Relationships Between Abuse and Physical/Mental Health in a Sample of Urban Help-Seeking Women

By

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ABSTRACT

Physical and sexual abuse are problems that cross all ethnic, racial, geographic, and socioeconomic boundaries. The literature has consistently shown that the most prominent victims of family violence are women, teenagers, children and the elderly. There has also been increasing evidence for ethnocultural differences in the experience of physical and sexual abuse, with Aboriginal women being abused more often than their non-Aboriginal counterparts. The present study explored the physical and mental health of a sample of 172 Aboriginal and non-Aboriginal women in Montreal who were seeking shelter and social services. Between group differences in history of physical and sexual abuse, and in demographic, socioeconomic, medical, family/social, substance abuse, and psychological domains were explored. This study also explored adverse childhood experiences in relation to history of childhood sexual abuse.

The majority of the sample were single women who were economically disadvantaged, as shown by low employment, dependency on welfare, and need for temporary shelter and other services. They reported high rates of lifetime psychological distress (anxiety, depression), as well as attempted suicide (54.1%) and current substance abuse problems (52.3%). When the sample was stratified for ethnocultural background, the analyses indicated few differences between Aboriginal and non-Aboriginal study participants. They were comparable in terms of demographics, socio-economic background, and medical history. In terms of abuse history, Aboriginal women were more likely than non-Aboriginal women to have been

physically abused in their lifetimes, but there were no differences in history of sexual abuse. Aboriginal women reported higher rates of pregnancies over their lifetime and during adolescence ($\leq$18 years of age).

When the sample was stratified for childhood sexual abuse history, analyses indicated that those who were abused experienced more family-related problems, including serious relationship problems with their parents, and a family history of psychological problems. They were also more likely to have experienced childhood neglect, violent home environments, and to have had a teenage pregnancy. Those with a history of childhood sexual abuse were also significantly more likely to have attempted suicide and to have received treatment for a psychological problem in their lifetimes.

The results suggested that the women in this sample were a highly disadvantaged group, raised in chaotic home environments characterized by childhood physical or sexual abuse and neglect. Many were also currently suffering multiple forms of psychological distress while dealing with daily stresses of living in the city and navigating health and social services. The use of trauma as an explanatory concept for the experience of sexual abuse against women was discussed.

RÉSUMÉ

L'abus physique et sexuel est un problème qui traverse toutes limites ethniques, raciales, géographiques, et socio-économiques. La littérature a régulièrement montré que les victimes les plus éminentes de violence dans les familles sont les femmes, les adolescent(e)s, les enfants et les personnes âgées. Il y a des preuves croissantes pour les différences ethnoculturelles, dans l'expérience d'abus physique et sexuel, les femmes aborigènes se faisant abuser plus souvent que leur homologues non-aborigènes. Cette étude a exploré la santé physique et mentale d'un échantillon de 172 femmes aborigènes et non-aborigènes dans Montréal qui cherchaient un abri et des services sociaux. Les inégalités dans l'histoire de l'abus physique et sexuelle et dans les variables démographique, socio-économiques, médicales, familiales/sociales, l'abus de substances et psychologique on été examines entre les groupes. A travers cette étude on a aussi examiné les expériences adverses dans l'enfance en relation avec l'histoire d'abus sexuel dans l'enfance.

L'échantillon consistait en une majorité de femmes célibataires ayant un désavantage économique, tel que démontré par un faible taux d'emploie, une dépendance pour rapport avec services sociaux et le besoin temporaire d'avoir un abri ou d'avoir recours à d'autres services. Elles ont rapporté un taux élevé de détresse psychologique durant leur vie (anxiété, dépression), ainsi que des attentas de suicide (54%) et des problèmes d'abus actuel de substances (52.3%). Dans bette etude, lorsqu'on a stratifié l'échantillon selon l'arrière plan ethnoculturel, l'analyse a indiqué

de différences entre les participantes aborigènes et non-aborigènes. Elles étaient comparable en terme de démographie, d'arrière plan socio-économique et d'histoire médicale. Pour l'histoire d'abus, il était plus probable que les femmes aborigènes aient été abusées physiquement pendant leur vie que les femmes non-aborigènes, mais il n'y avait aucune différences dans l'histoire d'abus sexuel. Les femmes aborigènes on rapporté un plus haut taux de grossesses pendant leurs vie et pendant l'adolescence ($\leq$ 18 ans)

Lorsque que l'échantillon a été stratifié pour l'histoire d'abus sexuel dans l'enfance, les analyses ont indiqué que celles qui ont été abusé ont expérimenté plus de problèmes familiale, incluant de sérieux problèmes reliés aux relations avec leurs parents. Il était aussi plus probable qu'elles aient expérimenté de la négligence pendant l'enfance, un environnement violent à la maison ainsi que des grossesses pendant l'adolescence. Sensiblement pour celles avec une histoire d'abus sexuel pendant l'enfance, it était plus probable quelles aient tenté de se suicider et quelles aient été traitées pour un problème psychologique durant leur vie.

Les résultats ont suggéré que les femmes dans cet échantillon étaient une groupe grandement défavorisé, élevé dans des environnement de foyers chaotiques caractérisés par de l'abus physique ou sexuel et de la négligence pendant l'enfance. Plusieurs souffraient actuellement de formes multiples de détresse psychologique en étant aux prises avec le stress quotidien de vivre dans une ville, navigant dans les services de la santé et sociaux. L'utilité du traumatisme comme concept explicatif pour l'expérience d'abus sexuel contre les femmes a été discutée.

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Introduction

Violence against women is a universal problem. There are many factors associated with the experience of physical and sexual violence including gender, ethnocultural background and socioeconomic status. Costs are high for the women and children being physically and/or sexually mistreated every day across the globe. In addition to suffering minor injuries, they are at increased risk of death due to interpersonal violence (Campbell, Garcia-Moreno & Sharps, 2004; Quinlivan & Evans, 2005; Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). There is some evidence that the majority of women (77%) who are killed by their partners have a history of being physically abused by them in the past (Koziol-McCain et al., 2006). Through a meta-analysis of literature pertaining to pregnancy associated deaths, Shadigan and Bauer (2005) concluded that the majority of women killed during or soon after a pregnancy die at the hands of their partners. While information on mortality stratified by socioeconomic status is limited in Canada (Health Canada, 2003), there is some evidence that mortality rates are highest amongst people with low socioeconomic status (Tsey, Whiteside, Deemal & Gibson, 2003). Rates of physical and sexual abuse over lifetime differ across ethnocultural groups, with higher rates of abuse among Aboriginal[1] peoples compared to other populations. It has been estimated that

[1] The word Aboriginal is used here to refer to a heterogenous ethnocultural group that includes members of Native nations (e.g., Mohawk, Cree, Mikmaq, Atikamekw, etc.), as well as Inuit and Métis peoples who otherwise are not defined as Indians under the Indian Act. The word Aboriginal may be best compared to the words European, Asian, and Latino, that are used to identify people from a particular geographic area, but are differentiated linguistically, culturally, and historically.

violence-related mortality (including domestic violence injuries and suicide) is three to five times higher for Aboriginal women, compared to women from all other ethnocultural backgrounds in Canada (Native Women's Association of Canada (NWAC), 2002). However, there are few in-depth cross-cultural comparisons of abuse characteristics and their long-term consequences for Native and non-Native people.

The literature also suggests that many children are growing up in homes characterized by family discord, violence, emotional abuse, and sexual assault. Since childhood sexual abuse is a relatively invisible crime, accurate prevalence data on child sexual and physical abuse in Canada does not exist. However, a Health Canada report provides some insight into the incidence of physical and sexual abuse in childhood. The Canadian Incidence Study of Reported Child Abuse and Neglect[2] estimated that there were 2.25 per thousand substantiated cases of child physical abuse and 0.86 per thousand substantiated cases of child sexual abuse in Canada (Trocmé & Wolfe, 2001). Relatively little is known about differences and similarities in the experiences of adverse life events such as childhood sexual abuse and neglect between Aboriginal and non-Aboriginal women.

This study explores interrelationships between physical/sexual abuse and other adverse life experiences among Aboriginal and non-Aboriginal women residing in one of Canada's largest metropolitan areas. Within the scope of the present study,

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The words Native and Aboriginal will be used interchangeably.

[2] The maltreatment cases referred to in this study are those that were reported to and investigated by child welfare services in Canada. (Trocmé & Wolfe, 2001)

relationships between lifetime and childhood sexual abuse and physical/mental health were explored among a sample of help-seeking Aboriginal and non-Aboriginal women. Study participants were recruited from a number of shelter and social service centres in Montreal, Quebec. Information collected included the nature and extent of physical and sexual abuse, history of mental health problems including depression, anxiety, suicidal ideation, and substance abuse, and physical health related issues.

The principal goals of this thesis were to:

(a) determine whether Aboriginal and non-Aboriginal women accessing shelter and social services in the city had similar lifetime and childhood histories of physical and sexual abuse, mental health difficulties (including depression, anxiety, and suicidal tendencies), and substance abuse.

(b) examine relationships between history of childhood abuse and physical health, current and lifetime psychological problems and substance dependence.

(c) determine associations between history of family problems including parental substance abuse, parental psychological problems, and childhood neglect.

(d) determine whether childhood sexual abuse is associated with higher rates of physical and mental health problems in adulthood.

To accomplish this, the thesis is divided into five chapters. The first chapter provides an overview of the prevalence of lifetime and childhood experiences of physical and sexual abuse among women, and research on the sequella of abuse in relation to physical and mental health. Chapter one ends with an outline of the study's rationale, objectives and hypotheses. Chapter two provides information on study

methodology, procedures, and statistical analyses. The third chapter presents results of analyses stratified by ethnocultural background, and childhood sexual abuse. Analyses presented therein explored relationships between the two grouping variables and history of family relationships, current psychological functioning, and substance use. The fourth chapter presents analyses of childhood sexual abuse in a sub-sample of women who completed an interview on childhood experiences of care and abuse. The final chapter presents a general discussion of study results and conclusions. The final discussion also includes an analysis of historical trauma as an explanatory concept for sexual abuse against Aboriginal women.

Chapter 1

The Prevalence of Physical and Sexual Violence Against Women

Defining Abuse

The term sexual abuse represents a wide range of sexual maltreatment including exposing one's genitals to another, and unwanted touching and kissing on one end of the continuum, to forced anal or vaginal intercourse on the other. Physical abuse also involves a wide range of actions that can cause bodily harm; this category of abuse encompasses slapping, punching, and kicking, as well as the use of objects such as belts or whips to strike other persons. Both forms of abuse often involve the use of force or threats against the victim. Current knowledge of physical and sexual abuse against women is limited by two important factors. First, discerning trends in interpersonal violence internationally, nationally, and even locally is hindered by the use of varying definitions of physical and sexual abuse across research studies, since there are no universal definitions of violence or abuse. Second, accurate prevalence data on the perpetration of physical and sexual violence among women and children is virtually impossible to catalogue, due to under reporting of abuse. Existing information however does indicate that physical and sexual violence are major physical and mental health concerns for women and children across the globe. The following section reviews the research literature on these forms of violence against Aboriginal and non-Aboriginal women in adulthood and childhood, their associated factors, and physical and mental health consequences.

Sociodemographic Factors

Studies have shown that the peak rates of physical violence against women usually occur among young women aged 15 to 24 years old (Curtis, Larsen, Helweg-Larsen, Bjerregaard, 2002). According to a Statistics Canada study (n=12,300), 30% of married and previously married women in the ten provinces have been physically or sexually abused by their partners. In addition, 50% of women experienced some form of physical or sexual violence since the age of 16 (Statistics Canada, 1994). Another study compared the 1993 Violence Against Women Survey (VAWS) and the 1999 General Social Survey on Victimization (GSS) and found a general decline in rates of spousal physical or sexual abuse[3] in Canada from 12% to 8% (Statistics Canada, 2001). Five years following that estimate, GSS data still indicated a 7% rate of spousal abuse, representing 653,000 women aged fifteen years and over across Canada who experienced some form of physical or sexual abuse (Statistics Canada, 2005). The majority of these women were pushed, shoved or slapped (40%), while others were beaten, choked or threatened with a gun or knife (23%), sexually assaulted (16%), threatened or had something thrown at them (11%), or kicked, bit, hit, or hit with an object (10%) (Statistics Canada, 2005). A report prepared for the World Health Organization (Krug et al., 2002) reviewed 48 population-based studies worldwide and found rates of lifetime physical abuse against women ranging from 10-69%. National rates of sexual abuse for women in the United States have ranged from

[3] GSS questions on spousal violence were based on definitions of physical and sexual violence contained in the Canadian Criminal Code (Statistics Canada, 2005).

15-30% (Cherlin, Burton, Hurt & Purvin, 2004; Kramer, 2004).

Rates of physical and sexual abuse also vary by women's health and socioeconomic status. Higher rates of abuse are commonly found among young women with lower socioeconomic status and fewer years of education than other women (Brems & Namyniuk, 2002; Field & Caetano, 2004; Flake, 2005; Heaman 2005; Kramer, Lorenzon & Mueller, 2003). In one medical help-seeking sample (n= 1268) from the Midwest United States, rates of lifetime physical and/or sexual abuse were 50-57%, and 26% for sexual abuse (Kramer et al., 2003). Perpetrators of sexual abuse against these women were primarily partners (39%), other family members (20.4%), and fathers (9%).

In one study of 351 female students aged 16 and older, 21.9% experienced some form of sexual abuse before the age of sixteen (Chen, Dunne & Han, 2006). Definitions of sexual abuse ranged from perpetrators' exposure of genitals to the child, to vaginal and anal intercourse. Fourteen percent of females sexually abused had physical contact with their abusers, and of those experiences, 2.6% involved genital contact or sexual intercourse (Chen et al., 2006). Rates of childhood abuse vary, and rates of abuse within some populations may be relatively low. For instance, it has been found as low as 2.5% for sexual abuse, and 8.9% for physical abuse in a majority middle-class random sample (n= 628) of urban-dwelling women (Akyuz, Sar, Kugu & Dogan, 2005).

There is also evidence for ethnocultural differences in the experience of physical and sexual abuse in adulthood. Violence studies conducted in the United

States consistently find higher rates of abuse among ethnic minority Blacks and Hispanics compared to Whites (Field & Caetano, 2004). In their review of interpersonal violence research, Field and Caetano (2004) report that relatively little is known about rates of physical and sexual abuse among Native Americans. However, existing evidence does indicate higher levels among this ethnocultural group (e.g., Bubar & Thurman, 2004; Wahab & Olson, 2004). While estimates indicate that rates of physical and sexual abuse among Native American women are as high as 80%, the quality of the evidence is suspect due to study sampling (Hamby, 2000). Hamby explains that many studies rely on clinical samples, and national estimates include relatively small numbers of Native Americans.

Similarly, in Canada there are few studies examining physical and sexual violence among Aboriginal peoples. Aboriginal-focussed violence research in Canada is typically limited by small study samples and the underuse of standardized instruments. According to the literature that does exist, physical and sexual violence are considered major problems for many Aboriginal people in Canada (e.g., Archibald, 2004; Bopp, Bopp & Lane, 2006, Dion Stout, Kipling & Stout, 2001; Muhajarine & D'Arcy, 1999; Ontario Native Women's Association (ONWA), 1989; Pauktuutit Inuit Women's Association, 2005; Royal Commission on Aboriginal Peoples (RCAP), 1997). For instance, a document prepared by the Ontario Native Women's Association indicated that 80% of a sample of urban and rural dwelling Aboriginal

women (n= 104) who responded to a survey mailing[4] had been abused (ONWA, 1989).

Childhood abuse has also been identified as a form of maltreatment differentially experienced by Aboriginal and non-Aboriginal females. Farley, Lynne & Cotton (2005) investigated history of child abuse among female prostitutes in Vancouver, British Columbia. Fully half of their sample (52%) were Aboriginal women. Study findings indicated that the majority of women had been sexually abused (82%) and physically abused (72%) during childhood. Compared to non-Aboriginal women in the sample, Aboriginal women reported significantly higher rates of childhood physical abuse (81% versus 58%) and childhood sexual abuse (96% versus 82%). While this study sample represents an atypical population and cannot be generalized to other Native groups, it does indicate that there are pockets of Aboriginal women in the city who have been experiencing multiple disadvantages over the course of their lifetimes. One of the main goals of the current study is to investigate whether there are differences in history of physical/sexual abuse between Aboriginal and non-Aboriginal women in an urban help-seeking sample.

Stronger evidence for differences in rates of lifetime physical and sexual abuse between Aboriginal and non-Aboriginal women in Canada can be found in nationwide studies of domestic violence. The General Social Survey data from 1999 indicated Aboriginal women were more likely to have been physically abused (20% versus 7%)

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4 The survey was distributed to women living in urban and rural areas identified by the ONWA's network of local affiliates (ONWA, 1989).

and their children were more likely to have witnessed spousal violence (57% versus 46%), compared to non-Aboriginal women (Statistics Canada, 2001). More recently, Statistics Canada (2005) collected information on spousal abuse in a random sample of 24,000 women and men across Canada. It was reported that Aboriginal women are more than three times more likely to experience physical abuse than non-Aboriginal women, with 21% of Aboriginal women victims of spousal violence, compared to 7% of non-Aboriginal women (Statistics Canada, 2005). Furthermore, Aboriginal women were more likely than non-Aboriginal women (54% versus 37%) to have experienced more severe forms of physical abuse (to have been beaten, choked or threatened with a gun or knife) and sexual assault (can include sexual assault with a weapon, and sexual assaults causing physical injury) (Statistics Canada, 2005).

Rates of sexual abuse among Aboriginal and non-Aboriginal women were also compared in a large study of women seeking routine gynecological care from a community health centre in Winnipeg. Young & Katz (1998) performed secondary analysis of data gathered to explore associations between sexual behaviour and cervical infections in a cross-sectional sample of women. Of the 1003 eligible women, 843 (43.6% Aboriginal) participated in a nurse administered questionnaire designed to collect basic sociodemographic information and history of sexual activity in addition to medical history. Analysis revealed that compared to non-Aboriginal women, Aboriginal women were significantly more likely to have been sexually abused (44.8% versus 30.1%). Among women who reported sexual abuse, the majority of incidents occurred in childhood alone (74%), followed by adult-only

experiences (16.6%) and sexual abuse in both childhood and adulthood (9.4%) (Young and Katz, 1998). However, these women differed on indicators of socioeconomic status, with Aboriginal women twice as likely to be unemployed and have an education that did not surpass eighth grade.

In summary, there is overwhelming evidence for the effects of age, socioeconomic status, and ethnocultural background on the experience of physical and sexual abuse. Women with multiple sociodemographic disadvantages are facing the highest levels of abuse. In particular, young women with low levels of education and income are at highest risk. There is also evidence for ethnocultural-related differences in the experience of abuse, with minority groups exhibiting the highest rates of abuse. There is also some evidence for an Aboriginal, non-Aboriginal divide in rates of abuse, with Aboriginal women faring worse by comparison.

Sequella of Physical and Sexual Violence against Women

Medical Problems

According to a World Health Report (Krug et al., 2002), interpersonal violence can be considered a risk factor for both short and long-term health problems. Physical and sexual abuse affects women's health in a number of ways, including headaches, gastrointestinal problems, chronic pain, fatigue, and insomnia (Kramer, 2004; Kramer et al., 2003; Krug et al., 2002). Health issues related to forced sexual activity include pelvic/abdominal pain, STDs, and HIV/AIDS (Campbell, Woods, Chouaf & Parker, 2000). Poor ratings of physical health for women in the general

population have been associated with a history of sexual abuse (Thompson, Arias, Basile & Desai, 2002; Walker et al., 1999) and physical abuse (Bensley, Eenwyk & Simmons, 2003). There is also evidence for a relationship between abuse and poor health among Aboriginal women. Curtis and colleagues (2002) found that Inuit men and women in Greenland were equally likely to have been the victim of physical violence (women 47%, men 48%). However, Inuit women who were physically abused were more likely than their male counterparts to rate their health as poor, to suffer from chronic disease, and to have recently experienced health problems. Thus, while diabetes, high blood pressure, heart problems, and arthritis have been readily identified as major health concerns for Aboriginal people (e.g., Statistics Canada, 2001b), acts of physical and sexual violence have also been associated with adverse health consequences. Compared to others, Aboriginal people experience more severe forms of physical abuse, are more likely to suffer physical injury stemming from acts of spousal violence (Aboriginal 43% versus 31% non-Aboriginal), and are more likely to fear for their lives as a result of their physical abuse victimization (Aboriginal 33% versus non-Aboriginal 22%) (Statistics Canada, 2005).

Thus there is evidence that the physical and sexual abuse of women can have potentially long lasting adverse effects on the physical health of women. In addition to more immediate physical injuries, a host of chronic medical problems rate highest among physically and sexually abused women. There are also indications that physical and sexual violence can negatively affect women's reproductive health, through unwanted pregnancies, miscarriages, and sexually transmitted diseases (Krug et al.,

2002). The next section provides some information on what is known about the reproductive health consequences of physical and sexual abuse among non-Aboriginal and Aboriginal women.

Reproductive Health

Violence during pregnancy has been identified as a major health issue for women and their children (e.g., Cokkinides & Coker, 1998; Campbell, 2001; Campbell et al., 2000; Heaman, 2005). Negative consequences of abuse have also been identified for unborn children. In addition to maternal stress and substance abuse during pregnancy, poor pregnancy outcomes (such as pre-term births) have been attributed to physical and sexual assaults of pregnant women (Heaman, 2005).

Physical and sexual abuse during pregnancy is a problem particular to young women. Many studies have indicated a risk factor relationship between early life sexual abuse and pregnancy at a young age (e.g., Butler & Burton, 1990; Chandy, Blum & Resnick, 1996; Fiscella, Kitzman, Cole, Sidora & Olds, 1998; Kellogg, Hoffman, & Taylor, 1999; Rainey, Stevens-Simon & Kaplan, 1995). For instance, in one study of 1900 women (of mixed ethnic heritage) recruited from 44 urban and rural sites in the US, the rate of teen pregnancy among women with a childhood history of sexual abuse (33%) was double the rate of those without (Kenney, Reinholtz & Angeline, 1997). In a study of relationships between childhood physical/sexual abuse, conduct disorder, alcohol abuse, and domestic violence in an alcohol treatment seeking population, researchers similarly reported that more than

one third (36%) of the women in their study who had a history of sexual abuse also had a history of teen pregnancy (Kunitz, Levy, McCloskey & Gabriel, 1998). Adolescent mothers are particularly at risk for physical abuse victimization (Gessner & Perham-Hester, 1998; Harrykissoon, Rickert, & Wiemann, 2002; Rosen, 2004). There is evidence that young women who were more severely abused (whose child sexual abuse experiences involved attempted or completed sexual intercourse) were more likely to have multiple sexual partners, to have higher earlier onset of consensual sexual intercourse, and pregnancies before the age of 18 (Fergusson, Horwood & Lynskey, 1997).

Ethnocultural background is also a salient factor in the violence-pregnancy relationship. It should be noted that while teenage pregnancy has been identified as a major health and social issue for Aboriginal (e.g., Archibald, 2004; Dion Stout & Kipling, 1999; Health Canada, 1999; Save the Children Canada, 2000; Ontario Federation of Indian Friendship Centres (OFIFC), 2002; Pauktuutit Inuit Women's Association, 2005) and non-Native women (e.g., Carter &Spear, 2002; Fessler & Kane, 2000; Ross, 2002), the rate of teenage pregnancy among Aboriginals has been found to be four times higher than the national rate (Health Canada, 1999). According to a report prepared for the Aboriginal Nurses Association of Canada, girls as early as 12 years of age are becoming pregnant (Dion Stout and Kipling, 1999). Pregnant Aboriginal women have been identified among those with the highest risk for family violence (RCAP, 1997; Heaman, 2005; Muhajarine & D'Arcy, 1999).

Wyatt, Guthrie, & Notgrass (1992) suggested that the relatively high rates of

unintended pregnancies and abortions among women with histories of sexual abuse may be the result of feeling powerless, and experiencing difficulty in voicing their sexual and contraceptive needs to their sexual partners. An increased risk of pregnancy among sexually abused girls may be mediated in part by a significant increase in high-risk behaviour such as failure to use birth control, multiple sexual partners (e.g., Stock, Bell, Boyer & Connell, 1997), and an early onset of sexual intercourse (e.g., Chen, Dunne & Han, 2006; Fergusson, Horwood & Lynskey, 1997; Roosa, Tein, Reinholtz & Angelini, 1997). The Ontario Federation of Indian Friendship Centres (OFIFC, 2002) report that sexually abused Aboriginal youth are more likely than their non-abused counterparts to forego contraceptive use during sexual intercourse, have multiple partners and be involved in a teen pregnancy.

The literature thus indicates that physical and sexual abuse are problems for women throughout their lifetimes. Abuse occurring during childhood and adulthood is profoundly associated with physical health risks among adolescent and adult women. Concern has also been given to the mental health of women in relation to a history of physical and/or sexual abuse. For instance, compared to pregnant women without a history of physical abuse, women who are physically abused during pregnancy are more likely to suffer from mental health problems (anxiety, depression, suicide attempts, and drug/alcohol abuse), engage in numerous sexual activities, to have unplanned or unwanted pregnancies, and to have lower levels of social support (e.g., Briere & Runtz, 1990; Datner & Ferroggiaro, 1999; Hamberger & Ambuel, 2001; Heaman, 2005; Jasinski, 2001; Wyatt, Guthrie & Notgrass, 1992). Increasing

attention is thus being given to the long-term effects of physical and sexual abuse on women's mental health. The following section reviews research linking physical/sexual abuse experiences and mental illness.

