CHILDHOOD SEXUAL ABUSE, REVICTIMIZATION AND
SUBSTANCE USE AMONG A CLINICAL SAMPLE:
IMPULSIVITY AND INSIGHT
AS RELATED FACTORS

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By
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ABSTRACT

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A relationship between childhood sexual abuse (CSA) and substance abuse has been empirically validated through many different studies, within both community and psychiatric populations (Bailey, 2007; Arellano, 1996; Plant, Miller, & Plant, 2004; Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999). Substance abuse can also be thought of as a risk factor for revictimization (Classen, Palesh, & Aggarwal, 2005). The relationship between sexual assault, both CSA and revictimization, and substance use has been consistent throughout research. However, research which distinguishes between risk factors, correlates, and consequences is limited in scope. Therefore, it is necessary for research to focus on the possible mediating and moderating effects between CSA, revictimization, and substance use. This current study examined CSA and revictimization in relation to substance use in a psychiatric population.
Impulsivity and insight were also examined for their potential role in the relationship between CSA and substance abuse, and revictimization and substance abuse. Results indicated that, in this sample, substance use was independent from the presence of CSA, $X^2 (2, 115)=1.62, p=.45$. It was also determined that substance use was independent from revictimization, $X^2 (2,115) =2.54, p=.28$. Additionally, there were no differences in either insight or impulse based on group. Difficulties related to archival studies, subjectivity of assessment, institutional constraints, and hospital policies are discussed in regards to the results of this study.
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CHAPTER 1
INTRODUCTION

There has been extensive research into the relationship between childhood sexual abuse (CSA) and the negative effects on psychological functioning and development (Herman, 1992). Many studies have also found a strong relationship between sexual abuse and drug dependence (Arrellano, 1996). However, research has not yet clarified and expanded on this relationship. Therefore, this current study aimed to examine how substance use is related to CSA and revictimization. The potential roles of impulsivity and insight in the relationship between CSA and substance use, and adult revictimization and substance use were examined.

**Childhood Sexual Abuse**


A) the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or
B) the rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children (Child Welfare Information Gateway, 2013).

CSA has found to be associated with a number of negative mental health consequences: substance abuse, feelings of powerlessness, stigmatization, sexualization, dissociation, avoidance, numbing and many more (Baynard, Williams, & Siegel, 2001). Additionally, avoidance, numbing, and self medicating through substance use may become lifelong maladaptive coping strategies and consequently increase the risk for psychological distress.

A number of studies have examined the relationship of CSA to adult psychological distress. Prevalence of reported CSA within psychiatric populations has been reported to range from 12% to 50% which is higher than the rates of CSA reported in community samples (Brown & Anderson, 1991: Bryer, Nelson, Miller, & Kroll, 1987: Mullin, Martin, Anderson, Romans, & Herbison, 1993). Wurr and Partridge (1996) reported that it is highly likely that a high proportion of psychiatric inpatients may suffer from a history of CSA unbeknownst to their psychiatrists, which would only serve to compound the prevalence discrepancy between clinical and community samples. Using a randomly selected community sample of 26,229 adults in five different states, the Center for Disease Control (CDC) found an overall CSA prevalence rate of 12.2% for all adults, with a distribution of 17.2% in females and 6.2% in males (Center for Disease Control, 2010). Of those reporting rape, 42.2% of female victims were first raped before age 18, with 29.9% being raped between the ages of 11 and 17. In another study of rape in childhood, first accounts of rape before the age of 10 were reported by 12.3% of females and 27.8% of males (Black et al., 2011). Considering the prevalence rates in community
and clinical populations, the need for in-depth research into the psychological consequences of CSA is not only warranted but necessary.

Dinwiddie et al. (2000) determined that individuals with a history of CSA were more likely to have received a diagnosis of conduct disorder as a child and major depression, panic disorder, and/or alcoholism as an adult than their corresponding non-abused twins. They were also more likely to report a history of suicidal ideation and a history of suicide attempts. Lab and Moore (2005) found that men who report histories of childhood sexual abuse, also reported more of the following problems: anxiety, depression, sleep disorders, extreme anger, dissociative disorders, obsessive compulsiveness, and interpersonal difficulties such as becoming involved in further abusive relationships. The lifelong and pervasive emotional and physical affects of CSA, whether male or female victims, can often have devastating individual, interpersonal, and psychological consequences.

