiatrist and at least you can get the money back on Medicare". But my psychiatrist charged $172 a session. And it was about $102 back on Medicare and so I was paying out almost the same amount of money anywhere.* [CSA only]

> *Finance because I guess its pretty common knowledge that you get what you pay for and in the public system its pretty hard to wait on a waiting list . . .* [CSA with substance misuse]

Access to CSA counselling was hampered by barriers of culture and language for women from non-English speaking backgrounds and by geographical isolation for women in rural areas:

> *. . . being in a situation where you are not completely comfortable and you still have to be emotional. You know how difficult it is to get emotional in a language when you . . . if you start crying, then you've lost the words because you have to think about what are you going to say. I still had to think in that time. So I think that the counselling in Spanish helped me a lot, because you know, you get some support in your own language.* [CSA only]

. . . country areas are so isolated and there's no facilities, no counselling facilities, there's nothing. Children don't have any alternative. That's what happened to me. I couldn't talk to my family. I couldn't talk to ANYbody. So I had to keep it inside me for nearly 20 years. [CSA only]

Changing therapists

Another problem of access encountered by those seeking help because of CSA resulted from interruptions in the therapy process by time-limited therapy or changes in the therapist's circumstances. These interruptions to therapy disrupted the development of trust in the therapeutic relationship and women who chose to continue therapy elsewhere had to disclose to new people:

But the worse thing about it is you've just sta... it takes a long time for me as a survivor to trust someone. And I've just started to open more deeply and often they go. Like, because they're all through government things — that happened with my last one and [current counsellor]*'s told me, you know, there's a limit to how long she can see me.* [CSA only]

I'd seen her for 18 months. She was doing like a thesis or something, connecting child sexual abuse to [symptom] *and she took me on, on my doctor's request. And after that long, she decided I didn't have* [symptom] *so she really couldn't see me. She wanted to concentrate on that. And it was like [sigh] oh boy. And she said "Look I'm happy to refer you on" and that's like . . .*
[CSA with substance misuse]

Dreadful. Because you've got to start all over again. And you've got to talk about everything that's happened to you, all over again. [CSA only]

Well-managed transitions between therapists might compensate for necessary interruptions. At a certain stage in therapy, the woman might be able to use the transition to develop her own confidence:

I felt really scared. And then the next counsellor was very good. But when she finished up, I was a bit stronger, this time to go onto the next counsellor. Thinking about it now, I can see that I have got stronger along the way . . .
[CSA wtih substance misuse]

Group differences in making contact

Women's accounts of the obstacles they encountered when they sought help have different implications for the two groups with current substance misuse and a CSA history. Sixty percent of women in the drug and alcohol with CSA group had not been asked whether they had experienced CSA while receiving treatment for substance misuse. It was unusual for women in this group to have discussed their experiences of CSA with any health care providers prior to their current treatment program. This study supports other findings (Briere and Runtz, 1987; Rose, 1991; Herman, 1992; Pribor and Dinwiddie, 1992) that the silence arises from the

interaction between professional reluctance to explore deeper emotional issues and women's fears of disclosure. Voluntary disclosure in the context of all-female groups provided one solution to this problem.

For women in the CSA with substance misuse, the data highlighted two important implications for making contact with help providers. First, women with lower levels of dependence or fewer symptoms of substance misuse may have difficulty persuading health providers that they need intervention. This possibly is related to the earlier observation by women in this group that the choice of treatment for women with less severe dependence is limited. Second, help-seeking aimed specifically at the CSA was hampered by professional reluctance, therapy interruptions and limited services. This raises a question about the purpose of screening for CSA when the availability of affordable specialist services is limited.

4.4 WOMEN'S NEEDS IN TREATMENT

The treatments and therapies included in this sample ranged widely in their orientation. Many, but not all, of the drug and alcohol treatment programs strongly emphasised the disease model of dependence. A small number of drug and alcohol treatment programs included cognitive-behavioural techniques and one of these was aimed at moderate drinking goals. Therapies for CSA included cognitive-behavioural, psychodynamic, feminist and client-centred approaches.

It is not within the scope of this project to assess the differences between these approaches but, rather to look for common needs that women bring into treatment which should be addressed, regardless of treatment orientation. Themes emerging from the qualitative analysis of women's help-seeking and treatment experiences relate to both substance misuse and CSA. These included the needs for safety, acceptance, solidarity, education and empowerment.

Safety

In Herman's (1992) model of the stages of recovery from trauma, the central task of the first stage is the establishment of safety. The traumatised person needs a safe refuge. Ideally, the service provider should address dangers arising from external factors, such as abusive relationships, and dangers arising from the client's own self-destructive behaviour. Herman's recommendations about safety are supported by this analysis.

The data indicated that women sought a safe refuge from physical dangers that arose in the world outside treatment or counselling. There was also a strong need to have assistance in containing frightening emotions during the process of change and this has importance implications for relapse prevention since substance misuse was sometimes used as a way of containing frightening emotions. Despite these strong needs for safety, the data also revealed a disturbing theme of abuse by treatment staff and professionals.

Safety from "out there"

Fears for safety were particularly emphasised by women seeking help in response to a crisis. Some women first began to realise the extent of their problem when their own children were endangered because of their behaviours. Others decided to seek help because there was a danger to self, because of self-destructive behaviours including suicide or accidental overdose. Crises also included domestic violence and abusive sexual experiences. Ideally, service providers would offer an immediate protection from further harm as well as a caring environment in which the client could work towards future resolution of such safety issues.

For substance dependent women, residential drug and alcohol treatment programs were valued as safe havens from any threats to their resolutions to change:

> *You know, the discipline was really good and they really help you not to go out and drink. Some of the places, like they let you out for the weekends. Well I couldn't take that risk 'cos I knew I'd go to the pub. Whereas here your supervisor, or somebody all the time — one of the girls — you're always with*

someone to stop you, to go a different direction to the pub.
[Drug and alcohol with CSA]

And I thought it was good because they take a lot of your money and that was my main thing to get me out there with, if I had money. And if I didn't have money, there's no way I could go out there. [Drug and alcohol with CSA]

Clients also needed assistance to let go of this safety and progressively build the independence required to move back "out there":

I think the one fault is that I got too comfortable there. And was very big for me - the transition back to the wider society. [Drug and alcohol only]

CSA and other abusive experiences may predispose women to specific dangers that are not addressed by all residential programs. One woman recalled how previous attempts at help-seeking had been thwarted because of the pressure of heterosexual contact in mixed-sex programs:

I sound weak an' all that but I had to - obviously in [mix-sexed program] . . . I had to really concentrate so hard not to plug into someone else . . . Like, you know, feel comfortable with, flirt with because that makes me feel good . . .
[Drug and alcohol with CSA]

She had experienced a compulsive attraction to abusive relationships and was at the point of suicide when she sought help from the all-female program at Jarrah House. She welcomed the opportunity for time-out during which she could explore the meaning of heterosexual relationships and their interconnection with her low self-esteem and substance misuse:

I said the other day "I know I'd be usin' or I'd be dead if I w... if I couldn't come here". 'Cos I can't, I always get into relationships if I go to mixed rehab. My whole attitude towards myself has changed since I've been here and thats in three weeks. Its just changed so much. [Drug and alcohol with CSA]

Safety from "in here"

CSA survivors were often wary of seeking help because of the potentially overwhelming emotions that might be stirred in them. Women's reactions to therapists who were reluctant to acknowledge deeper issues indicated that they viewed therapy or treatment as an opportunity to explore emotions that they had previously felt unentitled or afraid to face:

You know, I don't have to be a super-Mum or a superwoman. I'm allowed to feel scared. I'm allowed to feel, you know, feel sad and I'm allowed to feel anything that I do feel and not to push it down. [Drug and alcohol with CSA]

An essential feature of safety stressed by Herman (1992) is the need for therapy to match the woman's state of readiness by appropriate referral and during counselling. The first stage of safety needs to be established before moving to the later stages of `remembrance and mourning', and `reconnection':

And he provides me a safe space to do that and to let things out very gradually, in as much as I had to get a tolerance for a lot of the memories that came forth. There is also for me a tolerance associated with getting comfortable with the emotions. And they're not only the bad ones but the good ones as well. [CSA only]

. . . she's skilful - she knows when its time to go into feelings and when its time to get into the adult and do something. [CSA only]

According to Herman (1992), the establishment of safety allows the client to move to the next stage of therapy where past events are reconstructed and their meaning is explored. From there, she will develop the confidence to reshape her lifestyle around this new meaning in the third stage of `reconnection'. Herman (1992) maintained that "A form of therapy that may be useful for a patient at one stage may be of little use or even harmful to the same patient at another stage" (p156).

There is some support for this idea in the current study. For example, one woman described her experience of referral to a CSA therapy group. Shortly before the referral, she had experienced intrusive emotional changes and had begun to re-examine old memories and recall new ones. She found herself out of step with the group:

. . . it was for people like, they already had some background in counselling because they [did not] *address the abuse itself but more the effects and how do you cope with it and the social side of the abuse . . . Because I mean, I was not prepared for considering the problems yet or things like that.* [CSA only]

The woman was still adjusting to her new awareness of the impact of CSA whereas the group were working on tasks more relevant for Herman's (1992) last stage of therapy, such as long-term management and rebuilding relationships. Group meetings stirred up a sense of helplessness in the face of overwhelming emotions:

. . . it could have been a mistake if I couldn't have had the counselling later. You know, because what I was going to do with all the stuff? Once I start with it? [CSA only]

Herman (1992) argued that "The patient and therapist together must learn to negotiate a safe passage between the twin dangers of constriction and intrusion". Without proper containment by the therapist, strong emotions were potentially dangerous:

What happened, he eventually got down to the root of the problem and that hurt a lot because I'd forgotten about it. Well, apparently he was very clever because he got it out of me. And that's when I started to try and commit suicide and that's when I ended up in hospital. Because of the memories of that, I was starting to have really bad nightmares and so forth. [Drug and alcohol with CSA]

Another important feature of safety in the process of counselling or treatment is the reassurance that the therapist or other group participants will not be harmed by the woman's expression of dangerous emotions such as anger:

. . . just started months of absolute rage and destruction and whatever in my therapy. I was just murderous and I got a lot out of my system at that stage. And she was frightened, she said, a couple of times. But I mean I had, from my therapy, got a lot of skills about how to vent that rage in a safe way. [CSA only]

The safety of bein' able to express how you feel. The environment — non-threatenin' environment, sort of things like that, you know, that you can express your feelings. I mean, you could possibly, you know, go crazy or whatever. You know, its a safe place. You're not sort of liable to hurt yourself or others. [Drug and alcohol with CSA]

Using substances to feel safe

As Young (1990) has suggested, emotional safety may be one of the prerequisite conditions for relapse prevention, particularly for CSA survivors. Women sometimes indicated that they specifically used drugs to cope with trauma-related emotions:

Oh, started drinking. Pretty heavily. That sort of . . . When you're dead drunk, you don't feel anything. [Drug and alcohol with CSA]

Insecurity. Fear. I had panic attacks when I was very young. Scared of the night. I'd bomb myself out to go to sleep. Generally scared of walking outside the front door. Insecurity. Not liking myself at all. And thats why I started. I just always had to be out of it. To deal with going to school and dealing with everyday life. [Drug and alcohol with CSA]

The defense was doubled-edged. Although substance misuse helped women to block out feelings of grief or shame, intoxication sometimes unlocked feelings of anger and rage:

I might have fears around going to sleep or things I don't wanna deal with, so I drink to squash 'em down. And it works for that, although I don't know what I'm like when I've been drinking. I become quite aggressive and not very pleasant to be around and that disturbs me because I believe that that's a problem as well.