Mental Health Consequences

There is an abundance of literature suggesting that females with histories of childhood sexual abuse are particularly more likely than others to have drug and alcohol problems later in life (e.g. Dinwiddie et al., 2000; Kindler et al., 2000; Wenzel, Hambarsoomian, D'Amico, Ellison & Tucker, 2006). Large co-twin studies of relationships between childhood sexual abuse and later psychopathology indicate that in addition to other mental health problems including depression and conduct disorder, individuals with histories of childhood sexual abuse are significantly more likely than others to develop substance use disorders in adulthood (Dinwiddie et al., 2000; Kendler et al., 2000). Research indicates not only a link between history of abuse and substance abuse, but more severe drug/alcohol problems and psychiatric comorbidity among those who had been abused (Brems & Namyniuk, 2002, Robin, Chester, Rasmussen, Jaranson & Goldman, 1997).

There is also evidence for a link between lifetime physical and sexual abuse and drug/alcohol abuse among Aboriginal women in particular. In one study of urban Aboriginals, individuals with a current drug or alcohol abuse problem were more than four times more likely than others to have been recently physically abused (substance abusers 13.6% versus non-substance abusers 3.1%) (Jacobs & Gill, 2002a). Substance

abusers in that study were also more likely than non-substance abusers to have a lifetime history of physical abuse (65.7% versus 40.5%). A "dose-response" association between severity of physical/sexual abuse and higher likelihood of mental health problems including substance abuse, PTSD, and mood disorders was identified among Aboriginal women using primary health care services in New Mexico (Duran et al., 2004). Through logistic regression analyses on a sample of 1660 Natives in another study, researchers also found that severity of childhood physical and sexual abuse was associated with an increased risk for substance dependence in adulthood (Koss et al., 2003). Their study results also indicated a 7-fold increase in risk for alcohol dependence among women who experienced four or more types of child maltreatment (for instance, physical abuse, sexual abuse, emotional abuse, physical and sexual abuse, physical neglect, and emotional neglect). It has been suggested that some women resort to substance abuse as a coping strategy following sexual abuse (Kaukinen & DeMaris, 2005).

Depression and suicidal ideation have also been identified as mental health consequences of physical and/or sexual abuse (Csoboth, Birkas, & Purebl, 2005; Meadows, Kaslow, Thompson & Jurkovic, 2005; Zlotnick et al., 2006). In one national study of females 15 to 24 years of age (n=1141), researchers found that compared to women with no history of physical or sexual abuse, women with a lifetime history of either physical or sexual abuse were suffering more severe symptoms of depression, established by higher mean scores on the Beck Depression Inventory (BDI) (Csoboth et al., 2005). History of childhood sexual abuse in

particular has been linked to depression, suicidal ideation and repeated suicidal behaviour among women (Akyuz et al., 2005; Boudewyn & Liem, 1995; Chen et al., 2006; Dube et al., 2005; Goldstein et al., 2005; Howard & Wang, 2005; Murthi & Espelage, 2005; Roy, 2005; Turner, Finkelhor & Ormrod, 2006; Ystgaard, Hestetun, Loeb & Mehlum, 2004).

Jacobs and Gill (2002b) found that 40% of a sample of urban Aboriginals had been physically and/or sexually abused at some point over their lifetimes. The study examined the relationship between history of abuse and social, psychological and emotional problems. Three abuse groups were created for statistical analyses: those never abused (NA), those physically abused (PA), and those physically and/or sexually abused (PSA). Compared to the NA group, the PA and PSA groups reported significantly higher rates of lifetime anxiety (NA 42.4%, PA 48.1%, PSA 71.9%), depression (NA 37.0%, PA 59.6%, PSA 75.3%), suicidal ideation (NA 30.4%, PA 56.9%, PSA 71.1%), and attempted suicide (NA 18.5%, PA 46.2%, PSA 54.6%). When the sample was stratified by gender, a differentiation in history of abuse was evident with women experiencing rates of sexual abuse almost two times higher than their male counterparts (females 48.4% versus males 25.6%) (Jacobs & Gill, 2002b).

The literature thus indicates that physical and sexual violence, and mental health problems are intricately intertwined. Data convincingly demonstrate that individuals with a history of sexual or physical abuse in lifetime or childhood experience more mental health problems including substance abuse, depression, and suicidal ideation (Boudewyn & Liem, 1995; Brems & Namyniuk, 2002; Kunitz et al.,

1998; Pirard, Sharon, Kang, Angarita & Gastfriend, 2005; Ratican, 1992; Robin et al., 1997; Teusch, 2001). There is also evidence that Aboriginal women are experiencing particularly high rates of mental health problems that are associated with histories of physical and sexual abuse (Brems & Namyniuk, 2002; Gutierres & Barr, 2003; Jacobs & Gill, 2002b).

Rationale, Objectives and Hypotheses

The literature reviewed above suggests that there are socioeconomic and ethnocultural differences in the experience of physical/sexual abuse, with some evidence that Aboriginal and socioeconomically disadvantaged women in particular experiencing these problems at rates higher than their counterparts. Sexual abuse in particular is associated with potentially long-term negative impacts for Aboriginal and non-Aboriginal victims alike that affect physical and mental health in a variety of ways. For instance, these abuses broadly implicate higher risk for later development of mental health problems including substance abuse, depression, anxiety, and suicidal ideation. The literature on violence however is largely limited by a focus on either lifetime or childhood abuse alone, and varied definitions of physical and sexual abuse, and underuse of comparisons of abuse among women across differing socioeconomic strata.

The current study explored the health and mental health of similarly low socioeconomic status (SES) urban Aboriginal and non-Aboriginal women seeking shelter and social services in Montreal. It is a follow-up to the mental health study

conducted by Jacobs and Gill (2002a, 2002b) in the urban Aboriginal community of Montreal, which found statistically significant differences in rates of psychological distress and substance abuse among Aboriginals who had been physically and sexually abused. That study also indicated that women were at higher risk for abuse compared to males. These results prompted a closer investigation of associations between history of lifetime and childhood abuse and mental health among socioeconomically disadvantaged Aboriginal and non-Aboriginal women in the city of Montreal.

An important focus of this thesis was to examine relationships between multiple adverse life experiences including neglect, physical abuse, and sexual abuse during childhood in relation to health and mental health among these Aboriginal and non-Aboriginal women. Within the literature there is a continued call for investigations into associations between women's experiences of physical and sexual abuse and health factors such as pregnancy, substance abuse, and mental health problems including depression, anxiety and suicidal behaviour. This line of inquiry is explored in the current study.

The first objective of this study was to explore whether low SES Aboriginal and non-Aboriginal women who are accessing shelter and social services in the city have similar histories of physical and sexual abuse, psychopathology (including depression and suicidal tendencies), and substance abuse. This was accomplished by collecting information on: a) lifetime and childhood experiences of physical and sexual abuse, b) self-reported symptoms of depression and other psychological distress, and c) the severity of problems and the need for intervention for psychological problems

including attempted suicide, and drug or alcohol abuse.

Based on the literature review, it was expected that levels of physical and sexual violence would vary by ethnocultural background. It was also expected that as a life stressor, history of abuse would be strongly associated with likelihood of mental health problems.

1. Compared to non-Aboriginal women, Aboriginal women will have higher rates of physical and sexual abuse in their lifetimes.
2. Aboriginal women will show higher rates of psychological problems, including depression, anxiety, and substance dependence, compared to non-Aboriginal women.
3. Compared to non-Aboriginal women, Aboriginal women would have higher rates of lifetime pregnancies and teen pregnancies.

The second objective was to shed light on adverse exposures during childhood in relation to current state of physical and mental health in this low SES sample of women. This was accomplished by collecting information on: a) family history of drug, alcohol, or psychological problems, b) information on history of childhood care and neglect. Statistically significant differences in experiences of childhood physical or sexual abuse, family violence, and teenage pregnancy were expected as a function of differences in ethnocultural background. It was also expected that multiple types of mistreatment in childhood would have a cumulative, or 'dose response' effect on the likelihood of having a psychological or substance abuse problem as an adult.

Ethnocultural differences in these relationships were also explored.

4. Women who had been sexually abused in childhood will also report more health-related problems, have had more pregnancies, and have higher rates of teen pregnancy.

5. Women with histories of childhood sexual abuse will have higher rates of current and lifetime mental health problems including depression, anxiety, suicidal ideation, and substance abuse, compared to women with no history of sexual abuse during childhood.

The following chapter outlines the study methodology and analyses used to test these hypotheses.

Chapter 2

Methodology and Procedures

Participants and Research Sites

Montreal is a large Canadian city with a diverse multiethnic population numbering 3,287,645 (Statistics Canada, 2006). According to the 2001 Aboriginal Peoples Survey, the total non-reserve Aboriginal population in Canada numbered 713,000 (Statistics Canada, 2003). First Nations comprise the largest group (358,000), followed by Metis (295,000), and Inuit (46,000). The majority of these individuals (68%) were living in urban areas (Statistics Canada, 2003). Size estimates of Aboriginal people residing in the Montreal area have varied over the years, from 45,230 (Statistics Canada, 1991) to 9,965 (Statistics Canada, 1996a), and 11,090 (Statistics Canada, 2001a).

Study participants were women of varying ethnocultural backgrounds seeking emergency shelter and/or social services in Montreal. All women, aged 16 years and older who were seeking help with social services, mental health problems, or with food vouchers, meals, and housing at one of the participating service organizations were eligible to participate in the study. To gain an ethnically diverse sample of help-seeking women, participants were recruited from nine sites, including drop-in centres, social service agencies, and shelter organizations on the island of Montreal. Seven of the target organizations were women's shelters including the Native Women's Shelter (NWS), L'Abris Despoire, L'Arret Source, La Dauphinelle, Le Parados, Le Carrefour, and the West Island Women's Shelter.

Each shelter provided a wide range of services for women in difficulty including individual counselling, group therapy, and social activities. Shelter services also included assistance in applying for financial aid, family allowance, low-cost housing, and obtaining identification such as social insurance cards, birth certificates, and medicare cards. Furthermore, shelter services were directed towards meeting basic needs through prepared meals and food vouchers, clothing, and temporary shelter, in addition to providing referrals to drug and/or alcohol detoxification and treatment centres, psychotherapists, legal counsel, and help finding medical or dental care. These organizations also offer follow-up services to help women develop and maintain healthy lifestyles after their departure. While the NWS was established to meet the needs of Aboriginal women specifically, the services of the remaining six shelters were not tailored to meet the needs of any specific ethnocultural group. In addition to the aforementioned services, the NWS also offered aid in obtaining Native status cards that were needed to access to Native drug or alcohol treatment centres, and it provided access to Native healing ceremonies and consultations with Native healers and elders.

The two remaining research sites were Chez Doris and the Native Friendship Centre of Montreal (NFCM). These drop-in social service centres are major interaction points for Non-Aboriginal (Chez Doris) and Aboriginal women (NFCM, Chez Doris) within the urban community. With the exception of temporary residence, these centres provide the same types of services offered at the women's shelters. The NFCM and Chez Doris are information and referral centres located in the East and

West of Montreal respectively. They provide a wide array of services to women in the city. They provide social services including aid with employment issues, obtaining legal identification including Native status cards and Inuit beneficiary numbers, low-cost housing, legal consultations, and provide resource information and referrals for physical and mental health care in the city. In addition to these services, they also provide more fundamental services such as food and clothing depots, and daily lunches. Daily social events are organized including arts and crafts, and workshops on various issues of personal development.

Recruitment

Research assistants made weekly visits to the targeted service organizations to recruit subjects. Researchers were introduced by staff to all clients during group meetings at shelters, and in common rooms at the two service centres. The researchers gave brief bilingual descriptions of the study to clients, outlining the aim to interview women using health and social services in the city. It was explained that information gathered in the interviews would lead to a greater understanding of the issues or problems they were experiencing. They were informed that information would be collected in a number of life domains including medical, legal, drug/alcohol use, family/social relationships, and psychological history.

Bilingual printed notices and information about the study were posted in public areas at each site. The procedure for enrollment in the study consisted of the following steps: 1) obtaining informed consent; 2) conducting the initial interview to

collect information on sociodemographics, medical history, legal history, drug/alcohol use, family/social relationships, and psychological problems; 3) collecting additional measures with self-report instruments. Interviews were conducted on site from Spring 2002 to Autumn 2005.

Detailed Procedures

1) Information and Informed Consent

Data for the current study were collected in the context of a larger follow-up study of mental health among help-seeking Aboriginal and non-Aboriginal females in Montreal. The sample of urban help-seeking women were invited to participate in a project designed to gather information on issues or problems they may have faced while accessing social services in the city. Participating in the project would provide them the opportunity to voice their opinions and concerns in a confidential environment. It was explained to subjects that the study was designed to gather information about the life experiences of women using social services in the city, with regard to family and social relationships, medical history, legal history, drug and alcohol use, and violence. In the process of obtaining informed consent, study participants were informed that 1) they could decline to answer any of the questions in the interview, 2) should they decide, they could withdraw from the study at any point during interview, 3) the initial interview would last approximately 1½ hours, 4) participation in a second follow-up interview would be requested, but should they decide, they could decline further participation in the study.

2) Conducting the Initial Interview

Interviews were conducted in the subject's preferred language, in either English or French with any one of four female interviewers (two Aboriginal, two non-Aboriginal). During this interview information was collected in a number of domains including sociodemographics, medical status, employment and education, drug and/or alcohol use, legal status, recent and lifetime physical and sexual abuse, and psychological status using the Addiction Severity Index (ASI) (McLellan et al., 1990). Detailed descriptions of the ASI and all study instruments are provided below in the section on measures. Information was also collected on number of pregnancies, teen pregnancy, and abuse during pregnancy, and on family history of drug abuse, alcohol abuse, and psychological problems. Following each interview study participants were given $20.00 in the form of gift certificates for Pharmaprix or Zellers to compensate them for any costs incurred to travel to the interviews.

3) Self-Report Questionnaires

Two bilingual self-reports were also used in the interview. The Beck Depression Inventory (BDI) (Beck & Steer, 1987), and Child Abuse and Trauma Scale (CATS) (Sanders & Becker-Lausen, 1995), were used to collect additional mental health and abuse related information including a) recent depressive symptomatology, b) sexual experiences before the age of 18, and c) sexual abuse, neglect, and punishment, during childhood.

4) Second Interview

In the process of gaining consent during initial interviewing, potential study participants were informed that upon completion of the initial interview, they may be invited to complete a second interview to follow-up on some of the issues covered in the first. Prior informed consent to tape-record all second interviews was obtained from all subjects.

5) Conducting the Second Interview

The second interview, also conducted in the subject's preferred language (English or French), collected information on experiences of care (e.g. supervision, neglect, parental antipathy) and abuse (physical, sexual, psychological) before the age of seventeen using the Childhood Experiences of Care and Abuse (CECA) interview. Study participants who completed this interview were remunerated a second time with $20.00 in gift certificates for Pharmaprix or Zellers to compensate them for any costs incurred to travel to the research site for the interviews.

Measures

Substance Abuse and Psychological Problems: Information on substance use (e.g., alcohol, cannabis, cocaine, hallucinogens, etc.) and psychopathology (e.g., depression, anxiety, suicidal ideation, etc.) was collected using the fifth version of the Addiction Severity Index (ASI) in French (RISQ, 1996) and English (McLellan et al., 1990). The ASI is a validated, structured interview designed to collect information

in seven domains including medical history, employment, psychological status, legal status, family/social relations (including lifetime history of physical, sexual abuse) and substance abuse. Information is gathered on subjects' lifetime and recent (past 30 days) status in these seven areas. Within each domain, a number of items relating to recent problem severity are weighted to create a composite severity score. Composite scores range from 0 (no significant problem) to 1 (extreme problem). The psychometric properties of the ASI have been found to be excellent with high interrater reliabilities for all composite scores (Alterman, Brown, Zaballero & McKay, 1994). The drug and alcohol subscales have been shown to have interrater reliability ranging from 0.86 - 0.96 and test-retest reliabilities of 0.92. The ASI has been widely employed in Quebec, and had been recommended by the Le Comite-Conjoint MSSS-Reseau sur la selection d'instruments d'evaluation de la clientele, Quebec (Boivin, 1990). This structured interview has been previously employed within many diverse ethnic populations including Aboriginal people (e.g., Jacobs & Gill, 2002a; Jacobs & Gill 2002b).

Psychological Distress: The Beck Depression Inventory (BDI) is a 21-item self-report that rates the severity of cognitive, affective, somatic, and vegetative symptoms of depression on a four-point scale from neutral to severe. The total score can range from 0 to 63, reflecting the overall level of depression experienced in the week prior to the test (Beck & Steer, 1987). The BDI has been used extensively in clinical and non-clinical samples. The psychometric properties of the BDI are good,

with internal consistencies ranging from 0.86 (in clinical samples) and 0.81 (in non-clinical non-clinical samples) (Beck, Steer & Carbin, 1988). Bilingual versions of this instrument were used, in French (Bourque & Beaudette, 1982) and English (Beck & Steer, 1987).

Childhood Physical/Sexual Abuse and Neglect: Information on childhood physical, sexual and emotional abuse was collected using French and English versions of the Child Abuse and Trauma Scale (CATS). The CATS is a 38-item self-report questionnaire devised to measure various forms of physical, sexual and emotional maltreatment. The instrument was created to measure the existence of childhood abuse in a manner sensitive to individuals' perceptions of the impact of childhood abuse (Sanders & Becker-Lausen, 1995). It's questions are both broad (e.g., "Were there traumatic or upsetting sexual experiences when you were a child or teenager that you couldn't speak to adults about?") and specific (e.g., "Before you were 14, did you engage in any sexual activity with an adult?"). It yields a quantitative index of the frequency and extent of various types of negative experiences in childhood and adolescence (Sanders & Becker-Lausen, 1995). Each item is rated on a five-point scale (0-4) yielding an overall index of childhood trauma as well as three subscales of negative home environment/neglect, sexual abuse, and punishment. The CATS subscales have been shown to have internal consistency ranging from 0.63 - 0.86. Test-retest reliabilities were 0.91 for the neglect/negative home atmosphere subscale, 0.85 for the sexual abuse subscale, and 0.71 for the punishment subscale (Sanders and

Becker-Lausen, 1995).

Childhood Physical/Sexual Abuse, Neglect, and Parental Antipathy: The Childhood Experience of Care and Abuse interview (CECA) (Bifulco, Brown & Harris, 1994) was used in the second interview to explore the nature of childhood experiences. It is a semi-standardized instrument that uses lead questions and additional probes to explore the lives of individuals up until the age of 17. Probes are used to collect concrete information on timing, duration, and descriptions of experiences of care and abuse. The CECA was designed to determine the characteristics of abuse during childhood, such as the number of perpetrators, the relation of the perpetrator(s) to the abused, and both the duration and severity of abuse. It also encourages subjects to provide details of the care received by primary care givers including supervision and affection. Severity ratings of physical abuse, sexual abuse, neglect and parental antipathy in the CECA are based on objective information about these experiences during childhood. Originally created in English, the CECA was translated into French by researchers at the Université du Québec à Montréal (Tousignant et al., 1999).

The CECA interviews were tape recorded and relevant data was filled onto CECA schedules and rating sheets. Portions of the data were transcribed verbatim, including sections on parental neglect, antipathy, and child physical and sexual abuse. Sections of the narrative text were filled onto the mini rating schedules A and B of the CECA, and severity ratings were assigned following the criteria established for the

CECA by Bifulco (2002). This instrument has excellent inter-rater reliability for physical abuse (0.82), sexual abuse (1.00), and relationship to perpetrator (0.98).

Statistical Plan and Data Analyses

Data from initial semi-structured interviews with all study participants were coded and entered into a database using the software program Microsoft Excel. Following verification of data accuracy, statistical analyses were conducted using the microcomputer version 13.5 of the Statistical Package for the Social Sciences (SPSS, 2004).

(1) The first objective of this research was to explore ethnocultural differences in physical and mental health, including the experience of lifetime physical and sexual abuse, depression, and suicidal tendencies, and problem drug or alcohol use. Aboriginal and non-Aboriginal women were compared on basic socio-demographics including age, marital status, years of education, employment status, and monthly income. Comparisons were also made on history of medical status (e.g., number of pregnancies in lifetime, recent and lifetime illnesses), psychological status (e.g., recent and lifetime psychological distress including depression, anxiety, suicidal thoughts, attempted suicide, and recent depressive symptomatology), and recent and lifetime drug and alcohol use. Aboriginal and non-Aboriginal women were compared for similarities or differences in lifetime history of physical or sexual abuse, and help-seeking for health or mental health problems. Comparisons were made using the chi

square test for categorical data, and Student's t-tests for continuous data with a Bonferroni correction for multiple comparisons.

(2) The second objective was to explore associations between history of childhood abuse and current state of physical and mental health. This exploration involved the investigation of relationships between childhood history of sexual abuse and variables relating to current medical status, psychological status, and substance abuse. This variable was created by combining 4 items on the CATS: 1) Before you were 14, did you engage in any sexual activity with an adult?, 2) Were there traumatic or upsetting sexual experiences when you were child or teenager that you couldn't speak to adults about, 3) Did you have a traumatic sexual experience as a child or teenager?, and 4) Did your relationship with your parents ever involve a sexual experience? A positive response to any of these items indicated a history of child sexual abuse.

Between group differences were explored using student's t-tests for continuous health and mental health variables by child sexual abuse history (childhood sexual abuse versus no childhood sexual abuse), such as days experienced medical or psychological problems. Categorical data were examined with chi square analysis. Post-hoc tests were performed using a Bonferroni correction for multiple statistical comparisons. Adjusted chi square analysis (with Yates continuity correction) was also used to compare groups by ethnocultural background (Aboriginal/non-Aboriginal) and childhood sexual abuse (yes/no) for categorical variables.

An additional aspect of the analysis was to determine associations between

childhood sexual abuse and other adverse experiences of childhood, including neglect, parental substance abuse, and parental psychological problems. Using information gleaned from the literature concerning factors associated with multiple adverse childhood experiences (ACEs), a new continuous variable was created for this analysis. It comprised a total count of adverse experiences including family history of substance abuse (parental drug/alcohol use), childhood sexual abuse (child sexual abuse by a parent), physical abuse (ever physically mistreated), witnessing violence (physical abuse of another family member, sexual abuse of another family member), neglect (felt unwanted/emotionally neglected, had to take care of self before old enough). The measure of association for categorical data was the chi square test, and Student's t-tests for continuous data. A Bonferroni correction for multiple comparisons was applied on all statistical tests. Two-way chi square tests with a Yates continuity correction for low cell counts were used to compare groups stratified by ethnocultural background (Aboriginal/non-Aboriginal) and childhood sexual abuse (yes/no) on a number of categorical variables.

Subsequently, variables relating to ethnocultural background, depression, drug/alcohol abuse, childhood maltreatment, and family history of drug/alcohol abuse and psychological problems were used to determine their relative associations with lifetime suicide attempts in multiple regression analysis. This type of regression analysis allowed the use of nominal, ordinal, and interval independent variables to explore these dichotomous dependent variables; it's usefulness for this type of research has been noted (Hosmer and Lemeshow, 1989). Variables relating to

ethnocultural background, severity of substance abuse and social problems, adverse childhood events, were also used in hierarchical linear regression analysis of association with severity of psychological distress. The stepwise model of entry was used for this analysis, allowing a test of each independent variable for their individual contribution to the variance in the dependent variable.

Chapter 3

Results of First Interview

The physical and mental health of urban help-seeking women were explored in relation to multiple factors such as ethnocultural background, age, socioeconomic status, and physical and sexual abuse history. A number of hypotheses were developed based on research literature reviewed, and results from a study of the mental health of Aboriginal peoples in an urban milieu by Jacobs and Gill (2002a, 2002b). These hypotheses were tested, and their results and other statistical comparisons are reported in the following sections.

Ethnocultural Stratification

Sociodemographic Information

A total of 172 service-seeking women were interviewed for this study. To test the first three hypotheses of this study, the sample was stratified into two groups based on data collected on ethnocultural background; Aboriginal (including all Native, Inuit and Metis women) and non-Aboriginal women[5]. Statistical comparisons between these groups were conducted to determine whether there were differences in sociodemographics (e.g., age, education, employment status), histories of abuse, substance abuse problems, and psychological status. The sample breakdown was 48.3% Aboriginal (83), and 51.7% non-Aboriginal (89) women. The four largest

[5] While the heterogeneity of both Aboriginal and non-Aboriginal groups on primary sociocultural factors such as geographic location, language, culture, history, are acknowledged, they are treated here as two separate groups.

Aboriginal groups were Inuit (31.3%), Cree (25.3%), Mohawk (8.4%), and Innu (8.4%). The majority of non-Aboriginal women (91%) were Caucasian. A Native language was the mother tongue for almost two-thirds (62.7%) of Aboriginal women, with the remaining English (27.7%), and French (9.6%). For non-Aboriginal women, almost two-thirds (62.9%), reported French as their mother tongue followed by English (23.6%), and other (13.5%). The majority of Aboriginal women chose to complete the interview in English (88%), and the language of choice for more than two-thirds of non-Aboriginal women was French (65.2%).

Results presented in Tables 1 through 7 indicate that Aboriginal and non-Aboriginal women were very similar in respect to sociodemographic variables. The two groups of women were alike in terms of age and marital status; both groups were equally likely to have ever been married or in a common-law relationship as not. The majority of both groups were residing in a shelter at the time of interview, and were using these services for similar reasons, primarily for temporary shelter. Despite the high rate of current residence in a shelter, most women had been living with a partner or alone in the past three years.

