EXPLORING THE PHENOMENON OF RECOVERY FOR CHEMICALLY DEPENDENT WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

by

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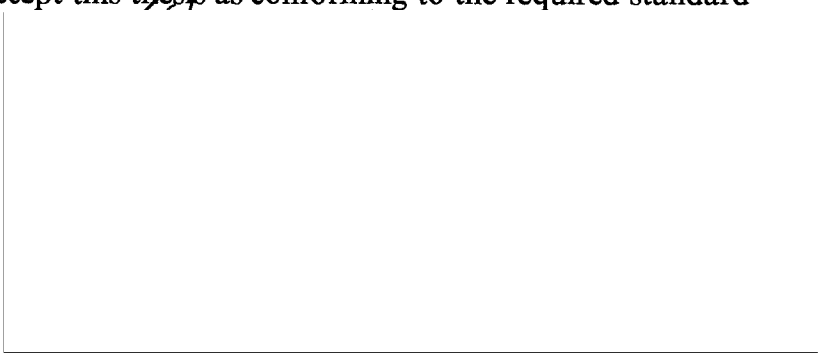

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ABSTRACT

This study explores the influence of childhood sexual abuse on the recovery process from chemical dependence for women. A feminist perspective is utilized in the qualitative design which elicited rich information from the interviews held with eight women. The participants who volunteered, were referred by their counsellors from a Drug and Alcohol residential treatment program and out-patient clinic. The recovery stories as shared by these women were audio taped and the interpretation of their responses was directed by the grounded theory method of data analysis. Two themes emerged from the analysis: 1) Self-Discovery Through Story Sharing and, 2) Symptomatic Relapse, which captured the complex intertwining nature of recovery from chemical dependence where the process is compounded by the aftereffects of childhood sexual abuse trauma. All eight women reported a desire to maintain a drug and alcohol free lifestyle but repeatedly found themselves abusing substances until they understood the connection between their addiction patterns and the aftereffects of being survivors of childhood sexual abuse. Chemical dependence and childhood sexual abuse have been viewed as distinct "treatment" issues, however, these findings suggest the issues be addressed simultaneously if chemical abstinence is to be a realized goal in recovery.

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I would especially like to thank the eight women who participated in this study. Their contribution enriched this study as they individually shared their recovery story and their hope for other women on this healing path. Many thanks go to Dr. Mary Russell, Dr. Betty Carter, and Dr. Kathryn McCannell for their guidance and support throughout my studies and particularly for their insight and encouragement for this project.

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CHAPTER ONE

INTRODUCTION

Recovery from chemical dependence for women is a complex issue where little is yet known because few research studies have focused directly on women and their issues specific to recovery. Three primary recovery models have been utilized to assist people with chemical dependence: 1) the controlled drinking model; 2) the medical [disease] model and 3) the biopsychosocial dysfunctional model (Gorski, 1986) but these models were developed from research based on men's experiences. A critique of the research will be outlined later in this chapter along with a description of the three recovery models in chapter two. Recovery as a term explains the process of healing from chemical dependence and is often characterized as abstinence from drugs and alcohol with a full return to optimal biopsychosocial functioning (biopsychosocial dysfunctional model). Such functioning includes the ability to cope with day to day stressors, reestablish healthy relationships with others, and eliminate drugs and alcohol as an intervening method of dealing with life's problems through complete abstinence. A feeling of "wholeness" and balance in ones' life is a recovery goal. This recovery model, however, does not examine the influence of the cultural socialization that shapes the lives of men and women. Thus, a feeling of

wholeness may have a different meaning dependent upon gender, ethnic or racial background, class, sexual orientation, or disability because "meaning" is culturally and socially determined. In this century alone, women were not accorded the same rights and liberties as men. For instance, women did not become persons in Canada until 1929, up to that time, they could not be appointed to the senate. Emancipation for women occurred slightly before 1929 but at different times depending on which province the women lived and white women were allowed to vote much earlier than First Nations' women or other minority women. If a woman is native, lesbian, from a minority group, disabled or poor, she suffers additional jeopardy. Historically, it appears most societies have condoned physical violence towards women in intimate relationships (Dobash & Dobash, 1979, 1992; Clark & Lewis, 1977; Pagelow, 1984; Schecter, 1982) and today women are still fighting for the legal sanctions to have a say over their own bodies (Pro Choice - Abortion Laws). Thus, what does it mean for a woman to feel whole with such societal pressure to conform? These socially constructed conditions, from a feminist perspective, are believed to influence women's choices and experiences. Such socialization and its influence is apparent in the addiction field once an exploration of women's experiences in recovery from chemical dependence is undertaken. One aspect of women's experiences that has received little attention is the impact of childhood sexual

abuse on the recovery process for chemically dependent women even though a high incidence of childhood sexual abuse among chemically dependent women has been documented.

This study, guided by a feminist framework, explores the impact of childhood sexual abuse issues on women's recovery process from chemical dependence. This topic area was purposively chosen because of the numerous concerns voiced to me by women with whom I have worked professionally. As a drug and alcohol counsellor for more than twelve years, I have heard women share over and over again the struggles they have had in trying to maintain a drug-free lifestyle, explaining that the traumatic memories of abuse they experienced as children overwhelm and bombard them in their adult life whereby returning to active addiction seems like the only plausible solution to eliminating the pain. Such statements as "I'd rather be drunk then remember" were echoed repeatedly. Along with the influence of my professional experience to pursue this topic, I was also personally motivated. As a survivor of childhood sexual abuse, I also battled with a drug and alcohol problem for years. Doctors prescribed drugs for me starting at the age of ten, never enquiring why a child so young could be in so much distress. I learned at the age of twelve, at a party my parents were having, that alcohol made me feel better and enabled me to sleep without nightmares, and thus the rollercoaster began. Numerous attempts

at "sobriety" ended in failure perpetuating the spiral disintegration of my self-esteem and self-worth. I finally reached the doors of Alcoholics Anonymous and managed to stay "clean and sober" (drug-free) for two years. However, as my feelings surfaced, no longer masked and subdued by chemical suppression, I felt I was in an emotional crisis and desperate, losing the desire to live. Looking back, I felt isolated and alone because the unwritten rule in AA is that you keep the discussions focused on your problems with alcohol. Although helpful, the program did not meet my need to understand my experiences. At one meeting, a woman shared about her drinking and its association to having been sexually abused as a child. I clung to her every word, but later heard comments by other members that she should not have shared that "stuff". I recall one person saying, "pretty soon we won't know what kind of meeting we are at because they'll be talking about eating problems, work problems and other addictions." "You have to deal with being an alcoholic first and then look at all that other stuff". There may be some merit in the perspective of staying singly focused, however, it presented a barrier for me in my healing. When my emotional decline landed me in a treatment centre, because I was considered at high risk for relapse, the answers finally started to surface. I was one of the lucky ones because the treatment centre for chemically dependent women that I attended focused on all areas that impact women's lives, including childhood sexual abuse.

As a result of my personal and professional involvement in this area of chemical dependence and sexual abuse, I wanted to know more about other women's experiences in the hopes that exposing information publicly might assist women with these dual issues in the future.

Many Alcohol and Drug treatment centres focus on addiction as it interferes in a person's present life circumstance such as health problems, job impairment, problems in interpersonal relationships and so forth, with recovery aimed at changed behaviours and attitudes in order to attain and maintain "sobriety". This approach ignores past life-experiences as an influencing factor toward the onset of a chemically dependent life-style thus omitting the possible influence of these issues, i.e. childhood sexual abuse, on the recovery process from chemical dependence. Although most drug and alcohol counsellors do acknowledge that underlying issues from child abuse to battering relationships can affect a woman's ability to stay drug free, many program mandates do not allow for the extensive intervention that would be required to assist women to resolve their issues in conjunction with dealing with their substance abuse problems.

Women's recovery issues differ from men's in numerous ways, with some being directly related to their status in society and some due to the division of labour along gender lines. This study focuses on childhood sexual abuse as one

possible factor influencing recovery from chemical dependence, however, it is important to understand the variety of issues faced by women in recovery which have already been researched to some extent. This chapter will provide an overview of the various issues that have compounded the understanding of women's experiences of chemical dependency and recovery.

Historical Aftermath

Research, policies and practice in the addiction field from the 1940's to the present have been responsible in many ways for the ineffective services historically provided for women who are chemically dependent. The ethnocentric and androcentric biases of research methodologies, are particularly blatant in the fields of mental health and medicine (Forth-Finnegan, 1990). The two fields that have been instrumental in research on addiction and women's psychological health, are only one part of a larger picture which has been shaped by the patriarchal, hierarchical, capitalist Western societal structures.

Feminist scholars and the women's health movement have confronted the norms set by androcentric research. They also have challenged mainstream medicine, arguing that scientific knowledge has been constructed around a male-centred cultural view of women's place in our society (Zimmerman, 1987). An historical account of the research on chemical dependence will exemplify the androcentric biases that have left a legacy of marginalization of women's

experiences.

Efforts to help alcoholics by the professional community during the mid-1940's were almost non-existent (Straus, 1976). This followed the period of the temperance movement where alcohol problems were viewed as a moral deviance that required spiritual or religious intervention. However, the "alcoholism movement" did begin during the 40's and the medical model of alcoholism was developed to help combat the stigma and prejudice created by the temperance era so that people with alcohol problems would seek help (Ames, 1985). Also during this time, Bill Wilson, the co-founder of Alcoholics Anonymous, sobered up in 1935 and was a key figure in the future of alcoholism treatment.

The AA program has been a very successful self-help recovery program for alcoholics and helped Bill Wilson and thousands like him over the years to get sober and maintain a sober lifestyle. It is important to note though, that Bill Wilson was influenced by white, male, middle-class Christian values of the 1930's when he began to develop the twelve step program. As Kasl (1992) points out, "most of the men who were instrumental in putting together the AA program and whose experiences were to be recorded in Alcoholics Anonymous, the AA "Big Book", came from similar backgrounds" (p. 3). The experiences were drawn from the stories of one hundred white men but only one woman. Bill Wilson had a law degree and was an experienced stockbroker, such

credentials are held in esteem in Western culture, which aided his cause in recruiting support from the medical profession in assisting alcoholics to "get sober" in the United States during this time period.

The disease concept of alcoholism gained recognition from the World Health Organization (1952) and the American Medical Association (1961). This model depicts alcoholism as a progressive disease process that, if not arrested, leads to death. Commonly used definitions are:

> Alcoholism is a disease in which the person's use of alcohol continues despite problems it causes in an area of life (Kinney & Leaton. 1982, p. 41).

> Alcoholism is a chronic disease manifested by repeated implicative drinking so as to cause injury to the drinker's health or to his social or economic functioning (Keller. 1960).

As a result of the acceptance of the disease concept, and the work done by Jellinek (1946) outlining the phases of alcoholism, research began to flourish. The research was conducted by men about men's experiences of alcoholism. Documentation of women's experiences concerning chemical dependence was virtually non-existent as only a handful of research on women and substance abuse was published before 1970 (Harrison and Belille, 1987).

Many of the articles and studies that are available today concerning women and chemical dependence begin by highlighting the lack of research

specific to women. Most of the literature dealing with alcoholism/drug dependence have viewed women as a subgroup or "special population" (Fellios, 1989). Since white anglo-saxon males have primarily been the population studied, women and other minority groups have been compared to the standards set by white men, both as subjects and as researchers, thereby viewing everyone else as deviant from this norm. As a result, many issues relevant to a person's gender, race, sexual orientation and culture have virtually been ignored or minimized. Although some shifts in addiction research have occurred, these "special populations" continue to be marginalized. Harrison and Belille (1987) point out that it is essential "to recognize that substance abusing women are not a homogenous population and that socio-cultural transitions may profoundly impact the context of women's chemical dependency" (p. 578). One such transition cited by the study was the influence of the acceptance of marijuana use during the seventies which showed up in the responses made by women who were in their twenties during that time period (70's) versus the women who would have been much older and did not use marijuana.

Chemical dependency is known to cross all gender, ethnic, class, and cultural lines but differences can impact recovery. A critical component of recovery is the risk of relapse which often means a return to active addiction. One study by Weiner, Wallen and Zankowski (1990) reflects the all encompassing difficulties

encountered by women from low socio-economic backgrounds:

> Poverty and social disorganization do not directly cause relapse, but problems related to daily life under such conditions represent significant risk factors. The temporary pleasure of a "quick fix" may be more difficult to resist if one is forced to reside in a blighted inner-city community, surrounded by poverty, illiteracy, dilapidated housing, unemployment, broken families, high crime rates, random violence, rampant drug dealing and use, inadequate schools, high infant mortality rates, filth, poor health care, and inadequate public services. The commonly found association between despair, demoralization, and relapse is further compounded in these communities by feelings of helplessness, hopelessness, and impotence - a breakdown of the spirit caused by the inability to realistically visualize a brighter future for one's self or one's children (p. 240).

Many chemically dependent women are abandoned by their husbands, and are therefore often solely responsible for the care of their children (Weiner et al, 1990), which complicates their efforts at recovery.

In 1982, the Journal of Studies on Alcoholism abstracted forty-nine studies of drinking, problem drinking, and alcoholism related to women. These forty-nine studies constituted more than the total number of English published studies between 1929 and 1970 (Wilsnack and Beckman, 1984) with earlier studies maligned with myths and stereotypes, portraying women alcoholics as sexually promiscuous (Lisansky, 1957).

The lack of female centred research and the negative attitudes generated by previous research i.e. the myth about sexual promiscuity, has sustained the stigmatization of women with drinking problems. Wilsnack, Wilsnack & Klassen (1986) discovered that women are not more promiscuous but the lingering societal beliefs have "promoted sexual victimization of women by considering women who drink as acceptable targets for male aggression" (Blume, 1990, p. 18). One study, by William George and colleagues (1988), explored attitudes towards men's and women's drinking. College students were shown videos or written scripts of women and men dating. The scenes depicted the characters drinking either soft drinks or alcoholic beverages. Women were rated to be more sexually available and more likely to have intercourse when shown drinking alcoholic beverages (George, Gournic & McAfee, 1988). Such stigma has been regarded as a frequent barrier to treatment encountered by women (Blume 1990).

Today, there is still less acceptance for a woman alcoholic than for a man (Hunter, 1990). Studies have shown that only 1 out of 10 men stay with their alcoholic wives/partners compared to 9 out of 10 women who stay with their alcoholic husbands/partners (Kinney & Leaton, 1982). This stems from women's role in society as the nurturer and caregiver, who cannot fulfil her duties in child rearing and as a homemaker or provide for the needs of her

husband when in a state of chemical intoxication. Such deviance from her role is seriously frowned upon and words such as "disgusting" are often used when referring to an intoxicated woman, especially when in a public place, with such comments as "she probably has small children at home" even though she may be single and without children. In contrast, if the husband/man is seen drunk, comments such as "oh, Joe's had a bit too much to drink again" may be made without reference to his family obligations.

Blume (1990) points out that most of the research conducted to evaluate treatment effectiveness have either ignored women completely or have included women with men in the same treatment program, assuming that men's and women's needs are similar. Some of the possible reasons that current resources are more geared toward men are captured by Reed:

> Many of the reasons are related to the social acceptability of various drugs at different times in history, and the types of social and personal costs that society wants to reduce or control. Others are related to stereotypical views of women and men, as well as general knowledge about women within social sciences and human services...women have historically been more likely than men to use socially acceptable drugs and to perceive their use of psychoactive substances as a form of coping...men are more likely to engage in rule-breaking behaviour and illicit drug use, and to perceive their use as serving social and recreational purposes. ...drinking - and especially drunkenness - is more permissable for men, and may even be an

> expected component of the male role in many subcultures. Strong societal disapproval of such behaviours in women has led to more shame and secrecy for women, and less recognition of women's alcoholism (1987, p. 152).

Reed's summation places women's experiences within a social and cultural context that must be understood if effective policies and resources are to be made available and geared towards women's needs in healing from chemical dependence.

Women Survivors & Addiction Research

The Women's Movement during the seventies extricated women's issues into public view with a resultant increase in focus on women's issues generally and alcohol and drug problems specifically. Still, women received very little attention from researchers in the addiction field until recently. Although research on women and alcoholism/chemical dependency was increasing during the seventies, the research on women and their specific issues or needs in recovery from chemical dependence has continued to lag behind.

For the purposes of this study, I will use the terms "alcoholism", "drug addiction" and "chemical dependency" interchangeably. Most of the literature available on women's addiction problems has concentrated on alcoholism, therefore, interchanging the terms of chemical dependency, alcoholism, and drug addiction broadens the base of knowledge for exploring women's issues as they

relate to addiction. Another reason for grouping the terms, has to do with the fact that very few people are addicted and/or abusing only one particular substance but more commonly combine various drugs and/or alcohol. The term "chemical dependency" is commonly used as a catch-all name to include any drug that is mood or mind altering regardless of the form the drug may take i.e. liquid - alcohol; pill - tranquilizers; powder - cocaine and so forth.

While examining the literature, it was apparent to me that a lack of understanding or the omission of women's life experiences exists and reflects the institutional forms of oppression women repeatedly encounter. The following two examples (sexual dysfunction and depression) outline some of the biases and methodological discrepancies I have found.