Bulik, Prescott, and Kendler (2001), using a community based sample of adult female twins, confirmed previous research which indicated that CSA is associated with an increased risk for serious psychiatric and substance use disorders. Greater rates of psychiatric illness and distress were found among the twins who experienced CSA. These results were obtained even when controlling for background family factors. It was also determined that certain factors related to the assault increased the risk of psychopathology. The following factors were all associated with a higher risk of psychopathology: attempted or completed intercourse, closer relation of perpetrator to the victim, the use of force or threats, and reaction of others to disclosure. This study did not find an increased risk for psychopathology as related to the age at which the
individual was first abused, the number of, or the gender of the perpetrators. Two factors found to protect against future psychopathology were how strongly the individual was affected at the time of abuse (less affected indicated protection) and whether reporting the abuse was effective in putting an end to the abuse. Furthering these findings, Shafer and Fisher (2011) found that victims of CSA who also had a psychotic disorder had an earlier onset of illness, a more severe clinical course, higher number of hospitalizations, lower remission rates, and poorer compliance with treatment in relation to those with CSA and no reported psychosis. These studies highlight the importance of not conceptualizing CSA as a homogeneous trauma, but instead acknowledging that both the nature and the impact of CSA exist along a continuum.

In addition to the increased risk of psychological distress, the consequences of CSA may also predispose an individual to future victimization. Research using both community and clinical samples has found that women with a history of CSA are 2.4 to 3.5 times more likely to experience sexual assault as an adult as opposed to women with no history of CSA (Cloitre, Cohen, & Scarvalone, 2002). This relationship between CSA and revictimization has been empirically validated through many different studies, within both community and psychiatric populations (Cloitre, Cohen, & Scarvalone, 2002; Classen, Palesh, & Aggarwal, 2005; Fleming, Mullin, Sibthorpe, & Bammer, 1999). Fargo (2009) lists several factors which have been indicated as risk factors for adult sexual victimization: CSA, alcohol use, illicit drug use, poverty, psychological difficulties, high risk sexual behaviors and liberal attitudes towards sex, early negative family factors, and impaired risk recognition. In addition, he reports that the most consistently observed and strongest risk factor for sexual assault is prior victimization.
Research involving a female psychiatric inpatient sample determined a history of CSA created a three-fold increase in risk for revictimization, regardless of race, education, and economic status (Cloitre et al., 1996). Therefore, adults with a history of CSA are not only battling the direct consequences of the early abuse but also an increased risk of revictimization.

Similar to CSA, sexual revictimization has been correlated with increased distress associated with psychiatric disorders, problems with addiction, and difficulties in interpersonal, behavioral, and cognitive functioning (Cloitre, Cohen, & Scarvalone, 2002). Van der Kolk and Fisler (1994) describe that when trauma occurs at an early age, problems such as dissociation, somatization, problems in affect regulation, and other symptoms related to Posttraumatic Stress Disorder can occur. These problems can then increase the risk of the development of psychiatric and interpersonal difficulties. Classen, Palesh, and Aggarwal (2005) found evidence which suggests that sexual revictimization is associated with significantly more distress when compared with one incident of sexual victimization. They found that revictimization, as compared to one incident of abuse, has been found to have a stronger relationship with depression, current and lifetime diagnoses of PTSD, elevated anxiety, impaired affect regulation, and a higher likelihood of substance use and attempted suicides. Thus, the consequences of CSA, as outlined above, are amplified by revictimization.

**Substance Abuse**

Multiple studies have found evidence of a link between CSA and an increased risk for substance abuse (Plant, Miller, & Plant, 2004: Filipas & Ullman, 2006: Santor et al., 2007: Spak, Spak, & Allebeck, 1998: Saunders, Kilpatrick, Hanson, Resnick,
Walker, 1999). Using a sample of 1052 women and 975 men in the UK, Plant, Miller, and Plant (2004) determined that sexual abuse experienced before the age of 16 was strongly associated with illicit drug use for both men and women. In a national probability sample of adult women, childhood sexual abuse involving penetration increased the odds of lifetime substance abuse treatment participation by 5.15 times (Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999). In terms of specific substances, the same study found CSA involving penetration increased the odds of misuse of prescription drugs by 3.67 times, lifetime marijuana use by 3.09 times, lifetime use of hard drugs (cocaine, heroine, angel dust, etc.) by 3.51 times, and lifetime alcohol use by 2.39 times. The connection between CSA and substance use has been empirically validated within community samples, as described above. However, research within clinical samples is more limited in scope, especially among adult clinical populations.