Non-Aboriginal women were however residing in Montreal much longer than Aboriginal women (Aboriginal 7.1 ± 1.4 years, non-Aboriginal 24.6 ± 1.9 years; $t(166) = -7.1$, $p = 0.0001$). This suggests that Aboriginal women may have more recently migrated from smaller communities to the city. Information provided in Table 1 also indicates that Non-Aboriginal women also had the potential for stronger family support systems while in the city since they reported having more family members

Table 1: Selected Sociodemographics Overall and Stratified by Ethnocultural Background (n=172)

	Overall (n= 172)	Aboriginal (n=83)	Non-Aboriginal (n=89)
Age (± SEM)	38.8 ± 0.9	37.7 ± 1.1	39.9 ± 1.4
Marital Status			
Never Married/Common-law	54.1%	50.6%	57.3%
Ever Married/Common-law	45.9%	49.4%	42.7%
Lived With (past 3 years)			
Partner/Family	47.7%	57.3%	40.7%
Alone/Nothing stable	50.0%	42.7%	59.3%
Number of Dependents (± SEM)	0.8 ± 0.08	0.7 ± 0.2	0.3 ± 0.07
Number Family Members in Montreal (± SEM)	2.7 ± 0.3	1.8 ± 0.25	3.5 ± 0.56*
Number Years Lived in Montreal (±SEM)	16.33 ± 1.4	7.1 ± 1.4	24.6 ± 1.9*
Living in a Shelter	72.1%	78.3%	66.3%
Why in Shelter			
Temporary shelter	43.0%	48.8%	38.6%
Fleeing abusive relationship	18.6%	19.5%	18.2%
Counselling/Support/Other	9.3%	9.8%	9.1%

Groups were compared using Student's t-tests and Chi-square analysis.
* significant differences between groups $p < 0.05$, corrected for multiple comparisons.

living in the greater Montreal area than non-Aboriginal women. Both groups of women were also comparable socioeconomically (see Table 2). While non-Aboriginal women received on average 1.5 more years of formal education, there were no significant differences between Aboriginal and non-Aboriginal women in patterns of employment in the past three years. The majority were unemployed and relying on welfare as their main source of financial support.

History of Abuse and Mental Health

The first hypothesis to be tested was that compared to non-Aboriginal women, Aboriginal women would have higher rates of physical and sexual abuse in their lifetimes. To test this hypothesis, chi square analysis was used to compare the two ethnocultural groups on recent and lifetime history of physical and sexual abuse. Results indicate that Aboriginal and non-Aboriginal women were equally likely to have recently experienced physical or sexual abuse (see Table 3). They were also equally likely to have been sexually or emotionally abused in their lifetimes. However, with rates of lifetime physical abuse high overall (82%), Aboriginal women were significantly more likely to have been physically abused in their lifetimes compared to their non-Aboriginal counterparts (Aboriginal 91.5%, non-Aboriginal 76.7%; ^{2} (1), 6.74, $p<0.009$). However, Aboriginal women did not have significantly higher rates of child/teen sexual abuse or neglect/living in a negative home atmosphere according to analyses of mean scores on the CATS neglect (Aboriginal 1.8 ± 0.1; non-Aboriginal 1.9 ± 0.09) and sexual abuse subscales (Aboriginal 1.2 ± 0.1; non-

Table 2: Indicators of Socioeconomic Status Overall and Stratified by Ethnocultural Background (n=172)

	Overall (n= 172)	Aboriginal (n=83)	Non-Aboriginal (n=89)
Number Years of Education (± SEM)	11.1 ± 0.2	10.3 ± 0.31	11.8 ± 0.39*
Employment Pattern (past 3 yrs)			
Employed	32.6%	35.4%	30.3%
Unemployed or Student/Retired	66.9%	64.6%	69.7%
Currently on Welfare	65.1%	61.0%	69.7%
Monthly Income (± SEM)	$596.63 ± 28.34	$573.57 ± 45.33	$618.10 ± 34.93
Days Experienced Employment Problems (Past 30) (± SEM)	4.4 ± 0.7	5.3 ± 1.2	3.6 ± 0.9
Mean ASI Employment Composite Severity score (± SEM)†	0.9 ± 0.01	0.9 ± 0.2	0.9 ± 0.2

Groups were compared using Student's t-tests and Chi-square analysis.
* significant differences between groups $p < 0.05$, corrected for multiple comparisons.
†ASI – Addiction Severity Index composite scores range from 0 to 1.0, with higher scores indicating greater problem severity.

Table 3: History of Abuse Overall and Stratified by Ethnocultural Background (n=172)

	Overall (n= 172)	Aboriginal (n=83)	Non-Aboriginal (n=89)
Experienced in Past 30 Days			
Physical Abuse	18.6%	22.0%	16.1%
Sexual Abuse	9.9%	7.3%	12.6%
Emotional Abuse	40.1%	39.0%	43.0%
Experienced in Lifetime			
Physical Abuse	82.0%	91.5%	76.7%*
Sexual Abuse	70.3%	74.4%	69.0%
Emotional Abuse	82.6%	82.9%	85.1%

Groups were compared using Student's t-tests and Chi-square analysis.
* significant differences between groups $p < 0.05$, corrected for multiple comparisons.

Aboriginal 0.9 ± 0.9).

The second study hypothesis was that Aboriginal women would show higher rates of psychological problems, including depression, anxiety, and substance dependence, compared to non-Aboriginal women. As illustrated in Tables 4 and 5, rates of psychological distress were high for the entire sample, and there were differences in the experience of recent and lifetime psychological distress between Aboriginal and non-Aboriginal women. Chi square analysis of the data revealed that contrary to the stated hypothesis, Aboriginal women did not report higher rates of recent (past 30 days) or lifetime psychological distress than non-Aboriginal women. In fact, compared to non-Aboriginal women, Aboriginal women reported lower rates of recent depression [^{2} (1) = 6.94, p=0.008]. They were also less likely to have been prescribed medication to treat a psychological or emotional problem in the past month [^{2} (1) = 12.04, p= 0.001] and in lifetime [^{2} (1) = 5.54, p= 0.019]. Aboriginal women also and had a lower mean ASI psychological composite severity score [t (163) = -2.57, p= 0.011] than non-Aboriginal women. There were no between group differences in rates of lifetime depression or anxiety, and they were equally likely to seek treatment for a psychological/emotional problem in their lifetimes.

Chi square and t-tests were also used to test categorical and continuous data on drug and alcohol use from the ASI. Similar to other mental health factors, there were few differences in drug and alcohol use between women from these two ethnocultural groups (see Table 6). Contrary to one study hypothesis, Aboriginal women were not more likely than non-Aboriginal women to have a current substance

Table 4: Psychological Distress in Past 30 Days Overall and Stratified by Ethnocultural Background (n=172)

	Overall (n= 172)	Aboriginal (n=83)	Non-Aboriginal (n=89)
Experienced in Past 30 Days			
Any Psychological Problems	69.8%	63.4%	78.2%
Depression	41.3%	31.7%	51.7%*
Anxiety	50.6%	43.9%	58.6%
Thoughts of Suicide	26.2%	25.6%	27.6%
Prescribed Medication in Past Month	33.1%	20.7%	46.0%*
# Days Experienced Psychological Problems in Past Month (± SEM)	13.1 ± 1.0	9.3 ± 1.3	16.6 ± 1.4*
Mean Beck Depression Inventory Score (± SEM)	18.8 ± 1.1	17.5 ± 1.6	19.8 ± 1.5
Mean ASI Psychological Composite Severity score (±SEM)†	0.3 ± 0.02	0.28 ± 0.03	0.39 ± 0.03*

Groups were compared using Student's t-tests and Chi-square analysis.
* significant differences between groups $p < 0.05$, corrected for multiple comparisons.
†ASI – Addiction Severity Index composite scores range from 0 to 1.0, with higher scores indicating greater problem severity.

Table 5: Psychological Distress in Lifetime Overall and Stratified by Ethnocultural Background (n=172)

	Overall (n= 172)	Aboriginal (n=83)	Non-Aboriginal (n=89)
Experienced in Lifetime			
Depression	75.6%	78.0%	75.9%
Anxiety	73.8%	73.2%	77.0%
Thoughts of Suicide	68.0%	70.7%	67.8%
Attempted Suicide	54.1%	59.8%	50.6%
Ever Prescribed Medication for a Psychological problem	57.0%	48.8%	66.7%*
Ever Sought Help for a Psychological Problem	68.0%	62.2%	75.9%

Groups were compared using Student's t-tests and Chi-square analysis.
* significant differences between groups $p < 0.05$, corrected for multiple comparisons.

Table 6: Drug/Alcohol Use Overall and Stratified by Ethnocultural Background (n= 172)

	Overall (n= 172)	Aboriginal (n=83)	Non-Aboriginal (n=89)
Currently Smokes Cigarettes	65.7%	81.7%	51.7%*
Current Substance Abuse Problem	52.3%	57.8%	49.4%
Ever Treated for a Drug or Alcohol Problem	37.8%	48.1%	29.9%*
Number of Days Used in Past 30 Days (± SEM)			
Alcohol (any use)	3.4 ± 0.6	4.4 ± 0.9	2.4 ± 0.6
Cannabis	3.4 ± 0.6	6.0 ± 1.2	1.1 ± 0.5*
Cocaine	1.4 ± 0.4	1.6 ± 0.7	1.1 ± 0.5
Amount of Money Spent on Alcohol (Past 30 Days)	$67.17 ± 17.91	$114.10 ± $35.97	$25.63 ± $9.52*
Amount of Money Spent on Drugs (Past 30 Days)	$63.85 ± 16.86	$92.44 ± $30.21	$38.23 ± $16.72
Number of Years Used in Lifetime (± SEM)			
Alcohol (any use)	14.8 ± 0.9	14.8 ± 1.1	14.8 ± 1.4
Cannabis	5.4 ± 0.6	7.9 ± 1.0	3.1 ± 0.7*
Cocaine	2.6 ± 0.4	2.7 ± 0.6	2.6 ± 0.6
Mean ASI Alcohol Composite Severity score (± SEM)†	0.13 ± 0.02	0.17 ± 0.22	0.19 ± 0.02
Mean ASI Drug Composite Severity score (± SEM)†	0.07 ± 0.008	0.07 ± 0.01	0.06 ± 0.01

Groups were compared using Student's t-tests and Chi-square analysis.
* significant differences between groups $p < 0.05$, corrected for multiple comparisons.
†ASI – Addiction Severity Index composite scores range from 0 to 1.0, with higher scores indicating greater problem severity.

abuse problem. However, Aboriginal women were more likely to be current cigarette smokers [^{2} (1) = 17.16, p= 0.0001], they used cannabis more often in the past month [t (165) = 3.94, p= 0.0001], and spent more money on alcohol in the past month [t (162) = 2.50, p= 0.01]. Compared to other women, Aboriginal women also used cannabis for more years [t (164) = 3.90, p= 0.0001], and were more likely to have been treated for a drug or alcohol problem in the past [^{2} (1) = 5.89, p= 0.015]. Mean ASI alcohol and drug composite severity scores demonstrated no differences between Aboriginal and non-Aboriginal women, however it was evident that many of the women were experiencing some problems related to drug or alcohol use.

Physical Health

Results of chi square analysis and t-tests of health variables are presented in Table 7. The third study hypothesis was that compared to non-Aboriginal women, Aboriginal women would have higher rates of pregnancies and teen pregnancy. Data supports the third hypothesis, with differences in history of childbearing, with Aboriginal women having more pregnancies in lifetime [t (162) = 3.27, p= 0.001]. Aboriginal women also reported more pregnancies before the age of eighteen [^{2} (1) = 8.59, p= 0.003], compared to non-Aboriginal women[6]. Analyses further demonstrated that this sample of help-seeking women were experiencing a number of medical problems in the past year, including pain in extremities or chest and

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While Aboriginal women were more likely to have children (Aboriginal 2.7 ± 0.2, non-Aboriginal 1.2 ± 0.2; t (162) = 5.6, p= 0.0001), both groups reported few dependents. Among women with children, there were no differences in likelihood of having at least one child in foster care or adopted out of family (Aboriginal 21.3, non-Aboriginal 30.6%).

Table 7: Physical Health Overall and Stratified by Ethnocultural Background (n=172)

	Overall (n= 172)	Aboriginal (n=83)	Non-Aboriginal (n=89)
# Pregnancies in Lifetime (± SEM)	3.4 ± 0.2	4.2 ± 0.3	2.7 ± 0.3*
Had a Pregnancy <18 years of age	37.8%	54.2%	31.0%*
In the Past Year Experienced			
Pain in legs, arms, stomach	66.3%	62.2%	70.8%
Chest pains	37.2%	40.2%	34.8%
Fatigue	74.4%	65.9%	83.1%*
Insomnia	64.5%	61.7%	68.5%
Has a chronic medical problem	55.2%	52.4%	58.4%
Sought help for medical problems in the past year	66.9%	74.4%	67.1%
# Days Medical Problems in Past 30 (± SEM)	16.6 ± 1.0	15.1 ± 1.5	18.0 ± 1.4
# Times Hospitalized in Lifetime (± SEM)	4.5 ± 0.5	4.1 ± 0.5	4.8 ± 0.8
Mean ASI Medical Composite Severity score (± SEM)†	0.5 ± 0.02	0.5 ± 0.04	0.6 ± 0.04

Groups were compared using Student's t-tests and Chi-square analysis.
* significant differences between groups $p < 0.05$, corrected for multiple comparisons.
†ASI – Addiction Severity Index composite scores range from 0 to 1.0, with higher scores indicating greater problem severity.

insomnia[7]. An ethnocultural difference emerged in the experience of fatigue, with non-Aboriginal women reporting higher rates than Aboriginal women [^{2} (1) = 6.78, p= 0.009]. They did not differ in rates of chronic medical problems, or in the likelihood of seeking care from a medical practitioner for a health problem. Among those who needed medical care in the past year, one difference in help-seeking was found. Non-Aboriginal women were more likely to have sought care from a general practitioner, while Aboriginals largely sought care from hospitals or clinics [Aboriginals: GP 25%, hospital 75%, non-Aboriginals GP 52.6%, hospital 47.4%; ^{2} (1) = 9.07, p= 0.003].

For women who reported experiencing health problems in the past year but did not seek medical care (n= 46), the most cited reasons for not seeking help were: wanting to solve the problem on her own (66.7%), believing the problem would get better by itself (52.2%), had sought care in the past but it did not help (37.0%), thought help wouldn't do any good (33.3%), and being unsure where to go for help (26.1%). Most women possessed the identification required to access health and social services in the city. In all, 77.3% had a social insurance card, 85.5% had a medicare card, and 69.2% had a copy of their birth certificate. For Aboriginal women, 61.2% had a status card (for Natives), or documentation of a beneficiary number (for Inuit); these forms of identification are necessary for access to specialized services such as Native drug/alcohol treatment centres and federal non-insured health benefits. In addition to the ASI questions on medical status, Aboriginal women were asked if

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To assure respondents understood the term insomnia, they were asked if they had 'problems falling asleep or staying asleep'.

they would like to have access to a medical centre that would provide services exclusively to Aboriginal peoples. The majority of Aboriginal women (70.3%) were in favour of having this option.

Summary of Ethnocultural Stratification

Results presented here indicate that this help-seeking sample of women were from a lower socioeconomic status, with low employment rates and high dependence on social assistance. These women had also been experiencing a number of problems including substance abuse and psychological distress. There were differences in the experience of recent psychological distress among Aboriginal and non-Aboriginal women. For instance, non-Aboriginal women were more likely than Aboriginal women to report feeling depressed in the past 30 days. However, this finding is curious since there were no between group differences in experiencing depressive symptomatology in the preceding week, expressed by similar mean scores on the Beck Depression Inventory (BDI). Rates of lifetime psychological distress were very high for the entire sample, and Aboriginal and non-Aboriginal women were equally likely to seek mental health care. Mean ASI psychological composite severity scores were higher for non-Aboriginal women, suggesting that they were currently experiencing more severe mental health related problems.

Lifetime rates of emotional, physical and sexual abuse were high for the entire sample. When stratified by ethnocultural background, results showed that Aboriginal women were more likely to have been physically abused in their lifetimes,

corroborating previous research. Contrary to the hypothesis stating that Aboriginal women would have higher lifetime rates of both physical and sexual abuse, there were no between group differences in history of sexual abuse. Aboriginal women did however report higher rates of pregnancies and teen pregnancies. The review of existing literature suggests that little is known about Aboriginal/non-Aboriginal differences in rates of sexual abuse and its association with physical and mental health status. In the interest of exploring factors associated with a history of sexual abuse, the next series of analyses were designed to further explore relationships between the experience of sexual abuse during childhood and physical/mental health status. All further analyses were performed on the total study sample, irrespective of women's ethnocultural background.

Stratifications by Childhood Sexual Abuse History

An additional grouping variable was created to explore relationships between the experience of sexual abuse during childhood and problems in a number of domains, including psychological, substance use, and family/social problems. Information on the experience of sexual abuse collected by the Child Abuse and Trauma Scale (CATS) self-report was used to create this grouping variable. It comprised two categories: those never sexually abused during childhood (NA), and those who experienced childhood sexual abuse (CSA).

Analyses by this variable revealed that women with and without histories of childhood abuse were comparable on primary sociodemographic characteristics. The

two groups were similar in ethnocultural background (NA: Aboriginal 47.9%, non-Aboriginal 52.1%; CSA: Aboriginal 46.4%, non-Aboriginal 53.6%). They were also comparable in age (NA 39.6 ± 2.0 years, CSA 38.8 ± 1.1 years), marital history (ever married/common-law: NA 45.8%, CSA 46.4%), and usual living arrangement in the past three years (with partner/family NA 45.8%, CSA 50.5%). Additionally, neither abuse group had significantly higher levels of education (NA 10.3 ± 0.5, CSA 11.6 ± 0.3), and were equally likely to be unemployed and receiving welfare as their primary source of income (NA 54.2%, CSA 69.4%).

Characteristics of Family and Social Relationships

Characteristics of family and social relationships are presented in Table 8. Women in the CSA group were significantly more likely to have experienced problems with their parents in their lifetimes [^{2} (1) = 17.92, p=0.0001]. A two-way chi square analysis of relationship problems with parents by abuse history and ethnocultural groups (Aboriginal, non-Aboriginal) revealed significant differences between groups. Both Aboriginal and non-Aboriginal women who were sexually abused as children were significantly more likely than those never abused to have had serious relationship problems with their parents in their lifetimes (Aboriginal: NA 40.9%, CSA 71.2%, ^{2} (1) = 6.01, p=0.014; non-Aboriginal: NA 44.0%, CSA 82.8%, ^{2} (1) = 12.77, p=0.0001).

While neither group was more likely to report that a parent ever had a drug or alcohol problem, individuals in the CSA group were significantly more likely than

Table 8: Selected Family Characteristics Stratified by History of Childhood Sexual Abuse (n=160)†

	NA (n=48)	CSA (n=112)
Ever Had a Close Relationship With		
Parents	76.6%	60.9%
Sibling(s)	69.8%	64.8%
Spouse	63.6%	57.4%
Ever Had Serious Problems With		
Parents	42.6%	77.3%*
Sibling(s)	46.5%	58.7%
Spouse	68.9%	84.3%
One or Both Parents Ever Had a Drug/Alcohol Problem	57.4%	70.1%
One or Both Parents Ever Had a Psychological Problem	40.0%	63.2%*
# Days Experienced Family Problems in Past 30 (± SEM)	3.9 ± 1.4	3.8 ± 0.8
# Days Experienced Social Problems in Past 30 (± SEM)	5.9 ± 1.6	5.7 ± 0.9
Mean ASI Social Composite Severity Score (± SEM)‡	0.15 ± 0.03	0.23 ± 0.02

Groups were compared using Independent Samples t-tests and Chi-square analysis.
* significant differences between groups $p < 0.05$, corrected for multiple comparisons.
†Twelve study subject failed to complete the CATS sexual abuse questions.
‡ASI – Addiction Severity Index composite scores range from 0 to 1.0, with higher scores indicating greater problem severity.

those in the NA group to report that one or both parents had experienced a psychological problem in their lifetimes [^{2} (1) = 6.91, p=0.009]. A two-way chi square analysis of family history of psychological problems by ethnocultural background and history of CSA revealed between abuse group differences for Aboriginal women only. Compared to those never abused, Aboriginal women who were sexually abused as children were significantly more likely to report that one or both parents had a psychological problem [^{2} (1) = 6.28, p= 0.025].

Additional Adverse Childhood Experiences

Table 9 presents results of selected adverse childhood experiences by the two abuse groups. Analyses determined that women in the CSA group had significantly higher means scores on the CATS neglect/negative home environment [t (158)= -6.86, p= 0.0001] and punishment [t (158)= -3.56, p= 0.0001] subscales. The CSA group was also significantly more likely than the NA group to have experienced a number of adverse events during childhood. They were significantly more likely to live with verbally abusive parents [^{2} (1) = 23.28, p=0.0001], have witnessed physical violence [^{2} (1) = 16.33, p=0.0001], and sexual abuse [^{2} (1) = 11.43, p=0.001] perpetrated against other family members. Compared to the NA group, the CSA group were also more likely to have had a fear of being sexually abused when either parent was intoxicated [^{2} (1) = 16.38, p=0.0001]. Two-way chi square analyses of individual CATS items revealed that the significance between abuse groups remained for both Aboriginal and non-Aboriginal women in witnessing parents verbally abusing

Table 9: Selected Adverse Childhood Experiences Stratified by History of Childhood Sexual Abuse (n=160)†

	NA (n=48)	CSA (n=112)
Mean CATS Neglect Subscale (± SEM)	1.2 ± 0.1	2.2 ± 0.08*
Mean CATS Punishment Subscale (± SEM)	1.7 ± 0.1	2.2 ± 0.08*
Mean Number of ACEs (± SEM)	2.2 ± 0.2	5.5 ± 0.2
Selected CATS Individual Items		
Did your parents verbally abuse each other?	40.4%	80.0%*
Did you ever witness the physical mistreatment of another family member?	40.4%	74.1%*
Did you ever witness the sexual mistreatment of another family member?	6.4%	31.5%*
When either of your parents were intoxicated, were you ever afraid of being sexually mistreated?	8.3%	40.7%*

Groups were compared using Independent Samples t-tests and Chi-square analysis.
* significant differences between groups $p < 0.05$, corrected for multiple comparisons.
A Yates correction was applied on tests with cell counts less than 10.
†Twelve study subject failed to complete the CATS sexual abuse questions.

each other (Aboriginal NA 30.4%, CSA 72.0%, ^{2} (1) = 11.24, p=0.002; non-Aboriginal NA 50.0%, CSA 87.3%, ^{2} (1) = 12.70, p=0.001), and was ever afraid of being sexually mistreated when either parent was intoxicated (Aboriginal NA 8.7%, CSA 46.2%, ^{2} (1) = 9.87, p=0.004; non-Aboriginal NA 8.0%, CSA 35.7%, ^{2} (1)= 6.71, p=0.02). Significance remained for Aboriginal women only for witnessing both physical (NA 26.1%, CSA 80.8%, ^{2} (1) = 20.67, p=0.0001) and sexual (NA 8.7%, CSA 44.2%, ^{2} (1) = 9.06, p=0.006) mistreatment of another family member. One third (33.9%) of all women with a history of CSA reported that their relationships with their parents had involved a sexual experience.

Physical and Mental Health Characteristics

The fourth hypothesis tested in this study stated that women who had been sexually abused in childhood would report more health-related problems, more pregnancies, and higher rates of teen pregnancy. Table 10 shows that the majority of results did not support this hypothesis. In terms of physical health status, rates of medical problems and help-seeking were comparable across abuse groups. For example, there were no significant differences in the experience of acute or chronic medical problems, as more than half of both groups reported a chronic medical problem (NA 52.1%, CSA 55.9%), and most had sought help for a medical problem in the past year (NA 63.6%, CSA 74.8%).

In terms of childbearing, there were no differences between groups in number of lifetime pregnancies, abortions or miscarriages. However, significant differences

Table 10: Selected Physical Health Characteristics Stratified by History of Childhood Sexual Abuse (n=161)†

	NA (n=48)	CSA (n= 112)
# Pregnancies in Lifetime (± SEM)	3.2 ± 0.5	3.5 ± 0.3
Had a Pregnancy <18 years of age	25.5%	47.2%*
In the Past Year Experienced		
Pain in legs, arms, stomach	60.4%	69.4%
Chest pains	29.2%	39.6%
Fatigue	75.0%	76.6%
Insomnia	56.3%	71.2%
Has a Chronic Medical Problem	52.1%	55.9%
Sought Help for Medical Problems in the Past Year	63.6%	74.8%
Where Sought Help in Past Year		
Hospital/CLSC/Clinic	64.3%	59.0%
General Practitioner	35.7%	41.0%
# Days Medical Problems in Past 30 Days (± SEM)	17.5 ± 1.9	16.4 ± 1.3
# Times Hospitalized in Lifetime (± SEM)	2.7 ± 0.5	5.4 ± 0.7
Mean ASI Medical Composite Severity score (± SEM)‡	0.54 ± 0.05	0.53 ± 0.04

Groups were compared using Independent Samples t-tests and ANOVA.
†Twelve study subject failed to complete the CATS sexual abuse questions.
‡ASI – Addiction Severity Index composite scores range from 0 to 1.0, with higher scores indicating greater problem severity.

between groups were found in history of teenage pregnancy. The rate of teenage pregnancy in the CSA group was nearly double that of the NA group [^{2} (1) = 6.39, p= 0.01]. A two-way chi square analysis of teenage pregnancy by ethnocultural background and abuse history showed no significant differences in rates for Aboriginal and non-Aboriginal women.

Hypothesis five stated that compared to women with no history of childhood abuse, women who were sexually abused childhood would have higher rates of current and lifetime psychological problems including depression, anxiety, suicidal ideation, and substance abuse. As shown in Table 11, there were between group differences in the experience of any psychological problem in the past month, with those in the CSA group reporting higher rates than those in NA group [^{2} (1) = 16.90, p= 0.009]. However, there were no significant differences between abuse groups on individual indicators of recent psychological distress (including depression, anxiety, and suicidal ideation). A two-way chi square analysis of any psychological problem in the past month by history of CSA and ethnocultural background revealed significant differences for non-Aboriginal women only. Non-Aboriginal women with a history of CSA were significantly more likely to have experienced any psychological problems in the past month (NA 60.0%, CSA 85.0%, ^{2} (1) = 6.35, p= 0.025).