Women alcoholics are frequently reported to experience sexual dysfunction (Wasnick, Schaffer & Bencivegno, 1980) and speak of self-medicating for sexual problems and needing a drink in order to feel comfortable enough to engage in sexual activity (Romand, 1988). A causal relationship between sexual dysfunction and alcohol consumption was established due to the positive correlation of the data. Many studies, however, have not even queried if sexual abuse was a contributing factor to sexual problems and just linked alcohol consumption to the presenting problems of sexual dysfunction. Yet, many studies show that sexual dysfunction, or, as I prefer to call it, sexual

discomfort is directly related to the boundary violations experienced by survivors of childhood incest/sexual abuse (Meiselman, 1978; Herman, 1981; Finkelhor, 1979).

A second major symptom commonly cited for alcoholic women has been depression. Some studies have found depression to be the primary diagnosis with alcoholism secondary (Hezler and Pryzbeck, 1988; Hesselbrock, Meyer, and Keener, 1985) with both studies indicating that depression was primary in approximately two thirds of alcoholic women suffering from depression. Depression is also a common denominator for survivors of childhood sexual abuse. However, asking the type of questions that may uncover a history of sexual abuse is missing from the studies, therfore, information on that relationship has been largely absent from the literature.

Such research results, as cited above, have the potential to lead people to draw the wrong conclusions. This risk is even higher with a history that has routinely victimized women and relegated women's problems to some kind of intrinsic and intrapsychic defect. The mental health and medical field have left women a legacy of encouraged self-blame, guilt, and responsibility for "others" (Gottlieb, 1987; Berlin, 1987; Caplan, 1987). The feminist movement has assisted women in challenging the male world view of women's experiences. "Women began to discover that the experts' answer to the Woman Question was

not science after all, but only the ideology of a masculinist society, dressed up as objective truth" (Ehrenreich & English, 1979, p. 5).

Over the past two decades more research has begun to focus on the connection between sexual abuse and chemical dependency for women. Covington (1986) provides a summary of the data on sexual abuse and alcoholic women stating that these women were subjected to "a wider variety of sexual abuse perpetrators, experienced more instances of abuse, had more multiple incidents, and were subjected to longer durations of sexual abuse than the nonalcoholic women. The alcoholic women also reported more incidents of incest and rape." (p. 37).

Even with such startling statistics, the research to date is limited with regards to **recovery** for chemically dependent women who were victims of incest or childhood sexual abuse.

Social worker Barbara Ball and colleagues formed the Women's Post Treatment Centre in Winnipeg, Manitoba in 1985 in response to the overwhelming needs expressed by their clients who best understood the link between sexual abuse and chemical dependency. Ball (1990) succinctly summarizes the dilemma of addiction treatment for women:

> Chemical dependency was understood as a "disease" and only a disease. This definition led to looking for a solution within a woman's

> psychology and physiology without reference to a woman's current and past experience and how she was perceiving and interpreting it. Because of this mindset, what "addicted" women were beginning to describe about abuse experiences (to those who would listen) was being largely ignored by policy makers and in treatment programs (p 15).

Covington (1986) also stresses the importance of dealing with sexual abuse issues in alcoholism treatment centres if recovery is to be a reality. Yet, in 1993 little progress has been made in changing policies or treatment mandates. What little progress has been made is a result of more and more helping professionals, like Barbara Ball, speaking out about the common denominator of sexual abuse as it relates to chemical dependency and substance abuse for women.

Oppressive Power Relationships

A feminist analysis routinely examines the relations of power and the inequalities of power relationships within systems providing a framework for understanding the context of human experiences, and especially the experiences of women. Kasl provides such a feminist perspective when she looks at the influences of patriarchy, hierarchy and capitalism as social constructs that influence women's chemical dependence.

The dominant group determines the "culture" in any society and patriarchy is one such manifestation. Kasl (1992) states:

> ... patriarchy, hierarchy, and capitalism create, encourage, maintain, and perpetuate addiction and dependency. Patriarchy and hierarchy are based on domination and subordination, which result in fear. This fear is expressed by the dominators through control and violence, and in the subordinated people through passivity and repression of anger. The external conflict of hierarchy between dominants and subordinates becomes internalized in individuals, creating personal inner chaos, anxiety, and duality. To quell the inner conflict people resort to addictive substances and behaviour (p 53).

A glaring example of maintaining the "status quo" through the oppression of another person is heard in the words of one woman Kasl interviewed, "I'm addicted because I was born into a culture that allowed me to be a victim of incest, abuse, violence, poverty, and sexism. There was never care and protection for me" (Kasl, 1992, p. 65). This woman's experience is a clear indication of the victimization women encounter in societies that value one sex over another. "Because patriarchy assigns a secondary position to women, it creates a hierarchy, in which human value is determined by gender, race, class, position, religion, age, appearance, ethnic background, and physical ability" (p. 55).

The media is also a powerful means of communicating the dominant agenda because it infiltrates every area of people's lives from billboard ads to television newscasts, from newspaper articles to sex-typed children's toys. The

public is bombarded daily with ads for drugs, alcohol, and food espousing quick fixes to our every ills, from helping people to relax, to sleep better, and to feel better, ignoring the realities of many people's lives. "Instead of affirming life, we are taught to medicate ourselves in order to cope with it." (Kasl, 1992, p. 55). Advertising and the media further define femininity and masculinity and sex roles in our society. Such advertising creates a climate in which certain attitudes and images are presented as normal and therefore acceptable. The image of the "superwoman" of the 90's, of the Mom nurturing her children and husband while holding down a full-time job, dressed in an executive suit with that never ending smile, is enough to lead to hospitalization exhaustion. McConville (1983) points out that: "women have talked about how the resulting negative feelings about themselves can lead into the spiral of problem drinking -a devastating illustration of what happens when we internalise images of ourselves and judge our 'success' or 'failure' in relation to them." (p. 60). Thus, if a woman does not feel happy in her role as "superwoman" than the inadequacy is somehow an inherent reflection of herself and interpreted as a failure.

Historically, childhood sexual abuse has not been directly addressed in alcohol and drug treatment services and this is not surprising since the phenomenon has only been part of public discourse for the past decade. Recent research has indicated that three out of four chemically dependent women are

survivors of childhood sexual abuse (Rohsenow, Corbett, & Devine, 1988; Covington, 1986). Aurora House, a treatment centre for chemically dependent women in Vancouver, British Columbia, estimates that ninety-five percent of the women seen report a history of childhood sexual abuse. Aurora's statistics may be higher because it is one of the few treatment facilities that addresses the issue of sexual abuse concurrently with the issue of addiction. Considering the high incidence of sexual abuse among chemically dependent women, a need to acknowledge the interrelatedness of addiction and childhood sexual abuse is paramount if women are to be protected from this vulnerability in their recovery process.

Drugs and alcohol have the perceived effect of repressing painful stimuli and memories. As a result, mood and mind altering substances may provide a coping mechanism for women with histories of childhood sexual abuse. Thus, during the recovery process, where complete abstinence of mood and mind altering substances is required, feelings and memories begin to surface because the repressing effects of drugs and alcohol are no longer present. The pain associated with the surfacing abuse memories and feelings may be too great, resulting in a return to established coping patterns, and a return to active addiction. Dolan (1991) points out the necessity of resolving sexual abuse if preventing symptomatic relapses is to occur. Recent research has purported that

childhood sexual abuse is a strong predictor of future chemical dependence for women and relapse may result if it is not addressed (Rohsenow et al. 1988; Young, 1990). Thus, it appears that a reciprocal relationship exists between unresolved sexual abuse and active addiction for many women.

Summary

The limited research focus on women's experiences in recovery from chemical dependency has left women vulnerable to ineffective policies which influence program mandates, treatment facilities, and healing models.

Due to the general marginalization of women in most research studies, a feminist perspective is used in this study so that women's voices will be heard. The women who participated in this study shared their recovery stories from a place of personal healing which I incorporated in the interpretations of the data. In keeping with a feminist stance, the essence of the womens' healing, from their own words, is apparent in the analysis.

A clear understanding of womens' experiences of the recovery process is essential if social workers and other helping professionals are to provide effective services that enhance the recovery process for this population.

This study, "Exploring The Phenomenon of Recovery For Chemically Dependent Women Survivors of Childhood Sexual Abuse" was conducted in the hopes that some light could be shed on the issues encountered by women in

recovery from chemical dependence and how their healing has been impacted by the sexual victimization experienced in childhood.

The next chapter examines three models of recovery and previous research findings that have been influenced by various theoretical perspectives. Chapter three discusses methodology, chapter four deals with the results of the study while chapter five concludes with implications for the social work profession and other helping professions.

CHAPTER TWO

LITERATURE REVIEW

Models of Recovery

Numerous recovery models and treatment program designs have been developed from the perspective of relapse prevention. Relapse is commonly referred to as a return to using alcohol and drugs. Most of the research to date, in the drug and alcohol field, has focused on relapse rather than on recovery. Difficulty in operationalizing and reaching consensus on the term recovery contributes to the lack of research on the phenomena of recovery (Maddux and Desmond, 1986). As a result, a combination of recovery and relapse issues will be examined in the literature.

Three main models of recovery have influenced the addiction field and treatment programs over the years. These are referred to as the Controlled Drinking Model, the Abstinence Model, and the Biopsychosocial Dysfunctional Model (Gorski, 1986).

The controlled drinking model's emphasis is on establishing healthy drinking patterns in which a person takes responsibility for their alcohol intake, does not over consume and lose control. This model has not proven to be very effective for people who have become physically dependent on alcohol. The

Sixth Special Report to the U.S. Congress on Alcohol and Health stated that:

> In general, the bulk of the clinical and scientific evidence appears to support the interpretation that once significant physical dependence has occurred, the alcoholic no longer has the option of returning to social drinking...; hence, abstinence is the most appropriate goal for alcoholic persons (National Institute on Alcohol Abuse and Alcoholism, 1987, p. 136).

This model, however, has proven to be a viable solution for people considered to be alcohol "abusers" where no physical dependence is exhibited (Pendery, Maltzman, and West, 1982).

The Abstinence Model promotes complete abstinence of drugs and alcohol with abstinence used as the measure of successful recovery. The disease model programs have traditionally utilized the abstinence model and based treatment outcomes on recovery being complete abstinence, and a return to using drugs and/or alcohol viewed as a relapse. One of the limitations of this model is "that it fails to measure a variety of factors other than alcohol and drug use that significantly affect recovery and relapse" (Gorski, 1986, p. 8).

The biopsychosocial dysfunction model on the other hand, defines a broad base of factors that are commonly associated with recovery and relapse, incorporating the complex interaction among the physical, psychological, and social levels (Gorski, 1986). This model, which emerged from clinical practice

during the 1970's to the present time, is defined in the recent literature (Donovan, 1986; Gorski and Miller, 1986), and identifies high risk situations and stresses the need for individual treatment planning in order to reverse such factors that create risks of relapse. This model considers underlying issues for each individual which may impede recovery. Gorski (1986) argues that people who are raised in "dysfunctional families", for instance, often develop "self-defeating personality styles" that may interfere with their ability to cope and achieve recovery. The labelling and ideological jargon in this statement is common throughout traditional research studies. As a feminist, I would prefer to say that some people develop ways of coping which prove beneficial in getting them through unhappy family situations but later interfere with their ability to achieve recovery.

The most commonly used model of recovery is that presented by Alcoholics Anonymous (AA) which is based on the disease concept of alcoholism. AA views alcoholism as an incurable disease which involves a lifelong recovery process. Many treatment services are either based on AA's twelve-step model of recovery or utilize it as an adjunct to treatment. This model uses both the Abstinence Model and aspects of the Biopsychosocial Dysfunctional Model of recovery. This model stresses abstinence from all drugs and alcohol, with any substance use called a relapse. The recovery process

entails a holistic approach of healing the physical, spiritual, mental, and emotional self through working the twelve steps. For example, step 2 "Came to believe that a power greater than ourselves could restore us to sanity." (Alcoholics Anonymous, 1976, p. 59) reflects the spiritual connection to an outside power which will relieve the mental anguish - "restore us to sanity". All of the steps focus on a group process of growth where you are not alone in your struggle, step 1 "We admitted..., step 2 "...a power greater than ourselves..." (see Appendix A - the 12 Steps) thus giving rise to new social networks, a new social identity, and new interests as a result of working these steps and being involved in the twelve step program.

Although AA has helped many women in their recovery from alcoholism, just as many have reported their experience as oppressive due to its masculinist model (mackinnon, 1991; Kasl, 1992; Berenson, 1991). Berenson (1991) outlines the feminist critique of the recovery movement stressing that this movement has incorporated and reinforced the following characteristics:

> 1. *An emphasis upon the private and personal at the expense of the public and political* - While the experience of powerlessness [AA's first step " We admitted we were powerless...] may be liberating for some women is some respects, it does nothing to address the very real social, political, and economic power inequalities that exist. Focusing on their private growth may distract many women, and men, from questioning and changing

oppressive power arrangements based on gender.

> 2. *A denigration and pathologizing of traits associated with femininity* - The very development of terms like codependence and "women who love too much," the labelling of behaviours and relationship patterns as diseases, combined with the focus upon powerlessness as a key component for healing, have all served to increase stigmatization and to reinforce women's social conditioning. Women wind up blaming themselves for personal and relationship problems instead of getting angry and taking assertive action to change their situation.
>
> 3. *A tendency toward self-abnegation and the unquestioning acceptance of authority* - While Alcoholics Anonymous and its Twelve Step offshoots give theoretical lip-service to spirituality as non-dogmatic and non-hierarchical, in practice they wind up asking women to be **subservient** to male authority. The AA Twelve Steps refer to "**God** as we understood **Him**," [my emphasis added] and women who are working the steps are called upon to make amends for damage done to them. (p 78).

It is important to add here that many AA group members recommend that you translate the program in any way that fits for the individual person using the slogan "take what you need and leave the rest behind" in an attempt to be all inclusive of the membership. However, the use of the term "God" denotes a christian god who is male (Him) alienating those who may relate to a Goddess, spiritual guide, or other religious or spiritual powers.

Charlotte Kasl (1992) offers women an alternative to the "Twelve Step Model" in her Sixteen Steps for Discovery and Empowerment. (See Appendix B) and invites women to use these steps in any way that suits their individual needs and also to change them if they so desired.

Jean Kirkpatrick founded the recovery program, Women For Sobriety (WFS), in 1976 during her personal struggle to recover from alcoholism. Kirkpatrick (1986) attended AA but felt it did not meet her needs. Kirkpatrick believes that women have different reasons for drinking than men and therefore women also have differing needs in recovery. Her thirteen "step" program is designed "to build up women's fragile egos and battered self-esteem through self-discovery, and to release the shame and guilt through the sharing of experiences, hopes, and mutual encouragement" (Kasl, 1992, p. 166). (See Appendix C for Kirkpatrick's 13 - Statements)

There are hundreds of Women for Sobriety groups established across the United States but fewer exist here in Canada. Although one group did exist in Vancouver, British Columbia for many years, it folded and to my knowledge has not been restarted. Thus alternatives to the AA self-help recovery program are very limited for women.

The recovery process as described by AA, refutes the notion that relapse occurs as a single isolated event but instead sees relapse as evolving over time

with altered attitudes and behaviours, called "stinking thinking". This means that someone does not just return to using drugs and alcohol by consciously making a choice to do so but instead, over a period of time, begins to rationalize the use of drugs and alcohol and denies previous problems directly related to their substance abuse and a change in attitude is evident. These altered attitudes are self-defeating and destructive in nature. During recovery, the focus is on changing these negative attitudes into positive self-loving ones in order to prevent relapse. "Until the alcoholic is ready to let go absolutely of their old ideas, the chances of staying sober are nil" (Alcoholics Anonymous, 1976, p. 58). One such "old idea" may be the belief that the person can control their drinking again. This notion of controlling one's drinking is in direct contrast to AA's model, but, forms the basis of the Controlled Drinking Model, as described earlier in this chapter.

Relapse prevention is commonly viewed as a recovery tool. The various relapse prevention strategies provide the impetus for different treatment models which are geared toward maintaining abstinence from mood and mind altering drugs and enhancing the recovery process. Thus, it is necessary to understand the numerous theories that exist to explain the phenomenon of relapse. Some of the major theories are discussed in the remainder of this chapter under the headings of Biological, Social Learning, and Psychological Theories. The final

section of this chapter focuses on a brief discussion of the various sexual abuse theories to set the context of this study.

Theories on Addiction

A. Biological Theories

Genetic theories focus on altered metabolism which predispose the individual to becoming an alcoholic (Schuckit et al., 1985). The risk of developing alcoholism increases where a history of alcoholism is present in the family of origin. As a result of this genetic link and change in metabolism, abstinence is advocated as the treatment choice if relapse is to be prevented (Schuckit and Duby, 1982). Conditioning theory incorporates the withdrawal syndrome and the concept of craving in explaining relapse. When the abstinent alcoholic, once conditioned, is faced with environmental "triggers", i.e. sitting in a bar with friends, and emotional stimuli, i.e. drink to relieve stress, the sensation of withdrawal may be percieved by the person, increasing the likelihood of relapse in order to alleviate the withdrawal symptoms. (Wesson et al, 1986).

These biological theories have been popular in advancing the "disease" concept of alcoholism. Thus, a person is not responsiblie for causing their addiction and requires treatment in order to get "well".