While still limited in scope, several researchers have empirically linked sexual abuse and substance use within clinical adolescent samples (Bailey, 2007). Singer, Petchers, and Hussey (1989) found that adolescent psychiatric inpatients with a history of CSA were significantly more likely to report illicit drug and alcohol use as opposed to other adolescent inpatients with no history of abuse. Likewise, Hawke, Jainchill, and De Leon (2000) studied 938 adolescents from a drug treatment program and found that 64% of girls and 24% of boys reported a history of childhood sexual abuse. Similar research among adult clinical samples is also needed.

Current research indicates that the relationship between CSA and substance abuse exists even when other variables are controlled in the analyses. One such study completed by Spak, Spak, and Alleback (1998) found that sexual abuse occurring before
the age of 13 significantly increased the odds of alcohol dependence even after controlling for familial alcohol problems, family dysfunction, psychopathology, and early deviant behavior. Similarly, Kilpatrick et al. (2000) found that sexual abuse contributes to substance use even when controlling for demographic variables that are often related to substance use.

Substance abuse has also been determined to have an effect on the relationship between CSA and adult revictimization among many different populations. Messman-Moore and Long (2000) concluded that women with a history of CSA were more likely than women without a history to experience unwanted sexual contact while using drugs or alcohol. Women who then are revictimized as adults report even greater substance abuse than women who report a history of CSA alone (Filipas & Ullman, 2006). Kalichman et al., (2001) using a sample of gay men, determined that men who were revictimized used more tobacco, cocaine, and methamphetamine than those without an abuse history. These studies, however, have focused on community samples. It is yet unexplored whether these relationships hold for clinical samples.

Deliramich and Gray (2008) suggest that something specific to the traumatic event of being sexually assaulted appears to lead to a greater increase in alcohol use as opposed to other traumas. Sexual assault survivors as compared to motor vehicle accident survivors reported a greater increase in posttraumatic alcohol consumption. This increase in posttraumatic alcohol consumption was also found to predict an increase in posttraumatic sexual activity. This suggests that utilizing alcohol as a coping strategy can lead to a greater likelihood of engaging in risky sexual behavior. A recent study by Lutz-Zois, Phelps, and Reichle (2011) found that among college females, alcohol use mediated
the relationship between CSA and adult revictimization. Consequently, while the alcohol consumption may have started out as a coping mechanism, it actually transforms into another avenue that may lead to further victimization. Indeed, Messman-Moore and Long (2002) found that CSA and alcohol/substance use were independent predictors of revictimization.

Substance abuse can be thought of as either a risk factor for revictimization or a maladaptive strategy for dealing with the consequences of victimization (Classen, Palesh, & Aggarwal, 2005). It is theorized that substance abuse is often used as a way to self-medicate against the negative feelings associated with victimization. Whether a risk factor or a consequence, research indicates a relationship between sexual assault and substance abuse and a need for further investigation into this dynamic.

**Impulsivity and Insight**

**Impulsivity.** Impulsivity is a multidimensional construct that has been associated with an enhanced vulnerability to drug use (Perry & Carroll, 2008). Many different studies using behavioral, neurobiological, and imaging techniques have confirmed the association between impulsivity and addictive behaviors such as drug abuse (Perry & Carroll, 2008). Drug use, along with its association with impulsivity, has also been connected with risky behaviors such as: the sharing of drug paraphernalia, exchange of sex for drugs or money, and criminal activity (Bornovalova, Daughters, Hernandez, Richards, & Lejuez, 2005).