There were no differences in severity of psychological distress between the NA and CSA groups, indicated by similar mean scores on the ASI psychological composite severity score (see Table 11). A hierarchical linear regression analysis was conducted to examine factors associated with current psychological problems, with

Table 11: Recent Psychological Distress Stratified by History of Childhood Sexual Abuse (n=161)†

	NA (n=48)	CSA (n=112)
Experienced in Past 30 Days		
Any Psychological Problem	58.3%	78.6%*
Depression	33.3%	46.4%
Anxiety	43.8%	55.4%
Thoughts of Suicide	20.8%	30.4%
Prescribed Medication in Past Month	31.3%	35.7%
Mean Beck Depression Inventory score (± SEM)	18.3 ± 1.6	20.0 ± 1.1
Mean ASI Psychological Composite Severity score (± SEM)‡	0.3 ± 0.04	0.4 ± 0.02
Current Substance Abuse Problem	43.8%	58.0%
Mean ASI Alcohol Composite Severity score (± SEM)‡	0.09 ± 0.02	0.2 ± 0.02
Mean ASI Drug Composite Severity score (± SEM)‡	0.08 ± 0.02	0.07 ± 0.01

Groups were compared using Independent Samples t-tests and Chi-square analysis.
* significant differences between groups $p < 0.05$, corrected for multiple comparisons.
†Twelve study subject failed to complete the CATS sexual abuse questions.
‡ASI – Addiction Severity Index composite scores range from 0 to 1.0, with higher scores indicating greater problem severity.

the ASI psychological severity composite score as the dependent variable. The variables selected for inclusion were based on the literature review indicating that sociodemographic, substance use, social, and childhood mistreatment factors have been found to be associated with psychological distress. The order of entry was as follows: step one included ethnocultural background (Aboriginal and non-Aboriginal); the second step included the ASI alcohol, drug, and social composite severity scores; the CATS punishment, sexual abuse, and neglect subscales, as well as number of adverse childhood experiences (ACEs) were included in the third and final step. Table 12 presents a summary of the hierarchical linear regression. Ethnocultural background was significant in the first and final steps of the regression, accounting for 3% of the variance in the severity of current psychological problems. Results also indicated that higher ASI drug and social composite severity scores were significantly associated with higher severity of psychological problems. The ASI drug and social composite severity scores accounted for 22% of the variance in the ASI psychological composite severity score, making these the strongest factors associated with current psychological problems. Higher rates of childhood neglect were also significantly associated with greater severity of current psychological problems.

Results of lifetime rates of psychological distress stratified by childhood abuse are presented in Table 13. These study results in part support the stated hypothesis, illustrated by higher rates of certain psychological problems in the CSA group, compared to the NA group. While there were no differences in lifetime rates of depression or anxiety, compared to the NA group, the CSA group reported higher

Table 12: Summary of Linear Regression for Variables Associated with ASI Psychological Composite Severity Score (n= 150)

Variable	R	R2 change	Beta	p value
Step 1				
Step: F (1, 148) = 4.329, p = 0.039	0.17	**0.028**		
Ethnicity			0.169	0.039
Step 2				
Step: FΔ (3, 145) = 13.978, p = 0.0001	0.5	**0.218**		
ASI Alcohol Composite Severity score			0.125	0.137
ASI Drug Composite Severity score			0.241	0.004
ASI Social Composite Severity score			0.317	0.0001
Step 3				
Step: FΔ (4, 141) = 3.372, p = 0.011	0.56	**0.066**		
CATS Punishment Subscale			-0.090	0.346
CATS Sexual Abuse Subscale			-0.002	0.988
CATS Neglect Subscale			0.437	0.002
ACEs			-0.154	0.244

ASI - Addiction Severity Index
CATS - Child Abuse and Trauma Scale

Table 13: Lifetime Psychological Distress Stratified by History of Childhood Sexual Abuse (n=161)†

	NA (n=48)	CSA (n= 112)
Experienced in Lifetime		
Depression	68.8%	80.4%
Anxiety	64.6%	80.4%
Thoughts of Suicide	52.1%	76.8%*
Attempted Suicide	37.5%	63.4%*
Ever Prescribed Medication for a Psychological Problem	52.1%	60.7%
Ever Treated for a Psychological Problem	52.1%	77.7%*
Ever Treated for a Drug or Alcohol Problem	33.3%	41.4%

Groups were compared using Independent Samples t-tests and and Chi-square analysis.
* significant differences between groups $p < 0.05$, corrected for multiple comparisons.
†Twelve study subject failed to complete the CATS sexual abuse questions.

rates of suicidal ideation [^{2} (1) = 9.65, p=0.002] and attempted suicide [^{2} (1) = 19.12, p=0.003]. The CSA group were also significantly more likely to have sought treatment for a psychological problem in their lifetimes [^{2} (1) = 10.48, p=0.001].

Two-way chi square analyses of lifetime suicidal ideation, suicide attempts, and psychological treatment seeking by history of CSA and ethnocultural background produced varying results. Significant differences in lifetime suicidal ideation by abuse groups remained significant for non-Aboriginal women only. Compared to others, non-Aboriginal women who were sexually abused as children were significantly more likely to report they had seriously contemplated suicide in their lifetimes (NA 48.0%, CSA 75.0%, ^{2} (1) = 5.82, p=0.016). Ethnocultural differences were also found in lifetime rates of attempted suicide and psychological treatment seeking. Significant differences between abuse groups remained for Aboriginal women only, with Aboriginal in the CSA group reporting significantly higher rates of lifetime suicide attempts (NA 39.1%, CSA 71.2%, ^{2} (1) = 6.89, p=0.018) and ever being treated for a psychological problem (NA 34.8%, CSA 75.0%, ^{2} (1) = 11.02, p=0.002).

Logistic regression analysis was used to explore which of a set of independent variables had the strongest associations with ever attempting suicide (yes/no). Independent variables included ethnocultural background (Aboriginal and non-Aboriginal) in step one; lifetime depression and substance dependence in step two; and adverse childhood experiences of neglect, sexual abuse, number of adverse experiences, and family history of substance abuse and psychological problems were included in the third and final step. Table 14 shows that lifetime depression was

Table 14: Summary of Results of Logistic Regression for Lifetime Suicide Attempts (n= 152)

Variable	B	Wald (df)	p value
Step 1 Nagelkerke R2 = 0.008 Step: χ^2 (1) = 0.885, p = 0.347 NS			
Ethnicity	0.295	0.514 (1)	0.473
Step 2 Nagelkerke R2 = 0.201 Step: χ^2 (3) = 24.746, p = 0.0001	$\Delta\chi^2$ (2) = 23.861, p = 0.0001		
Lifetime Depression	-1.897	17.894 (1)	0.0001
Substance Dependence	-0.463	1.685 (1)	0.194
Step 3 Nagelkerke R2 = 0.306 Step: χ^2 (9) = 39.513, p = 0.0001	$\Delta\chi^2$ (6) = 14.767, p = 0.022		
CATS Punishment Subscale	0.578	3.961 (1)	0.047
CATS Neglect Subscale	0.057	0.025 (1)	0.874
CATS Sexual Abuse Subscale	0.358	1.494 (1)	0.222
ACEs	-0.032	0.049 (1)	0.825
Parental Drug/Alcohol Abuse	-0.152	0.132 (1)	0.716
Parental Psychological Problems	-0.177	0.195 (1)	0.659

ASI - Addiction Severity Index
CATS - Child Abuse and Trauma Scale

significantly associated with lifetime suicide attempts. It also shows that higher mean scores on the CATS punishment subscale are significantly associated with suicide attempts over the lifetime. Neither substance abuse or any of the childhood mistreatment or family history variables were significantly associated with lifetime suicide attempts in this sample.

Regarding characteristics of drug and alcohol use, the study results did not support the hypothesis that women with a history of childhood sexual abuse would be more likely to report a current substance abuse problem. Those in the CSA group were no more likely to report having a current drug or alcohol problem, and did not report more years of alcohol use to intoxication, or years of using more than one substance. Additionally, neither group was more likely to ever received treatment for a drug or alcohol problem. There were also no group differences in mean scores on the ASI psychological, alcohol, or drug composite severity scores.

Summary of Child Sexual Abuse Stratification

Women in the CSA and NA groups were similarly middle-aged, with 10-11 years of education, currently unemployed, and reliant on government social assistance as a primary source of income. Women with a history of childhood sexual abuse reported the highest rates of problems with parents and family history of psychological problems. History of childhood sexual abuse was significantly associated with interpersonal difficulties with parents for both Aboriginal and non-Aboriginal women. Similar analysis for family history of psychological problems by

abuse groups and ethnocultural background revealed that the association between childhood sexual abuse and family history of psychological problems only remained significant for Aboriginal women. The two leading factors associated with severity of current psychological distress were severity of drug and social problems, followed by childhood neglect.

Compared to individuals never sexually abused during childhood, women a history of childhood abuse were more likely to have been raised in home environments characterized by violence and family discord. Their home lives included witnessing verbally abusive behaviour between parents, and witnessing the physical and sexual abuse of other family members. Fear of being sexually abused when either parent was intoxicated was reported more often by women with a history of CSA. They were also significantly more likely to have been neglected (e.g., left home alone as a child, had to take care of herself before she was old enough, or felt unwanted/emotionally neglected) and receive severe punishments in childhood (e.g., was severely punished for not following rules of the house, or parents hit or beat her when she did not expect it). This was demonstrated by higher mean scores on the CATS neglect and punishment subscales.

Those with and without histories of childhood sexual abuse were similar on many indicators of physical health. Results regarding associations between history of CSA and teen pregnancy corroborate study findings in the literature. Compared to those who had never been sexually abused in childhood, individuals with a history of CSA were significantly more likely to have had a pregnancy before the age of

eighteen. There were no ethnocultural differences in rates of teenage pregnancy by abuse groups.

Childhood abuse is a salient factor for mental health in this help-seeking sample of women. Regardless of ethnocultural background, women with a history of sexual abuse in childhood did indeed report higher rates of certain psychological problems over their lifetimes, compared to women who had never been sexually abused. In particular, women who were sexually abused in childhood/adolescence were significantly more likely than others to report problem behaviours including suicidal ideation and suicidal attempts. Further analysis revealed that non-Aboriginal women who had been sexually abused in adulthood were significantly more likely to experience any psychological problems in the month preceding the ASI interview. Ethnocultural differences also emerged in two-way chi square analyses of lifetime rates of suicidal ideation and attempted suicide. The association between CSA and suicidal ideation was statistically significant for Non-Aboriginal women only, while the association between CSA and suicidal attempts remained significant solely for Aboriginal women.

These results compel a further investigation of childhood correlates of severity of childhood sexual abuse among a sub-sample of women who completed an additional interview using the Childhood Experiences of Care and Abuse (CECA) interview. The following chapter summarizes the results of these analyses.

Chapter 4

Results of Second Interview

Participants Versus Non-Participants

Following the first interview with the Addiction Severity Index (ASI), Child Abuse and Trauma Scale (CATS), and Beck Depression Inventory (BDI), women were invited to complete a second interview. Using the Childhood Experiences of Care and Abuse (CECA), the second interview collected detailed information on supervision, neglect, parental antipathy, and physical/sexual abuse before the age of seventeen. In total, 55 women (38.27%) of the starting sample completed the CECA interview.

In order to compare women who did and did not agree to participate, chi square analysis and t-tests were performed on categorical and continuous sociodemographic, physical/sexual abuse, and psychological variables. Results indicate that there were no sociodemographic differences between the two groups of women. As shown in Table 15, Aboriginal and non-Aboriginal women were equally likely to participate in the second interview. Both participants and non-participants were in their late thirties, were equally likely to have never been married, and to have been living with family in the past three years. The majority of women in both groups were residing at a women's shelter at the time of interview. They were also comparable on common indicators of socioeconomic status; most were unemployed, and receiving social assistance at the time of the initial interview.

Table 15: Select Sociodemographics Stratified by CECA Participants and Non-Participants (n=144)†

	Non-Participants (n=89)	Participants (n=55)
Aboriginal	52.8%	47.2%
Non-Aboriginal	41.8%	58.2%
Living in a Shelter	75.3%	74.5%
Why in Shelter		
Temporary shelter	40.9%	50.0%
Fleeing abusive relationship	23.9%	14.8%
Counselling/Support/Other	10.2%	9.3%
Number Years Lived in Montreal (± SEM)	14.9 ± 1.9	18.4 ± 2.4
Age (± SEM)	39.7 ± 1.2	37.8 ± 1.7
Marital Status		
Never Married/Common-law	53.9%	52.7%
Ever Married/Common-law	46.1%	47.3%
Number of Dependents (± SEM)	0.5 ± 0.1	0.4 ± 0.1
Number Family Members in Montreal (± SEM)	2.9 ± 0.4	2.4 ± 0.4
Lived With (past 3 years)		
Partner/Family	52.3%	47.3%
Alone/Nothing stable	47.7%	52.7%
Number Years of Education (± SEM)	10.7 ± 0.4	11.9 ± 0.3
Employment Pattern (past 3 years)		
Employed	38.2%	29.6%
Unemployed or Student/Retired	61.8%	70.4%
Currently on Welfare	67.4%	64.8%
Monthly Income (± SEM)	$603.23 ± 43.86	$590.08 ± 43.34

Groups were compared using Student's t-tests and Chi-square analysis.
†This number represents the number of women eligible for the interview, and excludes 7 women who were interviewed before research assistants were trained to conduct the CECA, and 3 women whose first interviews contained incomplete information on lifetime physical/sexual abuse history.

participate in the second interview had similar histories of lifetime physical abuse (Non-Participants 94.3%, Participants 92.7% and sexual abuse (Non-Participants 83.1%, Participants 76.4%). In terms of psychological status, women from both groups were experiencing high levels of psychological distress in the past month including depression (non-participants 44.9%, participants 43.6%), anxiety (non-participants 53.9%, participants 54.5%) and suicidal ideation (non-participants 29.2%, participants 29.1%). They also reported similar rates of depressive symptomatology in the previous week, indicated by mean scores on the Beck Depression Inventory (non-participants 21.2 ± 1.3, participants 18.4 ± 1.4). Lack of difference continued in lifetime history of psychological problems, with similar rates of depression (non-participants 76.4%, participants 81.8%), anxiety (non-participants 78.7%, participants 76.4%), suicidal ideation (non-participants 73.0%, participants 76.4%), and attempted suicide (non-participants 60.7%, participants 56.4%). Overall, there were no significant differences in sociodemographic, physical/sexual abuse, or psychological variables between groups, suggesting that those participants who completed the CECA interview did not represent a biased sample. The major reasons for non-completion were scheduling difficulties, subjects not showing up for appointments, subjects not having time to do the interview, and study drop-out. Efforts were made to reschedule appointments with women when initial plans to meet failed; confidential messages were left for them at the shelter/organization where they were contacted, and calls were made when subjects were able to provide phone numbers where they could be reached. Others were not interested in doing the second interview for

reasons including not wishing to discuss their childhoods, or not wanting to be interviewed a second time.

Severity of Childhood Sexual Abuse

In the CECA interview, subjects are asked the lead question: When you were a child or teenager did you ever have an unwanted sexual experience? Additional probes are used to collect information on timing/duration, and examples/descriptions of events. The CECA is an investigator-based interview, wherein the interviewer judges the severity ratings with consensus ratings within the research team to avoid bias in rating severity. The severity assigned to sexual abuse incidents is based on the subjects' descriptions of events and take into account the frequency, duration, and type of sexual mistreatment experienced by women before the age of seventeen. Severity rating also considers the individual's relationship to the perpetrator, as well as age and status of the perpetrator (whether a family member or someone in authority), degree of sexual contact, and involvement of force or coercion (Bifulco et al., 1994). An individual's abuse experiences are assigned to one of four severity groups: 'little/none', 'some', 'moderate', and 'marked'.

For analytic purposes, these four groups were recoded into three childhood sexual abuse severity groups. The groups were never abused (NA), those who reported 'little - some' sexual abuse, or moderate abuse (MA), and those who experienced 'moderate- marked' levels of abuse, or severe abuse (SA). Results presented in Table 16 indicate that rates of parental antipathy, neglect, and physical

abuse during childhood are high for all three CSA severity groups. While chi square analysis could not be performed because of limited sample size, the data suggest that those in the MA and SA groups experienced higher rates of adverse childhood events, with those in the SA group reporting the highest rates for most variables, including witnessing both physical and sexual mistreatment of another family member during childhood.

Groups were also compared using ANOVA for select continuous variables. While no significant group differences were found for either CATS neglect or punishment subscales, there was a significant difference in mean number of adverse childhood events (ACEs) [$F(2, 53) = 10.03$, $p < 0.0001$]. Compared to those in the NA and MA groups, the SA group reported the highest mean number of events. These study results provide further evidence that there is a clustering of early life family and home environment problems for individuals who have been sexually abused during childhood.

The following section presents analysis of the verbatim text of material tape recorded during the CECA interview.

Women's Thoughts/Explanations for Childhood Abuse Experiences

Ancillary aims of this thesis were to explore whether Aboriginal women were more likely than non-Aboriginal women to articulate their abuse experiences through discourses of 'collective' (ethnic, community) or 'historical' trauma and to explore

Table 16: Childhood Correlates of Childhood Sexual Abuse Severity (n=55)

	NA (n= 17)	MA (n= 18)	SA (n= 20)
CECA Indicators of Care/Abuse			
Parental Antipathy	58.8%	61.1%	75.0%
Neglect	29.4%	66.7%	60.0%
Physical Abuse	58.8%	72.2%	95.0%
CATS Subscales			
Neglect/Negative Home Environment Subscale (± SEM)	1.8 ± 0.18	2.09 ± 0.18	2.36 ± 0.16
Punishment Subscale (± SEM)	1.7 ± 0.18	2.10 ± 0.23	2.27 ± 0.14
Mean Number of ACEs (± SEM)	3.7 ± 0.5	5.5 ± 0.4	6.3 ± 0.3*
Selected CATS Individual Items			
Did your parents verbally abuse each other?	60.0%	82.4%	83.3%
Did you ever witness the physical mistreatment of another family member?	50.0%	83.3%	90.0%
Did you ever witness the sexual mistreatment of another family member?	6.3%	33.3%	40.0%
When either of your parents were intoxicated, were you ever afraid of being sexually mistreated?	18.8%	50.0%	50.0%

Groups were compared using ANOVA for continuous variables
Chi-square analysis could not be conducted due to low cell counts.
*p-values indicate statistical significance after using a Bonferroni correction for multiple comparisons

similarities and differences between Aboriginal and non-Aboriginal women's narrative constructions of abuse. As a supplement to the CECA, an additional question regarding childhood abuse was asked at the end of the CECA interview. This question was created to illicit the subjects' thoughts about the abuse they experienced, and allow an exploration of their explanations for abuse. The question was: Thinking back as an adult on your abuse experiences, do you have any thoughts or explanations for what happened to you? (On the occasion that a woman misconstrued the question to mean she was being asked if she in some way caused the abuse to happen, she was asked an additional question): Why do you think people do bad things like that?

A total of thirty-nine women responded, and two main answers emerged through a thematic analysis of the qualitative data. Women were equally likely to explain that the abusive actions were a result of some mental defect on the part of the perpetrator or that the abuse was a learned behaviour. Many explained that in retrospect, they believed that their perpetrators acted as they did because they had unresolved psychological or emotional problems. In other words, sexual abuse was not conceived as a cultural artifact, but a result of individual psychopathology.

> *"Y'a pas choisit d'être de même. Mais j'pense qu'y avait pas ehh... c'est vraiment juste? Cause d'la maladie, tu sais? Qu'était p'être en psychose.*
>
> Non-Aboriginal woman, age 20

> *"There's nothing you can do to stop this. ..These sick people, you know, they're just going to keep doing it, it's been going on for millions of years. What do you do? They say, they say its in the, that gene, that's in the brain, that does these things, .."*
>
> Aboriginal woman, age 44

Aboriginal and non-Aboriginal women were equally likely to conclude that the abuse they experienced resulted from a pattern of learned abusive behaviour that spanned generations.

> *"Well, I don't know if it's bad upbringing. I think it's their mother somewhere – it's their bad upbringing – it's not genetic –I find it's the lack of nurturing, and the lack of responsibility of the parents. They're not there for them, or they let the abuse go on and on so it perpetrates abuse from generation to generation. I find it's super bad parenting."*
>
> Non-Aboriginal woman, age 52

In some cases, women seemed to absolve their perpetrator's responsibility for their actions because they had been abused themselves:

> *"They were taught that, they were brought up in a certain way . . . abuse was passed on from one generation to the next. They didn't know better. Their lives growing up were just the same or as worse as mine."*
>
> Non-Aboriginal woman, age 45

> *"I feel sorry for the, ...my uncle what he did to me because he... it's not his fault, he'd been there too."*
>
> Aboriginal woman, age 43

Others however did not accept this as a viable explanation. For instance, one woman explained:

> *"I think its choice. .. I think its choice. They're reasoning human beings, you know, they can reason to get up in the morning, go to work, go to school, whatever, drive the car, right?" "I don't buy it "well they were abused, so that's why they're, they abused me" I*

> *don't buy it, I don't accept it, it's not a justification for me. I do believe that the fact that they were abused maybe made them, angry. Well I know what that is, I know what anger is, I'm angry.. but you can't use that to say "oh well, that happened to me, so I'm going to do it to somebody else."*
>
> Aboriginal woman, age 62

None of the study participants indicated that their ethnocultural background was a factor in their abuse experiences. These narratives suggest that childhood sexual abuse may be more strongly associated with family and social factors, than with ethnocultural differences in this sub-sample of women. Individual women do not necessarily hypothesize a collective or historical explanation for their adverse experiences, but rather more local ones entrenched in home environments rife with family dysfunction and psychological problems.

Methodological Considerations

A total of 172 help-seeking Aboriginal and non-Aboriginal women were interviewed for this study. They were sampled from women's shelters and social service centres in Montreal's urban core. The interpretation of these study results must consider potential bias due to study sampling. Bias may have resulted from the fact that women who participated in the first and second interviews of the study may have been different from those who chose not to. They may differ for instance in socioeconomic status, psychological status, or frequency of service use. This sample may reflect the experiences of women who accessed social services more often than others, and represent a particularly distressed group of women. In addition, the findings reported here may not be generalizable to women with sexual abuse histories who are off the service grid, because this study focussed on women who were currently seeking help from service organizations in the city. Because this sample was collected in Montreal, the characteristics of the sample may reflect differences that are particular to this geographic region. This invites caution to generalization to other populations. Finally, the research design cannot provide causal information on relationships between histories of adverse childhood experiences and current family, physical, and mental health problems. Information on abusive experiences were collected retrospectively, and therefore may be affected by long-term recall and reporting bias. This suggests that longitudinal research of associations between these factors is needed.

Chapter 5

General Discussion

Ethnocultural Differences

Analysis of data on ethnocultural differences presented in Part I of Chapter 3 indicate that there were differences between Aboriginals and non-Aboriginals in this urban help-seeking sample of women. The majority of the sample were single women at severe economic disadvantage as shown by low levels of formal education, low rates of employment, high dependency on welfare, and need for temporary shelter and other services. Aboriginal and non-Aboriginal study participants experienced similar socioeconomic disadvantages.

The first hypothesis tested in this study was that compared to non-Aboriginal women, Aboriginal women would have higher rates of physical and sexual abuse in their lifetimes. As expected, Aboriginal women were more likely than non-Aboriginal women to have been physically abused in their lifetimes. This finding corroborates results from past General Social Surveys on violence against women in Canada (Statistics Canada, 2001; Statistics Canada, 2005). One report stated that Aboriginal women were nearly three times more likely to have been physically abused in their lifetimes (Statistics Canada, 2001). There are however two important differences between the results reported by Statistics Canada and those found in this study. First, the rates of physical abuse in this study are much higher than those found by Statistics Canada. Second, the difference in rates of physical abuse between Aboriginals and non-Aboriginals is less marked, possibly due to the fact that socioeconomic status

(SES) was similar across the two groups. Contrary to the stated hypothesis however, there was no ethnocultural difference in lifetime rates of sexual abuse. More than one-third of both Aboriginal and non-Aboriginal groups had been sexually abused in their lifetimes (74.4% and 69.0% respectively). This finding contradicts existing evidence that Aboriginal women experience sexual abuse at two to three times higher rates than non-Aboriginal women (see Wahab & Olson, 2004). This may be due to the fact that women in the current study were of a similar socioeconomic status, while previous evidence compared rates of sexual violence among Aboriginals against national rates that represented persons from many socioeconomic strata.

The second hypothesis was that Aboriginal women would show higher rates of psychological problems, including depression, anxiety, and substance dependence, compared to non-Aboriginal women. As a group, the women interviewed for this study reported high rates of psychological distress, with nearly three-quarters reporting serious anxiety (73.8%) and depression (75.6%) in their lifetimes. Lifetime rates of suicidal ideation and attempted suicides were similarly high (68% and 54.1% respectively). More than half (52.3%) also reported a current substance abuse problem. When the sample was stratified by ethnocultural group, some differences emerged in recent and lifetime psychological distress. Contrary to the stated hypothesis, non-Aboriginal women were more likely than non-Aboriginal women to have been recently depressed, and they reported significantly more days of psychological distress in the month preceding the initial interview. There were however no ethnocultural differences in recent or lifetime anxiety, and lifetime

depression. Similarly, there were no ethnocultural differences in reporting a current substance abuse problem. However, Aboriginal women were more likely than their non-Aboriginal counterparts to currently smoke cigarettes, have higher rates of current and lifetime illicit drug use (cannabis), and have been treated for a drug or alcohol problem in the past. One possible explanation is that compared to non-Aboriginal women in this sample, Aboriginal women were more amenable to substance abuse treatment, though no data was collected in this study to allow an exploration of that hypothesis.