[CSA with substance misuse]

I used to play up, I guess, I used to get drunk and abuse people because I couldn't do it before then. [CSA with substance misuse]

Unsafe clinical practices

Since women often seek help because of safety issues, it is particularly disturbing to hear reports

that women's safety has been threatened within treatment settings by exploitative counsellors or workers. Apart from sexual or romantic involvement, unethical practices included unloading the therapist's own problems onto the client, and public humiliation particularly in a mixed-sex group program:

> *Like, perhaps they thought you were flaunting yourself in front of the men, you'd be made to wear like big bag sort a dresses, you know, a dress that covers ya whole body and stuff. You have to walk round with toilet rolls around your neck and all this stuff. Like, its all based on humiliation and that.*
>
> [Drug and alcohol with CSA]

The most prominent and disturbing form of abuse by help-providers was the erotic or romantic involvement of therapist with client. One woman entered a drug and alcohol residential treatment program to escape from a counsellor who had pressured her to be romantically involved with him:

> *I mean, he's told me he's loved me and things like that. Its become very, very dysfunctional. And we're still sort of involved with each other. And its another reason why I thought "If I can separate from this and come in here . . ." 'cos I have tried to separate but he phones me up and tells me I have to come back and you know . . .* [Drug and alcohol with CSA]

Other women were sexually abused by therapists or drug and alcohol workers:

> *What* [drug and alcohol worker] *actually did was set me up with one of his mates, for his convenience.* [Drug and alcoh
>
> *I told the person what was inside me in terms of being in relationship with her. And then she took it. Well, she actually sexualised it, actually. And from being an erotic connection between . . . she sexualised it in what she suggested that I do.* [CSA only]

That this was most often reported by women with CSA histories, regardless of treatment service, suggests that unethical clinicians target clients who are vulnerable:

> *And of course, I was vulnerable at that stage. He'd helped me out in so far as getting me somewhere to live, you know which - I can see now, but at the time, you know, I couldn't see very clearly at all.* [Drug and alcohol with CSA]
>
> *But with my background, it was just sort of messin' me up in the head, you know. Which actually was causing me to drink more.* [Drug and alcohol with CSA]
>
> *And this is what people don't understand. They think that the patient can make a choice and the patient cannot make a choice. Can never make a choice. Can never make an informed choice.* [CSA only]

Therapist abuse has a significant impact on women's self-esteem, close relationships and their willingness to seek help again. The harm caused by therapist abuse was usually described as a betrayal of trust:

> *I've really had to go over, this last few months, to get over the extreme humiliation of it all — because I really felt that I did have a very clear idea of what I was looking for in therapy when I started the psychotherapy with her. To coming out totally confused. And in my emotional relationships with people around me — just totally cut off!* [CSA only]

> *So now, like, since then I, if another male doctor touched me, I'd just used to cringe — I wouldn't even let them. Wouldn't. Well, I mean I have a male doctor . . . but to touch me anywhere he wasn't supposed to touch me, then I'd just go to bezerk.*
>
> [Drug and alcohol with CSA]

> *Unfortunately, I came across a couple of unscrupulous people that used Christianity as a means of wooing myself and others like me into bed. And, of course, that really broke a lot of trust. 'Cos I knew that Christianity was somewhere where I could get help.* [CSA only]

Acceptance and honest self-appraisal

The second stage of recovery from trauma identified by Herman (1992) involves a process of reconstructing and mourning the past. At that stage, the therapist plays a validating role that allows the client to reflect on the realities of the past and understand their meaning. This stage in Herman's model was paralleled in the present study by a process that women referred to in terms of acceptance and honest self-appraisal.

This study has demonstrated in many ways that most women who participated in the interviews had experienced rejection and unjust treatment by others during their child and/or adult years. Social stigma associated with both CSA and substance misuse was also a prominent theme in decisions about help-seeking. Not surprisingly, the results have shown a low average self-esteem across the sample. Feelings of unworthiness worked against help-seeking for some women because they feared rejection:

> *I just didn't like any of it really. I found myself, when I saw people, I think I was just tryin' to impress them and make them like me, more than getting help.*
>
> [Drug and alcohol only]

> *I didn't have long enough track marks. That's a big one that's really sick, like its not what or how much you use, its why we use. But in my mind, you know, I hadn't done long enough jail sentences* [Drug and alcohol with CSA]

Acceptance meant accepting the woman's substance dependence as a fact of life, validating that the CSA occurred, and recognising that there were emotions that needed to be acknowledged and that these were painful. It also meant respecting her personal choices. This acceptance had two outcomes. First, it allowed women to overcome the stigmatisation of their presenting

problem and stop self-blame:

> *I don't need to feel second class. That I can hold my head up high and, and I'm me. And people take me as they find me. And some people might have one leg. I just happen to not be able to drink.* [Drug and alcohol only]

> *And they taught us that we're sick people getting well. We're not bad people getting good.* [Drug and alcohol only]

> *. . . he did help me with ideas that - it never occurred to me that it wasn't me totally to blame.* [CSA with substance misuse]

> *. . . it was really good to be able to share that and to realise that you weren't the - you were the victim - you weren't the bad person. 'Cos if you get it off your chest - if you're just holding it inside and you've only got your own point of view on it - to get other person's or other people's points of view on it, then you realise that it wasn't that bad and you can work over it, you can get over it and you just get it off your chest.* [Drug and alcohol with CSA]

A non-judgmental approach on the part of the helper also enabled women to communicate honestly about their feelings, thoughts and behaviours. This honesty provided a basis for the client to review all aspects of her life and to realistically assess the possibilities for change:

> *Being able to get what, get it all out. Tell people really private things that I've had to keep to myself. And when I hear myself talk, I really find out how I'm really going. And what's, you know, what's really going on.*
> [Drug and alcohol with CSA]

> *. . . its like I can review things that I don't like of myself and things with my life that I don't like either and I can work those things and make something positive . . . I like feeling that I have the right to go there and do that thing for myself.*

Women experienced this honest self-appraisal as a very empowering process because they began to value their own needs and feel more in control. In described the role of the therapist at the second stage of trauma recovery, Herman (1992) recommended that the therapist normalise the client's responses and affirm the dignity and value of the survivor:

> *So I would say that what I expect is just be more in control of my life but not in the sense that I was before, you know. More with my self, more present and more in touch with what I want, what I need.* [CSA only]

> *The main thing's always been just to have somebody who'll listen. Who'll be interested and who'll listen and won't try to say "Oh no, no, its not like that. You know, you don't feel like this". Someone whose actually going to, just be there and validate me and, you know, make me feel less crazy.* [CSA only]

Obstacles to acceptance

The processes of acceptance and honest self-appraisal were disrupted by condescending, judgemental or dominating therapist behaviour or unfair judgement from other inpatients. Some women's observations focused on the abuse of power:

> *This particular doctor said that I was neurotic and then patronised me the whole time. And said "Oh yes, and come and see me, and dress nice and do this and do that as a woman" and I just couldn't believe it so I just ended up walking out and feeling completely like an idiot. And I never wanted to talk to anyone again.* [CSA only]

> *And a little bit too much at the mercy of the people in the community that are doing the second part of the program. Some of them tended to manipulate their positions and were actually telling us not to do things that they themselves were getting away with . . . I found there was a bit of criticism there, bit of judgementality, which I didn't think was helpful.* [Drug and alcohol only]

Another problem arose when service providers or other inpatients imposed their view of the problem without regard to the woman's real life story. Discourses about CSA were particularly susceptible to ill-informed, and sometimes discriminatory, application. For example, some woman were told that their sexual preferences were the outcome of CSA:

> *Because of my sexuality, she was putting on to me that I was sexually abused by my father or some other member in the family. And I just totally disagreed.* [Drug and alcohol only]

> *The negative things were that they told me I really wasn't a lesbian and that I can get over it. And that then going on to tell me I had to have sex with a man. That kind a stuff.* [Drug and alcohol with CSA]

Solidarity

For women in drug and alcohol rehabilitation programs and CSA therapy groups, solidarity was an important factor in processes of acceptance and honest self-appraisal. For reasons of social stigma, lack of trust and emotional distraction, women had often struggled to cope in secrecy. This led to a prominent theme of self-imposed isolation:

> *I've had a lot of problems trusting people. But worse than that, I had a lot of problems being present everywhere. So, bein' myself. So that means that if I relate with other people, everything's quite difficult. And also, I had a lot of problems believing that anybody . . . I mean, for example, if suddenly, just for accident, you would fell down and touch me, just for accident, I would felt immediately "What did she do? Why?". And I start thinkin' about it so I have a lot of problems staying with anybody. So that means that I've had very few friends. I've been very isolated most of the time — most of my adult life.* [CSA only]

Women with CSA backgrounds described their social vulnerability as deep-seated and difficult to overcome. Some women related the CSA to their avoidance of crowds, particularly groups of men. They found that social vulnerability obstructed their ability to seek help or participate in group programs:

> *If I start to feel isolated, or start to feel apart, or you know, like somebody standin' outside, tryin to get in. I'm more likely to take off. It throws me back to bein' a child again, you know. I don't wanna face that so I'll take off, you know, I'll look after myself, you know. But that's more in groups and things like that.*
> [Drug and alcohol with CSA]

> *And you got no chance of being alone in here. They make sure of that . . . That is a good for me 'cos otherwise I won't talk. I'll block right off. And they have helped me there. I mean, I'm not go outside now and talk to people. I wanna talk to them in here. I'll probably try and isolate. I shouldn't. But I am comfortable with people but I'm not gonna do that when I go home.*
> [Drug and alcohol with CSA]

The solidarity derived from group experiences was a strong antidote to self-imposed isolation. At a practical level, women could exchange information about resources and contacts. One woman found that attendance of CSA therapy group meetings in the evenings gave her the courage to go out at night. Positive group experiences involved mutual respect, social support during and sometimes beyond therapy, and shared common goals:

> *We don't all talk about our past to a great degree but we all know basically what's happened in one another's lives — just the basics. And everybody supports one another. Yeah. If one's down, the others will come to you. You know, they're always there to pull one another up.* [Drug and alcohol with CSA]

> *Just to help me, you know, give me a peace of mind. You know, they're all in it. Like we have the counsel meet..., like the meetings. And everybody's got different stories. But someway or another, we're all in the same boat. And we're all trying to do something better for ourselves instead of going the way we had been when we were bought up.* [Drug and alcohol with CSA]

Identification with others in the group enabled women to overcome the stigma associated with either substance misuse or CSA. The opportunity to meet others who were struggling with similar problems was described as a `normalising' experience that led to acceptance and honest self-appraisal:

> *Oh well they've given me a new way of looking at things. They've shown me that I'm not out there alone. There's a table full of them over there. That I'm not an outcast or a lesser person just because I'm an alcoholic. That I don't need to feel second class. That I can hold my head up high and, and I'm me. And people take me as they find me.* [Drug and alcohol only]

> *. . . just the fact that you're with other women who think and feel exactly like you*

do. So that you finally feel normal and you know why you've been thinking and feeling like you have all your life. [CSA only]

The group setting seemed to also facilitate CSA disclosure because it allowed women the opportunity to hear other people's disclosures first and explore the meaning of abuse from a safe distance before openly acknowledging their own experiences. This was particularly important for women in the drug and alcohol with CSA group who had rarely spoken to others about the abuse. Initial disclosure can be quite tentative:

It was more because of an incident that happened here and there's a woman that had similar experience to me and I saw the hard time she was going through but I didn't know that the experiences were so similar. And thats when it really hit me. . . . I just thought it was extremely normal, my family life. And now, I'm startin' to believe that its not normal for a stepfather to start touching up his stepdaughter.

[Drug and alcohol with CSA]

Well, it come up in women's group one day. I think I just got a bit upset about what the counsellor was saying. They were talkin' about something and they said they were doin' a course on rape and incest and I thought "What do you mean — incest?" Like incest is when the child or the person AGREES to their brother and sister. See I call THAT sexual abuse. And I got a bit stroppy and told 'em what I thought of it. That men should be castrated for such a thing. I just let that out a little bit — not a lot. But [group leader] picked up on it and said "No, I think I'll be your counsellor". [Drug and alcoh

Empowerment

Women recalled that at the time of seeking help, they had anticipated that therapy or treatment might teach them skills that they would be able to continue developing after termination. In particular they wanted to learn how to cope with distressing emotions, maintain long-term change in their substance use, improve relationships and care for themselves:

How to deal with triggers. You know, coping. You know, if your about to get depression, you know, how to sort of [pause] to react differently to it.