Genetic and Conditioning theories do not address whether or not women are affected differently from men in recovery yet studies have shown that alcohol

affects women differently than men physiologically. Women reach higher peak blood alcohol levels per dose of alcohol per pound of body weight (Greenblatt & Schuckit, 1976). Women are more vulnerable than men in developing late-stage physical complications such as fatty liver and hepatic cirrhosis, hypertension, and gastrointestinal hemorrhage (Blume, 1990). Special concerns specific to women are the affects of drugs and alcohol on the unborn fetus during pregnancy with complications of Fetal Alcohol Syndrome and other alcohol/drug related complications such as low birth weight.

B. Social Learning Theories

Marlatt (1978) points out that craving is defined as the anticipation of the reinforcing effects of alcohol, when viewed from the context of social learning theory. The relapse model from a social learning framework explores the relevance of high risk situations, the person's expectations about handling these situations without drugs, and the person's coping abilities in high risk situations (Wesson et al., 1986). Relapse will ensue if these high risk situations are not dealt with or anticipated during treatment. Cognitive and behavioral techniques are commonly used during treatment and recovery to prevent relapse. In the case of sexual abuse, a flashback would be an example of a high risk situation, "causing the survivor to temporarily associate powerfully to the reexperiencing of emotions and sensations associated with the sexual abuse trauma" (Dolan,

1991, p. 106). Dolan (1991) points out that "traumatic associational cues" may be triggered by an event that literally or symbolically resembles some aspect of the earlier trauma. This places the recovering person in a vulnerable situation in which a return to previous coping patterns, drinking, compulsive eating, self-mutilation and so forth, may result.

Traditional learning theory and social learning theory did not include human emotions and ideas because of the difficulty in operationalizing and measuring the variables and have been criticized for the lack of cognitive inclusion. However, with operant conditioning, "reinforcement" has proven to be a powerful avenue for increasing the likelihood of a particular behaviour (Berger, 1988). These traditional theories would not have addressed sexual abuse and the response to aftereffects as I have done in the example cited above. Yet, if you examine the operant conditioning and social learning theories, alcohol and drugs would provide the "positive" reinforcer of repressing painful stimuli. Considering the high risk of developing alcoholism if one or both parents are alcoholics, children from this type of background are influenced by their environment and learn that alcohol provides a means of coping with daily problems. Zimmerman (1983) claims that it is crucial for social learning theorists to look at the overall context of the learning process ie. environment rather than at the specific details of reinforcement.

C. Psychological Theories

Some studies have explored the relationship of stress (Moos & Finney, 1983) and negative life events as precursors to relapse (Moos et al., 1981; Marlatt & Gordon, 1980). However, the stressors outlined in these studies focused primarily on present negative life events i.e. divorce after treatment, and ignored the ramifications of past negative life events i.e. childhood sexual abuse, in the lives of chemically dependent women.

Psychodynamic theory, assumes that past experiences shape current behaviours (Maddux & Desmond, 1986). This theory could be useful in understanding sexual abuse as a high risk precursor to developing chemical dependence because it suggests a causal relationship exists between past experiences and current behaviour. As a result, this theory has the potential to support the idea that sexual abuse trauma experienced in childhood, if not treated, may result in behaviours conducive to the person's survival ie. escaping the pain and trauma through the use of drugs/alcohol.

Theories of Sexual Abuse: Recovery from Chemical Dependence

This study explores the impact of childhood sexual abuse on the phenomenon of recovery from chemical dependence. An overview of the various theories on sexual abuse aftereffects and the literature that examines the issues

of sexual abuse and chemical dependency concurrently is needed in order to understand women's experience of recovery.

One case study examined shame and relapse issues for the chemically dependent person concluding that "with a greater attention and focus on treating shame-based issues during recovery then potentially the percentage of clients who relapse could be reduced" (Brown, 1991, p. 82). The limitation of Brown's case study was that he used a male subject, using the term "clients", which leads to the assumption that these generalities are applicalble to women as well as men. Gender is not addressed specifically but generalities are made based on clinical experience of working with "clients" who struggle with the issues of "shame" and "relapse". Brown's focus on the dynamics of shame do however, assist in addressing womens' experiences of sexual abuse and chemical dependence. Sexual abuse survivors are wrought with shame-based conflict which, according to Brown, would need to be addressed in recovery programs if recovery is to be maintained.

Many studies have observed that childhood sexual abuse may be a predictor of future chemical dependence in women. Recent studies have found that over 75% of chemically dependent women in inpatient settings report histories of childhood sexual abuse (Rohsenow, Corbett & Devine, 1988; Covington, 1986). Blake-White and Kline (1985) point out that "the adult victim

of incest wants to avoid the anxiety of remembering; she wishes to forget the trauma and push it into the past. Methods used are total denial, abuse of alcohol, and excessive use of prescription and non-prescription drugs" (p. 396).

Children who experience prolonged, violent, intrusive trauma such as sexual abuse, and, especially where such abuse is instigated by a primary caretaker, create stressors "beyond the adaptive capacities of all but the most exceptional children and that will regularly produce a long-lasting traumatic syndrome" (Hermen et al., 1986, p. 1296).

This "traumatic syndrome" manifests itself in aftereffects which meet the Diagnostic and Statistical Manual-III-R (American Psychiatric Association, 1987) criteria in diagnosing Post-Traumatic Stress Disorder. Professionals who work in the field of addiction with sexual abuse survivors, have informed me that many of their clients display post-traumatic stress responses, from dissociating, nightmares and flashbacks of their experiences, to avoidance of these memories through the use of drugs and alcohol.

Courtois (1988) utilizes the Traumatic Stress/Victimization theory in directing her assessment of the aftereffects of sexual abuse and therapeutic approaches in which "trauma must be treated directly in conjunction with its symptoms and secondary problems." (p. 123). Drawing from Courtois' theory, chemical dependence could be viewed as the secondary problem, with craving

and potential relapse as the symptoms, along with any feelings and stress being experienced by the client herself. I support Young's (1990) contention that self-impairment underlies secondary symptoms, such as addictive behaviours. Young argues that with the emergence of memories during abstinence, recovery will not be maintained if the reparation of self is not initiated, by addressing childhood memories of abuse.

The traumatic stress/victimization theory affords the counsellor the recognition that the client's responses to traumatic stress are natural rather than pathological, acknowledging that the aftereffects and secondary elaborations may be maladaptive. Although maladaptive, feminist's would argue that the stress responses have been functional. The "recovery enhancers" described by the women in my study support the notion of functionality where drinking/drugging provides a means of coping with painful circumstances and recurrent memories.

Loss theory recognizes the paradox faced by many victims, "accepting the loss means admitting the inability to control the circumstances" (Courtois, 1988, p. 127). However, it is through grieving the losses encountered by incest/sexual abuse survivors that healing can begin. Belinger and Fleming (1992), in exploring chronic grief reactions for sexual abuse survivors, suggest that "rather than treating survivors as a homogeneous group, as is often the case which can

mask important differences, researchers might well consider the various tasks participants are struggling with" (p. 16). One such task, for the population in this study, would be to maintain drug and alcohol abstinence.

Feminist theory provides another framework from which an understanding of the sexual abuse/incest experience can be understood. Due to the high prevalence and secrecy of abuse of female children by fathers and trusted males, feminists have concluded that sexual abuse is an endemic societal manifestation of the power imbalance between the sexes (Russell, 1986). Moreover, feminist theorists have suggested that the sexual abuse of children and women serves a political function since it preserves the system of male dominance through terror, thus, benefitting all men whether or not they personally commit the sexual abuse (Herman, 1985; Griffin, 1986; Brownmiller, 1975).

Summary

The various models and theories outlined in this chapter provide the background information necessary for understanding the impact of traditional addiction treatment resources and the research that perpetuates use of male therapeutic models when responding to womens' experiences of chemical dependence.

The feminist ideology expressed in the research on sexual abuse and

treatment affords a new way of addressing childhood sexual abuse issues with an inclusion of chemical dependence as a coping skill developed for survival. Feminist scholarship also points to the need for including women's voices if their experiences are to be fully understood.

A feminist perspective validates womens' experiences and sees women as authorities of their own experience. The relationship between childhood sexual abuse and chemical dependence in women has been researched in terms of the former being a predictor of the latter, but little is known about the impact of sexual abuse experiences during the recovery period from chemical dependence.

The literature raises a number of important questions. For example, Does being a survivor of childhood sexual abuse influence the recovery process for chemically dependent women? Do unresolved sexual abuse experiences manifest as an internally generated precursor to relapse?

Due to the limited research in this area, I have chosen to adopt a qualitative design for this study which allows for a more in-depth exploration of the question: How does the impact of childhood sexual abuse influence the recovery process for chemically dependent women?

I shall now turn to my methodology chapter which explains in detail the the research process and provides the reader with an introduction to the eight women I interviewed.

CHAPTER THREE

METHODOLOGY

Design:

A qualitative exploratory design is utilized because such methods enable one to "uncover and understand what lies behind any phenomenon about which little is yet known" (Strauss and Corbin, 1990, p. 19). The literature review revealed that research on chemical dependence for women is limited. Information which explores the impact of childhood sexual abuse on the recovery process is also extremely limited. Due to the invisibility of women's experience in recovery, a qualitative approach enables the research to be data-driven whereby themes evolve directly from the data and thus directly from the women's experience who participated in this study. Patton (1990) suggests that:

> The strategy of inductive designs is to allow the important dimensions to emerge from patterns found in the cases under study without presupposing in advance what the important dimensions will be (p. 44).

As a feminist, I have selected a qualitative design from a feminist perspective as the method of inquiry because I believe it provides the best arena for women's voices to be heard and their lived experiences honoured. A qualitative design enables and encourages the researcher to "find out what

people's lives, experiences, and interactions mean to them in their own terms" (Patton, 1990, p. 22).

The Participants:

Two agencies in the drug and alcohol system of care in British Columbia assisted me in contacting women who might be interested in participating in a study that explored the impact of childhood sexual abuse on the recovery process from chemical dependency. Eight women volunteered to participate their time and shared their pain and recovery stories with me.

My selection of participants was purposive due to the nature of the subject matter. The eight women in this study were referred by their counsellors based on the following criteria:

1) women eighteen years of age or older
2) women who have been drug free for at least three months;
3) women who have disclosed a history of childhood sexual abuse to at least one other person;
4) Each participant's ability to partake in such an interview process was determined by each woman in consultation with her counsellor, to ensure that the interview material would not contribute to overstimulation of painful events/memories beyond the individuals ability/readiness to cope.

The criteria was set in the above manner due to the possibility that eliciting painful memories was high, thus the participants needed to be stable in their addiction recovery so as not to jeopardize them in any way.

I would like to introduce the reader to the women who shared their

experiences with me. Some of the participants requested that their first names be used, others chose alias names to protect their identity and to ensure confidentiality. All of them preferred to be mentioned by a name rather than a number or other differentiating code. Thus, I respect their request.

The eight women who shared their stories openly with me were Ann, Susan, Wendy, Kate, Tina, Lyn, Beth, and Lydia. As the women revealed their stories, I was deeply touched by their honesty and integrity and their courage and willingness to risk themselves in the hopes that sharing their experiences might help other women who struggle with the issues of chemical dependency and childhood sexual abuse.

General background information will provide an introduction to these women as a group without revealing their identities. The eight women in this study ranged in age from 22 to 40; two were employed full-time and the other six were unemployed; one woman was Métis, one was from an European/Spanish background, and the other six were of English descent, one of whom had native ancestry. One woman was a single mother with one child, two women were currently living with a partner (one male, and one female) and the other five were living either on their own or in a recovery house setting. The length of continuous sobriety ranged from three months to seven years. Two of the women had university degrees, five had taken courses or attended a college

program after high school and one woman had not completed high school.

Six women were raised in alcoholic homes where there was physical, sexual, and/or emotional abuse experienced. One woman described her family as caring and felt guilty, wondering how she could have become chemically dependent, until she recognized, in therapy, that her substance abuse was related to her having been sexually abused as a child. One woman described her childhood as chaotic in a home where her parents were non-demonstrative but not necessarily abusive.

All eight women had experienced physical and/or sexual abuse during their adult lives in their intimate relationships and two had been raped while intoxicated by acquaintenances with one woman having been raped three times, once by a stranger and twice by men she knew and had no reason not to trust.

The victimization and violence experienced by these women was repeatedly reported from childhood to the present, and included further victimization at the hands of those in counselling and positions of authority and trust during this period when two of the women sought help. Even after experiencing such adverse living conditions and abusive relationships, all eight women were hopeful about their futures and committed to healing their pain. I had contact with all eight women two to three months after the initial interview and all eight were still on a recovery path.

Interview Process:

In-depth interviews were held with each of the participants. From a feminist perspective, such interviews offer "access to people's ideas, thoughts, and memories in their own words" (Reinharz, 1992, p. 19).

An interview guide which consists mostly of open-ended questions (see Appendix D - interview guide) was used to assist the dialogue process. The guide was left open and flexible so that questions could be asked spontaneously and applicable to the direction the women took as they uncovered their experiences of the recovery process. The guide was presented to each participant with an explanation of the purpose of the study.

The questions were generated through discussions about this subject with people with experiences similar to the sample population, from my own experience working in the drug and alcohol field with women survivors of childhood sexual abuse, with other professionals' input, and was shaped partly by the literature review. Some of these questions were refined as the interview sessions progressed.

Initially, I had more questions, but found that richer information could be obtained by having the women in the last few interviews basically tell their "recovery story" and focus my questions from the content of the information they presented.

Validating the findings in qualitative research is particularly crucial because the researcher is often "working alone, without any standardized or validated instruments...[running] the risk of overgeneralizing" (Miles & Huberman, 1984, p. 230) or drawing false conclusions based on researcher bias.

Verifying the findings through follow-up interviews adds to the validity of a measure (Miles & Huberman, 1984). I conducted follow-up interviews with seven of the eight participants to ascertain that my interpretations accurately reflected their experiences. In keeping with a feminist stance, follow-up interviews, for the purpose of verifying findings, also honours women's experiences by not imposing external perceptions/interpretations of those experiences. All seven women agreed with the categories that conceptualized their experiences and they felt the themes accurately depicted their ongoing process of recovery.

The face validity was checked by consulting other professionals as to whether or not the questions in the interviews were adequately addressing the research question being explored and they appeared to be on target. One person said "I'm just so glad you are doing this kind of research and asking these kinds of questions as this has been a greatly ignored research area. I believe the questions posed in your guide will get at women's experiences at a deeper level conerning the recovery process and the impact on recovery as a survivor of

sexual abuse."

The information generated by the interview questions was found to be similar across participants, this strongly supports the accuracy of the measure.

In order to reduce "researcher effects on site" as Miles and Huberman (1984) discuss, two of the interviews took place in the women's homes and the information obtained was still consistent with the other six women. One woman, whose experience was different from the others, in that she rejected self-help groups, provided an outlier as she did not use the same language to describe her experiences whereas the other seven women used AA language, apparent if you are familiar with these meetings. However, her experiences were also similar to those of the other women in terms of the recovery process itself.

Exploring Her-Story:

I met with the staff and directors of the two agencies, Aurora House and North Burnaby Alcohol and Drug Counselling Services, involved in the study and presented my research proposal. Upon acceptance by them, with written permission obtained (see Appendices, E.1, E.2, & E.3), I submitted the research proposal to the University of British Columbia Office of Research Services for ethical review to conduct this study. The study was approved (see Appendix, F) by U.B.C. and the referring counsellors were contacted. An introductory letter (see Appendix G) was provided to the referring counsellors to give to their

clients, who then contacted me to set up interview appointments.

Private office space was provided by the two referring agencies and most of the interviews were conducted there but the option to meet elsewhere was left open to the individual women; one chose to meet in her home and another chose to meet off-site at a location convenient for her. The interviews were audio taped with permission in which each woman signed a consent form (see Appendices H & I) specific to taping the sessions. An explanation of the consent form and the purpose of using audio tapes was provided as well as an opportunity to refuse to be audio taped. The interviews ranged in length from one to one and a half hours, followed by a debriefing period that varied with each person from fifteen minutes to one hour. The debriefing with two of the women continued outside the formal setting as well, by going for a coffee at a nearby restaurant. This relaxed atmosphere seemed to generate even further discussion of some of the issues and is in keeping with feminist research methods which encourage involvement and interaction between the participant as opposed to more conventional research methods which emphasize detachment and value-free objectivity. Like many feminist researchers, I struggled with the notions of "objectivity" and "subjectivity". In order to remain honest to the women who participated in this exploration of personal discovery, I decided to disclose my personal connection, of being on my own recovery path of healing

from childhood sexual abuse and chemical dependency, to the topic of inquiry. As feminist researcher Reinharz (1992) reports, "starting from one's own experience is an idea that developed in reaction to androcentric social science" (p 261) and using self-disclosure creates a more egalitarian relationship with the hopes of providing safety and ease of participation. This comfort level was verified by each of the women, who told me after the interviews, that they appreciated knowing I was also a survivor and felt safe sharing with me. One woman commented "I shared more with you than I have with anyone else, but I knew you would understand and not judge me because you have been there". The women also expressed feelings of empowerment and elation for the opportunity to contribute something to other women as participants in this project. The comments from the debriefings were written down shortly afterwards in the field journal.