In terms of physical health, there were differences between Aboriginal and non-Aboriginal women. They did not differ in rates of chronic medical problems, or in the likelihood of seeking care from a medical practitioner for a health problem. As expected, results supported the third study hypothesis, in that compared to non-Aboriginal women, Aboriginal women did have higher rates of lifetime pregnancies and pregnancies before the age of eighteen. It is suggested here that these higher rates of teen pregnancies may have had a direct relationship with higher rates of lifetime physical abuse reported by Aboriginal women in this study sample. Previous research indicates that teenage pregnancy is associated with a history of risk factor for the experience of physical abuse among pregnant women in general, and adolescent mothers in particular (Fergusson, Horwood & Lynskey, 1997; Gessner & Perham-Hester, 1998; Harrykissoon, Rickert, & Wiemann, 2002; Rosen, 2004).

In summary, these results suggest that this low SES sample of women are suffering multiple forms of psychological distress while dealing with daily stresses of

living in the city and navigating health and social services. Given the high rates of unemployment and reliance on social welfare system in the Canadian population at any given time, these results also suggest that there is a sizeable subsection of the Canadian population who are dealing with coinciding socioeconomic, psychological, and emotional disadvantages.

Childhood Sexual Abuse

As mentioned previously, ethnocultural differences were found in lifetime rates of physical abuse in the study sample, with Aboriginal women reporting higher rates of this type of abuse. Analyses for ethnocultural differences in lifetime rates of sexual abuse however showed no difference between Aboriginal and non-Aboriginal women. Due to the lack of difference between ethnocultural groups in terms of lifetime sexual abuse history, subsequent analyses proceeded into a deeper investigation of relationships between childhood sexual abuse experiences and physical and mental health for women in the total study sample, disregarding ethnocultural background. Information on sexual abuse gathered from the Child Abuse and Trauma (CATS) self-report instrument was used to produce a dichotomous grouping variable for childhood sexual abuse. The variable included those who were never sexually abused (NA) and those with a history of childhood sexual abuse (CSA). The majority of women (58.1%) who participated in the first interview had a childhood history of sexual abuse.

Compared to women in the NA group, those in the CSA group experienced

more family-related problems. They were more likely to have had serious relationship problems with their parents, and to report that one or both parents had experienced psychological problems in their lifetimes. Psychological problems included problem alcohol/drug use, depression, anxiety, and problems controlling violent behaviour. Anecdotally, many respondents considered sexual abuse by a parent to indicate that they suffered from a psychological problem. Women in the CSA group were significantly more likely to have been neglected or raised in home environments characterized by violence. In addition to being sexually abused, these individuals were more likely to have been exposed to the potentially traumatic events of witnessing the physical and sexual mistreatment of other family members. Approximately one-third of women abused as children reported having a sexual experience with a parent during childhood/adolescence. It is clear that these women were not just exposed to sexual abuse, but were raised in very complex, detrimental home environments. These findings corroborate what is known in the literature. There is evidence that different types of childhood maltreatment rarely occur in isolation, and multiple exposure to different types of maltreatment (e.g., sexual abuse, physical abuse, verbal abuse, neglect) during childhood is strongly associated with increased likelihood of psychological problems and treatment seeking in adolescence (Turner et al., 2006) and adulthood (Duran et al., 2004; Teicher, Samson, Polcari & McGreenery, 2006; Tang et al., 2006).

Results from analyses of child sexual abuse data collected from women in the second interview of this study were presented in the previous chapter. A total of 55

women participated in the Childhood Experience of Care and Abuse (CECA) interview. Three categories were created for analysis based on severity of experiences: those with no, moderate, or severe abuse during childhood/adolescence. Due to small group sizes, chi square tests for association could not be performed. However, the data suggest that severity of child sexual abuse (based on frequency, duration, type of abuse experienced, and identity of the perpetrator) had a differential impact on the likelihood of problem family environments. Women who were severely sexually abused in childhood clearly experienced more adverse childhood events (ACEs) compared to women in the none or moderate abuse severity groups. This meant they were significantly more likely to have been neglected, physically abused, witnessed physical or sexual violence against other family members, and have a family history of substance abuse. It should be noted that the small sample size may have masked group differences in other mistreatment and psychological variables.

The link between the experience of childhood sexual abuse and troubled family environments has also been firmly established in the literature. Women with a history of CSA are more likely to have been raised in households characterized by parental drug or alcohol abuse and/or parental psychological problems including depression (Classen, Palesh & Aggarwal, 2005; Fergusson, Horwood & Lynskey, 1997; Dinwiddie et al., 2000; Kunitz et al., 1998; Scheutze & Das Eiden, 2005). In a longitudinal study of 520 women, Fergusson and Colleagues (1997) report that women with a history of CSA were more than twice as likely as women without a history of CSA to have had a parent with an alcohol problem (25.0% versus 10.9%)

or problem drug use (42.9% versus 24.3%).

The fourth study hypothesis was partially supported. With generally high rates of medical problems overall, including fatigue, insomnia, and chronic medical problems, there were no differences between abuse groups. While women who had been sexually abused in childhood did not report more health-related problems, or have more pregnancies, they did have higher rates of teen pregnancy ($\leq$18 years of age). The rate of teenage pregnancy among those abused was nearly double the rate reported by those who had never been sexually abused during childhood (47.2% versus 25.5%). These finding corroborate findings reported in the literature indicating higher rates of early pregnancy among females who had been abused during childhood/adolescence (e.g., Butler & Burton, 1990; Chandy et al., 1996; Fiscella et al., 1998; Kellogg et al., 1999; Kunitz et al., 1998; Rainey et al., 1995).

In terms of mental health, women who had been sexually abused during childhood fared worse than others on some indicators of psychological distress. Results partially supported the final hypothesis that women with histories of childhood sexual abuse would have higher rates of current and lifetime mental health problems, compared to women with no history of sexual abuse during childhood. Contrary to this hypothesis, there were no significant differences between abuse groups in rates of recent depression, anxiety, or suicidal ideation. The CSA group did however report significantly higher rates of experiencing any psychological problem in the past month. Linear regression of the ASI psychological severity composite score revealed that in addition to childhood neglect, severity of drug problems and social problems were

strongest factors associated with current psychological problems. Thus, problem drug use and social context are more proximal mediators in the severity of distress experienced by women in this study.

Women in the CSA group however, were significantly more likely than women in the NA group to have seriously contemplated suicide or attempted suicide in their lifetimes. They were also more likely to have sought treatment for a psychological problem in the past. Ethnocultural differences were found, with Aboriginal women in the CSA group significantly more likely than their non-Aboriginal counterparts to have ever attempted suicide, and to have received treatment for a psychological problem in the past. Through logistic regression, depression and severe punishment experienced during childhood were the two variables with the strongest associations with lifetime suicide attempts. A higher likelihood of attempting suicide among depressed individuals is well established in the literature (Goldstein et al., 2005; Ystgaard et al., 2004).

These study results thus indicated that a history of childhood sexual abuse was significantly associated with family relationship problems, adverse childhood experiences, and psychological distress. It is important to note that significant ethnocultural differences emerged in a number of these experiences (see Table 17). Even when controlling for socioeconomic factors between the two ethnocultural groups, Aboriginal women with a history of childhood sexual abuse emerged with a higher likelihood of witnessing physical and sexual abuse as children, have a family history of psychological problems, and have a history of suicide attempts and

Table 17: Summary of Ethnocultural Differences (n=160)†

	NA (n=48)	CSA (n=112)	Significance
As a Child, Witnessed the Physical Mistreatment of Another Family Member			
Aboriginal	26.1%	80.8% *	^{2} (1)= 20.67, p= 0.0001
Non-Aboriginal	54.2%	68.3%	–
As a Child, Witnessed the Sexual Mistreatment of Another Family Member			
Aboriginal	8.7%	44.2%*	^{2} (1)= 9.06, p= 0.006
Non-Aboriginal	4.2%	20.3%	–
Parental History of Psychological Problems			
Aboriginal	25.0%	58.3%*	^{2} (1)= 6.28, p= 0.025
Non-Aboriginal	52.0%	67.2%	–
Had Any Psychological Problem in Past Month			
Aboriginal	56.5%	71.2%	–
Non-Aboriginal	60.0%	85.0%*	^{2} (1) = 6.35, p= 0.025
Ever Attempted Suicide			
Aboriginal	39.1%	71.2%*	^{2} (1)= 6.89, p= 0.018
Non-Aboriginal	36.0%	56.7%	–
Ever Been Treated for a Psychological Problem			
Aboriginal	34.8%	75.0%*	^{2} (1)= 11.02, p= 0.002
Non-Aboriginal	68.0%	80.0%	–

Groups were compared using Chi-square analysis.
†Twelve study subject failed to complete the CATS sexual abuse questions.
* significant differences between groups $p < 0.05$, corrected for multiple comparisons.
A Yates correction was applied on tests with cell counts less than 10.

psychological treatment.

Existing research has shown that women with a history of child sexual abuse are at particular risk for sexual abuse revictimization in adulthood (Messman-Moore & Long, 2000; Messman-Moore, Long & Siegfried, 2000; Noll, 2005; Roodman & Clum, 2001; West, Williams & Siegel, 2000). It has also been shown that women who are revictimized will be more psychologically distressed than those who were never abused, or who had been abused in childhood or adulthood alone (Messman-Moore, Long, & Siegfried, 2000). It is unknown how many women in the study sample who were sexually abused in childhood went on to be sexually abused in adulthood. Because of this it cannot be determined whether psychological problems reported in adulthood are primarily because of child sexual abuse experiences, more recent abuse, or the cumulative effects of both types of abuse. Despite this shortcoming, it remains that women who have a history of CSA are experiencing psychological distress at alarmingly high rates, and there is evidence that Aboriginal women with a history of CSA are faring worse psychologically than their non-Aboriginal counterparts, being significantly more likely to have ever attempted suicide and treated for a psychological problem in their lifetimes.

Chapter 6

Conclusions and Future Directions

These study results indicate that childhood sexual abuse is a multifaceted problem for similarly socioeconomically disadvantaged Aboriginal and non-Aboriginal women in this help seeking sample. Previous research has established a link between history of childhood sexual abuse and PTSD in adulthood (e.g., Langeland, Draijer & Van den Brink, 2004; Libby, Orton, Novins, Beals & Manson, 2005). Research also shows that women are four times more likely than men to develop post-traumatic stress disorder (PTSD), and many cases are attributable to experiences of domestic violence (Vieweg et al., 2006). History of childhood sexual abuse has been linked to PTSD among non-Aboriginal (Langeland et al., 2004; Leitenberg, Gibson & Novy, 2004; Messman-Moore & Long, 2000; Sachs-Ericsson, Blazer, Plant & Arnow, 2005) and Aboriginal (Duran et al., 2004; Libby et al., 2005; Robin et al., 1997) women alike. Common risk factors for the disorder include low socioeconomic status, and family-related factors such as parental neglect, family history of psychiatric problems, and a poor social support system (Vieweg et al., 2006). There is evidence that the severity of responses to traumatic events declines over time. While the lifetime prevalence of PTSD in the general population is 8%, it has been shown that rates of PTSD decline from 94% one week after a traumatic event to 5.25% after an additional 9 months (Vieweg et al., 2006). While PTSD was not explored in the current study, the use of trauma as an explanatory concept for the perpetration and experience of sexual abuse against women is discussed here.

It has been suggested that psychological responses to the trauma of childhood sexual abuse are culturally determined (e.g., Barker-Collo, 1999; Wasco, 2003). Individual responses to trauma are framed within and influenced by experiences of living in social realities characterized by high levels of violence, racism and/or sexism. These factors influence women's expectations of safety. Trauma responses to physical abuse for instance are influenced by a number of factors including the degree of violence witnessed before, during and after an assault in the home or community.

In a review of trauma research, Wasco (2003) used a feminist framework to consider social and cultural influences on the level of psychological harm resulting from sexual assaults. Violence against women occurs in a`social and cultural context that may affect women's responses to trauma, and hinder the healing process. Society's views on sexual abuse can negatively affect women's help-seeking following an assault, including the tendency to victim-blame and absolve perpetrators' fault. The notion of living in a 'safe' world is an important concept, however the definition of safety varies by family and community (Wasco, 2003).

Barker-Collo (1999) explored ethnocultural differences in trauma responses in a study of Native and non-Native help-seeking women with histories of child sexual abuse. Compared to non-Native women, Native women were more psychologically distressed, evidenced by higher rates of negative symptomatology on the Trauma Symptom Checklist-40. Nevertheless, while educational backgrounds were accounted for in their analyses, other indicators of socioeconomic status (employment status, income level) were not. The ethnocultural differences reported by Barker-Collo may

therefore be a product of differences in SES between the two ethnic groups. It is suggested here that trauma response may be partially explained by a negative worldview influenced by early life exposure to multiple adverse experiences including sexual abuse, domestic violence, child neglect, and parental psychological or substance abuse problems occurring within low socioeconomic conditions.

The term trauma has also been broadly used to refer to a collective response to psychological pain and social injustice. For instance, Gray (1998) outlined the harmful effects that intergenerationally transmitted trauma can have on the health and well-being of Native peoples. The intergenerational transmission hypothesis suggests that certain behaviours are transmitted from generation to generation. It would suggest that those who experience and/or witness abuse during childhood are more likely to abuse their own children. Gray suggested that early life traumatic events lead to alcohol/drug use as a means of coping and escapism among Aboriginal peoples. Substance use and dependence were thought to in turn lead to an increased likelihood of experiencing trauma (e.g. interpersonal violence, poor health, poverty, injury) and revictimization (e.g. abusive relationships, prostitution).

Theoretically, causal links have been made between the nature of colonialist experiences (e.g. forced attendance in Indian residential schools, cultural loss, physical/sexual/psychological abuse)[8] and psychological distress experienced by many

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Between the mid 1800s and the 1970s, up to one-third of all Aboriginal children forcibly attended residential schools, where many spent the majority of their childhoods (Fournier and Crey, 1997). Many were sexually, physically, and emotionally abused in Canadian residential schools (Chrisjohn and Young, 1997; Fournier and Crey, 1997). Fournier and Crey (1997) provide some detailed accounts of the abuses suffered by Aboriginal children in residential schools. Ongoing sexual assaults included forced sexual intercourse, forced oral-genital or masturbatory contact, sexual touching and forced abortions. Physical assaults included sticking needles into tongues and the body, burning/scalding, beatings to points of unconsciousness, and electric shock. Emotional

Native peoples (Duran & Duran, 1995; Trimble, 1992; York, 1990). Anecdotal evidence suggests that there is an ongoing cycle of violence and substance abuse among Aboriginal peoples rooted in the abuse suffered by First Nations children in these institutions (e.g. Chrisjohn & Young, 1997; Fournier & Crey, 1997; Maracle, 1993; RCAP, 1997; Shorten, 1991). The term 'residential-school syndrome' was coined to refer to a grief cycle rooted in subsequent losses of traditional cultural elements such as language (York, 1990). It has been likened to the grief process that is undergone after the death of a loved one. These unresolved grief cycles have been associated with a deficit in the nurturing behaviour of residential school survivors, a trait passed from one generation to the next. Thus, the incidence of externalized psychological problems within successive generations has been used to operationalize the intergenerational transmission hypothesis.

Within the notion of a shared Aboriginal history, the term trauma has been used to represent the psychological distress experienced by Aboriginal peoples as a collective group. It has been described as 'cumulative' and 'historical' (e.g. Brave Heart, 1999; Brave Heart & DeBruyn, 1998, Robin et al., 1996). Brave Heart defined historical trauma as ". . . trauma over both the life span and across generations that results from massive cataclysmic events such as the Wounded Knee Massacre. It is similar to the survivor syndrome and survivor's child complex identified among Jewish Holocaust survivors and descendants" (Brave Heart, 1999). The term

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abuse included semi-nude public beatings, verbal assaults, and public strip searches. According to Fournier and Crey (1997), many residential school survivors later suffered from alcohol and drug abuse, insomnia, uncontrollable anger, and sexual problems. They also reasoned that due childhoods spent in residential schools, Aboriginal peoples were denied opportunities to learn good parenting skills.

historical trauma has also been used to refer to negative self-images for a group of people affected by adverse experiences of colonization. According to Brave Heart (1999), distorted values, self-concepts, and identities stem from a legacy of genocide, where identities have been formed on the basis of having been persecuted and oppressed. There is a constellation of psychological responses to historical trauma including depression, anxiety, substance abuse, suicidal ideation and other self-destructive behaviour (Brave Heart & DeBruyn, 1998; Brave Heart, 1999; Robin et al., 1996). Problem alcohol and drug use has been particularly singled out as a symptom of a larger 'social pain' experienced by First Nations peoples as a collective (e.g. Duran & Duran, 1995).

In a report prepared for the Aboriginal Healing Foundation titled Historic Trauma and Aboriginal Healing, Wesley-Esquimaux and Smolewski (2004) propose an alternative approach to the intergenerational hypothesis presented by Brave Heart and Yellowhorse. In what they coined the 'historic trauma transmission', they suggest that in lieu of regarding the trauma response as a single category, it should be understood as a collection of social disorders stemming from a shared history of maltreatment. They consider the symptoms of these disorders "manifestations of maladaptive social patterns"which are manifest in physically and psychologically destructive acts including suicide, sexual abuse, and domestic violence. As a social problem, it is proposed in this thesis that it is also important to understand that these problems more often occur in socio-cultural worlds characterized by co-occurring low socioeconomic status and high levels of family dysfunction, and gender inequality

within all populations regardless of historic maltreatment.

Trauma appears to be a catchall term and its application has widened to such an extent that its original meaning, namely a response to physical and mental injury, is in danger of being lost from view. Technical uses of the term trauma include investigations of responses to shocking or stressful events, and it is debatable whether the term should be used to describe psychosocial problems among ethnocultural groups. Using the term trauma as a blanket statement for the experiences of a heterogenous group of people without unpacking its meaning is counter-intuitive. It would be useful to move from overusing the term trauma, to using terms that are more representative the variation of responses to adverse events. This would normalise responses to difficult situations rather than stigmatise individuals and communities, and usher a move towards understanding the variability of emotional and psychological responses to stressful events. The risk of overgeneralizing the effects of past and recent events is real. Labelling Aboriginal peoples or any other ethnocultural group as 'traumatized' is harmful, as it removes a sense of agency, leaving a sad representation of helpless individuals unable to help one another and in need of being saved by an outside authority.

Explanations for physical and sexual abuse in Aboriginal communities have tended to be attributed to long-lasting effects of maltreatment by colonial authorities. However, danger lies in a wholly colonial dialogue since it diverts attention from other explanations. Links between poor physical health, mental health, loss of culture and past atrocities committed against Aboriginal people's are indelible. However, it

is necessary to move towards an understanding of why the problems of physical and sexual violence persist in communities characterized by low-income families with low rates of formal education. Child abuse and neglect are part of a larger phenomenon of violence, substance abuse, and psychological distress within multiproblem families. Considering that abuses are largely perpetrated by males within families and social environments rife with economic struggles, these abusive actions may be considered as a means of exerting control over others in difficult situations. The consequences of comorbid substance abuse problems only exacerbate the stress of living in poor communities and the results are often devastating. Aboriginal and non-Aboriginal women and children continue to suffer the most, as acts of physical and sexual abuse are often alcohol-related. Isolated incidents of maltreatment are rare, and abused women will often experience multiple forms of abuse, and other adverse events over the course of a lifetime.

Although the definitions for physical and sexual abuse vary, there is no doubt that these types of violence are universal problems for women. Within the context of this thesis, it is of note that ethnic differences in rates of sexual abuse reported elsewhere were not seen in this urban help-seeking population. Within this sample of socioeconomically disadvantaged women, it was clear that sexual abuse was not an Aboriginal women's issue, or an issue specific for women of any particular ethnocultural group. It is an issue for economically disadvantaged women who live within an environment characterized by poor family relationships, child neglect, and physical/sexual abuse, alongside problems of depression and suicidal ideation. The

dialogue shifts from ethnocultural differences in rates of sexual abuse to recognizing similarities in the experiences of women of a particular socioeconomic status. Future research should focus on exploring the characteristics and consequences of living in multi-problem families situated in all levels of socioeconomic status. Furthermore, future studies should also replicate the current findings with larger study samples of Aboriginal and non-Aboriginal women of varying ages and socioeconomic status in both urban and rural environments.

Sexual abuse will continue to be a leading focus of Aboriginal and women's mental health research. It is likely that the intergenerational transmission hypothesis will continue to be used to explain the proliferation of abuse against women and children, entwined with colonial and post-colonial discourses in Aboriginal and non-Aboriginal communities alike. In this sense sexual abuse is considered a chronic problem, alongside physical abuse, emotional abuse, neglect, and drug or alcohol abuse. Sexual abuse is a sign of multiple disadvantages within the families of these women. The rate of lifetime suicide attempts among women with a history of childhood sexual abuse was 63%. There is no way of knowing how many women who would fit in this disadvantaged, low SES group had committed suicide. It would be interesting to know more about the lives of those women.

Experiencing interpersonal violence however does not necessarily lead to problems later in life. We know there are differences in how people respond to trauma. Women's responses to abuse can be affected by any number of family, community, and broader social factors. Due to the need for individual and community

healing, it is becoming increasingly important for future research to explore the effects of individual resources (e.g. social support, family relations) and cultural beliefs on women's ability to cope with the stress of living with memories of past and current sexual abuse as well as other forms of maltreatment. Walters and Simoni (2002) for instance refer to 'traumatic stressors' in a discussion of culturally formed responses to negative life events including physical and sexual abuse. They suggest that Aboriginal women's ability to cope with adverse events including physical/sexual abuse is moderated by cultural identity and traditional healing. Women's positive cultural identification support healthy physical and mental health outcomes. There is increasing evidence of social and psychological resiliency among individuals with histories of childhood sexual abuse (Noll, 2005; Tyler, 2002; Wright, Fopma-Loy & Fischer, 2005). For instance, social support and suitable parental monitoring have been shown to reduce the risk for additional sexual activity and subsequent alcohol abuse in females with a history of childhood sexual abuse (see Hobfoll et al., 2002; Tyler, 2002). Having a supportive spouse has been identified as a protective factor for depression among women with a history of child sexual abuse (Wright et al., 2005). Future research among Aboriginals and non-Aboriginals in Canada needs to explore the factors that allow individuals to survive toxic environments characterized by family physical and sexual violence, neglect, verbal abuse, and parental substance abuse. We need to understand how individuals and communities successfully deal with traumatic events and co-occurring economic deprivation, and flourish in the face of adversity. Furthermore, future studies in this area should ascertain not only what

specific protective factors there are against the development of adverse physical and mental health outcomes, but what specific components of family, community, or culture are protective, and under what circumstances they protect against psychological distress.

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APPENDIX A

Approval for Study of Substance Abuse Among Off-Reserve Aboriginal Peoples

Centre universitaire de santé McGill
McGill University Health Centre
Les meilleurs soins pour la vie
The Best Care for Life

February 9, 2006

Dr. Kathryn Gill
Department of Psychiatry
Montreal General Hospital

RE: REC. 94-020 entitled "Substance Abuse Among Off-Reserve Aboriginal Peoples: Treatment Outcome."

Dear Dr. Gill:

We have received an Application for Continuing Review of the Montreal General Hospital Research Ethics Committee for the research study referenced above. The report was found to be acceptable for continued conduct at the McGill University Health Centre.

We are pleased to inform you that re-approval for the study was provided via review by the Co-Chair on February 9, 2006, **valid until February 2007**. It is noted in your report that the study is active with forty (40) subjects accrued since the last review.

At the MUHC, sponsored research activities that require US federal assurance are conducted under Federal Wide Assurance (FWA) 00000840.

We wish to remind you of the importance of maintaining REB status of your study on a yearly basis, and that it is the responsibility of the principal investigator to submit an Application for Continuing Review to the REB prior to the expiration of approval to comply with the regulation for continuing review of "at least once per year".

Should the research be concluded for any reason prior to the next review, a Termination Report is required for submission to the Committee once the study analysis is complete, to give an account of the study findings and publication status.

We trust this meets with your complete satisfaction.

Sincerely,

Denis Cournoyer, M.D.
Co-Chairman
GEN-Research Ethics Board
MUHC-Montreal General Hospital

Cc: Study file REC#94-020

APPENDIX B

Addiction Severity Index (ASI)

THE LIVES OF URBAN WOMEN

Subject ID#_____ Date (d/m/yr)_____
Interviewer:_____
Site of Interview:_____
Start Time_____ Stop Time_____

PART I - SOCIODEMOGRAPHICS

SECTION A: IDENTIFICATION

First, we would like to ask you a few questions about your background. We are asking these questions because we are interested in how people's cultural background may affect their use of or access to health services.

A 1. Where were you born? _____

A 2. What is your date of birth? (d/m/yr)_____

A 3. What reserve did you grow up in?_____

A 4. What is your Nation, band and status?_____

A 5. What is your first language (mother tongue)? _____

A 6. Where was your father born?_____

His date of birth? (d/m/yr) _____

His Nation, band and status_____

A 7. Where was your mother born?_____

Her date of birth? (d/m/yr) _____

Her Nation, band and status_____

A 8. What is your marital status?_____

single...1, married/common-law...2, divorced/separated....3, widowed...4

A 9. When did you come to Montreal? Why did you come here and with whom?