[Drug and alcohol with CSA]

I know how to get straight, but I don't know how to stay straight . . . Like I don't know how to fix my attitude, behaviour pattern. [Drug and alcohol with CSA]

It wasn't that I didn't like myself, wasn't that I had ever been suicidal, that I didn't want to be here. I just didn't know how to look after myself . . . I had a lot of loving but I just couldn't give it to myself. [CSA with substance misuse]

Indeed, the decision to seek help sometimes accompanied major cognitive shifts in the way that women viewed their experiences. They had already begun to challenge disabling discourses and were motivated to seek assistance in this process. For example, one woman sought help after re-examining her history of sexual relationships and starting to construct a new discourse about

being valued as a person:

> *Yeah, well I remember the last time I attempted to have sex. I was living with this guy and was in that month — my last month before I got clean. I just finally, it just hit me that this is not what I'm on this earth for and I proceeded to get on top of him. And I just got back off him and said "I'm not doing this anymore". And that's it. And I rolled over and lied there all night thinking "I want out. I don't want to work anymore. I don't want to have sex anymore. I've had being a fuck machine". Excuse me, but yeah [distressed].* [CSA only]

Another woman had experienced discrimination in her job with the defence forces. She had been in the forces for many years and her competence had been rewarded with promotions. Nevertheless, her work was constantly frustrated by subtle forms of sex discrimination:

> *I had a man above me who used to challenge everything I said. And its that he was used to working with males all the time and you know I made decisions and it wasn't supported.*

She had taken stress leave because of depression. On her return, she found that she had been unofficially demoted to an uncomfortable office space doing chores that nobody else wanted. When she finally decided to seek help for substance misuse, she also decided to leave her job and began to consider other career possibilities where her talents would be better appreciated.

The need for empowerment was particularly emphasised by women approaching the end of their CSA counselling. Therapy that they viewed as having successfully provided safety and acceptance had led them to develop new career aspirations and define new ways of relating to others:

> *I always have had a sense of that something is lost. I have something extra or something that I don't have with myself. I mean, I'm talking about myself as a whole. Since I started going — and despite that I've had a very bad period during the counselling — I feel that I've been doing things that I want to do with my life. For example, I started the uni, which was something I never dreamin' about before because I didn't feel the confidence to do it.* [CSA only]

> *I always go after men that aren't gonna treat me very well. It's a pattern that I'm trying to change at the moment. That's why I've chosen to be on my own for a while.* [CSA only]

> *Sometimes I don't want my husband to touch me or . . . just depends what sort of mood I'm in. I don't want to feel like [pause] if he hugs me, I just want him to hug me. I don't want everything to be sexual.* [CSA only]

Although empowerment might begin with the decision to seek help, the idea that it is particularly relevant during the later stages of therapy fits Herman's (1992) model of `reconnection' as the last stage in trauma recovery. One women sought help at a time when she had finished mourning the past and was ready for practical experiences that would enhance her self-efficacy:

. . . what I really needed help for, I thought, was dealing with it now. And I said I want to get up from this chair and go away. I don't want to go into some sort of funk because of what happened years ago. I want to be able to progress, not digress first. [CSA with substance misuse]

A successful solution suggested by her counsellor was that she join a women's group where she had the opportunity to apply her creative skills:

That was good to actually feel like I could do something. 'Cos there's a lot of feeling like ya can't do anything. So I guess that's what I got out of it. [CSA with substance misuse]

Group differences in needs satisfaction

Although women in all groups identified the needs of safety, acceptance, solidarity and empowerment, there was some variability in the prominence of these themes among different groups. Themes of empowerment tended to be more modest among women in the drug and alcohol with CSA group and focussed mainly on overcoming stigma, maintaining abstinence and preparing for future referrals. Seven of the 13 women in this group were new-comers to therapy and they particularly emphasised themes of safety and acceptance.

For those women in the CSA with substance misuse group who defined their substance use as problematic, plans to change their substance use were typically referred to in terms of empowerment. Those who had not sought help for CSA were nevertheless at a stage in their lives where they were re-examining their past, seeking safe relationships and thinking about pathways for change, including help-seeking.

5 DISCUSSION

The relationship between CSA and substance misuse

The hypothesis that CSA would be predictive of an earlier onset and greater severity of substance misuse was only partially supported. Among clients in drug and alcohol treatment, the main difference in substance misuse between CSA survivors and other women was an earlier age of first intoxication. CSA was a significant factor in accounting for the variation in age of first intoxication even after adjusting for age, maternal substance misuse and the number of traumas. The results suggest that the drug and alcohol with CSA group had an increased risk of early adolescent substance misuse, including intoxication and use of inhalants. This finding is consistent with studies of adolescent clinical populations (Flanigan et al., 1988; Singer et al., 1989) that have linked frequent intoxication with CSA, although a relationship with inhalant use was not found by Harrison et al. (1989).

CSA was not predictive of the severity of alcohol or other drug problems. Among women in drug and alcohol treatment, there were no differences between CSA survivors and other women in the diversity of substances used in the past, current consumption or severity of dependence. The range of results, however, might have been restricted because the women were sampled from a highly dependent clinical population, resulting in a floor effect. This idea could be tested with a non-clinical study of women with substance misuse.

The qualitative data revealed several ways that CSA and substance use might be linked in adolescence. First, some women described self-medication from an early age, even prior to the CSA. The need for such self-medication might arise in families where there is ongoing abuse or neglect. The combination of emotional pain from CSA and other traumas with the increased access to substances during early adolescence might predispose the CSA survivor to experimentation with self-medication.

Harrison et al. (1989) linked self-medication in the form of anaesthesia to the use of sedative drugs. In contrast to their findings, this study found no differences between the drug and alcohol treatment groups in the use of sedative drugs such as tranquillisers. Consumption of alcohol during the target month was higher for the CSA survivors but there were no other differences in alcohol use. The finding that CSA survivors reported cocaine and amphetamines as the main problem drug more frequently than other women was consistent with findings from other studies (Singer et al., 1988; Harrison et al.; 1989) and might reflect attempts to induce self-protective hypervigilance because of CSA (Harrison et al., 1989).

Second, early intoxication places girls at risk because of its detrimental effects on cognitive and physical functions. Moreover, participation in an adolescent substance misuse culture increases the risk of danger from intoxicated male adolescents (Moore and Fleming, 1989). According to Moore and Fleming (1989), the adolescent CSA survivor might become caught in a vicious circle characterised by continued coercive sexual behaviour, emotional pain denial through substance misuse, and dependence on a sub-culture that perpetuates sexual coercion and emotional pain.
Third, the impaired self-esteem model proposed by Paone et al. (1992) is especially relevant for

adolescent development within a peer culture. Women from all groups reported social reasons for starting to use substances, such as bolstering social courage or trying to fit in with a peer group. Traumagenic dynamics associated with CSA (Finkelhor and Browne, 1986) such as stigmatisation and powerlessness might particularly predispose some women to social anxiety.

A fourth possibility is that abuse or neglect in the family might prompt the girl to leave home early and enter situations that carry a high risk of sexual coercion and substance misuse (Finkelhor, 1979; Simons and Whitbeck, 1991). The results indicated that women in the drug and alcohol with CSA group had less residential stability during childhood and were more to likely to have run away or lived in an institution than other women. They left school earlier than other women. They were also more likely to have worked in the sex industry and some women attributed their sex work to the CSA, describing a traumatised sexual identity that made sex work easier.

Traumatising dynamics of CSA

The idea that adolescence is an important developmental phase for the association between CSA and substance misuse is further supported by the pattern of differences in CSA characteristics between the two CSA counselling groups. The CSA with substance misuse group were more likely to have been abused during adolescence by someone outside the family whereas the CSA only group were more likely to report incestuous CSA during early childhood. Although both groups began experimenting with substances earlier than women in the drug and alcohol only group, the use of substances for coping with the CSA trauma might be more salient for people who were abused during adolescence.

The results of this study highlight the theoretical problems associated with measuring the severity of CSA characteristics. All of the women in the current study had experienced a serious type of sexual behaviour and most had experienced a very serious type of behaviour. Many of the characteristics that the literature has linked with greater severity of trauma, such as duration of the abuse and abuse by a father figure were more frequently reported by women without substance misuse. This is possibly a sampling effect since all of the CSA only group were recruited from CSA counselling services. Perhaps women in this group were more attracted to CSA counselling because their experience of abuse was so obviously outside societal norms that it seemed to account for their current psychological distress.

Women might be less inclined to make attributions about the long-term impact of extrafamilial abuse at an older age, particularly when there are other competing explanations such as substance misuse. This is particularly so for women in the drug and alcohol with CSA group who appeared to have spent less time talking with others about the abuse and were more inclined to dismiss its importance.

In the light of this analysis, the reframing of the question by Finkelhor and Browne (1986) from `how severe?' to `what types of traumatising dynamics were present?' seems a reasonable one. The powerlessness of children is poignantly demonstrated in this study in that the most frequently reported form of physical coercion was intimidation by the inequalities of size and strength between abuser and victim. According to Finkelhor and Browne (1986) this early experience of powerlessness might contribute to anxiety, somatisation, dissociation and vulnerability to subsequent victimisation, all of which were more prevalent among CSA

survivors in this study.

The most frequently reported forms of psychological coercion included fear of losing the abuser's love, trickery or deception, and verbal persuasion. These psychological forms of coercion commandeer the child's cooperation in her own oppression, thereby laying the foundations for shame and self-blame. They also involve betrayal, which, according to Finkelhor and Browne (1986) disrupts the child's judgement about the trustworthiness of others, leading to further victimisation and problems with intimacy. These predictions were supported in this study by the CSA survivors' reports of shameful devaluation, difficulties with sexual intimacy and high rates of adult sexual abuse.

Another important dynamic highlighted in this study was the uncertain outcome of disclosure. Just under half of the women had disclosed during childhood and most of them thought that disclosure had made no difference or made things worse. The qualitative analysis showed that many adults had responded to disclosure by silencing the child and some women had even been punished for their disclosure.

Mediating factors

This study confirms research findings (Brown and Anderson, 1991; Edwall et al., 1989) that CSA does not occur in isolation but covaries with other traumas such as child physical abuse and emotional neglect, particularly in the context of the family. That this was the case regardless of whether or not the CSA survivor later developed substance misuse, suggests that these early traumas do not increase the chances of misusing substances. Nevertheless, the number of lifetime traumas was a significant factor in accounting for the variance of age of first intoxication. This may be because of the cumulative effect of these traumas on the need to self-medicate or build self-esteem. Alternatively, it could indicate that early experimentation with substances exposes the adolescent to a greater risk of other traumas as well as CSA.

The relationships between CSA and other early traumas were strongly demonstrated in the qualitative analysis of family power relations. In some families, the risk of CSA was increased by pervasive abuse, violence and denigration, typically perpetuated by the father but sometimes by both parents. In other families, there was a prominent theme of parental preoccupation which sometimes contributed to the risk of CSA through the emotional and physical abandonment of the child. Such family abuse or neglect is also likely to feed into the traumatising dynamics of the CSA and impede the child's recovery.

Paternal substance misuse was found to contribute to these dynamics. Only a third of the women in the drug and alcohol only group said that their fathers misused substances compared with more than a half of the women in the CSA groups. Paternal substance misuse was not only related to CSA but was also related to higher rates of child physical abuse and emotional neglect. The qualitative analysis revealed that paternal substance misuse contributed to a heightened atmosphere of danger in the home, through the father's own violence, increased levels of marital discord and exposure to other dangerous adults.
In contrast, maternal substance misuse seemed to relate more to the women's substance misuse than to their CSA experiences. In fact, maternal substance misuse was a significant factor in accounting for the variance in age of first intoxication, suggesting that it has a direct impact on

the child's behaviour as well as mediating the relationship between CSA and early substance misuse. The qualitative analysis indicates that some reasons for this association arise from the intense domestic relationship between mother and daughter and the mother's use of substances in the home. The development of substance misuse might be facilitated through identification with the mother's method of coping, disruption to the maternal relationship and/or increased access to substances.