Her-Story Unfolded:

The interviews provided rich information about the eight womens' experiences. Grounded theory was used to assist me in drawing out, comparing and summarizing the main categories and themes which arose. Grounded theory uses an inductive approach to analyzing data, this inductive approach generates hypotheses as opposed to testing them as in deductive research (Glaser & Straus, 1967). Although a form of deduction is used in this method, deduction is solely

used for expanding and for elaborating concepts and themes.

All eight audio tapes were transcribed and coded. Open coding, a process of "breaking down, examining, comparing, conceptualizing, and categorizing data" (Strauss & Corbin, 1990), was used, for complete interview see Appendix J. The coding was done line by line when appropriate, but sometimes, an entire sentence was used in order to capture the essence of what was being said. The transcripts were read and emerging concepts were coded on the right hand side (of the rough draft) of the transcript. The eight transcripts were compared and eight categories consolidated the concepts coded (see Tables 1 & 1a), which were also noted on the left hand margins of the rough transcripts. Utilizing the constant comparative method of analyzing and abstracting the data, two primary themes arose which reflect the overall experiences of the recovery process for these eight women (see Table 2, Ch. 4). An in-depth exploration of the categories and themes will be explored in chapter four which discusses the results of the analysis.

TABLE 1 - THE EVOLVING RECOVERY FRAMEWORK

RECOVERY ENHANCERS

OPEN CODES	PROPERTIES	CATEGORIES
PROBLEM RECOGNITION		
HELP SEEKING BEHAVIOUR		
EXTERNAL CONTACT (+)	hopefulness	I EXTERNAL SEARCH
CONNECTING WITH OTHERS		
INTIMATE RELATIONSHIPS		
SEXUAL TRIGGERS		
'NUMBING' BEHAVIOUR DELIBERATE	identification	II IDENTIFYING SEXUAL ABUSE/ADDICTION LINKS
PATTERN AWARENESS		
SELF-LOVE		
ACKNOWLEDGE/EXPRESS EMOTION	feelings	
SPIRITUALITY		
HOLISTIC HEALING		
COGNITIVE LINKS	thoughts	III SELF-CONNECTING
SELF-SEARCHING "who am I"		
ESTABLISH BOUNDARIES		
SELF-DISCLOSURE (SA)	behaviours	
D/A ABSTINENCE		
INTIMACY COMFORTABLE		
SEXUAL IDENTITY		
TRUST	exploration	IV RECLAIMING SEXUALITY
SAFETY		
BODY-IMAGE		

TABLE 1A - THE EVOLVING RECOVERY FRAMEWORK

RECOVERY BARRIERS

OPEN CODES	PROPERTIES	CATEGORIES
AUTHORITATIVE VICTIMIZATION		
BETRAYAL/LABELLING	systems	V OPPRESSIVE POWER
SEXUAL EXPLOITATION		
IMPOSED NEGATION OF EXPERIENCES		
DICHOTOMIZED TREATMENT		
NO SAFE PLACE		
SITUATIONAL "USING" TRIGGERS		
EMOTIONAL "USING" TRIGGERS	hopelessness	VI INWARD RETREAT
UNSUPPORTIVE FEEDBACK		
NEGATIVE SELF-TALK		
SILENCED BY OTHERS	feelings	
ALONENESS		
PERSONALIZATION OF TRAUMA		
ENTRENCHED BELIEF SYSTEM	thoughts	VII SELF-DETACHMENT
DENIAL		
MEMORY IMPAIRMENT		
OTHER FOCUSED		
SECRET KEEPING	behaviours	
OBLITERATE REALITY		
ISOLATION		
ESCAPISM		
MEMORIES/FLASHBACKS OVERWHELMING	despair	VIII SUICIDAL THOUGHTS/ATTEMPTS
RELIEVE EMOTIONAL PAIN		

KEY: D/A = Drug/Alcohol "Using" = consuming drugs/alcohol SA = Sexual Abuse (+) = positive

CHAPTER FOUR

RESULTS/DISCUSSION

Analysis of the eight transcripts revealed that the recovery process is a complex intertwining experience of events depicted by the two overall themes: 1.) Self-Discovery Through Story Sharing and 2.) Symptomatic Relapse.

Self-Discovery Through Story Sharing captures the overall importance expressed by the women of healing being generated not only by having the ability to share, but more importantly, by having the **safety** to share their stories. The women describe recovery as an ongoing process of life-long discovery, reaching ascending levels of awareness and understanding. The following categories: I. External Search, II. Identifying Sexual Abuse/Addiction Links, III. Self-Connecting and IV. Reclaiming Sexuality gave rise to theme one.

Symptomatic Relapse describes a phenomenon of events that create vulnerability in maintaining abstinence from using drugs and/or alcohol or a feeling of wellness and control of one's life. Symptomatic relapse can occur on a physical level with the ingestion of chemicals or on an emotional level with the onset of feeling defeated and suicidal. The categories: I. Oppressive Powers, II. Inward Retreat, III. Self-Detachment, and IV. Suicidal Thoughts/Attempts underlie the theme of symptomatic relapse (Table 2).

TABLE 2 - THE EVOLVING RECOVERY PROCESS

SUB-CATEGORIES	CATEGORIES	THEMES
Understanding Experiences		
Establishing Support Network	I EXTERNAL SEARCH	
Behaviour in Context	II IDENTIFYING SEXUAL ABUSE/ADDICTION LINKS	
Awareness of Issues Expanding		
		SELF-DISCOVERY THROUGH STORY SHARING
Self-Knowledge in Relation to Others		
Responsibility Allocation	III SELF-CONNECTING	
Physical, Emotional, Mental, & Spiritual - Holistic Healing		
Non-Abusive Relationships		
Honouring the Sexual Self	IV RECLAIMING SEXUALITY	
Accepting Sexuality/Sexual Orientation		
Family		
Community	V OPPRESSIVE POWER	
Institutions		
Environment		
Substance Abuse	VI INWARD RETREAT	
Low Self-Esteem		
		SYMPTOMATIC RELAPSE
Out of Body Experiences		
Voiceless	VII SELF-DETACHMENT	
Lack of Boundaries		
Alternative to Substance Abuse		
Punishment	VIII SUICIDAL THOUGHTS/ATTEMPTS	
Stop Sexual Abuse Memories		

CATEGORIES

Each category reflects a set of common experiences encountered by the eight women in this study. Exploring these categories will enable the reader to follow the journey these women have undertaken, and continue with, in their recovery process from chemical dependence and childhood sexual abuse. The descriptions of their experiences, quoted directly from the transcripts, provide an overview of the process of recovery which illuminates the themes generated from these womens' responses.

Each woman consistently sought answers to why she felt and acted the as she did, which gave rise to the category, external search. At the onset of trying to understand their experiences, these women often sought help through various avenues, from attending AA meetings to seeing professional counsellors:

> Ann - I tried a treatment centre for drugs and alcohol, I was really messed up.
>
> Lyn - My recovery began the day I called AA. The woman I spoke to was instrumental in my getting help.

Prior to reaching out for help, each woman had struggled in her own way to identify that either a chemical dependency problem existed or that the long-term effects of being sexually abused were interfering somehow in their lives. However, seven of the eight women sought help first through various drug and

alcohol resources. Upon making the initial contact, they all were able to maintain a period of abstinence from drugs/alcohol, but soon found themselves either "using" again or feeling depressed and suicidal. If they were able to stay connected with some kind of support system, AA, friends, or family, patterns of "using" drugs/alcohol became apparent and were connected to the haunting issues of sexual abuse.

The second category, Identifying Sexual Abuse/Addiction Links, resulted from the numerous responses by the eight participants which included a realization and identification of a connection between the issues of sexual abuse aftereffects and substance abuse. Often, the women described a situation that would 'trigger' the desire to 'use' drugs and/or alcohol to alleviate the feelings they were having. Wendy and Tina commented that:

> Wendy - I mapped out the sexual thing and realized I had never been sexual without being under the influence [of drugs and alcohol].
>
> Tina - It was easier to be sexual when I was drunk because there were less memories and flashbacks. On the other hand, it subjected me to a lot more abuse by lowering my guard and my boundaries, what I had left of them.

Throughout the interviews the women kept referring to feelings of not knowing who they were but appeared to keep searching out answers and explanations for why they felt as they did and why they found themselves in

particular situations. As they began to identify triggers, an awareness of a connection between the long term consequences of being sexually abused and drinking and drugging behaviours appeared to emerge. One woman said, "I never made the connection between my using (drinking/drug use) until I was sexual once while sober and the flashbacks were unbearable and all I wanted to do was drink".

Once the linkage between sexual abuse and addiction was made by the women, a feeling of relief and understanding ensued:

> Beth - I felt I opened a can of worms [as she spoke about being sexually abused as a child] but there was this big relief. I was able to see the common ground. I was able to see the connection between my childhood and why I am the way I am now.
>
> Lydia - I went to a treatment centre that looked at both sexual abuse issues and addiction. In the past, I stayed sober but never felt happy because I didn't get to the underlying stuff, the sexual abuse.

Barrett and Trepper (1991) discuss the apparent inter-connectedness between childhood sexual abuse and adult chemical dependence and argue that "it is important that clinicians working with either population understand the origins of both, and how they relate to and amplify one another" (p. 128).

Feelings of Self-Connecting, the third category, arose as the women were able to talk about their feelings around their experiences. Kate said:

> coping with my anger [in therapy] enabled me to uh to get on with my life and basically to discover that I had more deeply rooted problems than I was aware of in other therapy sessions, so I started working on those.

As the women continued to explore their individual issues, they were able to reclaim their sexuality by understanding the effects the abuse had on their sexuality. Wendy reflects this movement toward reclaiming sexuality, the fourth category, when she says, "he was the first person I ever took a chance with and slept with without the use of alcohol and drugs and it was ok." Wendy, who is a lesbian, said that coming to terms with her sexuality/sexual orientation was not difficult because of rejecting societal attitudes but was more troublesome because she had been abused by women. Once again, the more relevant issue was tied to being abused as a child.

Although these categories appear to fall into a linear order, quite the contrary was true. The intertwining aspects of the recovery process as described by the women in this study will be considered in more detail at the end of this chapter.

The following categories exemplify the barriers these women encountered in their recovery process. The most exasperating category for me as an interviewer and witness to the pain in some of these womens' eyes as they recalled their experiences, was what I call Oppressive Power. The eight women

reported various forms of oppression from feeling invalidated to outright abuse. The oppressors ranged from family members to professionals abusing their power as helpers. For example, some of the women were either told directly that their addiction had nothing to do with their sexual abuse, or that this is not the time and place to deal with these issues. This led to a questioning of their own reality because they intuitively knew that a connection between their childhood abuse and their "using" patterns existed. A clear example of this external oppression was profoundly experienced by Wendy when she was given an assignment by a drug and alcohol counsellor to write down the triggers she was aware of that precipitated drinking episodes. She wrote about the sexual abuse triggers, flashbacks, painful memories, and the need to be under the influence during sexual contact. Wendy recalls the following response from her counsellor:

> He just sat bolt upright in his chair saying 'this has nothing to do with your drug and alcohol addiction. These aren't the triggers I'm talking about. These aren't triggers!' I was just floored.

This response may have reflected the attitudes at that time as Wendy's treatment experience occurred in 1979. However, Kate was also referred to someone who specialized in sexual abuse but who did not address her addiction issues as recently as two and a half years ago (1991). Now she is seeing a counsellor who works with both issues together and she feels this person has

"helped me the most".

"Beth" also experienced similar barriers in her recovery both in a recovery house and at meetings she was attending for addiction problems during the past year:

> I felt AA was too limited for where I have to go in my recovery and the issues I have to deal with. Right now I am not involved in any AA support group. I would rather talk about my sexual abuse issues and other important issues in my life rather than *just* alcohol. At the recovery house, I felt I could not talk about the sexual abuse issues either. It was based on AA and focused strictly on alcohol problems. This helped me too, but, one of the counsellors said some damaging stuff about the sexual abuse when I told her about the connections I was making [because of the counsellors' personal experience] so I didn't feel I could talk to her because she wasn't neutral and I didn't feel safe.

Whenever the women encountered a negative situation or were unable to secure a feeling of safety, an Inward Retreat would occur:

> Ann - [after going to see a counsellor] I remember just crying hysterically and she didn't seem sympathetic but she didn't seem to not understand but she was very distant and just wrote everything down and that was it. I didn't tell anyone again for a long time.
>
> Lydia - I asked to be referred to a treatment centre for help but the counsellor wanted to send me to a place that advocated controlled drinking. I didn't feel heard. So, I just continued on. [drinking and using].

> Lyn - when I used drugs and stuff, it was an escape thing. I wanted to get away from myself and to make the pain go away and not think about it.

Numerous methods of coping with the memories of the abuse were utilized by these women with the most common being the use of drugs and alcohol. The unresolved trauma seemed to create a sense of Self-detachment:

> Wendy - I really thought I had a multiple personality problem for a long time. I was really appalled with myself and I'd get loaded.

> Tina - If somebody sat too close to me I'd flip, if somebody touched me I'd flip, if somebody said the wrong word that triggered off something I wouldn't necessarily have a picture of it, but I would just freak out...I had never felt that way before...looking back, I connect it [sexual abuse memories] to why I drank more and more. As I started drinking more and more, I turned from someone who never slept around at all to someone who some would call a slut.

Suicide thoughts/attempts were a continuous theme the women shared. Repeated attempts and/or thoughts were frequent throughout the recovery and using periods:

> Kate - I realized that in the past I had used alcohol as a way of hoping somebody would kill me. I would get incredibly drunk, put myself in very dangerous situations and hope that someone would kill me.

> Wendy - actually throughout the whole time I felt very suicidal.
>
> Tina - I had attempted suicide on numerous occasions because of the flashbacks. I just couldn't handle them!
>
> Ann - I was pretty well at the end of my rope, I was suicidal and uh, my whole life was just one big struggle and it kept going backwards, it wasn't going forwards at all.

Often, the women experienced numerous aspects of both the recovery barriers and the recovery enhancers as they sought answers and change in their lives. The entwined nature of the recovery process is complex and seemed to be influenced by both external influences, such as negative contact when they reached out for help, and internal convictions of self-loathing and feelings of unworthiness, which appeared to be a consequence of the trauma of being sexually abused in childhood.

The intricacies of the recovery process, although different in some respects for each individual woman, are generally portrayed by the categories outlined. These categories show the commonalities encountered by all eight women in this study and provide the background information which led to the formation of the two overriding themes that depict the overall process of recovery and healing.

THEMES

The two themes encompass the essence of the recovery process as experienced by these eight women as revealed in the interviews. The sub-categories, as outlined in Table 2 (p. 52), depict the circumstances that underlie the meanings inherent in the categories from which the themes emerged. Each theme will be examined with excerpts from the interviews that support these findings.

The first theme, **Self-Discovery Through Story Sharing**, was an evolving process that was generated by increased awareness through exploring and sharing in a safe place about their issues of sexual abuse and chemical dependence. Such sharing enabled the women to place their experiences within the context of their entire lives rather than simply focusing on the "self" as somehow damaged and therefore defective.

Each woman was at a different place in her healing, but had an awareness, none the less, of reaching a wholeness not felt before. The holistic integration of the physical, emotional, mental, and spiritual being seemed a critical aspect in the recovery process. As the women speak about their experiences and desires the notion of healing and self-discovery through story sharing becomes apparent:

> Kate - Recovery starts as very functional and at the end of my natural life it will be more of a spiritual progression. Very much like a child. A child starts off with, what you initially teach them, gross motor skills, and as an adult what you are looking at is requiring more philosophical skills. At the end of the recovery process, I see it as being at that more spiritual level.
>
> Ann - My connection to my higher power, which I got by going to meetings and sharing, was the catalyst to my cleaning up.
>
> Wendy - Recovery for me is just my whole being, spiritual, emotional, physical. It didn't happen until I was willing to open up, until I found someone safe to talk about the issues that were most important to me. The ones that I felt worse about myself, and that was my sexual abuse. Recovery affected my whole life. I mean recovery to me was getting past all those things.

The women talked about running and hiding from their lives for years because they felt either there was no safe place to share their stories, or the pain of sharing their stories would be too overwhelming. This desire for integration, as an ongoing process, is again supported by Kate's experience:

> When I was being sexually abused I had to block my feelings so I would go into a trance, leave my body, and so it was happening to my body but not to me. So it's very very easy for me to walk out of my body. To me it's still the issue and that's why I'm still in counselling because I can just walk away. I'd like to see a full body integration.

Young (1990) advocates that holistic healing must be a goal of treatment if

relapse is to be prevented and Miller (1991) promotes the healing aspects of "story-telling" when she says:

> We may not be completely comfortable with the simplifications offered in "Twelve-Step" problem formulations and interventions, but we need to work with what we can accept and value in this form of collective story-telling and spiritual empowerment.

Both authors lend credence to this theme of self-discovery through story sharing and I support Young's argument that "creative and healthful living becomes possible as the self, which was impaired and thereby dependent on addictive behaviours, is reconstructed and restored" (1990, p. 256).

The theme of Self-Discovery Through Story Sharing appears to fall on a continuum that reflects the challenges these women faced in gaining a sense of themselves. The following excerpts from the transcripts exemplify this journey:

> Wendy - I couldn't recover from my drug and alcohol abuse until I looked at my whole life. *My whole life.*

> Kate - Recovery fits in with a philosophy of life that I have, recovery is not a destination, but like life, it is a journey. I would go to therapy sessions and then stop and integrate what I had learned, and then when things fell apart again, I would go back.