In a review of the drug abuse literature, Perry and Carroll (2008) present the operational definition of impulsivity as “the inability to stop a behavior that has negative consequences, preference for immediate over delayed gratification, tendency to engage in
risky behaviors, heightened novelty-seeking, behaving without forethought or consideration for outcome, being inpatient when asked to wait, having a short attention span, and difficulty persisting at a particular activity” (p.2). Furthering this definition are two dimensions of impulsivity that dominate the drug abuse research: impaired inhibition and impulsive choice (Perry & Carroll, 2008). Impulsive choice involves choosing a smaller immediate reinforcer over a larger reward that occurs in the future. In terms of drug abuse this involves the individual choosing the immediate euphoric effects of drugs over the more longstanding good health, success at work, or healthy relationships. Impaired inhibition refers to the inability to stop a prevalent behavior.

Several studies have shown that substance abusers demonstrate higher levels of trait impulsivity and greater overall impulsivity than those with no such history (Hayaki, Stein, Lassor, Herman, & Anderson, 2005). Impulsivity also appears to be related to greater substance use severity in that individuals who report being dependent on multiple substances report greater trait impulsivity than those dependent on one substance (O’Boyle & Barratt, 1993).

An association between illicit drug use and adverse life events has been referred to throughout the substance use research, but possible explanations for this connection are not clear (Hayaki, Stein, Lassor, Herman, & Anderson, 2004). It is possible that adverse life events encourage an individual to self medicate through substance abuse as a form of coping, as previously proposed. Another explanation is that the use of substances increases the likelihood of adversity. A third possibility is that another factor is influencing the relationship between adversity and substance use- this factor may be impulsivity. Hayaki, Stein, Lassor, Herman, and Anderson (2005) found that there were
a number of adverse life events associated with substance-related diagnoses but not when adjusting for impulsivity. They concluded that impulsivity may partially mediate the relationship between number of substance-related disorders and adverse life events. It appears that the role of impulsivity and CSA as a specific adverse life event has yet to be determined, and research is needed into a possible relationship.

Messman-Moore, Ward, and Zerubavel (2013) researched impulsivity and emotional dysregulation in the context of sexual assault and substance abuse. They described impulsivity as problems controlling behavior while experiencing negative affect. Their findings suggest that even a small increase in impulsivity increases the risk for sexual revictimization greatly. They hypothesized that this increased risk may be due to an inability to negotiate risky situations or to identify risk. It is also a possibility that those higher in impulsivity were more likely to engage in risky drinking or substance practices which increased the likelihood of revictimization. Operating in this cyclical pattern, revictimized women also report greater difficulty inhibiting impulsive behavior. Consequently, the role of impulsivity needs to be further researched in the context of revictimization.

**Insight.** How victims of sexual assault conceptualize their experience can greatly affect how they think, feel, and behave after the assault. This insight into the trauma and possible consequences may help to protect the individual from further difficulties. Assessment of insight is important to all psychiatric treatment and research as it may dictate the starting point, scope, and direction of treatment. (Baier, Murray, & McSweeney, 1998). Much of the empirical research on insight is aimed at understanding the relationship between insight and various clinical (e.g. severity/type/duration of
disorder) and socio-demographic variables (e.g. age of onset, gender, and hospitalizations) (Markova & Berrios, 2006). Insight will be examined here for its potential role in the relationship between CSA and substance abuse, and revictimization and substance abuse.

Markova and Berrios (1992) distinguish between the Oxford English Dictionary (OED) definition of insight and the use of the word in psychiatry. The OED defines insight as “an inner sight, a discernment, wisdom, or glimpse of you beneath the surface” (p.850). However, in psychiatry the term refers to a state of mind or mental act, knowledge of which is inferred from the patient’s response to illness. Greenfield, Strauss, Bowers, and Mandelkern (1989) refers to insight as it applies to mental illness as falling into five main dimensions: 1) views about symptoms, 2) views about the existence of an illness, 3) speculation about etiology, 4) views about vulnerability to recurrence, and 5) opinions about the value of treatment. Kingsbury and Yi (2001) describe that insight at its most basic level is the belief that one’s thoughts, affect, or behavior are connected to other events. Markova and Berrios (2006) discuss the difficulty in determining an appropriate definition with the inconsistent use of terms that seem to be interchanged for insight. For example they describe that poor insight may be referred to as poor awareness, unawareness, impaired self-awareness, anosognosia, denial, and impaired self-consciousness. Correspondingly they assert that the same term has been used with different concepts throughout research. For purposes here, Greenfield, Strauss, Bowers, and Mandelkern (1989) definition will be used, for this is the premise in which the assessment of insight is determined within the hospital admission process.
Insight is assessed during many aspects of psychological treatment and is included in most standard mental state examinations (Markova & Berrios, 1992). Patients are classified as having no insight, good insight, or partial insight. However, Markova and Berrios (1992) encourage practitioners to look at insight as a process of thinking and feeling which cannot be separated from a person’s personality or make-up or from the psychopathology of the disorder itself. Therefore, factors such as intelligence, education level, cultural beliefs, ability to express one’s self, and emotional capacity must all be taken into account. Due to the intricate nature of insight and all the facets that are involved, Markova and Berrios (1992) state that true knowledge of one’s insight may never be complete. Nevertheless the connection of insight and psychological disorders and treatment is a scope for further exploration.