These results shed further light on the findings of Rose et al. (1991) who reported that among a sample of mental health clients, adult children of alcoholics had higher rates of both childhood sexual and physical abuse and substance misuse, especially if they were female. The current study indicates that paternal and maternal substance misuse differ in their impact on CSA and substance misuse among women. This raises a question about whether the same pattern of impact would hold in a study of men. Perhaps boys' identification with their fathers might have different implications for the development of substance misuse and the long-term effects of CSA and other childhood abuses.

Other potential mediators in the relationship between CSA and substance misuse among women included adult experiences of physical and sexual abuse. This study confirmed findings from other studies that CSA is related to adult sexual abuse (Fromuth, 1986; Russell, 1986; Siegel et al., 1987; Walker et al., 1992), suggesting that CSA survivors have an increased vulnerability to further sexual victimisation, regardless of whether or not they misuse substances. In contrast, adult physical abuse seemed to arise in association with substance dependence rather than CSA. Consistent with the findings of Miller et al. (1989), this abuse typically occurred in the context of a domestic relationship where both partners misused substances. It was also associated with work in the sex industry.

A complex clinical picture

The results of this study confirmed the hypothesis that among women in drug and alcohol treatment, women who have been sexually abused during childhood would have a higher incidence of psychological distress. A history of CSA was a significant predictor of CGHQ scores, even after adjusting for the mediating effects of emotional neglect and adult physical abuse.

CSA survivors had higher levels of somatisation, anxiety and depression at the time of the interview. These results are consistent with other studies (Briere and Runtz, 1988; Bushnell et al., 1992; Pribor and Dinwiddie, 1992; Walker et al., 1992) except that the difference in depression was marginally insignificant. This might be due to the depressive effects of substance misuse and withdrawal common to both drug and alcohol treatment groups. This study did not distinguish between such secondary depression and primary depression. Copeland et al. (1993) have argued that this distinction might be an important clinical issue for female drug and alcohol treatment clients.

Nevertheless, in the current study CSA survivors had significantly higher rates of attempted suicide than women in the drug and alcohol only group. The results indicated that the risk of suicide was particularly high for the drug and alcohol with CSA group, probably because of the combined effects of CSA and access to potentially lethal substances. The logistic regression

analysis indicated that the combination of CSA and substance dependence significantly contributed to the variance in attempted suicide even after adjusting for adult physical abuse and the number of traumas.

The high rates of adult physical abuse among both drug and alcohol treatment groups and its relationship with suicide attempts raises another important area of risk that needs to be addressed in treatment. That this typically occurred in the context of spousal violence where both abuser and victim were intoxicated highlights the importance of addressing domestic violence in drug and alcohol treatment programs with male as well as female clients.

This study replicated the findings of Briere and others (Briere and Runtz, 1987; Briere and Runtz, 1988; Elliott and Briere, 1992) that CSA is a predictor of adult symptoms of dissociation. It is interesting to note that all CSA survivors had elevated levels of dissociation regardless of current substance misuse. This suggests that substance misuse does not necessarily replace dissociation as a coping method. A linear regression analysis indicated that CSA was a significant predictor of dissociation for women with and without substance misuse even after adjusting for the effects of emotional neglect.

Consistent with other studies (Krahn, 1991; Rose et al., 1991), women with CSA had an increased risk of self-mutilation and eating disorders. It seems likely that these behaviours develop in a similar way to substance misuse, as maladaptive forms of coping with trauma. Both behaviours are related to an earlier onset of excessive substance use and alcohol use. Their associations with symptoms of psychological distress such as somatisation, anxiety and dissociation further supports the idea that these behaviours are methods of coping with negative affect resulting from CSA and other traumas.

CSA was strongly associated with adult sexual dysfunction. Although the prevalence of sex problems was high (44%) for the drug and alcohol only group, probably reflecting the detrimental effects of substances on sexual function (Wilsnack, 1984), the prevalence was even higher among CSA survivors, the majority of whom had experienced sex problems during adulthood. Sex problems were also higher among women who had experienced child physical abuse, emotional neglect or adult sexual abuse. A logistic regression analysis indicated that CSA predicted adult sex problems even after adjusting for the number of other traumas women had experienced.

Dissatisfaction with or dislike of sex were very prominent problems for all groups. Among CSA survivors, other prominent problems included difficulties with intimacy and trust, the association of sex with unpleasant emotions and flashbacks, feeling obliged to have sex without desire and unwanted attractions or sexual compulsions. Over half of the women with both current substance misuse and CSA backgrounds had used substances to overcome sexual difficulties. Dissociation and avoidance of sex were other common forms of coping and some women viewed celibacy as a key to their recovery from CSA.

There were no significant group differences in self-esteem at the time of the study although the trends in self-esteem were consistent with the cumulative effect of CSA and substance misuse reported by Carson et al. (1988). In qualitative interviews, CSA survivors described the impact of CSA on self-esteem in terms of a shameful devaluation, leading to feelings of unworthiness.

The women linked these feelings to self-destructive behaviour, social withdrawal and a disabling lack of confidence. The qualitative data showed that stigmatisation about substance misuse also led to social withdrawal and low self-esteem even among women who had not experienced CSA.
The results of this study indicate that women with CSA backgrounds have an increased risk of experiencing a range of psychological problems, such as anxiety, somatisation, dissociation, sexual dysfunction, and possibly depression. They also have a greater risk of attempting suicide, self-mutilation and eating disorders. Although there is no evidence that they will experience worse symptoms of substance misuse, the results do indicate that among women entering drug and alcohol treatment programs, those with a CSA history will have a more severe and complex clinical picture and might require additional specialist care.

Help-seeking

The main differences in help-seeking between the two groups who had experienced both CSA and substance misuse could be attributed to their different types of drug use and severity of dependence. The main problem drugs reported by the drug and alcohol with CSA group included heroin, stimulants and alcohol. They had severe levels of dependence. In contrast, the main problem drugs reported by the CSA with substance misuse group were alcohol and marijuana and they had only low to moderate levels of dependence. Consequently, although they were experiencing the same levels of psychological distress, women from the two groups defined their problems differently.

Women in the drug and alcohol with CSA group typically defined their main problem as a loss of control due to escalating dependence. They often sought help in response to a crisis, such as fear of suicide, substance-related health problems, domestic violence, or homelessness. They had more frequently experienced detoxication and psychiatric counselling than women in the drug and alcohol only group. They were also more likely to have been hospitalised for psychiatric reasons — usually due to overdoses — although this trend of difference was not statistically significant.

Women in the drug and alcohol with CSA group also had higher rates of treatment drop-out than the drug and alcohol only group. This result might be related to findings reported by Copeland and Hall (1992b) that CSA survivors were less likely to drop out of treatment if attending a gender-sensitive program. Issues of safety and acceptance were particularly emphasised by women in the drug and alcohol with CSA group in their accounts of treatment needs. Nevertheless, they often returned to the same agencies and attributed unsuccessful treatment outcome to their own lack of readiness to change.

Help-seeking for CSA issues was rare among this group and only 40% had ever been screened for CSA. The qualitative analysis suggested help-seeking for CSA in this group was obstructed by an interaction between professional reluctance to explore deep emotional issues and women's fear's about disclosure. Some women reported that all-female groups were an ideal setting to facilitate discussion and gradual disclosure about CSA.
The CSA with substance misuse group were quite different from the drug and alcohol with CSA group in their patterns of help-seeking. They either did not view the substance misuse as a problem or defined it as a coping response to underlying negative emotions related to the CSA and other traumas. Those who had considered seeking help for substance misuse were frustrated

by the lack of services aimed at moderate drinking.

For this group, the role of CSA in emotional or behavioural problems was often uncovered during the therapy or help-seeking process. Typically, women decided that they had a problem after a period of inertia or a breakdown in their usual coping methods. They either sought help in a pragmatic way or as part of a search for the source of the problem. The main agencies were outpatient counsellors such as psychologists and psychotherapists, specialist services such as Dympna House and sexual assault units, and psychiatrists.

The main obstacle to seeking help for CSA was that the demand for affordable specialist services outweighed the supply, resulting in long waiting lists and financial hardship due to counselling fees. In contrast to the drug and alcohol with CSA group, women in the CSA with substance misuse group viewed unsuccessful treatment outcome as a result of either professional incompetence or a therapist-client mismatch and responded by seeking help elsewhere.

This study supports the argument by Saunders (1993) that problem recognition is the most difficult step in the process of help-seeking. The main social influence on recognising either substance misuse or CSA as a problem is social taboo. The taboos tend to isolate women, preventing the articulation and processing required for problem recognition. On the other hand, social influences such as the need to improve relationships with children and sexual partners are also important facilitators of problem recognition.

Saunder's (1993) finding that difficulties in deciding that therapy or treatment might help with the problem are associated with social support, either because people seeking informal help first or they are dissuaded by social influences was generally not supported by this study. In contrast, women's decisions about the merits of seeking help were often made in isolation and based on personal factors such as their readiness to change, awareness and choice of services, and fears about the overwhelming emotions associated with CSA.

The third step of actually seeking help was heavily influenced by social factors. As noted by Walker et al. (1992), women often delay seeking help because of their family responsibilities. Our results, however, also supported Saunder's (1993) assertion that assistance from others can speed up the process of help-seeking. Other important factors influencing this step were the social stigma associated with disclosure of either problem and the adjustment required of the woman's sexual partner.

Along with the limited supply of services, the final step of making contact was often hampered by professional reluctance to address women's deeper concerns. Women cited the use of drug therapy instead of referral for counselling, a reluctance to diagnose substance misuse among women with low dependence or from middle class backgrounds, and disbelief about the CSA. Women in the CSA counselling groups also highlighted the problems of premature termination of therapy.

Saunders (1993) argued that the process of overcoming the four steps involved in help-seeking was in itself ". . . part of the change process of psychotherapy". This was true for some women in our study, where deciding to help was associated with a cognitive shift in the understanding of the problem and the development of new plans for the future.

The analysis revealed, however, that for substance misuse and CSA there are specific barriers to help-seeking that arise from societal taboos and emotional vulnerability. Consequently, women identified their primary needs in therapy and treatment as safety, acceptance, solidarity and empowerment. The establishment of safety, according to Herman (1992) is a basic necessity in the process of trauma recovery. Women in this study stressed the need for safety not only from external risks of substance misuse and abusive relationships but also from overwhelming emotions arising in the course of therapy. Ideally, therapy or treatment was paced according to the needs of the client and frightening emotions were contained in a way that made the client feel safe.

These findings suggest that an essential feature of relapse prevention plans for the CSA survivor might be the development of safe methods for coping with potentially overwhelming emotions. Copeland et al. (1993) cautioned that pressure on women to disclose about CSA in the absence of professionally trained staff and long-term support could contribute to relapse because of painful emotions. Similarly, Young (1990) argued that relapse might be a response to the surfacing of CSA-related memories or emotions that were previously masked by the substance misuse. She maintained that a key task of therapy was to teach the client to tolerate emotions that seem dangerous or destructive.

Two disturbing themes of unsafe and unethical practices emerged from this study. First, treatment staff sometimes imposed their view of CSA on the client, insisting that she had been abused because of her history of substance misuse or her sexual preference. This interpretation of CSA is ill-informed and, in practice, discriminatory. Second, there was a prominent theme of therapist abuse, ranging from humiliation of the client to sexual abuse. Women with CSA backgrounds were particularly vulnerable to abuse by therapists or treatment staff, leading to further traumatisation and a sense of distrust towards help-providers. Their experiences highlight the urgency of ensuring safety for female clients in all treatment services.

Recommendations for service providers

The conclusions of this study are qualified by recruitment difficulties among CSA counselling clients. Although none of the women in the CSA only group had current substance misuse, 42% had misused substances in the past. There was therefore some overlap between the two counselling groups that might have influenced their comparison. This sampling error in itself might reflect the covariance of CSA and substance misuse.

Another qualification relates to difficulties encountered in the recruitment of women in CSA counselling who had current substance misuse. In the CSA with substance misuse group, 47% of women were recruited outside counselling services and the total group was smaller than the other groups. Although based on sound therapeutic practices, the request of some services that women do not attend groups while under the influence of substances might discourage some women from attending, particularly if they have more severe levels of dependence.