> Ann - Recovery is a life long process. It's like a total reversal of my entire lifestyle, everything has changed. I don't think I'm the same person. I

> don't do the same things and don't enjoy the same activities. Every aspect of my life has been affected.

Recovery appears to be an evolving process where experiences begin to be understood and self-awareness increases. This integration of knowledge is reflected in Kate's statement:

> I look at my present behaviours and understand where they came from and what's nice is it gave me an opportunity to stop beating up on myself... So I've learned about boundaries, I've learned about being co-dependent, I've learned about appropriate and inappropriate behaviours. I have learned enormously. I see recovery as an ongoing process that I personally took in chunks. So recovery is ongoing but it's also escalating.

An awareness of the sexual abuse/addiction linkage enhanced this process of self-discovery and enhanced their ability to maintain their recovery from drugs and alcohol. Wendy talks about being able to recognize the connection between her abuse and "using" patterns and expressed the following:

> Recovery is not one piece, it's not like I drank, take away the booze, it was just impossible, that's what I had done and just kept drinking. I don't know if it's like that for everybody, but I certainly know what it took for me to get to a place where I now know I can stay sober. I had to deal with all my issues.

Gorski (1986) describes a recovery model that moves along a continuum which he calls stages, going from a "stabilization period" through to the

"maintenance period of recovery" where a focus on improving the quality of ones' life and living a productive lifestyle are maintained if sobriety-centred values are cardinal within the newly achieved lifestyle. This movement toward self-discovery apparent in Gorski's model would support the theme just described here.

The second theme, **Symptomatic Relapse**, depicts situations that have created a vulnerability to relapse for these women.

Throughout the recovery process, the women found themselves vulnerable to relapse when faced with a variety of new situations or circumstances that triggered the original trauma or addiction patterns. The following excerpts reflect these high risk circumstances of symptomatic relapse, each reflecting a different experience, yet, common to all of the women interviewed:

> Kate - I was looking for relief from my life which is why I continued to put myself in vulnerable situations [talking about the past when she was drinking]. But, I wanted someone else to take responsibility and to a degree that is still what I am hoping for in the counselling situation. As a sexually abused child and living in an alcoholic home, I felt burdened by responsibility and I'm still looking to unload that responsibility either through counselling or through death.
>
> Ann - Relationships are the hardest for me. When I have a lot of conflict in my relationships, my

> natural reaction is to use. It's like I can't deal with the heavy emotional stress. Recently I was with someone who started rolling a joint in front of me and just the thought of knowing that this person was going to get high kicked up a craving in me. I just had to leave and get out of there, even though I don't really want to use, the feelings to use were so strong.
>
> Susan - There is a tone in the program that's like the worst of the disease in action. Like the controlling, abusive, totalitarian, rigid thinking, male table thumping, you know, 'take the cotton out of your ears and put it in your mouth' stuff. I needed to talk about my experiences.

Gorski (1986) claims that "placing the phenomenon of relapse in its proper perspective within the recovery process, planning for the likelihood of relapse, and providing patients with skills to cope with the stresses that typically lead to the resumption of alcohol and other drug use" is critical (p. 6). Rose, Peabody, and Stratigeas (1991) found in their study that "nonrecognition [of abuse] by mental health professionals and the failure to intervene appropriately and early create devastating outcomes for clients who have been abused" (p. 411) such as relapse.

Relapse is a common phenomenon of recovery, as pointed out in the literature, and studies have shown that mortality rates for alcoholic women range from more than three (Schmidt & DeLint, 1972) to nine times (Gorwitz, Bahn, Warthen, & Cooper, 1970) that expected for women in the general

population. The alcoholic woman's life span is also shortened by fifteen years (Smith, 1983). Although you cannot draw causal relationships of sexual abuse causing relapse that will shorten women's lives there are strong indications that a relationship may exist. Relapse indicates a return to a previous state ie. drug/alcohol abuse.

A clear picture can be visualized about the symptomatic relapse phenomenon that repeatedly occurred for these women as their stories unfolded.

Wendy first attempted to quit drugs and alcohol at the age of twenty-three. She is now thirty-six and has two and a half years of continuous sobriety. Her description of her recovery suggests the need to look at the entire picture of the recovery process:

> At some point I grasped another year and a half of sobriety, it seems a year or a year and a half was a real milestone for me...It seems like for a long time, it was like chunks of years, then almost to the month I would have a year of sobriety and then use again.

Relapse episodes were also experienced at one level or another, whether that be physical or emotional, during continuous abstinence as reflected by the following comments

> Ann - I did a step four while I was in a recovery house. I felt overwhelmed by the guilt, shame, and remorse and deep down I felt like a rotten person. I couldn't face the things that I had done as a result

> of my drinking and it didn't even occur to me to consider the things that had been done to me. I spent two weeks crying and thought of over-dosing every day, I just wanted to kill the pain.
>
> Wendy - I would start talking about something and then go drink. I started drinking again just a little bit [after 1 1/2 years of sobriety], controlled, I just needed something to get me through the evening and I'd leave it at that.

Kate claimed that she did not experience a relapse during recovery because the past two years is the first time she acknowledged that an addiction problem existed. However, she did state that "quitting was easy for me because I think I just switched my addiction to nicotine". Kate also stated that in the past two years she had been drinking on two separate occasions but did not consider these a problem because she did not lose control.

Kate first sought help by contacting a psychiatrist when she was in her late teens because she was experiencing difficulties coping with her home environment but was unable to articulate what her issues were. The doctor did not question her about addiction or the possibility of being abused but rather focused on her speech. "The advice I had from the psychiatrist set me back quite substantially...his main concern was that I spoke too quickly and that was his main concern, to get me to slow down my speech." After two sessions she did not return to see this doctor. Kate's drinking and drug use continued, until two

years ago, with periodic abstinent periods which she says she did for her husband. She was able to quit for months at a time and thought this proved she did not have an addiction problem.

The prevalence of relapse, whether in an emotional sense or in an actual physical return to active addiction, points to the need to uncover hidden relapse predictors. Young (1990) believes that "one of the greatest unacknowledged contributors to recidivism in alcoholism and other addictions may be the failure to identify and treat underlying childhood sexual abuse issues" (p. 249)

Seven of the women relapsed several times before attaining continuous abstinence from drugs and alcohol which placed them at risk for further physical and sexual abuse, life-threatening health problems, and suicide. Hansen (1987) reported that "some therapists hold that one addresses the addiction and then refers the woman in order to deal with her sexual abuse experiences" (p. 9). Hansen (1987) argues that "separating sexual abuse treatment from addictions treatment assumes that these two issues are mutually exclusive and that sexual abuse is not an antecedent to addiction involvement" (p 9). I strongly agree with Hansen, and believe that such attitudes and policies only perpetuate barriers for women in recovery and serve to aggravate the struggles women already have in their recovery from chemical dependence which is reflected in the stories shared by the women in this study:

> Tina - I popped back all these pills. I don't think I wanted to commit suicide, [pause] I just wanted the pain to stop and the feelings to go away. I didn't want to remember all the sexual abuse.
>
> Lyn - In light of my recent suicide attempt I was willing to share whatever I needed to, to stay alive. For the first time, I realized I wanted to live. I saw this counsellor because of my attempted suicide and for the first time, I told somebody about the abuse, I broke my silence. It was quite a moment for me [smile], but unfortunately he really didn't help me. There was no follow-up from him because I wasn't an ongoing client of his.
>
> Susan - If I don't deal with this stuff, another abusive relationship will come along, or something else and I just can't take it anymore. I don't ever want to be used and abused again. I don't want to use or abuse myself. This stuff won't go away. If it would, I wouldn't have to be here [treatment centre for chemically dependent women]. If I could close a door on it and run, I would. I tried with drugs and alcohol but I couldn't drink enough to make it go away. If I drink again then they win. I go out there and end up in an institution or dead, those bastards [abusers] win!

One of the most horrendous aspects of the realties experienced by Tina, Lyn and Susan (quoted above), is that this additional trauma in their lives might have been prevented if adequate resources and knowledgeable support people had been available to them.

An illustration of the recovery process is depicted in Figure 1. It will be examined and explained by using the descriptions provided by Lyn, Tina, Lydia,

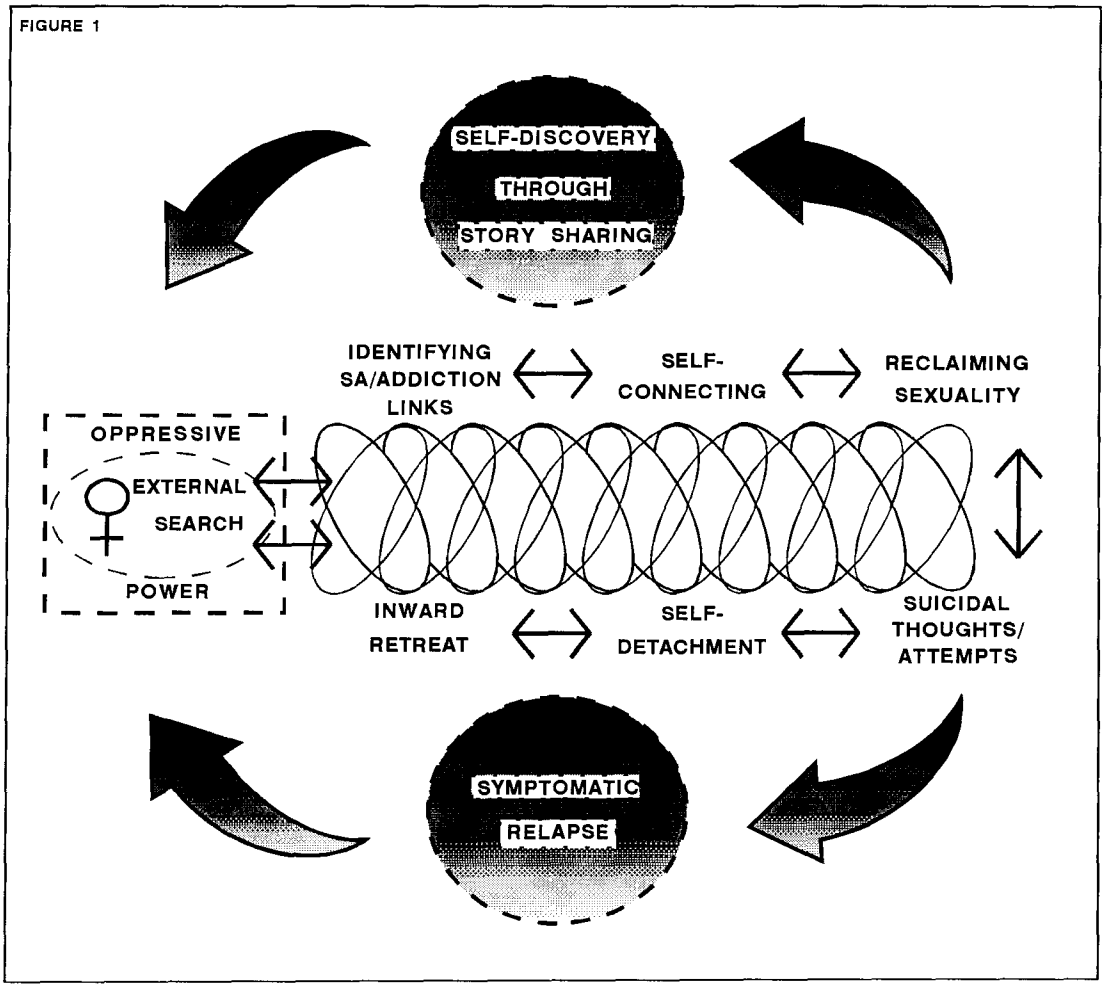
Wendy, Susan, Ann, Beth and Kate, to afford the reader a sense of the process in action. Perhaps using such a diagram will assist in looking for intervention points that might reduce the pain in women's lives who have been affected by chemical dependence and childhood sexual abuse.

Recovery in Motion

The complexity of the recovery process is exemplified in Figure 1, which provides a schematic view of the experiences described by the women.

THE RECOVERY PROCESS FLOW CHART

FIGURE 1



The motion within the chart reflects contstant movement, in various directions, capturing the "random chaos", as described by Wendy, of the recovery process. Dependent on positive or negative contact, one might spin off the spiral into one

of the various categories. The semi-permeable boundaries surrounding the two categories, External search and Oppressive power, and the two themes, Self-discovery through story sharing and Symptomatic relapse, shows the fluidity of in-and-out movement. For instance, as a woman searches for answers, **external search**, she may proceed to identifying abuse related triggers, or if contact and feedback is negative, she may feel torn and confused by the influences of **oppressive power** relations and may stay on the bottom circular track for a period of time where she may resort to an **inward retreat**. This may lead to a sense of **self-detachment**. This pattern may be interrupted, however, at any point where she would return to the upper track. Some of the precipitating factors that influence a change in direction might be a crisis, supportive contact with someone, a new insight and so forth.

Once a change has occurred, for instance, she may proceed to **self-connecting** and move on to **reclaiming sexuality**. If the "recovery enhancers" persist over time, then she will begin to shift to the upper right side of the chart where **self-discovery through story sharing** begins to become more established. A back and forth flow of events seems to occur, once again, dependent on the experiences encountered. If the experiences and changes in coping patterns are positive, she will tend to stay in the healing portion of the chart. However, if negative circumstances persist and **identifying sexual**

abuse/addiction links are not made, she may shift to the relapse circle.

The flow of the recovery process is very individualized. Although the women in this study had distinct commonalities as described by the various categories and themes, each woman's journey would be pictorially different on the chart described above.

This diagrammatic view of the recovery process for chemically dependent women survivors of childhood sexual abuse highlights the complexity of the process encountered by women. The chart also emphasizes several implications in which positive change can be implemented. Chapter five concludes the thesis with a discussion of implications for professional social workers, helping professionals from other disciplines, and others involved in program/policies for women recovering from chemical dependence who have also been victims of childhood sexual abuse.

CHAPTER FIVE

CONCLUSIONS AND IMPLICATIONS

The intent of this study was to conceptualize the impact of childhood sexual abuse on women's experiences of recovery from chemical dependence. The results indicate that issues of sexual abuse add to the complexity of the recovery process in such a way that if unrecognized may contribute to symptomatic relapse which could cost the woman her life as discussed in chapter four.

Although the data obtained in these eight interviews have been rich in extricating some of the influences which impact the recovery process for chemically dependent women survivors of sexual abuse, the results must be considered cautiously due to the small sample size. The generality of concepts delineated from these womens' experiences, however, may be applied over a wide variety of situations where similar histories exist (Glaser & Strauss, 1967).

A possible controversial point in the study might arise from the fact that I have worked in this area for many years and have ideas about the recovery process based on my own personal journey of healing. Thus it might be argued that I come to this research project with preconceived ideas influencing the nature of the questions and the outcome of the research topic. However, many

feminist researchers utilize the strenghts inherent in personal experience. Still, another researcher looking at the same data may have derived different themes and categories based on their valuing of statements differently than I have.

I believe that the most important aspect of exploring a relatively new is to generate dialogue and increase understanding. In this study, I wanted to engage with the participants in order to co-create knowledge. By contacting each woman to verify my interpretations of their experiences, ownership of this study is shared and the womens' stories are honoured.

Further research will strengthen the arguments posed in this study. A larger sample population would also make possible the generalizability of causal relationships which cannot be done in a qualitative study of this size. Thus the preliminary findings in this study will require further investigation but the present results certainly point to several implications necessary to explore for helping professionals working in this area.

Most of the research to date, based on male subjects, has guided the formation of policies and programs in place for addiction recovery. Since 1972, some studies have focused on chemically dependent women, but have only begun to explore the relationship between substance abuse and childhood sexual abuse.

Considering the findings in this study, which are corroborated by professional accounts of working with women in this population, intervention

and prevention strategies need to be examined and revised for this group. For instance, in the Alcohol and Drug programs in B.C., there is no mandate to treat sexual abuse issues nor is there a requirement that professionals working in treatment centres be trained in sexual abuse. Presently it is left to individual counsellor preference as to whether or not the issues of addiction and sexual abuse are being treated concurrently as reported by Hansen in chapter four.

Studies strongly corroborate that sexual abuse experienced in childhood is a predictor of future substance abuse (Rohsenow et al., 1988, Coleman, 1987). Thus, intervention must address these issues as dual recovery issues.

Professional awareness is necessary in both fields of work because sexual abuse counsellors if not aware of the addiction recovery process may inadvertently trigger a relapse if the client is not yet aware of her "using" triggers related to her sexual abuse.

Aurora House, one of the few treatment centres in Vancouver, that addresses sexual abuse issues, has an average wait list of five months which points to the need for addressing these issues together. It is estimated that 90-95% of the women who come to Aurora have been sexually abused as children. Many have sought treatment with two or more years of sobriety because they felt they were on the verge of relapse because of the surfacing abuse memories. As stated in chapter two, Brown (1991) argues that counsellors need to

understand the dynamics between shame and relapse, stressing that, "shame-based conflict needs to be addressed directly" (p. 80).

In Gorski's (1986) model, most relapses that occur during the "late recovery period" are attributed "either to the inability to cope with the stress of unresolved childhood issues or evasion of the need to develop a functional, low-stress personality style" (p. 9). I would argue that developing a functional low-stress lifestyle is not possible where unresolved sexual abuse issues exist.