Insight is often researched in terms of psychosis and schizophrenia since, by definition, psychosis means to be out of touch with reality (Markova & Berrios, 1992). Lack of insight is one of the most common symptoms of schizophrenia (Tranulis, Freudenreich, & Park, 2009). In one international study, Wilson, Ban, and Guy (1986) found that among 768 chronic patients, 89% denied their illness. This lack of insight is possibly one of the best predictors of poor outcome due to the fact that it may predispose an individual to not comply with treatment (American Psychiatric Association, 1994).

Level of insight has also been associated with substance use and sexual assault. Kingsbury and Yi (2001) report that it is likely that drugs and alcohol influence insight and indicated that those individuals with a mental illness who do not use substances report higher levels of insight than those who do use substances. Littleton, Axsom, and Grills-Taquechel (2009) compared victims of sexual assault that acknowledged the rape
with those who conceptualized the event as something less serious and did not acknowledge the rape. While 52% of all the victims reported hazardous alcohol use, there was a significant difference between the acknowledged and the unacknowledged groups. Of those individuals who did not acknowledge the sexual assault, 61% reported hazardous alcohol use as opposed to 38% of those who acknowledged the assault. The individuals who did not acknowledge the assault were also significantly more likely to report experiencing an attempted rape over the 6 month follow up. These results indicate that it is possible that insight into the source and nature of the sexual assault may decrease the risk of alcohol use and consequently subsequent risk.

The ability and insight to connect risky behavior (e.g. substance use) and unwanted results (e.g. assault) is beneficial in avoiding future victimization. Walsh, Dilillo, and Messman-Moore (2012) researched risk perception and the ability to acknowledge and extricate one’s self from risky scenarios. They discovered that emotional dysregulation as related to problems with awareness, differentiation of emotions, and negative secondary appraisal of emotions (e.g. feeling mad about being scared) may play a role in delaying risk perception. This lack of insight into one’s emotions and inability to detect risk may expose them to future victimization. However more research is needed into the dynamic between victimization, substance use and insight.

In studying CSA, revictimization, and substance use, it is very difficult to distinguish between the factors that increase the risk of substance use, factors that correlate with substance use, and the factors that are possible consequences of substance use. Therefore, it is necessary for research to focus on the possible mediating and
moderating effects between CSA, revictimization, and substance use. Consequently, the purpose of this study is to examine the relationship of CSA and substance use and the potential moderating effects of impulsivity and insight among an inpatient clinical sample. Consequently, the following hypotheses are presented:

1. There will be significant group differences regarding substance use between those with a positive history of CSA and those with a negative history. More specifically, those reporting CSA will have a greater likelihood of also reporting substance use.

2. There will be significant group differences regarding substance use between those with a positive history of revictimization and those with a negative history. Similar to above, those reporting revictimization will have a greater likelihood of also reporting substance use.

3. Insight and impulsivity will moderate the relationship between CSA and substance use. More specifically, higher levels of insight will decrease the relationship between CSA and substance abuse; impulsivity will increase the relationship.