Since many women did not view their substance misuse as problematic, the change to a behavioural criteria might have eventually attracted more women from counselling services had there been time available to continue recruitment. Another possibility that is consistent with the data is that women with low levels of dependence might change their substance use when they enter counselling, as part of an overall plan to find more effective ways of coping.

The results of this study indicate the need for a more coordinated approach to service provision. For example, hospitalisation due to overdose might be symptomatic of underlying trauma. Effective intervention at the primary health care level might therefore require appropriate screening and referral. Yet, women's accounts of experiences in primary health care indicate that there is a reluctance on the part of some professionals to address deeper emotional issues.

Similarly, the results indicate that among women entering drug and alcohol treatment programs, those with a CSA history will have a more complex and symptomatic clinical picture and might require additional specialist care. CSA screening also seems to be relevant for general outpatient services where CSA survivors might present for various symptoms of psychological distress.

The need for such screening raises a number of important clinical questions. First, how should we ask women about CSA and how much should we ask? The accounts of women in this study demonstrate that there are risks associated both with not asking at all and uncovering too much, too soon. There is a need to develop a screening approach that adjusts to the needs of the individual. One guiding principle suggested by Herman (1992) is the restoration of power and control to the survivor.

Second, how do we provide women with a safe context for disclosure. For someone who has not previously disclosed, screening as part of the initial intake assessment might be more threatening then a tentative disclosure in the context of a supportive group two weeks into therapy.

Finally, who will provide post-disclosure support? The purpose of CSA screening seems obscure and unsafe in the absence of available long-term psychological support. This study demonstrates the need for a coordinated network of specialist services available for referral. There needs to be a greater exchange of information between primary health care, drug and alcohol treatment and CSA counselling services. At the present time, there also appears to be a shortage of affordable professionals with appropriate training for CSA counselling. Three-quarters of the drug and alcohol treatment groups and one-third of the women in CSA counselling services were recipients of social security.

Moreover, women's accounts of their needs in treatment seem to support Herman's (1992) assertion that people progress through stages of trauma recovery and that effective referral will involve careful matching of clients with programs or therapy approaches, even after initial disclosure. Since CSA does not occur in isolation but is typically compounded by a range of other childhood and adult experiences, therapeutic models should have a broad definition of trauma. This study demonstrates the need for a flexible system of health services to deal with the serious risks associated with CSA.

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APPENDIX A: CONSENT FORM

I (name) .....

of (agency or home address) .....

.....

agree to participate in a study of personal and social experiences of women attending a variety of counselling services which is being conducted by the University of New South Wales. I agree to be interviewed about my family history, my experience of sexual assault, my emotional and physical health, my drug use and my experiences of counselling and other services. I understand that the interview will be audiotaped unless I request otherwise.

I understand that:

(i) all information that is collected will be kept strictly **confidential** and will be used solely for research purposes. Audiotapes and written notes will be coded with a number rather than my name. All audiotapes will be erased at the end of the study and this consent form will be stored separately from the interview material. Only the interviewer will have access to this material.;

(ii) my name will **not** be used in any publications about the study;

(iii) the research study is **not** related in any way to my counselling;

(iv) I am free to decline to participate in the study, without it affecting in any way the counselling I receive;

(v) if I agree to participate I am free to withdraw from the study at any time without affecting my subsequent counselling;

(vi) I am free to not answer some questions if I choose; and

(vii) I am free to stop the audiotape at any time.

I have been given an opportunity to ask any questions I have about the study.

Signed Date
Witness Date

APPENDIX B: SEMI-STRUCTURED INTERVIEW d&a

- *(Qualitative):* no notes taken but woman's response is audiotaped.
- *(Card):* woman selects appropriate option(s) from a card

****

Date: —— /—— / ——

Section A: *Everybody answers this section.* **Code:** ☐☐☐☐☐☐

Your background

1. Age (Yrs) ☐☐

2. When did you first come to this agency for help? (No. of days) ☐☐☐

3. How long since you last used your main problem drug? (No. of days) ☐☐☐

4. How many times have you moved around in the last six months? ☐☐
   No fixed address = 98

5. Who have you been mainly living with in the last six months? ☐☐

Parents	(01)	Children	(07)
Friend(s)	(02)	Relatives	(08)
Sexual partner	(03)	Parents and kids	(09)
Alone	(04)	No fixed address	(10)
Partner & Kids	(05)	Other	(11)
Institution	(06)	Specify	

6. Would you describe yourself as heterosexual, bisexual or lesbian? ☐☐

Heterosexual	(01)
Bisexual	(02)
Lesbian	(03)

7. Are you currently in a relationship? ☐☐

   Yes (01)

   No (02) 7a. Finish relationship, recently? How long ago (weeks)? ☐☐

8. Have you any children? How many? ☐☐

9. Have you had any (other) pregnancies? How many? ☐☐

Education & employment

10. How old were you when you first left school? ☐☐

11. What is your usual occupation? ☐☐

.....

12. For the majority of the last six months, were you? *(Card 1)* ☐☐

Employed full time	(01)	Sickness benefits	(05)	
Employed part time	(02)	Household duties	(06)	
Unemployed	(03)	Pensioner/retired		(07)
Student/trainee	(04)	In prison	(08)	

   12a. (If 03, 05) How many months since you last worked ☐☐

13. What is your main source of income or support ☐☐

Work	(01)	Parents	(05)
Social Security	(02)	Austudy	(06)
Crime	(03)	Other	(07)
Partner	(04)	Specify	

Health

14. Do you have any ongoing health problems (such as asthma, diabetes, arthritis)? ☐☐

Yes (01)
No (02)

15. Have you ever been hospitalised for psychological or emotional reasons? ☐☐

Yes (01)
No (02)

15a. (IF YES) What type of problem did you have? ☐☐

.....

16. Have you ever been treated or counselled for psychological or emotional reasons? ☐☐
(eg. anxiety or depression)

Yes (01)
No (02)

19. Are you withdrawing from any drugs at the moment? (Specify) ..... ☐☐

20. Have you ever had trouble with food or eating? ☐☐

Yes (01) Dissatisfied with weight (03)
No (02)

20a. (IF YES) What sort of trouble was that? ☐☐

Compulsive eating	(01)	Bulimia	(04)
Bingeing	(02)	Combination/both	(05)
Anorexia nervosa	(03)	Other (specify)	(06)

21. During your adult years have you ever experienced any difficulties or dissatisfaction with your sex life?

Yes (01) ☐☐
No (02)

21a. (IF YES) What kinds of difficulties have you experienced? *(Qualitative)*

22. Have you ever drunk alcohol or taken drugs to help overcome any sexual difficulties?

Yes (01) ☐☐
No (02)

23a. (IF YES) How often? ☐☐

Every time you have sex, if possible	(01)		
Most of the time		(02)	
Sometimes	(03)		
A few times	(04)		
Only with men	(05)		

23. During your childhood, BEFORE the age of 16, did anyone ever touch you in a sexual way or pressure you into having sexual contact, when you did not want to? ☐☐

Yes (01)
No (02)
Don't know (03)

23a. (IF DON'T KNOW) What makes you think that this could have been a possibility? *(Qualitative)*

23b. (IF YES) How many times did this happened to you? ☐☐☐
Repeatedly over time 199 Too many to count 998

23c. (IF 199) How long did that last (MTHS)..... ☐☐

23d. Have you ever had counselling specifically to deal with this? When? ☐☐

24. Have you ever experienced unwanted sexual contact SINCE you turned 16? ☐☐

Yes (01) Don't know (03)
No (02)

24a. (IF YES) How many times did this happened to you? ☐☐☐

25. How old were you the first time you were involved in a sexual relationship where you gave your consent? (YRS) ☐☐

26. Were you ever physically abused BEFORE you turned 16? ☐☐

Yes (01)
No (02)
Don't know (03)

27. Were you ever physically abused SINCE you turned 16? ☐☐

Yes (01)
No (02)
Don't know (03)

If adult abuse in a domestic context:

27a. Was the person who did this to you out of it/stoned/drunk at the time? ☐☐
Yes (01)
Sometimes (02)
No (03)

27b. Were you out of it/stoned/drunk when this happened to you? ☐☐
Yes (01)
Sometimes (02)
No (03)

27c. Was this abuse a once-only thing or was it ongoing? ☐☐
On-off (01)
Ongoing (02)

27d. If ongoing, for how long did this go on? (mths) ☐☐

28. Have you ever done sexwork/prostitution? ☐☐

Yes (01)
No (02)

28a. (IF YES) Was this mainly to support drug use? ☐☐

Yes (01)
No (02)

28b. Did you work mainly on: ☐☐

Streets	(01)	Home	(03)
Parlours	(02)	Other	(04)

29. Have you ever spent time in prison? ☐☐

Yes (01)
No (02)

30. Have you ever cut yourself or deliberately hurt yourself? ☐☐

Yes (01)
No (02)

31. Have you ever tried to kill yourself? ☐☐

Yes (01)
No (02)

31a. (IF YES) How many times has this happened? ☐☐

31b. How did you try to kill yourself? ..... ☐☐

31c. What factors do you think helped you to survive? *(Qualitative)*

The family you grew up with

32. Were your parents born in Australia? ☐☐

Yes (01)
No (02)
One only (03) Specify .....
ATSI (04)

32a. (IF NO) What is your parent's country of origin? ☐☐

.....

33. In what religion were you raised? ☐☐

Catholic	(01)	Muslim	(05)
Anglican (CofE)	(02)	No religion	(06)
Presbyterian	(03)	Other	(07)
Jewish	(04)	Specify	

34. When you were growing up and until you were 16, who did you mainly live with? ☐☐

.....

.....

(Probe) Did you have younger or older brothers and sisters?

35. What was your father's (step-father, male caretaker) main occupation? ☐☐

.....

36. What was your mother's (step-mother, female caretaker) main occupation? ☐☐

.....

37. How many times did you move from one place to another before you turned 16? ☐☐☐

38. On the whole, how would you describe your childhood up until you turned 16? *(Qual.)*
39. How would you describe your relationship with your mother up until you turned 16? *(Qul.)*
40. How would you describe your relationship with your father up until you turned 16? *(Qul.)*
41. How did your parents get on with each other? *(Qualitative)*

42. If there were disagreements in your family, what usually happened? *(Qualitative)*
43. What was the main way that your family showed affection, if any? *(Qualitative)*
44. Who were the people in your childhood who showed you the kind of affection that you wanted? *(Qualitative)*
45. What was the main way that your parents disciplined their children? *(Qualitative)*

46. * Family History of drug taking

Family History of Substance Use	Alcohol		Drugs	
When you were a kid, did anyone in your family have a problem with....	TICK IF YES	CODE NO.	TICK IF YES	CODE NO.
Mother		(01)		(01)
Father		(02)		(02)
Sister		(03)		(03)
Brother		(04)		(04)
Aunt		(05)		(05)
Uncle		(06)		(06)
Other (specify)		(07)		(07)

(IF YES) 46a. How did X's drinking/use of drugs affect your life when you were a child? *(Qualitative)*

Help-seeking

47. What prompted your decision to seek help on this occasion? *(Qualitative)*
48. What is the main reason you chose to come to this agency? *(Qualitative)*
49. What is the main way you feel this agency can help you? *(Qualitative)*

50. Is your partner supportive of you seeking help? ☐☐

Yes	(01)	Unaware	(03)
No	(02)	N/A	(04)

51. Is your family supportive of you seeking help? ☐☐

Yes	(01)	N/A	(04)
No	(02)	Mixed family support	(05)
Unaware	(03)		

52. Who is your main source of emotional support at the moment? ☐☐

.....

53. What factors (if any) have put you off seeking help in the past? *(Qualitative)*

54. Have you ever sought help elsewhere because of your problems with drugs or alcohol? ☐☐

Yes (01)
No (02)

54a. How many times have you been to . . .

Detox ☐☐

TC (eg. WHOS, Oddysey, Buttery, Karolika . . . 3mths plus) ☐☐

Other inpatient rehab (eg. 4-6 week rehab) ☐☐

MM ☐☐

Outpatient counselling ☐☐

Been to this agency before *(not counted in total)* ☐☐

Other (specify) ..... ☐☐

Total no. of times sought help for D&A ☐☐

55. Have you ever received other types of counselling or attended other types of treatment programs? *(Qualitative)*

56. What were the main things you found helpful in the programs/counselling that you have experienced? *(Qualitative)*

57. Was there anything unhelpful in these programs/counselling? *(Qual)*

(IF she has participated in counselling or treatment in the past, not including detox . . .)