More services need to be made available to this population. Many women with whom I have worked were turned away from drug and alcohol services because they had long term sobriety and were told that their problems were emotional and thus, they needed to seek services elsewhere. For many, this was not financially feasible or they feared that seeing someone who did not understand their addiction issues could jeopardize that aspect of their healing.

Research and resources are scarce when it comes to understanding and providing for the additional difficulties faced by the following groups: First Nation's women, other minority group women, Lesbians, or women with disabilities, to name only a few. Some of the difficulties faced by these women are institutional and societal racism, homophobia, limited wheelchair accessible facilities, and simply because of their gender, sexism, all of which place women in vulnerable positions in their recovery process from chemical dependency.

Women-centred research that addresses all aspects of every woman's life is critical if women are to be empowered in their healing. This study is a beginning step in understanding the relationship between chemical dependency and sexual abuse and its effects on the recovery process. The study reflects a more personal inward-looking process in examining revoery from chemical dependece and childhood sexual abuse. Future research examining more structural influences, such as quality of housing, poverty, access to employment training, childcare, etc. would benefit women by incorporating a more systemic analysis in the move toward holistic healing.

Another recommendation would be directed at including all children in Prevention Programs (drug and alcohol) because of the high prevalence of childhood sexual abuse and the potential for future chemical dependence as outlined in chapter two. Early treatment of sexual abuse could possibly prevent the development of future substance abuse.

I have only begun to scratch the surface of avenues to be explored and/or changed. Advocacy for clients in this population is a large area that requires much consideration. I hope that this study will spur interest in further, much needed, research.

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APPENDIX A

The Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.

2. Came to believe that a power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God, as we understood him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our short-comings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awaking as a result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.
(Alcoholics Anonymous, 1976)

APPENDIX B

Sixteen Steps For Discovery and Empowerment

1. We affirm we have the power to take charge of our lives and stop being dependant on substances or other people for our self-esteem and security.
   Alternative: We admit we were out of control with/powerless over_____, but have the power to take charge of our lives and stop being dependant on substances or other people for our self-esteem and security.

2. We come to believe that God/the Goddess/Universe/Great Spirit/Higher Power/ awakens the healing wisdom within us when we open ourselves to that power.

3. We made a decision to become our authentic Selves and trust in the healing power of the truth.

4. We examine our beliefs, addictions, and dependant behaviour in the context of living in a hierarchal, patriarchal culture.

5. We share with another person and the Universe all those things inside of us for which we feel shame and guilt.

6. We affirm and enjoy our strengths, talents, and creativity, striving not to hide these qualities to protect others' egos.

7. We become willing to let go of shame, guilt, and any behaviour that keeps us from loving ourSelves and others.

8. We make a list of people we have harmed and people who have harmed us, and take steps to clear out negative energy by making amends and sharing our grievances in a respectful way.

9. We express love and gratitude to others, and increasingly appreciate the wonder of life and the blessings we do have.

10. We continue to trust our reality and daily affirm that we see what we see, we know what we know, and we feel what we feel.

11. We promptly acknowledge our mistakes and make amends when appropriate, but we do not say we are sorry for things we have not done and we do not cover up, analyze, or take responsibility for the shortcomings of others.

12. We seek out situations, jobs, and people that affirm our intelligence, perceptions , and self-worth and avoid situations or people who are hurtful, harmful, or demeaning to us.

13. We take steps to heal our physical bodies, organize our lives,reduce stress, and have fun.

14. We seek to find our inward calling, and develop the will and wisdom to follow it.

15. We accept the ups and downs of life as natural events that can be used as lessons for our growth.

16. We grow in awareness that we are interrelated with all living things, and we contribute to restoring peace and balance on the planet.

(Kasl, 1992)

APPENDIX C

The Thirteen Statements

1. I have a drinking problem that once had me.
2. Negative emotions destroy only myself.
3. Happiness is a habit I will develop.
4. Problems bother me only to the degree I permit them to.
5. I am what I think.
6. Life can be ordinary or it can be great.
7. Love can change the course of my world.
8. The fundamental objective of life is emotional and spiritual growth.
9. The past is gone forever.
10. All love given returns.
11. Enthusiasm is my daily exercise.
12. I am a competent woman and have much to give others.
13. I am responsible for myself and my actions.(This was formerly, "I am responsible for myself and my sisters.")

(Kirkpatrick, 1976)

APPENDIX D
INTERVIEW GUIDE

The purpose of this study is to explore the recovery process for women, who are in recovery from substance abuse and who are survivors of childhood sexual abuse. I believe that it is essential to explore the area of recovery with women who have first-hand knowledge of what the experience of healing has been like for them.

1. Women view recovery in many different ways, could you describe what recovery means to you?
   a. drugs and alcohol - recovery?
   b. sexual abuse recovery?

This next question is very open, on purpose, because I think it is important for women to have an opportunity to share whatever they feel is important to them about the recovery process. If you feel stuck along the way, I can help by asking some questions about what you have already shared or explore new areas.

2. Could you describe your recovery to me from the beginning until now? It is kind of like telling your recovery story.
   - for example, from the first time you attempted to quit "using" or the first time you talked about the abuse with someone?

3. Children often find numerous ways to cope when they have gone through traumatic experiences. Can you describe what you did that helped you to cope after being abused?

4. Did your ways of coping change at anytime, from childhood until present?

5. Looking back over your recovery experiences, does anything/s in particular stand out that helped?
   ie. any particular situation, person, treatment centres etc.

6. Has there been anything in particular that has created a block for you during your recovery?

[some areas will be further explored as the woman shares her recovery story. Look for any problem areas she may have had. Any relapses? Length of sobriety? How does sexual abuse relate to her addiction recovery?]

APPENDIX E.1

FAMILY SERVICES OF GREATER VANCOUVER

NORTH BURNABY
ALCOHOL & DRUG
COUNSELLING
SERVICES

285 - 9600 Cameron St.
Burnaby, B.C.
V3J 7N3
Tel. **(604) 421-2228**
Fax (604) 421-2291

December 3rd, 1992

TO WHOM IT MAY CONCERN:

This letter is to confirm the willingness of North Burnaby Alcohol & Drug Counselling (Family Services of Greater Vancouver) to participate in the attached study ***"Exploring the Phenomenon of Recovery For Chemically Dependent Women Survivors of Childhood Sexual Abuse"*** to be conducted by Kathy Oxner.

This approval is dependent upon review by the UBC Ethics Review Committee.

If you have any questions, do not hesitate to contact me.

Yours truly,

Myrna Driol, M.A.
Clinic Co-Ordinator

cc: Kathy Oxner

APPENDIX E.2

Province of
British Columbia

Ministry of Health and
Ministry Responsible for Seniors

APPENDIX E.2

Alcohol and Drug Programs
Lower Mainland Regional Office
509, 4980 Kingsway
Burnaby, British Columbia
V5H 4K7

December 21, 1992

Ms. Gail Malmo,
Executive Director
Aurora House
2036 West 13th Avenue
Vancouver, B.C.
V6J 2H7

Dear Gail,

Re: Exploring The Phenomenon of Recovery for Chemically Dependent Women Survivors of Childhood Sexual Abuse

Thankyou for your information package faxed December 6, 1992 concerning the above research proposal.

I trust that the proposal has been approved from an ethical perspective by the University of British Columbia Behaviourial Science Screening Committee for Research and Other Studies Involving Human Subjects.

The Regional Office would look forward to learning of insights and recommendations which may arise from this research.

Yours truly,

Ted Mitchell
Area Manager

cc. Karen Abrahamson, Regional Director

MIT/MIT/jf/160-20

The Aurora Society
INCORPORATED UNDER THE SOCIETIES ACT

APPENDIX E.3

2036 West 13th Avenue, Vancouver, British Columbia V6J 2H7 Telephone 733-9191
Fax 733-8957

November 30, 1992

U.B.C. School of Social Work
6201 Cecil Green Park Road
Vancouver, B.C., V6T 1Z1

ATTENTION: Katherine Oxner

Dear Katherine:

I am pleased to inform you that the Aurora Society has granted you approval to conduct your research study at our facility.

We look forward to meeting with you in the new year. If I can be of any further assistance to you, please do not hesitate to contact me.

Sincerely yours,

Gail Malmo MSW
Executive Director

Funded by Ministry of Health – Alcohol & Drug Programs, Province of B.C.

The University of British Columbia
Office of Research Services
Behavioural Sciences Screening Committee for Research Involving Human Subjects

Certificate of Approval

PRINCIPAL INVESTIGATOR	DEPARTMENT	NUMBER
Russell, M.	Social Work	**B93-0050**

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT

CO-INVESTIGATORS:

Oxner, K., Social Work

SPONSORING AGENCIES

TITLE:

Exploring the phenomena of recovery for chemically dependent women survivors of childhood sexual abuse

APPROVAL DATE	TERM (YEARS)	AMENDED:
MAR 11 1993	3	

CERTIFICATION:

The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

Dr. R. Corteen *or*
Dr. I. Franks, Associate Chairs

Dr. R. D.Spratley
Director, Research Services

This Certificate of Approval is valid for three years provided there is no change in the experimental procedures

APPENDIX G
CONTACT LETTER

Dear Participant: [On Letterhead]

I am currently a graduate student at the University of British Columbia, completing my masters degree in social work. I am doing a study to explore women's experiences of the recovery process. My interest in this area has grown out of my work with women in the addiction field over the past twelve years.

I believe that women who are encountering addiction issues and have been sexually abused as children may have different needs during the healing process of recovery. Thus, I would be very interested in meeting with you to explore these issues together.

The study would involve two audio taped interview sessions lasting approximately one and a half hours each. The purpose of the second interview is to verify with you the accuracy of my interpretations of the experiences you shared with me in the first interview.

The interview questions are fairly open, for example, "Could you describe what the term recovery means to you?" but, some questions may stir up painful incidents concerning the sexual abuse you experienced during childhood. Your decision to not answer particular questions will be totally honoured.

Your participation is completely voluntary and you can withdraw at any time. Your right to agency service will not be compromised at any time throughout this study.

All information you share with me will be strictly confidential with no personal identifying information attached. The audio tapes will be destroyed after transcribing them into written form, no later than two months after the interviews. A copy of the final report will be a public document given to this agency and available at the University of British Columbia.

Your participation in this study will provide valuable information about the recovery process which I hope can assist you on your journey, and will provide much needed information to counsellors working in this area. If you are interested in participating in this study, please feel free to contact me through your counsellor or by calling: 876-0766, or 822-2255.

Sincerely yours,

Katherine Oxner

APPENDIX H
INTERVIEW CONSENT FORM

[On Letterhead]

PROJECT TITLE: Exploring the Phenomenon of Recovery for Chemically Dependent Women Survivors of Childhood Sexual Abuse.

INVESTIGATORS: Katherine Oxner BSW, MSW (candidate) - 876-0766
Supervisor: Dr. Mary Russell - 822-2795

The purpose of this study is to explore women's experiences of the recovery process from chemical dependence and how being survivors of childhood sexual abuse may influence this process.

As a participant, the study would involve two audio taped interview sessions lasting approximately one and a half hours each. There will be time available at the end of each meeting to discuss any feelings or concerns that may have come up as a result of the interviews.

A personal journal will be kept by me, containing your first name and telephone number only for purposes of contacting you. No personal identifying information will be on the document developed from the interviews and the audio tapes will be destroyed within two months of the interviews. Thus, strict confidentiality will be maintained.

A compensatory travel expense of $5.00 will be given to you at the beginning of each meeting.

Your participation is completely voluntary and if you chose to participate, you may withdraw from this study at any time, your decision to withdraw will in no way affect your treatment with this agency. If you have any questions concerning this study or your involvement, please feel free to contact me or my supervisor at any time (telephone numbers listed above).

I _____ understand the above statements and agree to participate in this research study conducted by Katherine Oxner.

_____ _____
Participant signature Date

_____ _____
Investigator signature Date

APPENDIX I
CONSENT FORM COPY RECEIPTT

[On Letterhead]

I _____ have received a copy of the consent form I signed granting permission to be interviewed by audio tape as a participant in the research project being conducted by Katherine Oxner.

_____ _____
Participant signature Date

_____ _____
Investigator signature Date

CONSENT FORM
(optional)

I _____ authorize Katherine Oxner to share with my

counsellor _____ information that was shared during our interview

session.

_____ _____
Participant signature Date

_____ _____
Investigator signature Date

APPENDIX J
INTERVIEW - TRANSCRIPT

Interview with Wendy

KO: When you think back to the first time you tried to quit alcohol and drugs or the first time you sought help for the issues of childhood sexual abuse, could you just go from there and describe what the recovery process has been like up until the present time?

Wendy: Uh .. the first time I probably tried to quit alcohol and drugs I was 23 and I had actually started going to Al-anon because my mother was alcoholic and .. uh .. I went to that off and on. I left home when I was 14 and she came to live with me when I was 17 so I could take care of her and I went through a lot of stuff and she ended up in AA. When I started Al-anon it was really bizarre as I wasn't hardly able to attend sober and I didn't really see that as a problem at the time until someone pointed it out that I might need to go to AA. So I thought yeah right so I started going to	Problem Recognition Help Seeking Behaviour No Safe Place Other Directed Obliterate Reality Denial

AA and uh I really just stumbled through it. I would only go for a month, drink, go for a week, drink, go for a couple of days, drink, and not really getting a firm grasp on my own problem. I kept on getting hung up on "oh it's my mother's problem" you know and not really believing [pause] and people always commenting on how young I was that perhaps that wasn't the right place for me anyway.	Help Seeking Behaviour Note: Motivation to quit apparent but continues to "use" - patterns of relapse? Imposed Negation of Experience
KO: the message was virtually you are too young to have a drinking problem.	
Wendy: oh yeah I can't remember how many times I heard "I spilt more on my tie than you ever drank. So it was hard.	Unsupportive Feedback Aloneness
KO: What made you decide at that point in time that drinking was causing you trouble or getting to be too much?	
Wendy: oh I recognized that locking my doors and closing all my curtains with a bottle of Captain Morgon and seeing how much I could drink might be a problem, [laughter] you know, without passing out.	Problem Recognition Awareness of Patterns Denial

I would isolate to the maximum and hide and uh I also had a lot of memories of things that I had done or been told that I had done over the years since I started drinking and drugging

Isolation

Memory Impairment

KO: How old were you when you started?

Wendy: I started drugging when I was around 12 and started drinking even before that [pause] I uh really don't know. I go back as far as my mother giving me an ounce of booze, brandy, in my bottle when I was around a year to keep me quiet and stuff because I had bronchitis and stuff so I look at that as giving a baby an ounce of alcohol as a lot of alcohol for their system. When I got a little older I would steal drinks and remember being rude.

[family history and childhood perspective]

Wendy: So from the time I can remember ... also being around aunts and uncles and they were all alcoholics ... so I drank forever, and ah, I did drugs since at least 12 and the first drugs were prescribed.

KO: Why were drugs being prescribed for you?

Wendy: uh according to them or according to me

[laughter].

KO: According to the doctors and you.

Wendy: Well, according to the doctors it was because I was hystrung like my mother, and according to me why I was sent to them was because I had no desire to stay at home so the school counsellors brought my Dad in. The worse thing to do, and they said so what's the problem here and my Dad said oh you know a young girl, her mother is very hystrung, and she is just like her and uh so with his permission they sent me off to the doctor to try and normalize me and that's the words they used, to make you normal, some people need insulin, some people need thyroid medication, and some people need tranquilizers you know to make them normal and so at 12 years old I was put on them and realized immediately that would just numb my awareness of what was going on and that was ok.

Labelling

Note: stereotyping: sexism - institutional oppression

No Safe Place/Betrayal

Secret Keeping

Labelling

Silenced by Others

Numbing Behaviour

Cognitive Links

KO: were you aware at the time what you wanted to numb out?