_____

_____

_____

_____

_____

_____

_____

A 10. How many of your family members are here in Montreal? Specify who?_____

_____

_____

_____

A 11. If living in a shelter, What are the circumstances that led you to be living in a shelter?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SECTION B: HEALTH PROBLEMS

Now, we would like to ask you about your health, some symptoms you may have experienced in the past and about any types of help you sought to deal with these symptoms or problems.

B 1. When was the last time you went to a clinic or doctor for a medical checkup?

_____

(days or months ago)

B 2. **In the last 12 months**, have you participated in any Native healing ceremonies? 0...No 1...Yes

IF YES, What kind?_____

(sweat lodge, healing circle, other)

B 3. **In the last 12 months**, have you sought the advice of a Native healer or elder for a medical or emotional problem? 0...No 1...Yes

IF YES, How many times?_____

B 4. Was (were) the experience(s) helpful? 0...No 1...Yes

Please explain_____

_____

_____

In the last 12 months, have you had a lot of trouble with:

B 5.	Pain in your legs, arms or stomach	[0] No	[1] Yes
B 6.	Chest pains	[0] No	[1] Yes
B 7.	Vomiting (not when pregnant)	[0] No	[1] Yes
B 8.	Feeling tired out, fatigued, or lacking enough energy to do the things you normally do	[0] No	[1] Yes
B 9.	Insomnia, not being able to fall asleep and sleep soundly, or waking up in the middle of the night	[0] No	[1] Yes

B 10. **In the last 12 months**, have you had a lot of trouble with any other symptoms or medical problems that were not mentioned? 0...No 1... Yes

IF YES, Describe._____

_____

_____

B 11. **In the last 12 months**, have you looked for or gone for help from any agency of health professional/doctor about the medical problems you described above?

IF YES, Who did you go to for help?_____

_____

IF NO, Why not?_____

_____

B 12. **Please tell me if any of these other reasons may be why you didn't go for help.**

1. I thought the problem would get better by itself	0... No	1... Yes
2. I was unsure about where to go for help	0... No	1... Yes
3. Help probably would not do any good	0... No	1... Yes
4. I had distance or transportation problems	0... No	1... Yes
5. I was concerned about what others might think	0... No	1... Yes
6. I would be ashamed or embarrassed	0... No	1... Yes
7. I wanted to solve the problem on my own	0... No	1... Yes
8. There was a language problem	0... No	1... Yes
9. I felt the services available would not be good for me	0... No	1... Yes
10. I went in the past but it did not help	0... No	1... Yes
11. I felt my culture/ethnic background wouldn't be understood	0... No	1... Yes
12. I felt there would be prejudice or racism against me there	0... No	1... Yes
13. I did not have a medicare card	0... No	1... Yes

Could you please explain?_____

_____

_____

_____

B 13. Would you like to have access to an Aboriginal medical centre? 0... No 1... Yes

Why? _____

_____

_____

_____

B 14. Do you have the following pieces of identification?:

a) Social Insurance Card	0... No	1... Yes
b) Birth Certificate	0... No	1... Yes
c) Baptismal Certificate	0... No	1... Yes
d) Medicare Card (If not, ask e)	0... No	1... Yes
e) Temporary Medicare Card	0... No	1... Yes
f) Band Card or Beneficiary Number	0... No	1... Yes

MEDICAL SECTION

How many times in your life have you been hospitalized for medical problems, not including pregnancies or births? *(Include o.d.'s, d.t.'s, exclude detox)* _____

How many pregnancies have you had in your lifetime? _____

Did any pregnancies end because of natural causes? 0... No 1… Yes If yes, how many? _____

Did any pregnancies end with an abortion? 0... No 1... Yes If yes, how many? _____

If pregnancy ended because of natural causes, what happened?

_____

_____

_____

_____

_____

_____

_____

If had an abortion, why did you have an abortion?

_____

_____

_____

_____

_____

_____

_____

When you were pregnant, were you ever hit, slapped, kicked, or otherwise physically hurt by someone? 0 = No 1= Yes If yes, by whom? (Circle all that apply)

	Husband	Ex-husband	Partner	Stranger	Other	Multiple
Total # times	_____	_____	_____	_____	_____	_____

When did this happen? Did this also happen before you were pregnant, and/or continue afterwards?

_____

_____

_____

How often did this happen?

_____

_____

_____

When you were pregnant, did anyone ever force to have sexual activities?
0 = No 1= Yes If yes, by whom? (Circle all that apply)

	Husband	Ex-husband	Partner	Stranger	Other	Multiple
Total # times	_____	_____	_____	_____	_____	_____

When did this happen? Did this also happen before you were pregnant, and/or continue afterwards?

_____

_____

_____

How often did this happen?

_____

_____

_____

Did you need medical treatment for injuries sustained while pregnant? 0 = No 1= Yes

Did you go to anyone for help? (hospital, CLSC, family doctor) 0 = No 1= Yes

Can you tell me why you did or did not?

_____

_____

SECTION D: ALCOHOL/DRUG USE

We would like to get some idea of whether you are currently drinking alcohol or taking any drugs.

D 1. Do you currently smoke cigarettes? 0... No 1... Yes
IF YES: How many do you smoke per day?_____

D 2. Can you tell me about the last time you had a drink or used drugs? Where were you (bar, home, park, etc.)?

_____
_____
_____
_____
_____

D 3. What did you have to drink? And how much? (Note size of beer and strength, type of spirits)

Beer_____
Wine_____
Hard Liquor_____

Did you drink that yourself, or did you share it with anyone? How many people?
_____

D 4. If you don't presently drink alcohol, why is that?

Against religious beliefs...1, Against personal beliefs...2, Dislike the taste...3, Bad for health...4, I stopped because I had problems...5, Flushing response e.g. nausea...6, Never drank alcohol...7, Other (specify)...8

_____
_____
_____

How old were you when you first stared drinking/using:

Alcohol/Drug	Age started	Age stopped

IF EVER INJECTED DRUGS.....

Did you share needles? 0... No 1... Yes

Did you know where to get clean ones? 0... No 1... Yes

IF EVER USED INHALANTS,.....

What do (did) you sniff?_____

At what age did you start sniffing?_____

If currently using, how often do you sniff?_____

If no longer using, when did you stop, and why?_____

_____

Do (did) you use solvents because you prefer (preferred) it, or when you run (ran) out of money?

_____

Do (did) you use solvents in combination with other drugs?_____(If yes, specify which drugs)

IF EVER BEEN TO TREATMENT FOR A DRUG OR ALCOHOL PROBLEM,.....

Where did you go for treatment?_____

_____

_____

_____

_____

Did you experience any barriers to treatment? 0...No 1... Yes

If yes, can you please explain what the problems were?

_____

_____

_____

_____

_____

Do you think there should be Aboriginal detox and treatment centres in the city? 0...No 1... Yes

If yes, Why?_____

_____

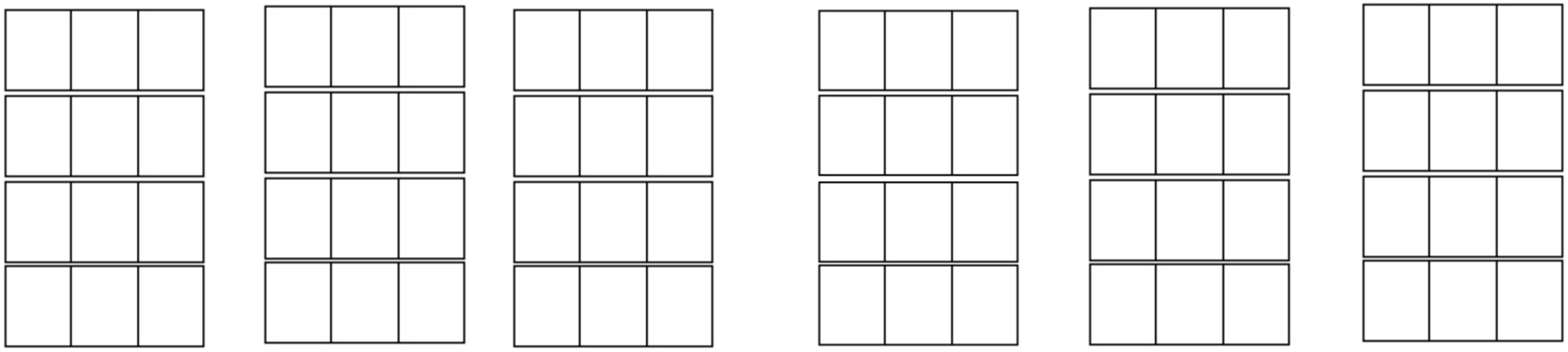
_____

_____

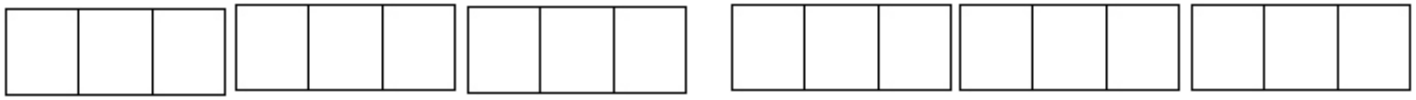
FAMILY HISTORY: Have any of these people ever had a drug/alcohol/psych problem they sought treatment for, or you think they should have?

Grandmother **Grandfather** **Grandmother** **Grandfather**

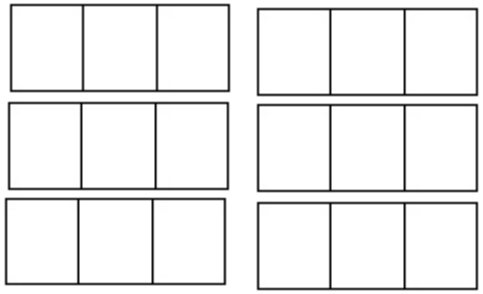
Uncles **Aunts** **Mother** **Uncles** **Aunts** **Father**



Brothers **Sisters**



Partners **Children** **Age, Live Where, With Who, Dates**



A =Alcohol problem
D = Drug problem
P = Psych problem
0 = Never had a problem
X = Uncertain or "I don't know"
N = Never a relative from that category

_____

_____

_____

If had a pregnancy at 18 years of age or under....

Who was the father? (age, background, how met)

_____

_____

_____

How long had you known him? How long had you been in a relationship?

_____

_____

_____

How would you describe your relationship? Were you very close?

_____

_____

_____

_____

_____

Did you feel you were ready for a pregnancy at that age? 0... No 1... Yes

(1= very negative; 2 = negative; 3 = neutral; 4 = positive; 5 = very positive)

Can you please explain?

_____

_____

_____

_____

_____

_____

_____

_____

_____

How did the father of the baby respond to this pregnancy? And did that change over time? Please explain. (1= very negative; 2 = negative; 3 = neutral; 4 = positive; 5 = very positive)

How did your parents (or other significant family members) respond to this pregnancy? And did their feelings about the pregnancy change over time? Please explain. (1= very negative; 2 = negative; 3 = neutral; 4 = positive; 5 = very positive)

Looking back, were there any problems for you having a child at that age? 0... No 1... Yes (problems with finances, family/social relationships, education, etc.)

Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? 0 = No 1= Yes

If yes, by whom? (Circle all that apply)

	Husband	Ex-husband	Partner	Stranger	Other	Multiple
Total # times	_____	_____	_____	_____	_____	_____

Within the last year, has anyone forced you to have sexual activities? 0 = No 1= Yes

If yes, by whom? (Circle all that apply)

	Husband	Ex-husband	Partner	Stranger	Other	Multiple
Total # times	_____	_____	_____	_____	_____	_____

Are you afraid of your partner or anyone you listed above? 0 = No 1= Yes

Can you please explain?

_____

_____

_____

_____

SECTION H: RECENT EVENTS

In the last 12 months, have you had...

1.	Difficulties at work or school	0... No	1... Yes
2.	Troubles with housing	0... No	1... Yes
3.	Troubles because people did not understand your language	0... No	1... Yes
4.	Troubles with the police or law	0... No	1... Yes
5.	Troubles with prejudice or discrimination	0... No	1... Yes
6.	Serious troubles because you did not have any money	0... No	1... Yes
7.	Illness or death in your family	0... No	1... Yes
8.	Been the victim of a crime or assault	0... No	1... Yes
9.	Difficulty getting child care	0... No	1... Yes
10.	Difficulty accessing services with Aboriginal content (ex. Therapy, DYP or court counsel)	0... No	1... Yes
11.	Problems with government agencies (ex. Welfare, DYP, court; child custody case)	0... No	1... Yes

If experienced problems with the DYP, please explain.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Addiction Severity Index 5th Edition

A. Thomas McLellan, Ph.D.
Kimberly A. Pukstas
Tara L. Deifenderfer

Remember: This is an interview, not a test

≈Item numbers circled are to be asked at follow-up.≈
≈Items with an asterisk are cumulative and should be rephrased at follow-up.≈

INTRODUCING THE ASI: Introduce and explain the seven potential problem areas: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychiatric. All clients receive this same standard interview. All information gathered is confidential; explain what that means in your facility; who has access to the information and the process for the release of information.
There are two time periods we will discuss:

1. The past 30 days
2. Lifetime

Patient Rating Scale: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.
The scale is: 0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely
Inform the client that he/she has the right to refuse to answer any question. If the client is uncomfortable or feels it is too personal or painful to give an answer, instruct the client not to answer. Explain the benefits and advantages of answering as many questions as possible in terms of developing a comprehensive and effective treatment plan to help them.

Please try not give inaccurate information!

INTERVIEWER INSTRUCTIONS:

1. Leave no blanks.
2. Make plenty of Comments (if another person reads this ASI, they should have a relatively complete picture of the client's perceptions of his/her problems).
3. X = Question not answered.
   N = Question not applicable.
4. Terminate interview if client misrepresents two or more sections.
5. When noting comments, please write the question number.
6. Tutorial/clarification notes are preceded with "•".

HALF TIME RULE: If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.

CONFIDENCE RATINGS: ⇒ Last two items in each section.
⇒ Do not over interpret.
⇒ Denial does not warrant misrepresentation.
⇒ Misrepresentation = overt contradiction in information.

Probe, cross-check and make plenty of comments!

HOLLINGSHEAD CATEGORIES:

1. Higher execs, major professionals, owners of large businesses.
2. Business managers if medium sized businesses, lesser professions, i.e., nurses, opticians, pharmacists, social workers, teachers.
3. Administrative personnel, managers, minor professionals, owners/proprietors of small businesses, i.e., bakery, car dealership, engraving business, plumbing business, florist, decorator, actor, reporter, travel agent.
4. Clerical and sales, technicians, small businesses (bank teller, bookkeeper, clerk, draftsperson, timekeeper, secretary).
5. Skilled manual - usually having had training (baker, barber, brakeperson, chef, electrician, fireperson, lineperson, machinist, mechanic, paperhanger, painter, repairperson, tailor, welder, policeperson, plumber).
6. Semi-skilled (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage guard, checker, waiter, spot welder, machine operator).
7. Unskilled (attendant, janitor, construction helper, unspecified labor, porter, including unemployed).
8. Homemaker.
9. Student, disabled, no occupation.

LIST OF COMMONLY USED DRUGS:

Alcohol:	Beer, wine, liquor
Methadone:	Dolophine, LAAM
Opiates:	Pain killers = Morphine, Diluaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Robitussin, Fentanyl
Barbiturates:	Nembutal, Seconal, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Xanax, Miltown, Other = ChloralHydrate (Noctex), Quaaludes Dalmane, Halcion
Cocaine:	Cocaine Crystal, Free-Base Cocaine or "Crack, and "Rock Cocaine"
Amphetamines:	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal
Cannabis:	Marijuana, Hashish
Hallucinogens:	LSD (Acid), Mescaline, Mushrooms (Psilocybin), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstacy
Inhalants:	Nitrous Oxide, Amyl Nitrate (Whippits, Poppers), Glue, Solvents, Gasoline, Toluene, Etc.

Just note if these are used:	Antidepressants,
	Ulcer Meds = Zantac, Tagamet
	Asthma Meds = Ventoline Inhaler, Theodur
	Other Meds = Antipsychotics, Lithium

ALCOHOL/DRUG USE INSTRUCTIONS:

The following questions refer to two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days.

⇒30 day questions only require the number of days used.
⇒Lifetime use is asked to determine extended periods of use.
⇒Regular use = 3+ times per week, binges, or problematic irregular use in which normal activities are compromised.
⇒Alcohol to intoxication does not necessarily mean "drunk", use the words "to feel or felt the effects", "got a buzz", "high", etc. instead of intoxication. As a rule of thumb, 3+ drinks in one sitting, or 5+ drinks in one day defines "intoxication".
⇒ How to ask these questions:
→ "How many days in the past 30 have you used....?"
→ "How many years in your life have you regularly used....?"

Addiction Severity Index, Fifth Edition

GENERAL INFORMATION

G1.ID No.: ☐☐☐☐☐☐☐☐☐☐

G2. SS No. : ☐☐☐ - ☐☐ - ☐☐☐☐

G4. Date of Admission ☐☐ / ☐☐ / ☐☐

G5. Date of Interview: ☐☐ / ☐☐ / ☐☐

G6 Time Begun: (Hour: Minutes) ☐☐ : ☐☐

G7. Time Ended: (Hour:Minutes) ☐☐ : ☐☐

G8. Class: 1. Intake 2. Follow-up ☐

G9. Contact Code: 1. In person
2. Telephone (Intake ASI must be in person) ☐

G10. Gender: 1. Male 2. Female ☐

G99. Treatment Episode No.: ☐☐

G11. Interviewer Code No./ Initials : ☐☐☐

G12. Special: 1. Patient terminated
2. Patient refused 3. Patient unable to respond ☐

Name

Address 1

Address 2

City State Zip Code

G14. How long have you lived at this address? (Years/Months) ☐☐ / ☐☐

G15. Is this address owned by you or your family? 0-No 1-Yes ☐

G16. Date of birth: (Month/Day/Year) ☐☐ / ☐☐ / ☐☐

G17. Of what race do you consider yourself? ☐
1. White (not Hisp) 5. Asian/Pacific 9. Unknown
2. Black (not Hisp) 6. Hispanic-Mexican
3. American Indian 7. Hispanic-Puerto Rican
4. Alaskan Native 8. Hispanic-Cuban

G18. Do you have a religious preference? ☐
1. Protestant 3. Jewish 5. Other
2. Catholic 4. Islamic 6. None

G19. Have you been in a controlled environment in the past 30 days? ☐
1. No 4. Medical Treatment
2. Jail 5. Psychiatric Treatment
3. Alcohol/Drug Treat. 6. Other: _____
•A place, theoretically, without access to drugs/alcohol.

G20. How many days? ☐☐
•"NN" if Question G19 is No. Refers to total number of days detained in the past 30 days.

ADDITIONAL TEST RESULTS

_____	☐☐☐
_____	☐☐☐
_____	☐☐
_____	☐☐☐
_____	☐☐
_____	☐☐☐
_____	☐☐☐
_____	☐☐☐
_____	☐☐☐

PROBLEMS	SEVERITY PROFILE									
	0	1	2	3	4	5	6	7	8	9
MEDICAL										
EMP/SUP										
ALCOHOL										
DRUGS										
LEGAL										
FAM/SOC										
PSYCH										

GENERAL INFORMATION COMMENTS

(Include the question number with your notes)

MEDICAL STATUS

M1. * How many times in your life have you been hospitalized for medical problems? ☐☐
- Include O.D.'s and D.T.'s. Exclude detox, alcohol/drug, psychiatric treatment and childbirth (if no complications). Enter the number of ***overnight*** hospitalizations for medical problems.

M2. How long ago was your last hospitalization for a physical problem? Yrs/Mos ☐☐ / ☐☐
- If no hospitalizations in Question M1, then this should be "NN".

M3. Do you have any chronic medical problems which continue to interfere with your life? 0 -No 1 - Yes ☐
- ***If "Yes", specify in comments.***
- A chronic medical condition is a serious physical condition that requires regular care, (i.e., medication, dietary restriction) preventing full advantage of their abilities.

M99. <**OPTIONAL**> Number of months pregnant: Mos ☐
- "N" for males, "0" for not pregnant.

M4. Are you taking any prescribed medication on a regular basis for a physical problem? 0 - No 1 - Yes ☐
- ***If Yes, specify in comments.***
- Medication prescribed by a MD for medical conditions; ***not psychiatric medicines***. Include medicines prescribed whether or not the patient is currently taking them. The intent is to verify chronic medical problems.

M5. Do you receive a pension for a physical disability? 0 - No 1 - Yes ☐
- ***If Yes, specify in comments.***
- Include Workers' compensation, exclude psychiatric disability.

M6. How many days have you experienced medical problems in the past 30 days? ☐☐
- Include flu, colds, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, abscesses from needles, etc.).

For Questions M7 & M8, ask the patient to use the Patient Rating scale.

M7. How troubled or bothered have you been by these medical problems in the past 30 days? ☐
- Restrict response to problem days of Question M6.

M8. How important to you now is treatment for these medical problems? ☐
- If client is currently receiving medical treatment, refer to the need for ***additional*** medical treatment by the patient.

INTERVIEWER SEVERITY RATING

M9. How would you rate the patient's need for medical treatment? ☐
- Refers to the patient's need for ***additional*** medical treatment.

CONFIDENCE RATINGS

Is the above information significantly distorted by: ☐

M10. Patient's misrepresentation? 0 - No 1 - Yes

M11. Patient's inability to understand? 0 - No 1 - Yes ☐

MEDICAL COMMENTS

(Include question number with your notes)

EMPLOYMENT/SUPPORT STATUS

E1.* Education completed:
- GED = 12 years. note in comments. Yrs/Mos ☐☐ / ☐☐
- Include formal education only.

E2.* Training or Technical education completed:
- Formal/organized training only. For military training, only include training that can be used in civilian life (ie., electronics, artillery) Mos ☐☐

E3. Do you have a profession, trade, or skill? 0 - No 1 - Yes ☐
- Employable, transferable skill acquired through training.
- If "Yes" (specify) _____

E4. Do you have a valid driver's license?
- Valid license; not suspended/revoked. 0 - No 1 - Yes ☐

E5. Do you have an automobile available?
- If answer toE4 is "No", then E5 must be "No". 0 - No 1 - Yes ☐ Does not require ownership, only requires availability on a regular basis.

E6. How long was your longest full time job?
- Full time = 35+ hours weekly; does not necessarily mean most recent job. Yrs/Mos ☐☐ / ☐☐

E7.* Usual (or last) occupation?
(specify) _____ ☐
(use Hollingshead Categories Reference Sheet)

E8. Does someone contribute to your support in anyway? 0 - No 1 - Yes ☐
- Is patient receiving any regular support (i.e., cash, food, housing) from family/friend. Include spouse's contribution; exclude support by an institution.

E9 Does this constitute the majority of your support? 0 - No 1 - Yes ☐
- If E8 is "No", then E9 is "N" .

E10. Usual employment pattern, past three years? ☐
1. Full time (35+ hours)
2. Part time (regular hours)
3. Part time (irregular hours)
4. Student
5. Service
6. Retired/Disability
7. Unemployed
8. In controlled environment
- Answer should represent the majority of the last 3 years, not just the most recent selection. If there are equal times for more than one category, select that which best represents the current situation.

EMPLOYMENT/SUPPORT COMMENTS
(Include question number with your notes)

EMPLOYMENT/SUPPORT (cont.)

E11. How many days were you paid for working in the past 30 days? ☐☐
- Include "under the table" work, paid sick days and vacation.

For questions E12-17: How much money did you receive from the following sources in the past 30 days?

E12. Employment? ☐☐☐☐☐
- Net or "take home" pay, include any "under the table" money.

E13. Unemployment Compensation? ☐☐☐☐☐

E14. Welfare? ☐☐☐☐☐
- Include food stamps, transportation money provided by an agency to go to and from treatment.

E15. Pensions, benefits or Social Security? ☐☐☐☐☐
- Include disability, pensions, retirement, veteran's benefits, SSI & workers' compensation.

E16. Mate, family, or friends? ☐☐☐☐☐
- Money for personal expenses, (i.e. clothing), include unreliable sources of income. Record ***cash*** payments only, include windfalls (unexpected), money from loans, legal gambling, inheritance, tax returns, etc.).

E17. Illegal? ☐☐☐☐☐
- ***Cash*** obtained from drug dealing, stealing, fencing stolen goods, illegal gambling, prostitution, etc. ***Do not*** attempt to convert drugs exchanged to a dollar value.

E18. How many people depend on you for the majority of their food, shelter, etc.? ☐☐
- Must be regularly depending on patient, do include alimony/child support, do not include the patient or self-supporting spouse, etc.

E19. How many days have you experienced employment problems in the past 30 ? ☐☐
- Include inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized.

For Questions E20 & E21, ask the patient to use the Patient Rating scale.

E20. How troubled or bothered have you been by these employment problems in the past 30 days? ☐
- If the patient has been incarcerated or detained during the past 30 days, they cannot have employment problems.

In that case an "N" response is indicated.

E21. How important to you now is counseling for these employment problems? ☐
- Stress help in finding or preparing for a job, not giving them a job.

INTERVIEWER SEVERITY RATING

E22. How would you rate the patient's need for employment counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

E23. Patient's misrepresentation? 0-No 1-Yes ☐

E24. Patient's inability to understand? 0-No 1-Yes ☐

EMPLOYMENT/SUPPORT COMMENTS

(Include question number with your notes)

ALCOHOL/DRUGS

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV

• *Note the usual or most recent route. For more than one route, choose the most severe. The routes are listed from least severe to most severe.*

		Past 30 Days	Lifetime (years)	Route of Admin
D1	Alcohol (any use at all)			
D2	Alcohol (to intoxication)			
D3	Heroin			
D4	Methadone			
D5	Other Opiates/Analgesics			
D6	Barbiturates			
D7	Sedatives/Hypnotics/ Tranquilizers			
D8	Cocaine			
D9	Amphetamines			
D10	Cannabis			
D11	Hallucinogens			
D12	Inhalants			
D13	More than 1 substance per day (including alcohol)			

D14. According to the interviewer, which substance(s) is/are the major problem? ☐☐

• Interviewer should determine the major drug of abuse. Code the number next to the drug in questions 01-12, or "00" = no problem, "15" = alcohol & one or more drugs, "16" = more than one drug but no alcohol. Ask patient when not clear.