4. Insight and impulsivity will moderate the relationship between revictimization and substance use. More specifically, insight will decrease the relationship between revictimization and substance abuse and impulsivity will increase the relationship.
CHAPTER 2
METHODS

Upon approval from the University of Dayton’s Research Review and Ethics Committee and approval from the hospital’s Institutional Review Board Committee a chart review was conducted using intake forms obtained from charts of all admissions over a 6 month period at an adult behavioral inpatient unit. Information concerning demographics, sexual assault history, substance use history, impulse control, and insight was gathered directly from the information gathered at during the intake interview that is conducted by a registered nurse. Information was transposed to the Patient Information Sheet (Appendix A). Each patient was coded with a four digit code beginning at 0001 and continued through the duration of research. There were four charts that were excluded due to the client having a documented significant cognitive disability (i.e., mental retardation, dementia). In the case of individuals having repeated admissions within the review period, their most recent admission which contained the more complete admission was utilized. In order to maintain as much cohesion as possible, the labels which the hospital utilized for race classification were repeated here.

Procedure

Both CSA and adult sexual abuse (ASA) were assessed as dichotomous variables by the admitting nurses and consequently, for purposes of this study, were coded as no
(0) and yes (1). Initially, the presence and severity of substance use was going to be calculated by using the positive indication of use, number of times per week, and duration (calculated by number of years). In hopes of getting as much information as possible, all three areas were recorded, which covered the scope of information taken in the admission assessment. However, many charts were missing the data in reference to duration and times per week, with some charts just indicating a positive response to substance use as a broad category. Therefore, substance use became a categorical variable and was coded as no (0) and yes (1).

The ratings on insight and impulse control were taken directly from the admission paperwork and the hospital defined rating system was utilized. The hospital uses a four-point rating scale, which, for the purpose of this study was coded as follows: impaired (1), limited (2), fair (3), and good (4). Both insight and impulsivity were utilized as continuous variables. Each patient’s rating was determined at the time of admission by admitting nurse after the completion of the interview. Determinations on the scales are made with the aid of Greenfield, Strauss, Bowers, and Mandelkern’s (1989) definition of insight and Perry and Carroll’s (2008) definition of impulsivity.

All identifying information was removed and the demographic information that was transposed to the information sheet was selectively chosen in order to avoid any identifying information, per hospital policy. Since all identifiable information was removed, consent was not required.

Participants

A total of 115 case files were reviewed. Ages ranged from 18 to 79 with a mean age of 38. (Refer to Table 1). Thirty-nine of the cases were positive for a history of CSA
and the ages ranged from 18 to 60 with a mean age of 35.0. Twenty-one of the total cases were positive for ASA. In accordance with previous research on psychiatric populations (Brown & Anderson, 1991; Bryer, Nelson, Miller, & Kroll, 1987; Mullin, Martin, Anderson, Romans, & Herbison, 1993), a third (33%) of this sample was reported to be victims of CSA. Of those reporting CSA, 39% also reported revictimization. Assessments were completed by 22 different registered nurses.

Table 1

*Descriptive Statistics.*

<table>
<thead>
<tr>
<th></th>
<th>39 CSA Cases</th>
<th>21 ASA Cases</th>
<th>15 Revic Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>115 Total cases</strong></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Males</td>
<td>56</td>
<td>48.7</td>
<td>13</td>
</tr>
<tr>
<td>Females</td>
<td>59</td>
<td>51</td>
<td>26</td>
</tr>
<tr>
<td><strong>Race:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Hispanic/Latino</td>
<td>110</td>
<td>95.7</td>
<td>38</td>
</tr>
<tr>
<td>African American</td>
<td>3</td>
<td>2.6</td>
<td>0</td>
</tr>
<tr>
<td>Other Minorities</td>
<td>2</td>
<td>1.7</td>
<td>1</td>
</tr>
<tr>
<td><strong>Diagnoses:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unipolar Depression</td>
<td>78</td>
<td>67.8</td>
<td>25</td>
</tr>
<tr>
<td>Bipolar Depression</td>
<td>16</td>
<td>13.9</td>
<td>8</td>
</tr>
<tr>
<td>Psychosis</td>
<td>21</td>
<td>18.3</td>
<td>6</td>
</tr>
</tbody>
</table>


CHAPTER 3
RESULTS

Analyses

Hypothesis one stated that there would be group differences in those reporting substance use in regards to CSA. In order to examine this, a Chi Square analysis was conducted comparing the history of substance use of those with a reported history of CSA to those with no reported history of CSA. Analyses indicated that substance use was independent of a history of CSA; there was no difference in substance use between those reporting CSA and those with no CSA. It was determined that the number of cases reporting substance use did not significantly differ in regards to the presence of CSA, $X^2 (2, 115) =1.62, p=.45$.