Wendy: Uh, I was aware of what was going on a lot

but sometimes I wasn't. I just was aware that I needed	Pattern Awareness
to escape and it was really important for me to escape.	Obliterate Reality
KO: Can I ask what it was you wanted to escape	Cognitive Links
from?	
Wendy: oh my home life, the abuse. From age 4 I was	
sexually abused, and my Dad was a batterer, and uh	
the sexual abuse and the physical abuse. The first	Pattern Awareness
sexual abuse I ever encountered was by a baby-sitter,	Sexual Exploitation
a girl a bit older than my sister, and she sexually abuse	Auth. Victimization
me for years and later it was my uncle. And I would	
just go to sleep. It was like a joke in my family, every	Sexual Exploitation
time anything got stressful I would just knock off and	
go to sleep. And uh I still do that. So uh at home I	Obliterate Reality
was always falling asleep.	Obliterate Reality
With both my parents there was sexual abuse, with my	Sexual Exploitation
father it was fondling. Something I haven't been	Auth. Victimization
talking about much until recently was the sexual abuse	Secret Keeping
by my mother. A lot of feeling bad, about that and	
that I was quote 'bad' and uh it made a lot of things	Negative Self-talk

complicated about what's mine. And uh so there's a very strong code of morale beliefs in the church that we didn't seem to adhere to at all and I just thought I was the bad person, I had heard about hell and I thought I was going there and things like that. And I would be told that too.	Entrenched Belief System Personalization of Trauma Auth. Victimization
KO: Do you think it was used as a threat to keep you silent?	
Wendy: Uh no, I would be threatened with hell, like going to hell for not eating my porridge so for sure. The hardest thing I have had to deal with was the first abuse being with a female. [Discussed lesbian issues, feeling bad when she came to terms with knowing she was a lesbian later in her adult life and equating this with the first abuse experience.]	Note: Institutional Oppression Auth. Victimization Sexual Identity
KO: Did you have anyone to turn to talk about what was happening to you?	
Wendy: No but I'd beg people to take me home though and I never said anything out loud. Just really asking someone to save me without saying from what.	Isolation Note: boundaries weak-self-detachment

Save me .. it is too much and I can't handle it... and them never really wanting to go into what it was. They really didn't want to deal with that.	Help Seeking Behaviour Secret Keeping
KO: In terms of recovery and your own healing around your childhood experience of sexual abuse, seeking help at 17, what happened after that in terms of your recovery?	Unsupportive Feedback (non-verbal)
Wendy: uh at 17 I was still feeling really bad about myself uh that I was, very suicidal, actually throughout that whole time I felt very suicidal. When I was 17 I moved out of a relationship I had had since age 15 and really hadn't had much time to think about myself I was always thinking about what he was going to do next. It was a very dangerous situation for me and uh I started taking Sundays off and make myself go do something by myself. The first step I made was trying to hook up with someone, I was going in to _____, and I went past a church and I went up to the church and I had never been in a catholic church in my life and anyways I went in and sat there and just	Negative Self-Talk Personalization of Trauma/ Relieve Emotional Pain Other Directed Other Directed No Safe Place Self-Love Help Seeking Behaviour

cried. I rarely cried, I don't remember crying very much. Just tears and nobody knew. I was just sitting there crying and somebody came up to me and starting talking to me and uh I was feeling so worthless through all that abuse and everything I felt so disconnected spiritually and to myself. I really thought I had a multiple personality problem for a long time. I was really appalled with myself and I'd get loaded. So I met this priest and uh said some of the things that happened at home and some of the things that happened and uh .. this person, I really, .. he showed signs of empathy to me. And uh .. it was really neat. Not long after that he would hold me in his lap and start kissing me and it was just like, again I just felt there was something wrong with me. That was my first, try to get some help.	Express Emotion Isolation Entrenched Belief System Negative Self-Talk Silenced by others Obliterate Reality Emotional (E) "Using" Trigger Self-Disclosure Connecting with Others Auth. Victimization Sexual Exploitation Personalization of Trauma/ Betrayal
KO: That was when you were 17.	
Wendy: yeah that was the first part of it and the second was when I started going to meetings. There I talked about resentment towards my mother and	Help Seeking Behaviour

found out that she and her siblings were abused by the same uncle and yet she [mother] used to send me there for summer holidays.	Self-Disclosure Betrayal
KO: That information must have been very painful for you.	
Wendy: yeah	
KO: What happened with your recovery during this time?	
Wendy: I just kept stumbling, yeah well I didn't recover, I just kept escaping. I ran away to _____	
and ah I ah helped set up an AA program. I went to a Dr. and asked if there was anyone who would go to AA and she gave me a list of people with names and numbers of people who might need the program so I	S & E "Using" Triggers Obliterate Reality Connecting with Others
phoned them all. I didn't know any better. [laughter]	Other Directed
and that was the beginning of AA in the _____. I ran into more of this "I spilt more on my tie than you ever drank" and also still feeling really bad about myself. The thing that kept on running through my mind no matter how sober I got, no matter how much	Imposed Negation of Experiences

I was taking care of myself was what a worthless human being I was. Absolutely worthless, hopeless, right! I think, people would see the outside of me and people admired me and liked me but my thought was if you ever knew, or got to know me you wouldn't like me. And it wasn't just sort of, it was a really strong belief system that I had and me knowing how bad I was and how evil I was how immoral I was you know, from all this stuff, from the past. It was just, it made me crazy. Uh .. it was like always staring at the edge of life and that black down there and that was just all of me. I'm not being dramatic, I would visualize that it was just very powerful and every time I got into that I would use again. It wouldn't take much to get me to that place. Simple things would send me to that place. Not being able to do my job well. uh loss of a relationship, I didn't, .. I couldn't even maintain a relationship with any nice people that came around, I would barely look at them. So, I ah .. finally when I got to be 19, I really felt that like I had to get a clearer	Negative Self-Talk Entrenched Belief System Note: incongruence of self and image presented to others - self-detachment Entrenched Belief System Personalization of Trauma Cognitive Links E "Using" Trigger Numbing Behaviour S "Using" Triggers Aloneness Obliterate Reality

picture on things, I had chunks of sobriety, what it was like to be sober, and something would happen. Plus that, trigger, there was always that thing in the back of my mind that I wasn't normal. That I needed drugs to feel normal. I was always going back and using drugs.	Self-Searching Note: desire for change - Self-Discovery E "Using" Trigger
KO: So you used drugs in order to feel ok.	
Wendy: No, Not ok, I just didn't care. No I never did feel ok.	Entrenched Belief System
KO: I guess I mean that you used to get that sense of normal.	
Wendy: No, ah I guess I believed that is what would make me normal but I never reached normal.	Denial ?
KO: OH I see,	
Wendy: Yeah I was looking for it but it was never there, it wasn't in a bottle, it wasn't in a bottle of pills, it wasn't anywhere. Normal! It just didn't happen. I didn't know what they were talking about but at least I felt numb. You know, if I took enough I felt numb and uh .. I could cope. By this point my mother had	Self Searching Entrenched Belief System Numbing Behaviour Cognitive Links

gone into a treatment centre and I knew about it and had been around it. So I went to a treatment centre and I quit my job.	Self Searching
One of the things that use to happen to me was that I ended up having zero memory around my body.	Memory impairment
And uh I really didn't know how to say to somebody,	Isolation
I don't feel anything and I just ended up	Secret Keeping
feeling...whenever that happened, whenever I would	E & S "Using" Triggers
have sex, It seemed like, that only reinforced that	Sexual Trigger
feeling of the abuse. The sex act would trigger that	Sexual Trigger
whatever, .. I could be sober for a long time, and have	D/A Abstinence
sex, and there was a real connection there.	Cognitive Links
KO: So it would kick up all the feelings and memories of the abuse?	Note: identifying SA/ addiction links
Wendy: It was, move into a relationship and before we had sex, I would use. In order to get into that intimate	
part of the relationship. I might being seeing	Situational "U" Trigger
somebody, but if I thought we might sleep together I	Sexual Trigger
would use. Afterwards, it would be worse using. I	Acknowledges Emotions
would also feel suicidal. So I went into treatment at	Help Seeking Behaviour

19, but I was so angry, I went in there really angry with everything, and angry that I had to do this. I went to one of the counsellors there, for the first time, and we	Help Seeking Behaviour /acknowledges Emotions
talked, and they had male counsellors there at that time, and it was a test [sigh]. He was a minister, and he	Help Seeking Behaviour Self Searching
wanted to know and said I want you to think about this, what is it that triggers you. You talk about being triggered all the time, what is it that triggers you. I	
had never verbalized that so I had to go away and think about it. I came back and I wanted to talk about	Secret Keeping Self Disclosure
the abuse and the abuse in my family, throughout my life. He just sat bolt upright in his chair and said this	Unsupportive Feedback
has nothing to do with anything to do with drug and alcohol addiction. These aren't the triggers I'm talking	Dichotomized Treatment Imposed Negation of Experiences
about. These aren't triggers. I was just floored because I thought ok what is it that I do and mapped	Silenced by Others
out the sexual thing and realized I had never been sexual without being under the influence even with a	Pattern Awareness Cognitive Links
man I had been with for over 2 years.	Note: Identifying SA/
KO: So you were very clear about what the triggers	Addiction Links

were for you. Again, somebody couldn't or wouldn't hear what you were saying?	
Wendy: No, No he wouldn't hear it. So him being straight and sober and a counsellor, my god, I must be really off the fucking wall if that's what I thought a trigger was and there must be something else out there if that can't be it. And I believed him. I didn't question him at that time. I just thought I'm really screwed. I really don't know what it is then. I just went into myself even more with anger so the next three months they threatened to throw me out of treatment because I wouldn't open up. The director at this point, who was a friend of my mothers, said she ain't going anywhere. I got really angry and quite aggressive and people were really nervous around me.	Silenced by Others Auth. Victimization Negative Self-Talk Silenced by Others Aloneness Personalization of Trauma Silenced by Others External Contact (+) Express Emotions
KO: Did you have any other support?	
Wendy: No, when I left there I went to quite a few AA meetings and I met a woman who was in treatment with me and we hung around a lot. I got involved in helping set up a house. There was no place safe for me	Help Seeking Behaviour Connecting with Others No Safe Place

to live. So I helped set up this house for women leaving treatment. This counsellor got involved and helped get this house ready for people to move in and to uh so I kept busy.	Connecting with Others External Contact (+)
KO: So, did being involved help keep you sober?	
Wendy: Keeping busy? yeah, yeah it did. I took the staying sober really seriously. If nothing else that's one thing I grabbed and held onto, again I recognized	D/A Abstinence
I had a real problem. I uh .. then one day I got a phone call to work at _____ and .. uh from the director who really liked me and I guess she saw what I was doing and what I represented at _____.	Problem Recognition External Contact (+)
KO: What kind of Job was it?	
Wendy: Working as a House Attendant. That really kept me going if nothing else. I was probably 21.	
Wendy: by this point I had started seeing an ADP counsellor and we started talking about the abuse .	Self Searching
I walked in and the only counsellor available was another man and I ended up just going this is really bad and I recognized it as being really bad and if there	Self Disclosure Note: Lack of choice & resources - Oppressive

is any way I can get a woman...but there just wasn't	Power (community)
any available. I was beginning to sense boundaries just	Establish Boundaries
on my own it was not that anybody had told me in particular but I read a book and I was going down the street and it really affected me. It was just sort of, Oh,..	
it's clear to me. Like we talked about it briefly at	Cognitive Links
[treatment ctre] but it was a different program back	Self Disclosure
then. I made up my mind. I don't want to be touched,	Establish Boundaries
you have one strike against you, you're a man, Ill give you 6 sessions and I'll see how it goes from there. And ah this person was really respectable, and very	
respectful of me. I told him there is a whole bunch	External Contact (+)
going wrong here and I don't see any salvageable parts	Negative Self-Talk
of it. The only problem with him was that he was so	
nice that again I couldn't tell him the truth about	Secret Keeping
myself. I knew how badly I looked at myself.	Entrenched Belief System
KO: When you talked about the abuse, you did talk to him about the abuse, was it in a general way?	
Wendy: Yeah it was in very general terms.	
KO: What was his reaction?	

Wendy: He would uh just, he recognized I guess how bad I felt about myself, I'd say that outloud, and he would always try to take the responsibility away from me. He was the first person to point out to me that I wasn't responsible for everything that ever happened to me. The other thing was, is that I didn't believe him. I'd hear it and feel good but in the end I'd say 'well he gets paid to say this'. Like my belief system was so entrenched and I thought it was very nice of him to say that, and felt cared for, but I didn't really trust that that was the truth. I knew it wasn't the truth. It was the first time I talked about it, well not the first because the priest was the first person I talked to. I think that priest saw me as some moral, a little sexual object, because that's how I looked at myself.	Express emotion Note: Allocation of responsibility for abuse - Identifying SA/ Addiction Links Entrenched Belief System Negative Self-Talk Entrenched Belief System External Contact (+) Personalization of Trauma/Self Disclosure
KO: It sounds like he took advantage of you when you were very vulnerable.	Sexual Exploitation/ Personalization of Trauma
Wendy: yeah extremely so. But this person didn't. This person looked at me and said Wendy you are a valuable person. I think he may have been the first	Auth. Victimization/ External Contact (+)

person that I ever impressed upon how close I was to	
killing myself all the time. Kathy there were years that	Relieve Emotional Pain
all I thought about was committing suicide. And I	Escapism
tried to do it also. Anyway, .. ah, .. after we met I	
started, I got into a situation, I was probably a year	Intimate Relationship
and a half past treatment and celibacy. I got involved	D/A Abstinence
with this woman I had been in treatment with and she	
started using [drugs] and got involved in a relationship	
with another woman. We were close and inseparable.	Connecting with Others
She kept putting alcohol right in front of me when she	Situational "U" Trigger
was using. She would always have my favourite	
alcohol around and knew what I liked to use. I t was	
important to her that I use with her and I started using	E & S "Using" Triggers
again. Her part in it was that she set it up but my part	
in it was that I did use. I wasn't taking care of myself	Denial
and I didn't know how. Here was this person that	Isolation
really cared about me and I just didn't know how to	
care about myself. And as soon as I drank again, she	Emotional "U" Trigger
looked at me and smiled and said "I knew you were no	E & S "Using" Triggers
better than me" and I just reinforced it.	

KO: How long did your drinking continue?

Wendy: I don't know how many months, but another thing that happened was as soon as I used, we got into a situation, her drug of choice was heroine and she knew I had used it in the past and things I was going through, she knew a lot about me, and uh she got some heroine and by that point it , what was the use? And basically that's what she told me. I was also, around that time, was in a car accident and was put on barbiturates and codeine and barbiturates was my hook [medical details]. I was in a lot of pain and I lost the job at _____ over it because they couldn't hold the job open for me for that length of time and uh so she ended up getting some heroine and we ended up using it together. Over the course of the evening she ended up initiating a sexual situation that I didn't want to happen and I kept voicing that, in my state, and we just ended up getting involved and it just triggered all sorts of stuff. I was a whore again. It was really devastating for me because I didn't want to have sex

Situational "U" Trigger

Dichotomized Treatment

E & S "Using" Triggers

Sexual Exploitation

Sexual Trigger

Negative Self-Talk

No Safe Place

with this person, and again I used because at that time	Emotional "U" Trigger
I had a lot of attractions for women but not her. I	Note: Sexual Identity
didn't find her attractive in that way at all, in fact I	
found her quite mean in the way she treated people.	
She got up in the morning and said well I'm out of	
here, I"m meeting some people for breakfast and I	
phoned My counsellor and said I'm going to kill	Help Seeking Behaviour
myself.	Relieve Emotional Pain
KO: Throughout this period of using had you been	
staying in contact with your counsellor regularly?	
Wendy: yeah	
KO: And he didn't know you were using?	
Wendy: I don't think he knew I was using, I didn't tell	
him. And I didn't tell him the truth about what	Secret Keeping
happened that night. I told him I used but I didn't tell	
him about ... the attack, it really was abuse. So I took	Cognitive Links
responsibility as "why did I let this happen". We had	Negative Self-Talk
talked about having no boundaries at great length and	
she knew about my abuse to a degree and my fear and	Betrayal
uh [pause] and so after that I went and talked to some	Emotional "U" Trigger

friends of hers and got really stoned. And within days I was sleeping with her best friend who was a guy. It was like save me get me out of here. He looked at me and said when I look at you I don't see your heart being in this life. Which, he was really drunk and stoned, and I said I don't know what the fuck I am doing here, this is not where I want to be and he said this is not where I want to be either. He didn't use like us. He drank a bit and used but it was like take it or leave it. He said I'll save you and I went and straightened up again. We went up to _____ and I was on my prescription medication for my medical stuff. And then I started abusing that. He was the first person I ever took a chance with and slept with without the use of alcohol and drugs and uh it was ok. I was surprised it was so ok. And it was the first time I didn't feel suicidal after sex but I still felt unclean. I really couldn't get over that hump of not feeling somehow unclean about the whole situation and I told him about my feelings about women and

Personalization of Trauma

Intimate Relationships/ Pattern Awareness

Connecting with Others

D/A Abstinence

Situational "U" Trigger

Trust

Intimacy Comfortable

Cognitive Links

Entrenched Belief System

Self Disclosure

that I probably wouldn't be with him very long but I had a lot of stuff to sort out. He was very open to me	Self Searching
and said I will enjoy you as long as I have you. He was a great person. I had to figure it out though.	Intimate Relationship (+) Self Searching
During all this time, the relationship with the priest was still occurring. It was a thread that went through this whole time.	Sexual Exploitation Auth. Victimization
Wendy: Meeting B__ helped me escape my fear of women for awhile, my fear of a relationship. He is totally a non-threatening person. Helped me escape this priest. I had a reason not to do these things anymore. Just safe.	Safety Denial Safety Connecting with Others Safety
KO: Did you quit drinking the whole time you were with B___ when you were in the _____?	
Wendy: No, no I didn't. At some point I grasped another 11/2 years of sobriety, it seems a year and a half was a real milestone for me. Then I used again and I don't really remember it. Until pretty much the time when B___ had a heart attack. Close to then.	Obliterate Reality Note: Relapse patterns

B___ had a heart attack, I was leaving him. I don't remember when I started using again, it was prior to leaving him.

Memory Impairment

KO: Nothing stands out for you during that time or what may have triggered that time.