D98 <**OPTIONAL**> According to the patient, which substance is the major problem? ☐☐

D15. How long was your last period of voluntary abstinence from this major substance? Mos ☐☐

• Last attempt of at least one month, not necessarily the longest. Periods of hospitalization/incarceration ***do not count***. Periods of antabuse, methadone, or naltrexone use during abstinence ***do count***.

•"00" = never abstinent

D16. How many months ago did this abstinence end? ☐☐

• If D15 = "00", then D16 = "NN".
• "00" = still abstinent.

D17. * How many times have you had: Alcohol DT's? ☐☐

• ***Delirium Tremens*** (DT's): Occur 24-48 hours after last drink, or significant decrease in alcohol intake, shaking, severe disorientation, fever, hallucinations, they usually require medical attention.

D18* Overdosed on Drugs? ☐☐

• ***Overdoses*** (OD): Requires intervention by someone to recover, not simply sleeping it off, include suicide attempts by OD.

ALCOHOL/DRUGS COMMENTS
(Include question number with your notes)

ALCOHOL/DRUGS (cont.)

How many times in your life have you been treated for :

D19. * Alcohol abuse? ☐☐

D20. * Drug abuse? ☐☐

- Include detoxification, halfway houses, in/outpatient counseling, and AA or NA (if 3+ meetings within one month period).

How many of these were detox only:

D21 * Alcohol? ☐☐

D22 * Drugs? ☐☐

- If D19 = "00", then question D21 is "NN"
  If D20 = "00", then question D22 is "NN"

How much money would you say you spent during the past 30 days on:

D23. Alcohol? ☐☐☐☐☐

D24. Drugs? ☐☐☐☐☐

- Only count actual ***money*** spent. What is the financial burden caused by drugs/alcohol?

D25. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days? • Include AA/NA ☐☐

D99. **<OPTIONAL>** How many days have you been treated in an inpatient setting for alcohol or drugs in the past 30 days? ☐☐

How many days in the past 30 have you experienced:

D26. Alcohol problems? ☐☐

D27. Drug problems? ☐☐

- Include: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

For Questions D28-D31, ask the patient to use the Patient Rating scale.
The patient is rating the need for additional substance abuse treatment.

How troubled or bothered have you been in the past 30 days by these:

D28. Alcohol problems? ☐

D29. Drug problems? ☐

How important to you now is treatment for these:

D30. Alcohol problems? ☐

D31. Drug problems? ☐

INTERVIEWER RATING

How would you rate the patient's need for treatment for:

D32. Alcohol problems? ☐

D33. Drug problems? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

D34. Patient's misrepresentation? 0-No 1-Yes ☐

D35. Patient's inability to understand? 0-No 1-Yes ☐

ALCOHOL/DRUGS COMMENTS

(Include question number with your notes)

LEGAL STATUS

L1. Was this admission prompted or suggested by the criminal justice system? 0 - No 1 -Yes
- Judge, probation/parole officer, etc.

L2. Are you on parole or probation? 0 - No 1 -Yes
- Note duration and level in comments.

How many times in your life have you been arrested and charged with the following:

L3 * Shoplift/Vandal		L10* Assault	
L4 * Parole/Probation Violations		L11* Arson	
L5 * Drug Charges		L12* Rape	
L6 * Forgery		L13* Homicide/Mansl.	
L7* Weapons Offense		L14* Prostitution	
L8* Burglary/Larceny/B&E		L15* Contempt of Court	
L9 * Robbery		L16* Other: _____	

- Include total number of counts, not just convictions. Do not include juvenile (pre-age 18) crimes, unless they were charged as an adult.
- Include formal charges only.

L17* How many of these charges resulted in convictions?
- If L3-16 = 00, then question L17 = "NN".
- Do not include misdemeanor offenses from questions L18-20 below.
- Convictions include fines, probation, incarcerations, suspended sentences, guilty pleas, and plea bargaining.

How many times in your life have you been charged with the following:

L18. * Disorderly conduct, vagrancy, public intoxication?

L19. * Driving while intoxicated?

L20. * Major driving violations?
- Moving violations: speeding, reckless driving, no license, etc.

L21 * How many months were you incarcerated in your life?
- If incarcerated 2 weeks or more, round this up to 1 month. List total number of months incarcerated.

L22. How long was your last incarceration? Mos
- Enter "NN" if never incarcerated.

L23. What was it for?
- Use code 03-16, 18-20. If multiple charges, choose most severe. Enter "NN" if never incarcerated.

L24. Are you presently awaiting charges, trial, or sentence? 0 - No 1 - Yes

L25. What for?
- Use the number of the type of crime committed: 03-16 and 18-20
- Refers to Q. L24. If more than one, choose most severe.

L26. How many days in the past 30, were you detained or incarcerated?
- Include being arrested and released on the same day.

LEGAL COMMENTS
(Include question number with your notes)

LEGAL STATUS (cont.)

L27. How many days in the past 30 have you engaged in illegal activities for profit? ☐☐
- Exclude simple drug possession. Include drug dealing, prostitution, selling stolen goods, etc. May be cross checked with Question E17 under Employment/Family Support Section.

For Questions L28-29, ask the patient to use the Patient Rating scale.

L28. How serious do you feel your present legal problems are? ☐
- Exclude civil problems

L29. How important to you now is counseling or referral for these legal problems? ☐
- Patient is rating a need for ***additional*** referral to legal counsel for defense against criminal charges.

INTERVIEWER SEVERITY RATING

L30. How would you rate the patient's need for legal services or counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

L31. Patient's misrepresentation? 0 - No 1 - Yes ☐

L32. Patient's inability to understand? 0 - No 1 - Yes ☐

LEGAL COMMENTS
(Include question number with your notes)

FAMILY HISTORY

Have any of your blood-related relatives had what you would call a significant drinking, drug use, or psychiatric problem? Specifically, was there a problem that did or should have led to treatment?

Mother's Side	Alcohol	Drug	Psych.
H1.Grandmother	☐	☐	☐
H2.Grandfather	☐	☐	☐
H3.Mother	☐	☐	☐
H4.Aunt	☐	☐	☐
H5.Uncle	☐	☐	☐

Father's Side	Alcohol	Drug	Psych.
H6. Grandmother	☐	☐	☐
H7. Grandfather	☐	☐	☐
H8. Father	☐	☐	☐
H9. Aunt	☐	☐	☐
H10. Uncle	☐	☐	☐

Siblings	Alcohol	Drug	Psych.
H11. Brother	☐	☐	☐
H12. Sister 1	☐	☐	☐

0 = Clearly No for any relatives in that category X = Uncertain or don't know
1 = Clearly Yes for any relatives in that category N = Never was a relative
•In cases where there is more than one person for a category, report the most severe. Accept the patient's judgment on these questions.

FAMILY HISTORY COMMENTS

FAMILY/SOCIAL RELATIONSHIPS

F1. Marital Status: ☐
1-Married 3-Widowed 5-Divorced
2-Remarried 4-Separated 6-Never Married
• Common-law marriage = 1. Specify in comments.

F2. How long have you been in this marital status (Q #F1)? Yrs/Mos ☐☐ / ☐☐
• If never married, then since age 18.

F3. Are you satisfied with this situation? 0-No 1-Indifferent 2-Yes ☐
• Satisfied = generally liking the situation.
• Refers to Questions F1 & F2.

F4. Usual living arrangements (past 3 years): ☐
1-With sexual partner & children
2-With sexual partner alone
3-With children alone
4-With parents
5-With family
6-With friends
7-Alone
8-Controlled Environment
9-No stable arrangement
• Choose arrangements most representative of the past 3 years. If there is an even split in time between these arrangements, choose the most recent arrangement.

F5. How long have you lived in these arrangements? Yrs/Mos ☐☐ / ☐☐
• If with parents or family, since age 18.
• Code years and months living in arrangements from Question F4.

F6. Are you satisfied with these arrangements? 0-No 1-Indifferent 2-Yes ☐

Do you live with anyone who:

F7. Has a current alcohol problem? 0-No 1-Yes ☐

F8 Uses non-prescribed drugs? 0-No 1-Yes ☐
(or abuses prescribed drugs)

F9. With whom do you spend most of your free time? 1-Family 2-Friends 3-Alone ☐
• If a girlfriend/boyfriend is considered as family by patient, then they must refer to them as family throughout this section, not a friend.

F10. Are you satisfied with spending your free time this way? 0-No 1-Indifferent 2-Yes ☐
• A satisfied response must indicate that the person generally likes the situation. Referring to Question F9.

F11. How many close friends do you have? ☐
• Stress that you mean ***close***. Exclude family members. These are "reciprocal" relationships or mutually supportive relationships.

Would you say you have had a close reciprocal relationship with any of the following people:

F12. Mother ☐ F15 Sexual Partner/Spouse ☐

F13. Father ☐ F16 Children ☐

F14 Brothers/Sisters ☐ F17 Friends ☐

0 = Clearly No for all in class X = Uncertain or "I don't know
1 = Clearly Yes for any in class N = Never was a relative
• By reciprocal, you mean "that you would do anything you could to help them out and vice versa".

FAMILY/SOCIAL COMMENTS
(Include question number with your notes)

FAMILY/SOCIAL (cont.)

Have you had significant periods in which you have experienced serious problems getting along with:

	0 - No 1 - Yes Past 30 days	In Your Life
F18. Mother	☐	☐
F19. Father	☐	☐
F20. Brother/Sister	☐	☐
F21. Sexual Partner/Spouse	☐	☐
F22. Children	☐	☐
F23. Other Significant Family (specify)_____	☐	☐
F24. Close Friends	☐	☐
F25. Neighbors	☐	☐
F26. Co-workers	☐	☐

- "Serious problems" mean those that endangered the relationship.
- A "problem" requires contact of some sort, either by telephone or in person.

Has anyone ever abused you?

	0- No 1-Yes Past 30 days	In Your Life
F27. Emotionally? • Made you feel bad through harsh words.	☐	☐
F28. Physically? • Caused you physical harm.	☐	☐
F29. Sexually? • Forced sexual advances/acts.	☐	☐

How many days in the past 30 have you had serious conflicts:

F30. With your family? ☐☐

F31. With other people (excluding family)? ☐☐

For Questions F32-35, ask the patient to use the Patient Rating scale.

How troubled or bothered have you been in the past 30 days by:

F32. Family problems ? ☐

F33. Social problems? ☐

How important to you now is treatment or counseling for these:

F34. Family problems
- Patient is rating his/her need for counseling for family problems, not whether they would be willing to attend. ☐

F35. Social problems
- Include patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Patient rating should refer to dissatisfaction, conflicts, or other serious problems. ☐

INTERVIEWER SEVERITY RATING

F36. How would you rate the patient's need for family and/or social counseling? ☐

CONFIDENCE RATING

Is the above information significantly distorted by:

F37. Patient's misrepresentation? 0-No 1-Yes ☐

F38. Patient's inability to understand? 0-No 1-Yes ☐

FAMILY/SOCIAL COMMENTS

(Include question number with your notes)

PSYCHIATRIC STATUS

How many times have you been treated for any psychological or emotional problems:

P1* In a hospital or inpatient setting? ☐☐

P2* Outpatient/private patient? ☐☐
- Do not include substance abuse, employment, or family counseling. Treatment episode = a series of more or less continuous visits or treatment days, not the number of visits or treatment days.
- Enter diagnosis in comments if known.

P3. Do you receive a pension for a psychiatric disability? 0-No 1-Yes ☐

Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:

		0-No Past 30 Days	1-Yes Lifetime
P4.	Experienced serious depression-sadness, hopelessness, loss of interest, difficulty with daily function?	☐	☐
P5.	Experienced serious anxiety/ tension-uptight, unreasonably worried, inability to feel relaxed?	☐	☐
P6.	Experienced hallucinations-saw things/ heard voices that others didn't see/hear?	☐	☐
P7.	Experienced trouble understanding, concentrating, or remembering?	☐	☐
P8.	Experienced trouble controlling violent behavior including episodes of rage, or violence? • Patient can be under the influence of alcohol / drugs.	☐	☐
P9.	Experienced serious thoughts of suicide? • Patient seriously considered a plan for taking his/her life. Patient can be under the influence of alcohol/drugs.	☐	☐
P10.	Attempted suicide? • Include actual suicidal gestures or attempts. • Patient can be under the influence of alcohol / drugs.	☐	☐
P11.	Been prescribed medication for any psychological or emotional problems? • Prescribed for the patient by a physician. Record "Yes" if a medication was prescribed even if the patient is not taking it.	☐	☐

P12. How many days in the past 30 have you experienced these psychological or emotional problems? ☐☐
- This refers to problems noted in Questions P4-P10.

For Questions P13-P14, ask the patient to use the Patient Rating scale

P13. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? ☐
- Patient should be rating the problem days from Question P12.

P14. How important to you now is treatment for these psychological or emotional problems? ☐

PSYCHIATRIC STATUS COMMENTS
(Include question number with your comments)

PSYCHIATRIC STATUS (cont.)

The following items are to be completed by the interviewer:
At the time of the interview, the patient was: 0-No 1-Yes

P15. Obviously depressed/withdrawn ☐

P16. Obviously hostile ☐

P17. Obviously anxious/nervous ☐

P18. Having trouble with reality testing, thought disorders, paranoid thinking ☐

P19. Having trouble comprehending, concentrating, remembering ☐

P20. Having suicidal thoughts ☐

INTERVIEWER SEVERITY RATING

P21. How would you rate the patient's need for psychiatric/psychological treatment? ☐

CONFIDENCE RATING

Is the above information significantly distorted by:

P22 Patient's misrepresentation? 0-No 1-Yes ☐

P23. Patient's inability to understand? 0-No 1-Yes ☐

PSYCHIATRIC STATUS COMMENTS
(Include question number with your notes)

RISQ Recherche et Intervention sur les Substances psychoactives - Québec
et la Fédération québécoise des Centres de réadaptation pour personnes alcooliques et toxicomanes

INDICE DE GRAVITÉ D'UNE TOXICOMANIE (IGT)

adapté de
ADDICTION SEVERITY INDEX (ASI)

5e version

° L'Indice de gravité d'une toxicomanie est l'adaptation de l'Addiction Severity Index de McLellan, A.T., Luborsky, L., O'Brien, C.P.(1980)

Janvier 1996

SYNTHÈSE DE L'INTERVENANT :

A. Estimation de la gravité du problème de l'usager

9							
8							
7							
6							
5							
4							
3							
2							
1							
0							
Problèmes	Alcool	Drogues	Santé phy.	Fam./Interp.	Psych.	Emploi/Ress.	Judiciaire A

B. Estimation du besoin additionnel de traitement de l'usager

9								
8								
7								
6								
5								
4								
3								
2								
1								
0								
Problèmes	Alcool	Drogues	Santé phy.	Fam./Interp.	Psych.	Emploi/Ress.	Judiciaire B	Judiciaire C

ATTENTES DE L'USAGER :

Signature de l'intervenant

CONSIGNES

- Les codes «9» (ou «99», «999», «9999») sont utilisés pour «NSP = ne sait pas» ou «refus = refus de répondre».
- Le N/A signifie «ne s'applique pas».

☞ Items objectifs critiques

Note : Il est important de remplir toutes les cases (sauf si indication «allez à»). En cas de doute, utilisez l'espace prévu pour les commentaires, en indiquant le numéro de la question et donnez le plus de détails possible.

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ALCOOL/DROGUES

A) Quelle est la date de votre dernière consommation (pour chacun des produits et la quantité consommée)?

B) Quelle a été votre consommation habituelle au cours des trois derniers mois (produits et quantité)?

Utilisez la grille suivante pour répondre à ces questions.

☞	30 dern. jours	Âge 1ière cons.	Âge cons. rég.	Années d'utilisation	Mode adm.
1. Alcool (toute utilisation)					
2. Alcool (jusqu'à intoxication)					
3. Héroïne					
4. Méthadone					
5. Autres opiacés/analgésiques					
6. Barbituriques					
7a) Autres séd./hypn./tranquillisants					
7b) Antipsychotiques/antidépresseurs/lithium					
8. Cocaïne					
9. Amphétamines					
10. Cannabis					
11. Hallucinogènes					
12. Inhalants					

CRITÈRES D'UTILISATION

Utilisation régulière =	Alcool **«jusqu'à intoxication» =**	**Mode d'administration =**	**Consigne =**
3 fois/semaine (ou session intensive de deux jours/semaine) pendant au moins un mois.	3 consommations ou plus d'alcool en une seule séance.	1- oral 2- nasal (sniffé) 3- fumé 4- injecté (non-intraveineux - non IV) 5- injecté (IV) 6- autres (spécifiez) _____	Utilisez N/A pour les questions concernant l'âge et le mode d'administration 99-NSP ou refus

☞ **13. Plus d'une substance par jour** (y compris l'alcool) — 30 dern. jours — à vie

☐☐ ☐☐

14. Quelle(s) substance(s) cause(nt) un problème majeur? ☐☐

Veuillez coder comme précédemment, ou
00 - pas de problème
15 - alcool et drogues (double toxicomanie)
16 - polydrogues
En cas d'incertitude, demandez au répondant.

☞ **15. Quelle a été la durée de votre dernière période d'abstinence volontaire de cette ou ces substance(s)?** (en mois) ☐☐

00 - Jamais abstinent
01 - au moins un mois
98 - 98 mois et plus
99 - NSP ou refus
N/A si 00, à Q. 14.

☞ **16. Depuis combien de mois cette abstinence a-t-elle cessé?** ☐☐

00 - Encore abstinent
98 - 98 mois et plus
99 - NSP ou refus
N/A - ne s'applique pas puisque n'a jamais été abstinent

☞ **17. Combien de fois avez-vous eu :**

- le *délirium tremens* (alcool)? ☐☐
- une surdose (drogues)? ☐☐

☞ **18. Combien de fois dans votre vie avez-vous été traité :**

- pour l'abus d'alcool uniquement? ☐☐
- pour l'abus de drogues uniquement? ☐☐
- pour l'abus d'alcool et de drogues? ☐☐

19. Parmi ces traitements, combien étaient des cures de désintoxication seulement :
N/A si 0, à la Q. 18

- pour l'alcool uniquement? ☐☐
- pour la drogue uniquement? ☐☐
- pour l'alcool et la drogue? ☐☐

20. Au cours des 30 derniers jours, combien d'argent estimez-vous avoir dépensé :
9998 = 9998$ et +
9999 - NSP ou refus

- pour de l'alcool? ☐☐☐☐
- pour des drogues? ☐☐☐☐

21. Au cours des 30 derniers jours, combien de jours avez-vous été traité en externe pour des problèmes d'alcool ou de drogues? (y compris AA-CA-NA)? ☐☐

22. Au cours des 30 derniers jours, pendant combien de jours avez-vous éprouvé :

- des problèmes d'alcool? ☐☐
- des problèmes de drogues? ☐☐

QUESTIONS 23 ET 24 : DEMANDEZ À L'USAGER D'UTILISER L'ÉCHELLE D'ÉVALUATION SUBJECTIVE (0 À 4).

23. Au cours des 30 derniers jours, dans quelle mesure avez-vous été perturbé ou préoccupé par :

- ces problèmes d'alcool? ☐
- ces problèmes de drogues? ☐

24. Dans quelle mesure vous semble-t-il important, maintenant, d'avoir un traitement pour :

- ces problèmes d'alcool? ☐
- ces problèmes de drogues? ☐

☞
ÉVALUATION DE GRAVITÉ PAR L'INTERVENANT (0 À 9)

25a) Quelle est votre estimation de la gravité du problème de l'usager :

- pour abus d'alcool? ☐
- pour abus de drogues? ☐

25b) Dans quelle mesure estimez-vous que l'usager a besoin de traitement :

- pour abus d'alcool? ☐
- pour abus de drogues? ☐

ÉVALUATION DE CONFIANCE
Les renseignements ci-dessus sont-ils sensiblement faussés :

26. ▪ parce que l'usager dissimule la vérité? ☐
1-Oui 2-Non

27. ▪ parce qu'il ne comprend pas les questions? ☐
1-Oui 2-Non

COMMENTAIRES :

ÉTAT DE SANTÉ PHYSIQUE

☞ **1. Combien de fois dans votre vie avez-vous été hospitalisé (24 heures et plus) pour des problèmes de santé physique?** ☐☐
(Y compris surdoses et *délirium tremens*; excluant désintoxication)
00 - aucune hospitalisation
98 - 98 hospitalisations et plus
99 - NSP ou refus

2. Combien de temps s'est écoulé depuis votre dernière hospitalisation pour un problème de santé physique?
00 - a été hospitalisé au cours des 30 derniers jours
99 - NSP ou refus
N/A - ne s'applique pas car n'a jamais été hospitalisé

années ☐☐ mois ☐☐

☞ **3. Avez-vous un problème chronique de santé physique qui continue de perturber votre vie?**

1-Oui 2-Non ☐

4. Prenez-vous régulièrement un médicament prescrit pour un problème de santé physique?

1-Oui 2-Non ☐

5. Au cours des douze derniers mois avez-vous consulté un médecin pour un problème de santé physique?

1-Oui 2-Non ☐

6. Souffrez-vous d'une incapacité permanente?

1-Oui 2-Non (allez à Q. 8) ☐

7. Cette incapacité est-elle le résultat d'un accident?

1-Oui 2-Non (allez à Q. 8) ☐

Si oui, était-ce : ☐
1. un accident de la **route**?
2. un accident de **travail**?
3. un accident survenu **à domicile**?
4. un autre type d'accidents (spécifiez)

_____

8. Au cours des 30 derniers jours, pendant combien de jours avez-vous éprouvé des problèmes de santé physique? ☐☐

QUESTIONS 9 ET 10 : DEMANDEZ À L'USAGER D'UTILISER L'ÉCHELLE D'ÉVALUATION SUBJECTIVE (0 À 4).

9. Au cours des 30 derniers jours, dans quelle mesure avez-vous été perturbé ou préoccupé par ces problèmes de santé physique? ☐

10. Dans quelle mesure vous semble-t-il important maintenant de recevoir un traitement pour ces problèmes de santé physique? ☐

☞
ÉVALUATION DE GRAVITÉ PAR L'INTERVENANT (0 À 9)

11a) Quelle est votre estimation de la gravité du problème de l'usager? ☐

11b) Dans quelle mesure estimez-vous que l'usager a besoin de traitement médical? ☐

ÉVALUATION DE CONFIANCE

Les renseignements ci-dessus sont-ils sensiblement faussés :

12. ▪ parce que l'usager dissimule la vérité?

1-Oui 2-Non ☐

13. ▪ parce qu'il ne comprend pas les questions?

1-Oui 2-Non ☐

COMMENTAIRES :

RELATIONS FAMILIALES/INTERPERSONNELLES

1. Êtes-vous présentement : ☐

1. marié(e) et vivant avec votre conjoint(e)?
2. vivant en union libre avec un(e) conjoint(e)?
3. séparé(e) (légalement ou non) ou divorcé(e) et ne vivant pas avec un(e) conjoint(e)?
4. veuf(veuve) et ne vivant pas avec un(e) conjoint(e)?
5. jamais marié(e) mais ayant vécu dans le passé avec un(e) conjoint(e) dans une union libre?
6. jamais marié(e) et n'ayant jamais vécu avec un(e) conjoint(e)?

☞ **2a. Depuis combien de temps êtes-vous dans votre situation présente?** (depuis l'âge de 18 ans, si code 6 à Q. 1).

années ☐☐ mois ☐☐

☞ **2b. Êtes-vous satisfait de cette situation?**

1-Oui 2-Non 3-Indifférent(e) ☐

3. Actuellement, êtes-vous : ☐

1. propriétaire de votre résidence?
2. locataire?
3. chambreur?
4. chez des parents?
5. en milieu institutionnel?
6. sans-abri?
7. autres : (spécifiez) _____

4. Conditions de vie habituelles :

	Actuellement	3 dern. années
	☐☐	☐☐

01. avec le(la) conjoint(e) et les enfants
02. avec le(la) conjoint(e) seulement
03. avec les enfants seulement
04. avec les parents
05. avec la famille
06. avec des amis
07. seul(e) ou en chambre
08. en milieu institutionnel
09. avec un(des) colocataire(s)
10. sans-abri
11. pas de conditions de vie stables (s'applique seulement aux 3 dernières années).

☞ **5a. Depuis combien de temps vivez-vous dans les conditions actuelles?** (depuis l'âge de 18 ans, si vous vivez avec vos parents ou votre famille.)

01- depuis 15 jours à 1 mois

années ☐☐ mois ☐☐

☞ **5b. Êtes-vous satisfait de ces conditions de vie?**

1-Oui 2-Non 3-Indifférent(e) ☐

6a. Vivez-vous avec quelqu'un qui a des problèmes avec l'alcool?

1-Oui 2-Non 9-NSP ou refus ☐

6b. Vivez-vous avec quelqu'un qui fait un usage non-médical de drogues?

1-Oui 2-Non 9-NSP ou refus ☐

7a. Avec qui passez-vous la plupart de vos temps libres?