Hypothesis two stated that there would be group differences in those reporting substance use in regards to a history of revictimization. Again Chi-Square analysis was utilized. Analyses indicated that substance use was independent of a history of ASA; it was determined that the number of cases reporting substance use did not significantly differ in relation to the presence of adult revictimization, $X^2 (2,115) =2.54, p=.28$.

Results for hypothesis two indicated no difference in substance use between those reporting revictimization and those with no revictimization. However, a review of the data indicated that the frequency of individuals who reported revictimization and substance use was triple that of the individuals that reported revictimization with no
history of substance use. Though these findings were not significant, the value of this information may warrant further analyses in the future.

Table 2

*Impulsivity and Insight Descriptive Statistics.*

<table>
<thead>
<tr>
<th></th>
<th>Impulse</th>
<th>Insight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>2.28</td>
<td>2.26</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>0.82</td>
<td>0.82</td>
</tr>
</tbody>
</table>

Ratings:
- Impaired 1 19.13% 20.87%
- Limited 2 39.13% 36.52%
- Fair 3 37.39% 39.13%
- Good 4 4.35% 3.48%

Hypotheses three and four were intended to examine impulsivity and insight and the relationships between CSA, revictimization, and substance use. The ratings of impulse control and insight were generated by the admitting nurse; a standard measure was not used. (Refer to Table 2). It would be anticipated that an individual with poor impulse control would have poorer insight (Perry & Carroll, 2008), so a correlational analysis was conducted on the impulse control and insight ratings as a validity check. Impulse control and insight were found to have a strong correlation ($r(114)= .83$, $p<.01$), indicating that the admitting nurses generally rated individuals with greater impulse control to have more insight. Thus, it appears that the behaviors assessed by the nurse were related in a manner which would be expected by impulse control and insight.

A 2x2 univariate analysis of variance (ANOVA) with CSA (yes, no) and substance use (yes, no) as the independent variables was utilized. The effects of CSA and substance use on impulsivity was examined and it was determined that there was no
significant interaction regarding CSA and substance use on impulsivity \((F(1, 110)=1.36, p=.25)\). There was also no main effect for CSA on impulsivity \((F(1, 110)=.19, p=.66)\) or for substance use on impulsivity \((F(1, 110)=.15, p=.70)\). The effect of CSA and substance use on insight was also examined. It was determined that there was no significant interaction regarding CSA and substance use on insight \((F(1, 110)=.66, p=.42)\). There was also no main effect for CSA on insight \((F(1, 110)=.27, p=.61)\) or for substance use on insight \((F(1, 110)=.22, p=.64)\).

Correspondingly, a 2x2 ANOVA with revictimization (yes, no) and substance use (yes, no) as the independent variables was utilized. The effect of revictimization and substance use on impulsivity was examined. It was determined that there was no significant interaction regarding revictimization and substance use on impulsivity \((F(1, 110)=.02, p=.89)\). There was also no main effect for revictimization on impulsivity \((F(1, 110)=1.74, p=.18)\) or for substance use on impulsivity \((F(1, 110)=.00, p=.99)\). The effect of revictimization and substance use on insight was also examined. It was determined that there was no significant interaction regarding revictimization and substance use on insight \((F(1, 110)=.03, p=.87)\). There was also no main effect for revictimization on insight \((F(1, 110)=.14, p=.87)\) or for substance use on insight \((F(1, 110)=.03, p=.87)\).

**Further Analyses**

Diagnoses and substance use was also examined in order to determine if there was any relationship between diagnoses and a particular substance. Using the whole sample of 115 cases, there was a significant effect between diagnoses and alcohol use \(X^2 (2, 115) = 9.12, p=.01\). Of the 50 who reported alcohol use, 41 of those had a
diagnosis of unipolar depression, 2 had a diagnosis of bipolar depression, and 7 had a
diagnosis of a psychotic disorder. It could be hypothesized that having a unipolar
depression diagnosis increased the likelihood of also using alcohol as a self medicating
technique though further analysis into this dynamic is needed.
CHAPTER 4
DISCUSSION

The purpose of this study was to examine CSA and revictimization in relation to substance use in a psychiatric population. Insight and impulsivity were also examined for their potential moderating roles. The results of this study did not support the hypotheses; however, there were many issues with this study that should be discussed as possible influences on the data.