58. Have you ever left a counselling or treatment program earlier than expected or before completing that program? ☐☐

Yes (01)
No (02)

58a. What were the main reasons you left early? *(Qualitative)*

58b. What aspects of those programs would have made you stay longer? *(Qual.)*

59. Were you ever referred somewhere else or offered aftercare services after previous counselling or treatment experiences? ☐☐

Yes (01)
No (02)

59a. (IF YES) Did that referral help you? ☐☐

Yes (01) Didn't take it up (03)
No (02) 58b. Why not? *(Qual.)*

60. While in treatment for problems related to your use of alcohol/drugs, were you ever asked whether you'd had childhood experiences of sexual abuse? ☐☐

Yes (01)
No (02)

60a. (IF YES) How did you feel about the way this was handled? *(Qualitative)*

61. Have you ever gone to self-help (fellowship) meetings or groups? ☐☐

Yes (01)
No (02)

61a. (IF YES) Which ones? ..... ☐☐☐

61b. What do you think about these groups? *(Qualitative)*

62. GENERAL HEALTH QUESTIONNAIRE

63. SELF-ESTEEM INVENTORY

64. TRAUMA LIST: See box below.

PLEASE READ THE LIST OF EVENTS BELOW.
Circle YES or NO to show whether or not any of these events have ever happened to you. If YES, write how old you were when the event first happened to you.

EVENT	Did this ever happen to you?	If YES . . . How old were you when it first happened?
I was involved in a fire, flood, or natural disaster.	YES NO	
I was involved in a life threatening accident	YES NO	
I witnessed someone being badly injured or killed.	YES NO	
I was threatened with a weapon, held captive or kidnapped.	YES NO	
I was seriously injured when someone attacked me	YES NO	
Someone I cared about was seriously threatened	YES NO	
I was seriously physically neglected as a child	YES NO	
I was serious emotionally neglected as a child	YES NO	

Section B: ***To be answered only by people who have been screened as yes for CSA.***

Code: ☐☐☐☐☐☐

The next few questions apply to your childhood experiences of unwanted sexual contact, before you turned 16.

1. Look at this card and tell me the number beside the category which most accurately describes your relationship to the person (or people) who pressured you to have unwanted unwanted sexual contact. *(List first three answers)*

(Card 2) ☐☐☐☐☐☐

Biological Father	(01)	Trusted neighbour or	
Step-father	(02)	friend of the family	(07)
Biological Mother	(03)	Acquaintance	(08)
Brother	(04)	Friend	(09)
Sister	(05)	Lover	(10)
Stranger	(06)	Other	(11)
		Specify	

2. Was this person/were these people male, female or both? *(See above)* ☐☐

Male (01)
Female (02)
Both (03)

3. Was this person/were any of these people at least five years older than you? ☐☐

Yes (01)
No (02)
Don't know (03)

4. Were you ever pressured into unwanted sexual contact by more than one person at a time? ☐☐

Yes (01)
No (02)

5. Did you ever become pregnant because of unwanted sexual contact before you were 16? ☐☐

Yes (01)
No (02)

5a. (IF YES) What happened? *(Qualitative)*

6. Listed on this card are some things that have happened to other women when they were children. For each one I would like you to tell me whether it happened to you once or more than once before you turned 16. *(Card 3)*

It did not happen to me (00)
It happened to me once (01)
It happened to me more than once (02)
I don't know if it happened to me (03)

A. Someone touched or fondled my body, including my breasts or genitals? ☐☐

B. Someone made me touch their body in a sexual way? ☐☐

C. Someone rubbed their genitals against my body in a sexual way? ☐☐

D. Someone touched my genitals with their mouth ☐☐

E. Someone made me touch their genitals with my mouth ☐☐

F. Someone tried to have intercourse with me ☐☐

G. Someone had sexual intercourse with me ☐☐

H. Someone had anal intercourse with me ☐☐

7. Were you ever physically harmed or threatened with physical harm when you experienced unwanted sexual contact? ☐☐

Yes (01)
No (02)
Don't know (03)

8. Use this rating scale to show what effect you believe the unwanted sexual contact before age 16 has had on your life. *(Card 4)* ☐☐

1. no effects on my life (01)
2. had a minor effect on some areas of my life (02)
3. had a major effect on one area of my life (03)
4. had a major effect on several areas of my life (04)
5. had a major effect on almost all areas of my life (05)

9. Before the age of 16, did you ever tell anyone about your experience of unwanted sexual contact? ☐☐

Yes (01)
No (02)
Hinted/not directly (03)

9a. (IF YES) Did telling someone make things better or worse for you? ☐☐

Better (01) No difference (030
Worse (02)

Although you may have had several different experiences of unwanted sexual contact before the age of 16, I would like you to focus on the experience that you think has had the MOST IMPACT on your life.

This may have been a one-off occasion or it might have ongoing.

10. How old were you when this happened or when it began? (YRS) ☐☐

11. How old was the person who pressured you into unwanted sexual contact? ☐☐

12. What was that person's relationship to you? *(Card 2)* ☐☐

.....

13. Look at *Card 3* again. During the experience of unwanted sexual contact with X which of these things happened once or more than once?

A. Someone touched or fondled my body, including my breasts or genitals? ☐☐

B. Someone made me touch their body in a sexual way? ☐☐

C. Someone rubbed their genitals against my body in a sexual way? ☐☐

D. Someone touched my genitals with their mouth ☐☐

E. Someone made me touch their genitals with my mouth ☐☐

F. Someone tried to have intercourse with me ☐☐

G. Someone had sexual intercourse with me ☐☐

H. Someone had anal intercourse with me ☐☐

14. What did you think might happen if you refused to go along with what X wanted? *(Qul)*

15. Look at this card and tell me the number or numbers next to the kinds of pressure or forced used by X to get you involved in unwanted sexual contact. *(Card 5)*

Type of pressure	**Code No.**	**Tick if YES**
They tried to talk you into it	(01)	
They said they would hurt you	(02)	
You were afraid they wouldn't like you or love you	(03)	
They said that someone else wouldn't like you or they threatened to turn someone else against you	(04)	
You believed that someone close to you could be harmed or abused	(05)	
They tricked or deceived you	(06)	
They bribed you or offered you a reward	(07)	
They scared you because they were bigger or stronger	(08)	
They pushed, hit or physically restrained you	(09)	
They threatened you with a weapon	(10)	
They drugged you or got you drunk	(11)	
They physically harmed or injured you	(12)	

16. What were the main feelings that you had at the time of the unwanted sexual contact with X? *(Qualitative)*

17. How have your feelings about what happened changed with time? *(Qualitative)*

18. Do you think your feelings in the past month have been influenced by your childhood experience of sexual abuse? How? *(Qual.)*

19. How has your memory of the event changed over time? *(Qual.)*

19a. Did you ever find yourself remembering the event even when you did not want to? (IF YES) How recently? (Years)

.....

19b. Did you ever have a memory block so that you couldn't remember some of the details? (IF YES) How recently? (Years)

.....

19c. Did you ever have dreams or nightmares about the abuse? (IF YES) How recently? (Years)

.....

20. A child's body can sometimes get sexually aroused by unwanted sexual contact even though the child may not want to feel that way. What do you think about this? *(Qualitative)*

21. What was your relationship with X like before he first abused you? *(Qualitative)*

22. In what ways did your relationship with X change after unwanted sexual contact had happened? *(Qualitative)*

23. Were you suspicious of X before it happened or did it come as a total surprise to you? *(Qualitative)*

24. In what ways did you try protect yourself from what was happening? *(Qualitative)*

25. Did you use any special thoughts or fantasies to help you get through it? *(Qualitative)*

26. How old were you when the unwanted sexual contact with X stopped? (YRS) ☐☐

27. How did it stop? *(Qualitative)*

28. <u>At the time</u> of the unwanted sexual contact, who did you think was responsible? *(Qualitative)*

28a. (IF SELF) What made you think that you were responsible? *(Qual.)*

29. Looking back now, why do you think it happened? *(Qual)*

30. Do you think there was anything positive about what happened? *(Qual.)*

31. What percentage of women do you think have had an experience like yours? ☐☐☐☐.....

32. At the time of the sexual abuse, what things made it hard for you to tell someone what was happening? *(Qual.)*

33. (If offender not mentioned) Was there anything that X did or said to make it harder for you to tell other people? *(Qualitative)*

34. Who was the first person that you ever told about what happened between you and X? ☐☐

35. What enabled you to take this step? *(Qualitative)*

36. How old were you when you told them? (YRS) ☐☐

37. What happened after you told them? *(Qualitative)*

38. Did telling someone lead to any changes in your close relationships with people? *(Qual.)*

39. Do you think that the abuse has had any affect on your adult relationships? ☐☐

Yes	(01)	39a. What kinds of affects have you noticed? *(Qual.)*
No	(02)	
Don't know	(03)	

40. Do you think that the abuse has had any effects on your adult sex life? ☐☐

Yes	(01)	40a. What kinds of effects have you noticed? *(Qual.)*
No	(02)	

41. (If not answered above) Has your childhood experience of sexual abuse ever led you to feel frightened of sex or frightened of some aspect of sex, during adulthood? ☐☐

Yes	(01)
No	(02)

42. Some women who have been sexually abused when they were kids, sometimes feel worried about how they might act towards children. Have you had any worries like this? What sorts of worries have you had? *(Qual.)*

43. Do you ever avoid doing things or going places <u>now</u>, because of your experience of sexual abuse during childhood?

Yes	(01)	43a. What kinds of things have you most recently avoided? *(Ql)*
No	(02)	

44. Has your childhood experience of sexual abuse changed the way you feel about yourself? In what ways? *(Qual.)*

45. What coping strategies have you mainly used to deal with any after effects of your childhood experiences? *(Qualitative)*

45a. (IF D&A) How has this helped you?

46. What personal strengths do <u>YOU</u> have that have particularly helped you to deal with these effects? *(Qualitative)*

Section C: ***To be answered only by people who have been screened as yes for D&A.***

d&a **Code:** ☐☐☐☐☐☐

Drug use history

1. I'm going to list some drugs that you may have used some time in your life. If you have used them, (a) how old were you when you first used them? (b) How old were you when you first began to use them regularly? (c) Which drugs were they?

Drug	Age first use	Age regular use	Which drugs?
1. Heroin/opiates eg. street methadone, morphine, pethidine, codeine			
2. Analgesics eg. aspirin, paracetamol			
3. Alcohol			
4. Cannabis			
5. Amphetamines eg. speed,XTC			
6. Cocaine eg. coke, snow, crack			
7. Tranquillisers eg. serapax, rohypnol, mogadon, valium			
8. Barbiturates eg. nebutal, seconal, nembudeine			
9. Hallucinogens eg. acid			
10. Inhalants eg. glue, kero			
11. Tobacco			

12. How old were you when you when first got drunk/stoned? ☐☐

14. How old were you when you first became aware that drugs/alcohol were a problem for you? ☐☐

16. When did you first enter treatment for drugs/alcohol? (Lag to treatmt in mths) ☐☐☐

(Write verbatum) .....

17. What are the main reasons you think you started to drink/do drugs? *(Qualitative)*

18. During the time that you have had a problem with drugs/alcohol, have you had sober/straight periods where you haven't had anything for at least two months?

If yes, how many times? (No = 00) ☐☐

18b. What factors contributed to you being able to have sober or straight times? *(Ql)*

18c. What was the usual reason for busting? *(Qualitative)*

19. *What proportion of your friends, or those people closest to you, currently use your main problem drug? ☐☐☐

20. What proportion of the people close to you currently have problems with drugs/alcohol or are in recovery? ☐☐☐

21. Does your partner have a problem with alcohol or other drugs? ☐☐

Yes (01)
No (02)
N/A (03)

Current Drug Use

22. What is your main problem drug? ☐☐

.....