1- La famille 2- Les amis 3- Seul(e) ☐

☞ **7b. Êtes-vous satisfait de cette façon de passer vos temps libres?**

1-Oui 2-Non 3-Indifférent(e) ☐

8. Combien d'amis intimes avez-vous? ☐☐

COMMENTAIRES :

Personnes / Questions	Mère bio.	Mère adopt.	Père bio.	Père adopt.	Frères Nbre :	Soeurs Nbre :	Conjoint	Enfants Nbre ♦ :	Autres parents imp.	Amis	Voisins	Coll. de travail
☞ 9. Avez-vous connu des périodes significatives de graves problèmes de relation avec ? 30 derniers jours												
à vie												
À votre avis, certains de vos proches ont-ils eu :					(1) (2)	(1) (2)		(1) (2)				
10. des problèmes avec l'alcool?							*	*				
11. des problèmes avec des drogues?							*	*				
12. des problèmes psychiatriques?							*	*				
13. Estimez-vous avoir établi une relation étroite et durable avec les personnes suivantes?												

1 - Oui 2 - Non 9 - NSP ou refus	N/A -ne s'applique pas car l'usager n'a aucune personne du type mentionné (exemple : pas de mère adoptive) ou n'a eu aucun contact ou personne décédée. (sauf Q.13) * Facultatif	♦ Demandez l'âge de ou des enfant(s) et inscrivez ici :

14. Avez-vous déjà été abusé émotionnellement (par des propos injurieux) :

- dans les 30 derniers jours? 1-Oui 2-Non ☐
- dans la vie? 1-Oui 2-Non ☐

15. Avez-vous déjà été abusé physiquement (en ayant eu des dommages corporels) :

- dans les 30 derniers jours? 1-Oui 2-Non ☐
- dans la vie? 1-Oui 2-Non ☐

16. Avez-vous déjà été abusé sexuellement (en vous faisant imposer des avances ou des relations sexuelles) :

- dans les 30 derniers jours? 1-Oui 2-Non ☐
- dans la vie? 1-Oui 2-Non ☐

☞ **17. Au cours des 30 derniers jours, pendant combien de jours avez-vous été en conflit grave :**

a) avec votre famille? ☐☐

b) avec d'autres personnes? (à l'exception de la famille) ☐☐

QUESTIONS 18-21 : DEMANDEZ À L'USAGER D'UTILISER L'ÉCHELLE D'ÉVALUATION SUBJECTIVE (0 À 4).

Au cours des 30 derniers jours, dans quelle mesure avez-vous été perturbé ou préoccupé par :

18. ■ ces problèmes familiaux? ☐

19. ■ ces problèmes de relation avec les autres (y compris les problèmes reliés à l'isolement et à la solitude)? ☐

Dans quelle mesure vous semble-t-il important d'obtenir un traitement ou de l'aide pour :

20. ■ ces problèmes familiaux? ☐

21. ■ ces problèmes de relation avec les autres? ☐

☞

ÉVALUATION DE GRAVITÉ PAR L'INTERVENANT (0 À 9)

22a. Quelle est votre estimation de la gravité du problème de l'usager? ☐

22b. Dans quelle mesure estimez-vous que l'usager a besoin de counseling familial et/ou interpersonnel? ☐

ÉVALUATION DE CONFIANCE

Les renseignements ci-dessus sont-ils sensiblement faussés :

23. ■ **parce que l'usager dissimule la vérité?**
1-Oui 2-Non ☐

24. ■ **parce qu'il ne comprend pas les questions?**
1-Oui 2-Non ☐

ÉTAT PSYCHOLOGIQUE

☞ **1. Combien de fois avez-vous été traité pour des problèmes psychologiques ou émotionnels :**

- dans un hôpital? ☐☐
- en clinique externe ou en pratique privé? ☐☐

Avez-vous connu une période prolongée, NE RÉSULTANT PAS DE LA CONSOMMATION DE DROGUES OU D'ALCOOL, au cours de laquelle vous avez :

☞ **2. eu une dépression grave? (tristesse, désespoir, perte d'intérêt importante, apathie, sentiment de culpabilité, crises de larmes)** (pendant au moins 2 semaines).

30 derniers jours ☐ **dans votre vie** ☐
1-Oui
2-Non
9-NSP ou refus

☞ **3. souffert d'anxiété ou de tensions graves? (sensation de tension, d'incapacité de se détendre, crainte déraisonnable)** (pendant au moins 2 semaines).

30 derniers jours ☐ **dans votre vie** ☐
1-Oui
2-Non
9-NSP ou refus

☞ **4. souffert d'hallucinations? (voir des choses, des gens ou entendre des voix qui n'existent pas, même si la durée a été brève)**

30 derniers jours ☐ **dans votre vie** ☐
1-Oui
2-Non
9-NSP ou refus

☞ **5. éprouvé des troubles graves de concentration, de mémorisation et/ou de compréhension?** (pendant au moins 2 semaines)

30 derniers jours ☐ **Dans votre vie** ☐
1-Oui
2-Non
9-NSP ou refus

Avez-vous connu une période, RÉSULTANT OU NON DE LA CONSOMMATION D'ALCOOL OU DE DROGUES, au cours de laquelle vous avez :

☞ **6. éprouvé des difficultés à maîtriser un comportement violent?**

30 derniers jours ☐ **Dans votre vie** ☐
1-Oui
2-Non
9-NSP ou refus

☞ **7. tenté de vous blesser intentionnellement** (autre que tentative de suicide)?

30 derniers jours ☐ **dans votre vie** ☐
1-Oui
2-Non
9-NSP ou refus

☞ **8. eu de fortes pensées suicidaires** (avec scénario)?

30 derniers jours ☐ **dans votre vie** ☐
1-Oui
2-Non
9-NSP ou refus

☞ **9. tenté de vous suicider?**

30 derniers jours ☐ **dans votre vie** ☐
1-Oui
2-Non
9-NSP ou refus

☞ **10. eu un médicament prescrit pour un problème psychologique ou émotionnel?**

30 derniers jours ☐ **dans votre vie** ☐
1-Oui
2-Non
9-NSP ou refus

11. Au cours des 30 derniers jours, pendant combien de jours avez-vous éprouvé ces problèmes psychologiques ou émotionnels? ☐☐

QUESTIONS 12 ET 13 : DEMANDEZ À L'USAGER D'UTILISER L'ÉCHELLE D'ÉVALUATION SUBJECTIVE (0 À 4).

12. **Au cours des 30 derniers jours, dans quelle mesure avez-vous été perturbé ou préoccupé par ces problèmes psychologiques ou émotionnels?** ☐

13. **Dans quelle mesure vous semble-t-il important, maintenant, d'être traité pour ces problèmes psychologiques ou émotionels?** ☐

QUESTIONS À L'USAGE DE L'INTERVENANT

AU MOMENT DE LA PRÉSENTE ENTREVUE, L'USAGER EST-IL :

14* **visiblement déprimé ou en retrait?**
1-Oui 2-Non ☐

15. **visiblement hostile?**
1-Oui 2-Non ☐

16* **visiblement anxieux ou nerveux?**
1-Oui 2-Non ☐

17. **A-t-il des difficultés à évaluer objectivement la situation, des troubles de la pensée, une pensée paranoïde?**
1-Oui 2-Non ☐

* Questions 14, 16, 19 : en cas de doute, demandez à l'usager.

18. **A-t-il des difficultés à comprendre, à se concentrer et à se souvenir?**
1-Oui 2-Non ☐

19* **A-t-il des pensées suicidaires?**
1-Oui 2-Non ☐

☞ **ÉVALUATION DE GRAVITÉ PAR L'INTERVENANT (0 À 9)**

20a. **Quelle est votre estimation de la gravité du problème de l'usager?** ☐

20b. **Dans quelle mesure estimez-vous que l'usager a besoin de traitement psychiatrique/psychologique?** ☐

ÉVALUATION DE CONFIANCE

Les renseignements ci-dessus sont-ils sensiblement faussés :

21. ▪ **parce que l'usager dissimule la vérité?**
1-Oui 2-Non ☐

22. ▪ **parce qu'il ne comprend pas les questions?**
1-Oui 2-Non ☐

COMMENTAIRES :

EMPLOI / RESSOURCES

☞ **1. Quel est le plus haut niveau de scolarité que vous avez complété?** (notez le code correspondant à la scolarité complétée) ☐☐

00. Aucune scolarité ou uniquement l'école maternelle
01. Première année
02. Deuxième année
03. Troisième année
04. Quatrième année
05. Cinquième année
06. Sixième année
07. Septième année
08. Huitième année ou secondaire I
09. Neuvième année ou secondaire II
10. Dixième année ou secondaire III
11. Onzième année ou secondaire IV
12. Douzième année ou secondaire V
13. Études **partielles** dans un cégep, une école de métiers ou un collège commercial privé, un institut technique, une école de sciences infirmières, une école normale
14. **Diplôme ou certificat d'études** d'un cégep, d'une école de métiers ou un collège commercial privé, un institut technique, une école de sciences infirmières, une école normale
15. Études **partielles** à l'université, **Certificat(s) universitaires**
16. Baccalauréat, Maîtrise ou Doctorat **acquis**

☞ **2. Autre formation** (perfectionnement/en cours d'emploi/chômage)

98 - 98 mois et plus
99 - NSP ou refus

mois ☐☐

☞ **3. Avez-vous une profession ou un métier?** ☐

1-Oui (Spécifiez) _____
2-Non

4. Avez-vous un permis de conduire valide? ☐

1-Oui
2-Non, permis non renouvelé
3-Non, permis suspendu
4-Non, n'en a jamais eu

5. Pouvez-vous disposer d'un véhicule automobile? ☐

1-Oui 2-Non
(codez 2, si pas de permis valide)

☞ **6. Quelle a été la durée de votre plus long emploi régulier?**

années ☐☐ mois ☐☐

7. Occupation habituelle (ou dernière occupation) ▒▒

Spécifiez :
_____

8. Quelqu'un d'autre contribue-t-il à votre soutien financier d'une manière ou d'une autre? ☐

1-Oui 2-Non

9. Si oui, cela représente-t-il l'essentiel de vos ressources financières? ☐

1-Oui 2-Non
N/A-ne s'applique pas car ne reçoit aucune aide financière

☞ **10a. Type d'activité habituelle au cours des trois dernières années :** ☐☐

1. travail à plein temps (35 heures/semaine)
2. travail à temps partiel (heures régulières)
3. travail à temps partiel (heures irrégulières ou travail à la journée)
4. travail saisonnier(combinaison travail chômage)
5. études
6. retraite
7. invalidité
8. chômage
9. séjour en milieu institutionnel
10. aide sociale (B.E.S.)
11. au foyer
12. autres (incluant activités illégales)
13. conditions instables (plusieurs situations de durées variables)

10b. Êtes-vous satisfait de cette situation?

1-Oui 2-Non 3-Indifférent(e) ☐

11. Au cours des 30 derniers jours, combien de jours de travail vous a-t-on payés (y compris un travail au noir)? ☐☐

Au cours des 30 derniers jours, combien d'argent avez-vous reçu des sources suivantes :
9998 = 9998$ et +, 9999 = NSP ou refus

12. emploi (revenu net)? ☐☐☐☐

13. prestations de chômage? ☐☐☐☐

14. aide sociale? ☐☐☐☐

15. **pension, prestations CSST, RRQ, IVAC SAAQ, allocations familiales, pension alimentaire?** ☐☐☐☐

16. **conjoint, famille ou amis, prêts et bourses, revenus imprévus tels TPS, retour d'impôts, loterie?** ☐☐☐☐

17. **sources illégales?** ☐☐☐☐

18. **Combien de personnes dépendent de vous pour la plus grande partie de leurs besoins (nourriture,logement, etc.)?** ☐

19. **Au cours des 30 derniers jours, pendant combien de jours avez-vous eu des problèmes d'emploi?** ☐☐
    00 - aucun jour (inclut aucune recherche d'emploi)

QUESTIONS 20 ET 21 : DEMANDEZ À L'USAGER D'UTILISER L'ÉCHELLE D'ÉVALUATION SUBJECTIVE (0 À 4).

20. **Au cours des 30 derniers jours, dans quelle mesure avez-vous été perturbé ou préoccupé par ces problèmes d'emploi?** ☐

21. **Dans quelle mesure vous semble-t-il important, maintenant, de recevoir de l'aide pour ces problèmes d'emploi?** ☐

☞
ÉVALUATION DE GRAVITÉ PAR L'INTERVENANT (0 À 9)

22a. **Quelle est votre estimation de la gravité du problème de l'usager?** ☐

22b. **Dans quelle mesure estimez-vous que l'usager a besoin de counseling d'emploi?** ☐

23. **Cette demande a-t-elle été provoquée ou exigée par votre employeur?**
    1-Oui 2-Non ☐
    N/A si pas d'emploi

24. **Avez-vous perdu ou quitté un ou plusieurs emplois à cause de la consommation de drogues ou d'alcool?**
    1-Oui 2-Non ☐

25. **Quel est le montant de vos dettes?** (détaillez en commentaires)
    99998 = 99998 $ et plus
    99999 = NSP ou refus ☐☐☐☐☐

26. **Quel est votre revenu personnel annuel?** (utilisez l'échelle des revenus ci-dessous) ☐
    1. 0 000 $ - 00 999 $
    2. 1 000 $ - 05 999 $
    3. 6 000 $ - 11 999 $
    4. 12 000 $ - 19 999 $
    5. 20 000 $ - 29 999 $
    6. 30 000 $ - 39 999 $
    7. 40 000 $ - 49 999 $
    8. 50 000 $ et plus
    9. NSP ou refus

27. **Quel est le revenu annuel de votre famille?** (Utilisez l'échelle des revenus de la question précédente) ☐

ÉVALUATION DE CONFIANCE

Les renseignements ci-dessus sont-ils sensiblement faussés :

28. ▪ **parce que l'usager dissimule la vérité?**
    1-Oui 2-Non ☐

29. ▪ **parce qu'il ne comprend pas les questions?**
    1-Oui 2-Non ☐

COMMENTAIRES :

SITUATION JUDICIAIRE

1. **Cette admission a-t-elle été imposée ou suggérée par le système judiciaire et/ou par le système social?**
   1-Oui 2-Non ☐

   Si oui → **lequel?** (N/A si non) ☐☐

   → Système judiciaire :
   01. agent de probation
   02. agent de libération conditionnelle
   03. avocat
   04. juge (libération sous caution)
   05. autres : (spécifiez) _____

   → Système social :
   06. intervenants de la CPEJ
   07. autres intervenants du réseau
   08. avocat ou juge (Tribunal de la Jeunesse)

2. **Présentement, êtes-vous :** ☐

   1. en libération conditionnelle?
   2. en probation?
   3. en maison de transition?
   4. autres (ex., prison, pénitencier, libération sous caution)? (spécifiez)_____
   5. aucune mesure légale?

Combien de fois dans votre vie avez-vous été inculpé (accusé) des infractions ou délits suivants :

3. **désordre, vagabondage, ivresse publique?** ☐☐

4. **infractions majeures au Code de la route?** (ex., conduite dangereuse, conduite sans permis)? ☐☐

5a. **De combien de ces inculpations avez-vous été reconnu coupable?** N/A si jamais inculpé ☐☐

5b. **Combien de sentences avez-vous reçues pour ces condamnations?** N/A si jamais condamné ☐☐

Combien de fois dans votre vie avez-vous été inculpé (accusé) des délits ou crimes suivants (c.f. Code criminel) :

☞ 6. **infractions contre l'application de la loi** (ex., désobéissance à une ordonnance de la Cour, bris de probation, entraves à la justice telles les évasions ou les omissions de comparaître)? ☐☐

☞ 7. **fraude** (ex., vol de carte de crédit, escroquerie telle fabrication ou usage de faux)? ☐☐

☞ 8. **port d'arme illégal** (ex., posséder ou utiliser une arme à feu sans permis)? ☐☐

☞ 9. **infractions hors classe** (ex., libelle diffammatoire, fabrication de fausse monnaie)? ☐☐

☞ 10. **drogues** (possession ou trafic)? ☐☐

☞ 11. **méfait** (ex., introduction par effraction, vandalisme, troubler la paix)? ☐☐

☞ 12. **conduite avec facultés affaiblies** (et/ou défaut ou refus de fournir un échantillon d'haleine ou de sang)? ☐☐

☞ 13. **vol** (recel, vol sans arme et sans menace de violence sur la personne)? ☐☐

☞ 14. **infractions d'ordre sexuel** (prostitution, proxénétisme)? ☐☐

☞ 15. **voies de fait** (menace de mort, agression physique)? ☐☐

☞ 16. **négligence criminelle** (délit de fuite)? ☐☐

☞ 17. **vol qualifié** (avec une arme ou menace de violence sur la personne)? ☐☐

☞ 18. **viol, inceste, agression sexuelle?** ☐☐

☞ 19. **homicide, meurtre** (tentative de meutre)? ☐☐

☞ 20a. **De combien de ces inculpations (6 à 19) avez-vous été reconnu coupable?** N/A si jamais inculpé ☐☐

20b. **Combien de sentences avez-vous reçues pour ces condamnations?** N/A si jamais condamné ☐☐

21a. Combien de mois avez-vous été détenu dans votre vie? mois ☐☐

00 - moins de 15 jours, ou jamais inculpé ou autres types de sentences (allez à Q. 24)
98 - 98 mois et plus
99 - NSP ou refus

21b. Cela représente combien d'épisodes de détention au total? ☐☐

22. Combien de temps a duré votre dernière détention? ☐☐
98 - 98 mois et plus
99 - NSP ou refus

23. Pour quel délit étiez-vous détenu? ☐☐
3-4, 6-19, code correspondant à l'item ou au délit
Si inculpations multiples, codez la + grave, les items étant ordonnés selon l'ordre croissant de gravité

☞ **24. Présentement, êtes-vous en instance d'inculpation, de procès ou de sentence?** ☐
1-Oui 2- Non (allez à Q. 26a).

Si oui, êtes-vous : ☐

1. en instance d'inculpation?
2. en attente de procès?
3. en attente de sentence?
4. autres : (spécifiez) _____

☞ **25. Pour quel délit?** ☐☐
3-4, 6-19, code correspondant à l'item ou au délit
Si plusieurs délits, notez le + grave, les délits étant ordonnés selon un ordre croissant de gravité

26a. À quel âge avez-vous fait votre premier geste délinquant (acte ou infraction passible d'être traduit en justice au criminel)?

00 si aucun geste délinquant ☐☐

26b. Quel âge aviez-vous lors de votre dernière inculpation pour un délit (code criminel)?

00 si aucune inculpation ☐☐

27. Au cours des 30 derniers jours, pendant combien de jours avez-vous été détenu? ☐☐

☞ **28. Au cours des 30 derniers jours, pendant combien de jours vous êtes-vous adonné à des activiés illégales en vue d'en tirer profit?** ☐☐

QUESTIONS 29 ET 30 : DEMANDEZ À L'USAGER D'UTILISER L'ÉCHELLE D'ÉVALUATION SUBJECTIVE. (0 À 4)

29. Dans quelle mesure pensez-vous que vos problèmes judiciaires actuels sont graves? (exclure les problèmes civils) ☐

30. Dans quelle mesure vous semble-t-il important maintenant, d'avoir de l'aide ou une consultation pour ces problèmes judiciaires? ☐

☞
ÉVALUATION DE GRAVITÉ PAR L'INTERVENANT (0 À 9)

31a. Quelle est votre estimation de la gravité du problème de l'usager? ☐

31b. Dans quelle mesure estimez-vous que l'usager a besoin de services juridiques ou de counseling? ☐

31c. Comment évaluez-vous son besoin de services psychosociaux en regard de son profil de délinquance? ☐

ÉVALUATION DE CONFIANCE

Les renseignements ci-dessus sont-ils sensiblement faussés?

32. ▪ **parce que l'usager dissimule la vérité?** ☐
1-Oui 2-Non

33. ▪ **parce qu'il ne comprend pas les questions?** ☐
1-Oui 2-Non

COMMENTAIRES :

APPENDIX C

Child Abuse and Trauma Scale (CATS)

HOME ENVIRONMENT QUESTIONNAIRE

This questionnaire seeks to determine the general atmosphere of your home when you were a child or teenager and how you felt you were treated by your parents or caretakers.

If you were not raised by one or both of your biological parents please indicate who raised you, their relationship to you, and at what age they started to take care of you.

Raised by: _____

(e.g. aunt, uncle, grandmother, friend of family, adoptive parents, etc.)

Your age when they started to care for you: _____

Please respond to the questions on the next page in terms of the persons who had the primary responsibility for your upbringing as a child.

USE THE FOLLOWING SCALE TO RESPOND TO THE QUESTIONS:

0 = NEVER

1 = RARELY

2 = SOMETIMES

3 = VERY OFTEN

4 = ALWAYS

To illustrate, here is an example question:
Did your parents criticize you when you were young? If you were rarely criticized, then you should circle number 1.

0 = NEVER 1 = RARELY 2 = SOMETIMES 3 = VERY OFTEN 4 = ALWAYS

Please answer all questions.

1. Did your parents ridicule you?---------- 0 1 2 3 4
2. Did you ever seek outside help or guidance because of problems in your home?---------- 0 1 2 3 4
3. Did your parents verbally abuse each other?---------- 0 1 2 3 4
4. Were you expected to follow a strict code of behaviour in your home? 0 1 2 3 4
5. When you were punished as a child or teenager, did you understand the reason you were punished?---------- 0 1 2 3 4
6. When you didn't follow the rules of the house, how often were you severely punished?---------- 0 1 2 3 4
7. As a child did you feel unwanted or emotionally neglected?---------- 0 1 2 3 4
8. Did your parents insult you or call your names?---------- 0 1 2 3 4
9. Before you were 14, did you engage in any sexual activity with an adult?---------- 0 1 2 3 4
10. Were your parents unhappy with each other?---------- 0 1 2 3 4
11. Were your parents unwilling to attend any of your school-related activities?---------- 0 1 2 3 4
12. As a child were you punished in unusual ways (e.g. being locked in a closet for a long time or being tied up)?---------- 0 1 2 3 4
13. Were there traumatic or upsetting sexual experiences when you were child or teenager that you couldn't speak to adults about?---------- 0 1 2 3 4
14. Did you ever think you wanted to leave your family and live with another family?---------- 0 1 2 3 4
15. Did you ever witness the sexual mistreatment of another family member?---------- 0 1 2 3 4
16. Did you ever think seriously about running away from home?---------- 0 1 2 3 4
17. Did you ever witness the physical mistreatment of another family member?---------- 0 1 2 3 4
18. When you were punished as a child or teenager, did you feel the punishment was deserved?---------- 0 1 2 3 4
19. As a child a teenager, did you feel disliked by either of your parents?---------- 0 1 2 3 4
20. How often did your parents get angry with you?---------- 0 1 2 3 4
21. As a child, did you feel that your home was charged with the

possibility of unpredictable physical violence?---------- 0 1 2 3 4

22. Did you feel comfortable bringing friends home to visit?---------- 0 1 2 3 4

23. Did you feel safe living at home?---------- 0 1 2 3 4

24. When you were punished as a child a teenager, did you feel "the punishment fit the crime"?---------- 0 1 2 3 4

25. Did your parents ever verbally lash out at you when you did not expect it?---------- 0 1 2 3 4

26. Did you have a traumatic sexual experience as a child or teenager?- 0 1 2 3 4

27. Were you lonely as a child?---------- 0 1 2 3 4

28. Did your parents yell at you?---------- 0 1 2 3 4

29. When either of your parents were intoxicated, were you ever afraid of being sexually mistreated?---------- 0 1 2 3 4

30. Did you ever wish for a friend to share your life?---------- 0 1 2 3 4

31. How often were you left home alone as a child?---------- 0 1 2 3 4

32. Did your parents blame you for things you didn't do?---------- 0 1 2 3 4

33. To what extent did either of your parents drink heavily or abuse drugs?---------- 0 1 2 3 4

34. Did your parents ever hit or beat you when you did not expect it?---- 0 1 2 3 4

35. Did your relationship with your parents ever involve a sexual experience?---------- 0 1 2 3 4

36. As a child, did you have to take care of yourself before you were old enough?---------- 0 1 2 3 4

37. Were you physically mistreated as a child or teenager?---------- 0 1 2 3 4

38. Was your childhood stressful?---------- 0 1 2 3 4

APPENDIX D

Study Advertisements

The Lives of Urban Women

Hello, our names are Kahá:wi Jacobs and Leandra Hallis. We are currently conducting interviews with women in Montreal. We would like to have the participation of women like you who are using health and social services in the city. We would like to talk to you about your physical and mental health including your history of medical problems, substance abuse, and traumatic experiences.

In order to participate you must be:

- ❍ 16 years or older
- ❍ currently residing in the city of Montreal or its surrounding areas

This study is completely confidential. Interviews last approximately 1½ hours. Those who are interviewed will receive $20.00 in gift certificates as compensation for their time.

If interested, you can contact us and we can arrange a time to meet to do the interview. Please do not hesitate to call and ask any questions you might have. You can reach us at 934-1934 ext. 42389.

We hope to talk to you soon!

La Vie des Femmes en Milieu Urbain

Bonjour, nous sommes Kahá:wi Jacobs et Leandra Hallis. Nous faisons présentement des entrevues avec des femmes séjournant/habitant à Montréal. On nous aimerions avoir la participation des femmes comme vous qui utilisent les services de santé et sociaux dans la ville. On nous aimerions vous parler de votre santé physique et mental incluant votre histoire des problèmes médicaux, l'abus des substances intoxicantes, et les expériences traumatisantes.

Afin de participer vous devez:

- avoir 16 ans ou plus
- habiter présentement dans la ville de Montréal ou ses environs

Cette étude est entièrement confidentielle. Les entrevues durent à peu près une heure et demi. Celles qui sont interviewée recevrons $20.00 pour indemnisation de leur temps.

Si vous êtes interesés, il vous sera possible de nous contacter afin que l'on puisse faire des arrangements pour une entrevue. S'il vous plâit, n'hesitez pas à nous contacter pour prendre rendez-vous ou pour avoir des plus amples informations. Vous pouvez nous rejoindre au (514) 934-1934 extension 42389.

On espère vous-parler bientot!