Wendy: NO [pause] It seems like for a long time it was like chunks of years then almost to the month I would have a year of sobriety and then use again. I couldn't go to AA. I knew what I needed to deal with I couldn't really get there. I tried going to a female counsellor who dealt with sexual abuse and I just would panic. Just absolute shear terror and I couldn't get to the point to where I could talk to her about this. I didn't feel safe with her at all. B___ and I would talk about the abuse, I never told him about my family in particular, oh the sexual abuse was also with my sister. My only sister. She would set it up also, she set it up that her boyfriend would come into my room and have sex with me. I was 13 and we had been drinking. I was absolutely freaked out. She knew about the baby-

Obliterate Reality

Dichotomized Treatment

Help Seeking Behaviour

Memories/Flashbacks

Overwhelming

Silenced by Others

No Safe Place (to share)

Self Disclosure

Note: important to share story - would jump back and forth from childhood experiences to present

sitter sexually assaulting me too. So I couldn't talk to	recovery process
my sister who was like the closest person in my life to	Betrayal
me. And she lived up in the _____. Then my	
mother, oh my mother, there, that's a trigger. My	
mother moved back to the _____ and that's when	Emotional "U" Trigger
I started using again at one point. All of a sudden	
she's in my face. I really had a hard time coping with	
her. I wouldn't let her touch me. I'd be nauseated if	Obliterate Reality
she touched me. Anyways I used in that time.	
KO: So how old are you know, for what you have	Emotional "U" Trigger
shared with me up to this point?	
Wendy: Probably, there's that gap I can't remember,	
it's just a sort of blur. Early 30's.	Memory Impairment
KO: So you have left B___,	
Wendy: We went to Mexico, and we had never taken	
a trip together and damn it we were going to even if we	
were splitting up. So we went to Mexico and uh I	
drank a lot in mexico and I had to get Valium to calm	
myself in between drinking. We got back. I had all	Note: Relapse
kinds of reasons to leave him. I thought I was dying in	

the relationship. I wasn't treating myself well and I wasn't treating him well. Nothing! That's when a real major shift happened. I came back from there. He had a heart attack within about two weeks and they didn't expect him to live. I didn't drink but I used, I wasn't sleeping, I was staying up all night, the doctor looked at me and I just looked like shit and the doctor said what's wrong and I went to talk to him and I said I can't handle this, I'm not coping very well. I'm not sleeping at all and from the time I was a little girl I could put myself to sleep. That's a tool I have and I can't find it, I was hysterical because I can't find it and I couldn't escape from how I was feeling. He says Wendy has there ever been any, were you ever sexually abused? And this wall came down. I could feel it, it was almost like you could hear it. I said that has nothing to do with anything. And it was just echoing what I had been told, what I was told in the 70's by the counsellor, it has nothing to do with it, it has nothing to do with it. I really believed that, I mean I knew how

Self Searching

E & S "Using" Trigger

Numbing Behaviour

Deliberate

Escapism

Safety

Pattern Awareness

Negative Self-Talk

Silenced by Others

Entrenched Belief System

bad it made me feel but I had already been told in no uncertain terms that that was something else, keep that somewhere else because that has nothing to do with what your life has been. So I uh. He started asking	Cognitive Links
more questions. He said I think what you are going through right now has a lot more, than what you are going through with B___. "It seems like there is a lot of stuff surfacing for you." And I just like, shit, I can't deal with this. You know, and I uh anyways we started talking and he finally started telling me that it	Imposed Negation of Experiences External Contact (+) Escapism
was ok just to talk about it if I had to talk about it. He was really cool, he had no experience with sexual abuse but he told me that he may not be the person to talk to but he would like my permission to find someone for me to talk to. I went home and I was shaking, absolutely shaking and I [pause] . The first thing that welled up was intense anger. I finally got really really angry. Almost uncontrollable. And I really prided myself in being controlled. All the feelings were uncontrollable. I think I was just so vulnerable and	Self Disclosure Safety Trust External Contact (+) Express Emotions Express Emotions

open because of all this other stuff going on. No	Cognitive Links
strength left to keep the lid on it. So I just started	
talking. He and I would talk and when I couldn't talk	
about something, at that point I had never verbalized	Self Disclosure
what had happened with my mother, that was the	Secret Keeping
hardest part for me. He says if you can't say	
something you could write it down for me. He gave	
me a lot of leeway. So I wrote it out. It was really	Safety
bizarre but it gave me a lot of insight into myself	Self Disclosure
because it was really little writing and I felt really little	Cognitive Links
when I was writing it. It was on a little tiny piece of	
paper, the whole story. Things I thought about myself,	
at that point in my life, I'm a business woman, I have	
strength, I have a position in the community, I had	Note: Story Sharing
been involved with politics all this stuff and here was	
this little tiny writing, and this little tiny person and I	
just felt so little. And, uh, uh, I was terrified. And I	
met T__. I knew this man through my business and he	Cognitive Links
phoned me at home one day just out of the blue and	Connecting with Others
said hi. I said T__ you can't believe what's going on	

for me and I knew he was great to talk to, what he was working on [book on sexual abuse]. Anyhow it was just those feelings of, there would be one step forward and then this ton of shit land on me again. All through that no matter how good I would feel about some little insight I might get, what became more powerful was the feelings of my worthlessness. And I had a really hard time getting past the fact that my being worthless. Spending money if I wanted to go to therapy, just anything that I was worth it. And in that time my doctor suggested I go to a woman's sexual abuse workshop. I went reluctantly. When B___ and I were together, 9 1/2 years, we only slept together the first three years. I always felt there was something wrong with my body. I use to do things to alter my appearance. To make myself unattractive. I would go from wearing very good clothes to wearing baggy clothes. Cut my hair, quit wearing make-up and just always do something to alter my appearance.	Trust Note: notion of intertwining process Cognitive Links Entrenched Belief System Negative Self-Talk Connecting with Others Personalization of Trauma
KO: Do you understand now why you would try and	Body Image (-)

alter your appearance?

Wendy: No I don't actually. Well, yeah I get really panicked even now at times. I just want to be left alone. Even gaining weight this past year, I had a situation develop that made me very uncomfortable. I felt unattractive in my personality, you know, being a human being and physically too.

Personalization of Trauma

Negative Self-Talk

KO: When you started talking to T__ and your doctor about your sexual abuse experiences, how was that in terms of your recovery process for drugs and alcohol?

Wendy: My recovery process, like, Kathy, it was so chopped up. I would start talking about something and then go drink. I started drinking again just a little bit, controlled, I just needed something to get me through the evening and I'd leave it at that. I wasn't drinking a lot. Then one day two and a half years ago I, [remembered earlier comments and jumped back]

Obliterate Reality

Entrenched Belief System

I didn't use anyone for support beyond them, I would just white knuckle it until I saw them again. Rather then turn to anybody---I would not call anybody from

No Safe Place - before

Note: establishing support network

AA, I had no support system, I could not talk to anybody about this. My doctor also introduced me to this woman who was suppose to be a sexual abuse counsellor from _____, and every time I told her about my abuse, every session she cried, she would burst into tears and fall apart and I would be sitting there trying to rescue her for the rest of the session. She use to say "that is so awful," and that is the word she use to use, awful. I would just cave in on myself. So I used during that time. It was that maintenance using. It was like every two days, whatever.	No Safe Place Self Disclosure Dichotomized Treatment Other Directed Silenced by Others Emotional "U" Trigger
The last time I ever drank was two and a half years ago and I don't remember anything. I came out of it desperate and suicidal. I realized I needed treatment again. Also, because I had worked in the system, it what kept me from going to treatment the second time. I needed it, but if I ever ran into anyone I knew or if they found out the truth... It was all that thing about the truth and the secrets. That was just my whole life.	D/A Abstinence Memory Impairment Memories Overwhelming Help Seeking Behaviour Secret Keeping

To maintain that secret. So I went to ADP and said I want treatment. I went to a place that didn't deal with long term issues, but that was ok. It was a co-ed living situation but we had women's groups for the first time. So I was really lucky in that and we talked surface about sexual abuse. By that point in my life, I really needed the AA Part of that whole thing, I was working on that other stuff. But I had never come to terms with God, My spirituality, ever. I never believed I was salvageable because of the abuse. And for the first time I talked and thought about it. I think for the first time, I had 34 years of processing under my belt, and I just needed some place calm and peaceful so that I could move through that. I was able to sort out the "exact nature of my wrongs" [AA: step 4] vs the nature of the wrongs done to me. And I was able to unload 90% of what I had been carrying. And sort out what somebody else had done to me and what I was responsible for. That was just freedom, absolute freedom for me. Because I took the "exact nature of	Secret Keeping Help Seeking Behaviour Dichotomized Treatment Safety Note: Need to share story Holistic Healing Spirituality Entrenched Belief System Note: Shares Story Pattern Awareness Safe place Self Searching Problem Recognition Note: Responsibility allocation Acknowledge Emotion

my wrongs" to mean my sexual abuse. When I did my	Cognitive Links
fourth step, my sexual abuse was in there, I was sexual	
at four, I was sexual at..... and that was so much of a	
hook.	Sexual Trigger
KO: So who helped you sort this out and understand	
the difference between your responsibility from	
someone else?	
Wendy: I had a female counsellor for a week and then	
they gave me another male. But this guy named ____,	
did the lectures there on the 4th and 5th steps, and it's	
really funny, he's a born again christian, a real	
different view of spirituality but what he was able to	
point out ah, I felt he was talking to me even though	Connecting with Others
there was a room full of people because that's what I	
was struggling with. and my belief system was so	Entrenched Belief System
entrenched. I don't know how to tell you this, but	
seriously it was the most important thing I had ever	Pattern Awareness
heard. I was able to look at people in AA, fear, the	External Contact (+)
fear went out the window. I cried for 24 hrs off and	Express Emotions
on, sobbing, just absolute relief to figure that out.	Cognitive Links

Even yet, with what I'm going through right now I want to keep taking it back. It's not a conscious thing, all of a sudden I start taking back responsibility for that [abuse]. I have this fear that I'm going to be held responsible and then I start feeling responsible and it's just a constant process. Oh that's fixed let's move on. I realize that was an important thing that happened for me.	Cognitive Links Entrenched Belief System Personalization of Trauma Labelling Cognitive Links
KO: Have you been sober since that treatment? And what has helped during this time?	
Wendy: yeah. I started going to a counsellor when I moved back to Vancouver. I kept seeing my doctor up in _____ and when I moved I immediately hooked up with a counsellor down here and have switched counsellors since. She wasn't able to do any more for me and I was able to see that. And that was a big change for me, well this isn't quite where I am at, I have moved beyond this. To think I was beyond something, not that I was so good, it was just I had worked out so much and gained so much strength. I	Help Seeking Behaviour Connecting with Others Problem Recognition Establish Boundaries Self-Love Holistic Healing

also started going to AA regularly for the first time.	External Contact (+)
T__ introduced me to another counsellor and she was stronger. I needed a stronger counsellor. I did more in the first two sessions than I've done in the last 15 years, [laughter]. It's just that I was ready, to say things outloud, and my fear of saying things outloud, I always had this thing that if you said something outloud then it made it real if you didn't say it outloud then it didn't have to be real.	External Contact (+) Self Disclosure Entrenched Belief System Secret Keeping Escapism
KO: As you have been working with her and talking about your childhood sexual abuse, have there been any times in the past five months that you felt like using drugs or alcohol? You have talked about wanting to use in the past whenever you started to talk outloud about these issues.	
Wendy: All the time.	
KO: Is there anything that is different this time from the past that has influenced you to decide not to use.	
Wendy: ah [long pause]	
Kathy: Because that has been one way of coping,	

something that has helped you get through all these years. Even if it caused you it's own set of pain.	
Wendy: There's a place I came to, that God had made me special, and I feel really special. The spiritual	Spirituality
connection, even my self-esteem. My present	Spirituality
relationship is negative towards my self-esteem, but	Intimate Relationship
when I'm away from that, my self-esteem, my sobriety, where I am in my growth, as a human being I'm able	
to feel real positive. Sometimes it's really hard And I	Holistic Healing
want to isolate still but I'm finally able to recognize	
what I want and what I need is two different things. I	Cognitive Links
never recognized that before. So I force myself to do	
things that is against my ingrained belief system. So I	Entrenched Belief System
go to AA, Call up my counsellor, I tell people how I	Connecting with Others
feel, how bad I,m feeling. I can do that sometimes. I	Self Disclosure
never use to do that I just isolated before. No secrets, I'm really out about my abuse, I'm really out about my	
sexuality, who I am and what I am. That gives me	Sexual Identity
strength, there is no hiding anymore. I think that's a	Trust (self)
lot of what it is, I don't have to hide anymore.	Safety

KO: Do you think, now that you've had all this experience, uh, is there anything that comes to mind that would have made a difference for you when you first sought help?

Wendy: Oh God yes. I grieve that all the time. Just more training uh, uh a willingness to talk about abuse. It would have made a real big difference if I hadn't met a priest that wanted to take me to bed. I realize now how much this has affected me. Talked about this with my counsellor, [pause] and it's just grieving that lost time.

Note: Need for trained professionals and safe place to share story

Cognitive Links

Express Emotion

KO: So you felt worse when you came up against that situation when you first reached out for help, to keep the secret.

Wendy: It just reinforced how I felt, not even reinforced, it added on to it. A sexual relationship with a priest was like the worst. But I didn't think the worst of him it was the worst of me. He's a wonderful person, if you had talked to me back then or even a few years ago. I could have done a speech for him at

Entrenched Belief System

Auth. Victimization

Personalization of Trauma/Cognitive Links

a friar's convention [laughter] or something and then he'd take me out of the depths, and then I thought , wait a fucking minute save me from what? That's what he told me he did. I just couldn't believe it. So yeah if there had been somebody there. And the second time after him, sorry, I'm going back a bit

KO: that's ok

Wendy: Somebody told me about someone who worked a lot with sexual abuse in the native community and my family being native on my mothers side, my uncle who abused me, I felt that maybe it was something in the native social system that I don't understand or that I need to know more about. I thought there was a higher prevalence of sexual abuse in native communities. So I went to this sexuality workshop so here is this person I had been told about, he was just great, and this guy was God as far as this person was concerned so I thought well, I'd like to meet this person. So it was really my second foray into meeting someone who is experienced in working with

Entrenched Belief System

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Personalization of Trauma / Cognitive Links

Self Searching

Help Seeking Behaviour

Connecting with [safe] Others

sexual abuse. [early 30"s of age, 4-5 years ago]. So I met this man, and said we have a mutual friend. He asked what my interest was in this area, and so I told him, it was mostly personal, that I hadn't worked out a lot of my own stuff yet. So he invited me up to his hotel room later to pick him up for supper and I went to go get him. I didn't think anything of it. He showed up to the door with nothing on but his shorts and he said oh you just caught me getting out of the shower, come on in. We had talked earlier about boundaries, all these things. I really had told him a lot about myself so it was like he had all this information about me. Ammunition. Within seconds this man was undoing my blouse and telling me how beautiful I was and telling me how attracted he was to me the minute he saw me. You know, all that shit. I'm standing there going, I could hardly breath, and could hardly talk. I think about it now and I just want to throw up. it was really devastating.	Connecting with Others Self Disclosure Betrayal Self-Disclosure/Betrayal Auth. Victimization Sexual Exploitation Note: voiceless - self-detachment
KO: Yeah especially since you were told he was	

someone out there helping people.

Wendy: Yeah, shit that was his workshop. It was about sexual abuse and about people in power abusing it. I finally was able to find my voice and stop him. Then he said I really didn't want to go for supper anyway. It was really hard and again I felt responsible. I felt like hell.	No Safe Place Auth. Victimization Establish Boundaries Betrayal Personalization of Trauma
Ko: Although we have been talking about this for the past hour and a half, do you have any particular definition of recovery?	
Wendy: Yeah, I think it's holistic. I couldn't recover from my drug and alcohol abuse until I looked at my life. My whole life. Recovery for me is just my whole being, spiritual ,emotional, physical. It didn't happen until I was willing to open up, until I found someone safe to talk about the issues that were most important for me. The ones that I felt worse about myself and that was my sexual abuse. No doubt about it absolutely no doubt about it. When I look at how I behaved, how I drank whenever I had sex. After	Holistic Healing Note: Identifying Sexual Abuse/Addiction Links Holistic Healing Spirituality Safety - Share Story Note: Identifying Sexual Abuse/Addiction Links

having sex with someone I would stand in the shower with cold water. There was such a connection there. Recovery affected my whole life. I mean recovery to me was getting past all those things. I still have flashbacks sometimes uh during sex, and I'm able to look at it. There need not be the fear. I can deal with it at another time. I have some place safe to go to talk about that. Recovery is not one piece, it's not like I drank, take away the booze, it was just impossible, that's what I did and I kept drinking. I don't know if it's like that for everybody but I certainly know what it took for me to get to a place where I know I can stay sober. And even then, in the last couple of days, I'm moving towards a complaint and laying charges against someone. I'm going to a meeting the day after tomorrow about that. Something in the back of my mind goes medicate me. Something is there that, the pain gets so intense, that its really subliminal and it ends up screaming. [laugh] Huh! it's time to go to a meeting.	Note: Self Discovery u n d e r s t a n d i n g experiences in context Holistic Healing Safety Pattern Awareness D/A Abstinence Connecting with Others Negative Self-Talk Connecting with Others

KO: So that's helping you right now.

Wendy: Yeah and talking to friends. Reach out. Me	Trust
being vulnerable has always meant time to be taken	Connecting with Others
advantage of but now I'm vulnerable and I trust for	Trust
the most part the type of people that I surround myself	
with. IT IS getting better!	Self-Love!