23. *Some women report feeling better when they use drugs or alcohol. How do you feel when you have your problem drug? *(Qualitative)*

24. ***(Group specific**; If on methadone):* what is your current dose (mg) [5mg=1ml]? ☐☐

Currently, are you abstinent or still using your main problem drug? ☐☐

Abstinent (01) For how long have you been abstinent? ☐☐
Still using (02)

****

If abstinent from current main problem drug for no more than 2 months,
administer OTI & HRBS

If abstinent from current main problem drug for longer than 2 months,
administer Quantity/Frequency table

****

Quantity/frequency table

Frequency and quantity of use refers to the month prior to your abstinence.

Drug Class	Frequency of use (e.g., daily, wkly)	Average quantity per use episode	Self-described steady/binge user
39. Heroin			
40. Other opiates			
41. Alcohol			
42. Cannabis			
43. Amphetamines			
44. Cocaine			
45. Tranquillisers			
46. Barbiturates			
47. Hallucinogens			
48. Inhalants			
49. Tobacco			

Injecting

50. How frequently did you inject in the month preceding treatment entry (e.g, daily, weekly)? ..... ☐☐

51. Did you either use someone else's used injecting equipment or pass your used equipment on to someone else? ☐☐

Yes (01) Don't know (03)
No (02)

52. Who was/were this person/people? (e.g., partner, friend) ☐☐

.....

53. Did you clean your injecting equipment with bleach? ☐☐

Yes (01) Don't know (03)
No (02)

Sexual Behaviour

54. How many people did you have sex with in the month before entering treatment? ☐☐

55. How often did you use condoms when having sex (e.g., always, 50% of the time)? ☐☐☐☐

56. Did you have anal sex? ☐☐

Yes (01)
No (02)

****

Everybody is asked the following questions.

****

57. Have you ever had Hepatitis? ☐☐

Yes (01)
No (02)
Don't know (03)

57a. (IF YES) do you know if it was B or C? ☐☐

B (01) Both (03)
C (02) Don't know (04)

58. Have you ever been tested for HIV? ☐☐

Yes (01)
No (02)
Don't know (03)

58a. (IF YES) What was the result? ☐☐

Positive (01)
Negative (02)

59. DEPENDENCE QUESTIONNAIRES

If main drug is alcohol, administer ICQ & SADQ-C.
If main drug is not alcohol, administer SDS.

APPENDIX C: THE FAMILY SYSTEMS

Verbatim summaries of the family systems by each woman in the qualitative sample.

*CLOSE AND HAPPY							
Kathleen Gp 2	Mother and father.	Both.	1	She's been a terrific mother.	We were close. A very loving father.	A lot of fighting between him and Mum.	We used to fight a lot but we were all very happy.
Judy Gp 2	Mother. Father died.	None.	4	My Mum encouraged me a lot. She was always there for me.	He was sick. But he was always there.	He played the mother role and my Mum played the father role.	I had the best childhood. I had everything.
Ella Gp 3	Mother and father.	None.	2	A really strong relationship. Really emotional.	Really fun father. When we became teenagers, he became very distant.	Traditional roles but that seemed to suit. So happy together.	Really lovely childhood. From [teens] very stressed.
*MOTHER DISTANT, FATHER LOVING							
Sylvia Gp 1	Mother and father.	Both.	1	If she wasn't at work, she was in bed with a migraine headache. Very distant.	Poor old Dad tried very hard. Strict in one way and in another not.	A reasonable relationship.	Strict. Reasonably happy. I would have responsibility of [sibling].
Vicky Gp 2	Mother and father.	None.	2	I never felt terribly close to her.	I used to do everything with my father when I was a tomboy.	Mum sort of went along with most things that he said.	I felt different to everybody. Isolated.
April Gp 2	Mother and father. Grandfather.	None.	2	Distant.	We had quite a good relationship. I was sort of always with my father.	Seemed okay.	Left to do all the chores. Otherwise, on my own.
*MOTHER LOVING, FATHER DISTANT							
Sarah Gp 2	Mother and father.	None.	2	I got on extremely well with my mother and we were great friends.	I idealised my father but he was often away. We placed him on a pedestal.	Wonderfully. Talked about [conflict] openly.	It was a very happy childhood.

Tatiana Gp 2	Mother and father, grandmother.	None.	2	A great deal of love. Compensated for my father.	I didn't have a relationship with him at all. We just never spoke.	Wonderfully. Loving.	Very strict, restrictive, religious.
Cecilia Gp 2	Mother and father.	None.	2	Very close to my Mum.	I felt like I never knew 'im. He was a workaholic.	They were very much in love.	Lonely. No sooner make friends and we'd move.
Gwen Gp 2	Parents divorced.	None.	1	We've always got on. She's always been there.	He was a good Dad at the time. I didn't see my father once they got divorced.	My father liked to be the boss, to take all the money off my Mum.	A lot more freedom. Ended up with me getting pregnant young.
Ruth Gp 2	Mother and father.	Both.	1	Similar personalities, we clashed over everything but close enough.	Pretty close, was away quite a lot.	Fine. Mum sort of raised on her own a lot of the time.	Alright until I hit my teens when [friend died].
Lynn Gp 4	Parents divorced. Mother remarried.	None.	3	Great, if we didn't talk about anything too personal.	(1) Father: I don't think I had a relationship. (2) Stepfather: Everything was his way and that was it.	I wonder what keeps [them] together 'cos all they do is fight and argue.	We moved all the time. Very hectic.
*BOTH PARENTS PREOCCUPIED OR DISTANT							
Isabelle Gp 1	Father died. Mother remarried	None.	0	Parts of her were warm and parts of her were cold. I couldn't stand my mother.	(1) Father: Really loving but disinterested. (2) Stepfather: Good to me [but sexually abusive].	She thought he was too tough, he thought she was too soft.	Children should be seen and not heard. Be good and don't get in the way.
Peggy Gp 1	Adopted parents separated.	Mother.	2	Saw her once a week [because] she was running her own business. I hated her [but] don't know why.	Hadn't been coming home for as long as I remember. He was my favourite, and I was his favourite.	They didn't talk . . . there was nothing between them.	Very independent. Had to fend for ourselves.
Magdalen	Mother and	None.	3	My mother had been a	Too busy. He was not at	They went for three	"[Mother] got sick

a Gp 3	father.			psychiatric patient. We weren't close.	home.	years without speak.	after you were born".
Netty Gp 3	Grandmother, institutions, parents.	Father.	1	She'd just sit in front of the television all day. Nervous breakdowns.	I was always embarrassed and I'd always walk along ahead or behind.	They loved each other but he'd punch her sometimes.	I had to basically parent them.
Marline Gp 3	Mother and father.	None.	3	She doesn't show any affection or any love. Quite distant.	He was rarely at home. I was [in teens] when the sexual activity started.	Seemed to get on. Don't remember disagreements.	We never stopped moving. I didn't have any friends.
May Gp 3	Mother, institution.	None.	3	The glamorous lady who used to visit me.	[Deceased]	—	Separated from everybody. I became rebellious.
Milly Gp 4	Father died. Mother remarried.	None.	4	We used to fight a lot. Very busy with the business.	(1) Father: Very strict, authoritarian. (2) Stepfather: Quite good.	Fought a lot. Natural father was more aggressive.	Chaotic. I took on a lot of responsibility. I was the mediator.
*BOTH PARENTS PREOCCUPIED OR DISTANT (Continued)							
Brenda Gp 1	Mother and father.	Father.	1	Very distant. She was always at work anyway.	Able to communicate more with him.	[She'd] throw anythink. She's cut 'im on the arm, one night.	My brother bashin' me up. You've gotta look after yourself and fight back.
Beth Gp 4	Parents separated.	None.	3	Cordial. Wasn't a touchy sort of person. In and out of mental hospitals.	I was his surrogate wife.	Nobody spoke! How can there be disagreements?	I was a very good girl. I was a sickly child.
*MOTHER DEMANDING, FATHER PERIPHERAL							
Alice Gp 1	Parents and extended family.	Both.	10	Very demanding. I can see now, because she had so much that she had to do.	I didn't really have a lot to do with him.	When they were drinking, a lot of violence.	Had to look after the kids a lot, very tiring for me.
Loretta	Mother and	Both.	0	Very abusive. She was a	He always let Mum deal	Very volatile.	A list of chores. If

Gp 3	step-father.			very dominating lady.	with me.	Fighting and getting drunk together.	they were done, there was another list.
Bonnie Gp 4	Parents divorced.	Father.	1	She's quite domineering. So I'd just keep the peace.	He used to be more protective of me and see my side of things.	A lot of fighting from the divorce. Very, very bitter.	A lot of responsibilities because of [sibling] . Had to support Mum.
Jerry Gp 4	Adopted parents.	None.	1	Suffered from pretty major depression. No concept of anybody but herself.	We' d see 'im and we got on but didn't really have anything to do with him.	Mum'd just "Oh, he doesn't care about me" and he'd be ignoring her.	I was `therapist', tryin' a resolve arguments between them.
*MOTHER DEMANDING, FATHER PERIPHERAL (Continued)							
Bernice Gp 4	Mother and father.	None.	2	Me trying very, very hard to make her happy.	Just someone that lived in the house. A complete non-entity.	He'd rant and rave and scream and she'd give in.	I came between them. Both expected different things.
*PATRIARCHAL: FATHER DOMINATES, MOTHER SUBMISSIVE							
Rosalie Gp 1	Parents and extended family.	Father.	4	She used to play with us and do everything that Dad wouldn't. She was lovely.	Always at the pub. Used to come home from the pub wasted and lash out at us.	Mum stuck with Dad because she had a [large] family.	Always forever getting the hidings - so we [siblings] were closer to each other.
Chloe Gp 1	Mother and father.	Both.	1	Close [but] arguments. Mum's too upset to go and see her [about problems].	He always put me down, like my mother, you know, "Women are sluts".	They would argue. Sometimes, Dad'd lay Mum out.	Unstable. Rocky. Abusive. I always felt like a burden.
Elaine Gp 1	Mother and father.	Father.	1	Very good. Just talking and being kind.	Alcoholic. Verbally and physically abusive. Neglected the family.	Unhappy marriage. Mum was always tryin' to calm him	Encouragement [to] do what I want when I leave. [Had]

						down and protect me.	trouble making friends.
Bridget Gp 1	Mother and father.	Both.	1	Never like mother-daughter relationship. Bit of a nagger. Poor old Mum.	It was like he never wanted to hear me really say anything.	Dad always drunk, Mum nagging him. She was at his beck and call all the time.	[They] used to call me an idiot and a fool and a no-hoper.
Tinne Gp 1	Mother and father.	None.	3	A very soft person. I know that she loved me but she was a very weak woman.	Horrible, ugly person that come and hurt me all the time. Violent to everybody.	I never saw her do anything that he didn't want her to do.	He did single me out. I copped the worse.
*PATRIARCHAL (Continued)							
Janice Gp 4	Mother and father.	Father.	3	She's always worried about what people think. She didn't really wanna be bothered with me.	He treated me dreadfully. He yelled at me, screamed at me, he hit me, called me stupid.	Dad used to yell a lot at Mum, too . . . He was God.	The only time I ever came to life was when I went to school.
Crystal Gp 4	Mother and father.	Father.	1	Most of her energy and attention was put on my younger sister.	I used to adore my father. And then, it changed after he [got sexually aroused].	They hated each other. Dad used to beat my Mum up.	Very lonely. And I was very wild.
Stephanie Gp 4	Parents, then aunt & uncle.	Mother.	4	I looked after her. I used to have to get her to the doctor and rescue the kids.	I was terrified of him. Used to come home and line us all up against the wall.	He physically abused her. Broke her wrist.	I was dislocated and things were not explained to me.
Amy Gp 4	Mother and father.	Father.	3	We loved Mum.	Always scared of him. Don't move do whatever he tells you to do.	Mum wouldn't have a say. Used to bash my mother too.	Very rough and insecure. A nightmare.
*BOTH PARENTS PHYSICALLY ABUSIVE							
Sandra	Mother and father.	Both.	3	Me mother'd get drunk. And she'd get [father] to	When he wasn't at work,	Me father 'd belt me mother. Mother 'd be	I was a housekeeper. I was there to rear

Gp 1	Institution.			the point where he'd bash me.	he was at the pub.	with other blokes.	my [siblings].
Rory Gp 3	Mother and father.	Both.	1	I hated her. Mum was crazy.	Most of the time, he didn't exist. Only there for extreme punishment.	They hated each other. Chasing each other with knives.	S'posed to be silent until they wanted us to say something.
Paola Gp 4	Mother and father.	None.	1	Once she started hitting, she couldn't stop.	I was alway fearful of him.	In their own world, which excluded us.	Very introverted and withdrawn.
*FOSTERED BUT NOT FAVOURED							
Harriet Gp 1	Aunt and uncle.	Both.	8	All [aunt] knew how to do was use a razor strap and hit me.	All I can remember is [uncle] being drunk.	Fighting a lot. Yelling and throwing things.	I never got any praise. Childhood was nothing. You're there to be bashed.
Joan Gp 1	Maternal grandmother.	None.	0	My mother died in childbirth. She said I was responsible.	When I was five he said that he was getting married. Never came back to see me.	—	You've got no rights. You know, you're OWNED.
Morna Gp 2	Adopted parents.	Mother.	2	A very cruel woman and a very selfish woman.	He's pretty inaccessible and follows what she says.	They're very close. But she runs the show.	Not encouraged to express yourself. They DID favour my sister [not adopted].
Clare Gp 3	Foster parents.	None.	1	Violent, stormy, pathetic. I was desperate for affection.	I barely saw him. Then all of a sudden, he was being sexually overt.	They seemed to just take each other for granted.	Compared to [biological son]. They thought I had bad blood.
Delphine Gp 4	Stepmother, father, institutions.	None.	3	[Stepmother] didn't want me around and she made sure I knew about it.	Overseas a lot. Worshiped him. That idolatry thing went [when he got sexual].	Plenty of yelling and later divorced.	"Women are supposed to clean houses and you can't

							even do that".
*MOTHER'S MOOD SWINGS, FATHER INEFFECTIVE OR DISTANT							
Myra Gp 1	Mother.	Mother.	2	When she was drinking I hated her. I was ashamed and frightened as well.	Rarely ever saw him.	—	Insecure, lonely. A lot of fear.
Noelene Gp 2	Foster homes and parents.	Both.	0	Morphine addict. Very sick, temperamental, changeable.	Frustrating cos he always too her side.	Resentment and anger. [Mother would] threaten to kill herself.	Always in trouble for things that I didn't know what I was in trouble for.
Lillian Gp 2	Mother and father.	Mother.	1	Never really very close. I'd find her staggering around. Was ashamed of her.	I was closer to him than Mum. He didn't have a lot of time to spend with me.	[During conflict] it was the silent treatment.	[Everyone] left [Mum] to me. I couldn't have any friends home.
Geraldine Gp 2	Mother and father.	None.	3	Totally terrified of my mother. She'd lose control once she started hitting us.	Could always talk to him. I was his princess. We didn't get to see him much.	A lot of anger towards him. [Mum] accusing 'im of having affairs.	Did what I was told. My father showed affection, but never any from my mother.
Pru Gp 3	Mother and father.	Both.	3	The relationship was either loving or hating. It was never just normal.	He was really sweet. He never had anything to do with me, really.	She'd throw things at him and abused him. He beat her.	Emotionally violent, more than physically. Chaos and turmoil.
Marjorie Gp 4	Mother and father.	None.	2	I was very afraid of her moods. Very depressive	Have good memories of him but he was always travelling.	Terrible. He hit my mother. Everything was a mess.	A miserable childhood. [Trying to be a] very good girl.
Pseudo-nym	Type of parental unit	Parental substance	No. of siblings	Quality of relationship with mother(s)	Quality of relationship with father(s)	Quality of parental relationship	Main experience of childhood

& group		misuse	at home				

*CHANGED VIEW OF PARENTS							
Gabrielle Gp 3	Mother and father.	None.	2	Embarrassed about my mother. Abusive, she'd play the victim.	Enjoyed talking to him. Distanced myself from the sadistic side.	My father didn't have much respect for my mother, embarrassed.	Happy family kind of facade. I didn't understand why I had such mood swings.
Edith Gp 4	Mother and father, streets.	Father.	4	She was jealous of me. Very abusive.	Sadistic. I used to think he was a lovely man. I'm now finding out.	Mum smashing my father over the head. He'd just be drunk.	Severely abusive and deprived.
Melaney Gp 4	Mother and father.	None.	3	Very distant. Affectionate to my brothers but never showed affection [to me].	I was very proud of him. I'm now realising that I was actually really terrified.	Appeared to have the perfect marriage. Just want to be on their own together.	She described me as being a difficult child. Tryin' to be very good.

Table A1: Verbatim summaries of the family systems by each woman in the qualitative sample

Note: Gp 1 = Drug and alcohol with CSA; Gp 2 = Drug and alcohol only; Gp 3 = CSA with substance misuse; Gp 4 = CSA only.
Where a parent remarried, comments regarding the natural and step-parents in the same column are numbered (1) and (2) respectively.

APPENDIX D: FREQUENCIES FOR MEDIATING FACTORS

Table A2: Group frequencies for four traumas involving abuse by others

Type of trauma	Drug & alcohol with CSA	Drug & alcohol only	CSA with substance misuse	CSA only
Emotional neglect	72% (n=36)	38% (n=19)	80% (n=24)	88% (n=44)
Child physical abuse	66% (n=33)	22% (n=11)	63% (n=19)	70% (n=35)
Adult physical abuse	78% (n=39)	66% (n=33)	50% (n=15)	50% (n=25)
Adult sexual abuse	68% (n=34)	44% (n=22)	63% (n=19)	72% (n=36)

Table A3: Group frequencies for paternal and maternal substance misuse

Parental substance misuse	Drug & alcohol with CSA	Drug & alcohol only	CSA with substance misuse	CSA only
Paternal	65% (n=31)	36% (n=18)	50% (n=15)	53% (n=26)
Maternal	32% (n=16)	28% (n=14)	27% (n=8)	16% (n=8)

APPENDIX E: REGRESSION ANALYSIS OF AGE FIRST INTOXICATED

R Square .37012
Adjusted R Square .33939

ANOVA: F=12.04587 Signif F=.0000

Variable	B	SE B	Beta	T	Sig T
Age 1	-5.5002	.8615	-.6378	-6.385	.0000
Age 2	-4.8327	.8239	-.5970	-5.865	.0000
Age 3	-4.5223	.7548	-.6461	-5.991	.0000
Gp 1	-1.6446	.5648	-.2320	-2.912	.0043
Gp 3	-.9925	.6659	-.1212	-1.490	.1387
Matdrug	-1.4571	.5452	-.1921	-2.673	.0085
Constant	20.0877	.7083		28.360	.0000

Note:
Group: (1) drug and alcohol with CSA; (3) CSA with Substance misuse; Referent: drug and alcohol only.
Age: (1) 16-24 years; (2) 25-29 years; (3) 30-34 years; Referent: 40+ years.
Maternal substance misuse (Matdrug): (1) Absent; (2) Present.
Dependent variable: Age of first intoxication.

Linear regression analysis of the relationship between study group membership and age of first intoxication not including number of traumas.

R Square .38803
Adjusted R Square .35292

ANOVA: F=11.05091 Signif F=.0000

Variable	B	SE B	Beta	T	Sig T
Age 1	-5.6397	.8558	-.6540	-6.590	.0000
Age 2	-4.8303	.8155	-.5967	-5.923	.0000
Age 3	-4.4936	.7472	-.6420	-6.014	.0000
Gp 1	-1.1992	.6067	-.1691	-1.977	.0503
Gp 3	-.6406	.6849	-.0782	-.935	.3515
Matdrug	-1.3271	.5439	-.1750	-2.440	.0161
Traumas	-.1933	.1023	-.1480	-1.890	.0612
Constant	20.7613	.7865		26.399	.0000

Note:
Group: (1) drug and alcohol with CSA; (3) CSA with Substance misuse; Referent: drug and alcohol only.
Age: (1) 16-24 years; (2) 25-29 years; (3) 30-34 years; Referent: 40+ years.
Maternal substance misuse (Matdrug): (1) Absent; (2) Present.
Traumas: Number of traumas from a list of 11.
Dependent variable: Age of first intoxication.

Linear regression analysis of the relationship between study group membership and age of first intoxication, including number of traumas.

APPENDIX F: REGRESSION ANALYSIS OF CGHQ

R Square .15936
Adjusted R Square .13617

ANOVA: F=6.87200 Signif F=.0000

Variable	B	SE B	Beta	T	Sig T
Gp 1	4.3451	1.5040	.26760	2.889	.0045
Gp 4	3.1801	1.6127	.1959	1.972	.0505
APA	2.7158	1.2670	.1696	2.139	.0341
Emotneg2	2.9088	1.3854	.1800	2.100	.0375
Constant	11.5023	1.3668		8.416	.0000

Note:
Group: (1) drug and alcohol with CSA; (4) CSA only; Referent: drug and alcohol only.
Adult physical abuse (APA): (1) Absent; (2) Present.
Emotional neglect (Emotneg2): (1) Absent; (2) Present.
Dependent variable: GHQ.

Linear regression analysis of the relationship between study group membership and the General Health Questionnaire (GHQ).

APPENDIX G: REGRESSION ANALYSIS OF DISSOCIATION

R Square .11715
Adjusted R Square .09901

ANOVA: F=6.45805 Signif F=.0004

Variable	B	SE B	Beta	T	Sig T
Gp 1	1.0265	.3979	.2437	2.580	.0109
Gp 4	.9966	.4195	.2366	2.375	.0188
Emotneg2	.6868	.3630	.1638	1.892	.0605
Constant	1.6990	.3009		5.646	.0000

Note:
Group: (1) drug and alcohol with CSA; (4) CSA only; Referent: drug and alcohol only.
Emotional neglect (Emotneg2): (1) Absent; (2) Present.
Dependent variable: Current dissociation levels.

Linear regression analysis of the relationship between study group membership and current levels of dissociation.

APPENDIX H: REGRESSION ANALYSIS OF SUICIDE ATTEMPTS

-2 Log Likelihood 185.071
Goodness of Fit 148.769

Model chi-square: χ^2=22.633, df=4, p=.0001.

Variable	B	S.E.	Wald	df	Sig	R	Exp (B)
Group			9.1445	2	.0103	.1574	
(1)	1.0921	.4557	5.7442	1	.0165	.1343	2.9805
(2)	-.1266	.4648	.0742	1	.7853	.0000	.8810
Traumas	.1553	.0795	3.8185	1	.0507	.0936	1.1680
APA	.3611	.4230	.7286	1	.3933	.0000	1.4349
Constant	-1.4171	.4501	9.9119	1	.0016		

Note:
Group: (1) drug and alcohol with CSA; (2) CSA only; Referent: drug and alcohol only.
Traumas: Number of traumas from a list of 11.
Adult physical abuse (APA): (1) Absent; (2) Present.
Dependent variable: (1) No suicide attempts; (2) Has attempted suicide.

Logistic regression analysis of the relationship between study group membership and attempted suicide.

APPENDIX I: REGRESSION ANALYSIS OF SEXUAL DYSFUNCTION

-2 Log Likelihood 158.704
Goodness of Fit 153.083

Model chi-square: χ^2=27.818, df=3, p=.0000.

Variable	B	S.E.	Wald	df	Sig	R	Exp (B)
Group			13.2676	2	.0013	.2229	
(1)	1.0240	.4680	4.7877	1	.0287	.1223	2.7842
(2)	1.8121	.5111	12.5714	1	.0004	.2381	6.1230
Traumas	.1833	.0804	5.2020	1	.0226	.1310	1.2012
Constant	-.9178	.4185	4.8098	1	.0283		

Note:
Group: (1) drug and alcohol with CSA; (2) CSA only; Referent: drug and alcohol only.
Traumas: Number of traumas from a list of 11.
Dependent variable: (1) No sex problems; (2) Has experienced sex problems.

Logistic regression analysis of the relationship between study group membership and lifetime sexual dysfunction.