Unfortunately, there has been a shift in the perceived purpose of short-term care and the way that psychiatric hospitals conduct therapy. More often than not, the focus of the stay is stabilization, and therapy is purposefully kept limited in scope as to not exacerbate the current symptoms. Hospital management may feel that issues related to such abuse are better addressed in outpatient therapy, and therefore, prefer not to discuss or question the patient concerning this abuse. Consequently, larger problems such as past sexual abuse may be minimized despite the fact that the patient’s current symptoms may actually stem from this traumatic event.

Due to the shift in the outlook of the hospital where the current study was conducted, the purpose and scope of this research had to be greatly decreased. The initial intent of this study was to conduct a much more thorough examination through multiple patient surveys and interviews. Unfortunately in the middle of the implementation stage
it was determined by hospital management that the subject matter was too intense for a short term facility. It was determined that it was unbeneficial to bring up such emotionally charged and difficult material during a hospital stay that was only aimed at immediate stabilization. Therefore, data collection had to be greatly minimized in order to comply with hospital policy. Not only did this affect the amount of data available but also the scope, reliability, and quality. Consequently, the data had to be obtained through archival methods which negatively affected this study as discussed below.

One issue that may have affected the data in this study was the subjectivity of the assessment. When a new patient is brought into the hospital, it is the responsibility of the admitting nurse to ask the assessment questions and to make a judgment on how to rate the individual on the various questions. Accurate assessments are, however, often elusive. Research has shown that some respondents with a history of childhood abuse withhold this information during interviews perhaps due to interviewer characteristics such as gender, race, or age, thereby mitigating the amount and accuracy of information disclosed. (Dailey & Claus, 2001).

There is also a risk of interview bias. There are three major sources of interview bias: the interviewer (prejudices, leading questions); the respondent (lying or evading questions); and the actual interview situation itself (especially the physical and social setting) (Marshall, 1998). In this situation, the nurse’s ability to accurately assess the patient could have been affected by factors such as: assessment abilities, previous training and experience, impressions or biases from prior admissions, time constraints, and personal issues interfering with his or her ability to properly assess. Issues related to the patient that may have affected assessment include but are not limited to: likeability,
honesty, admitting state, diagnoses, intoxication or other substance use upon admission, and previous admissions. Also, admission is often under less than favorable circumstances such as while the patient is under the influence or while under extreme distress, it may be in the middle of the night, or otherwise not conducive for an open and honest assessment, and the assessment may not be completed in an entirely private setting for safety reasons. It is likely that the subjective assessments that the nurses had to make (insight and impulse control) were likely answered to avoid the extremes, and therefore answer more in the “safe zone.” Evidence of this is indicated by the fact that approximately 75% of the responses for insight and impulse was either limited (2) or fair (3). Unfortunately, these issues tend to arise any time an assessment is completed through an interview process (Marshall, 1998). Ideally, a less subjective type of assessment could be utilized. It is likely that the subjectivity of the nurses and difficulty assessing the patients may have had a negative effect on the accuracy of data collected.

Another unforeseen issue with this study is related to a change in hospital policy immediately before data collection began. Prior to data collection, all charting was done manually without the use of computers. However, immediately before data collection began, the process changed to a computerized charting which affected the methods and questions that were utilized. The computerized charting seemed to decrease the amount and scope of information that was obtained during admission interviews. While it did give a more standardized approach, which is often preferred for the reasons stated above, it may have negatively affected data collection due to the more limited information obtained. Also, although training on the new techniques and system were complete at
time of collection, it was still a time of adjustment for the hospital staff. Ideally, data collection would have waited until the new assessment protocol was firmly in place.

As with most archival studies, missing or incomplete data was also damaging to this study. Whether due to the interim period in which staff was growing accustomed to the new system, an uncooperative patient, or carelessness on behalf of the interviewer, there were missing data regarding the frequency and duration of substance use which thus impacted the substance abuse ratings. Prior to the change in hospital policy, it was customary for staff to address substance abuse in a more thorough manner. Also prior to the shift, the hospital had a detoxification protocol in which patients could be admitted on strictly a detoxification basis with the absence of psychiatric difficulties. This promoted the treatment of substance abuse, even with the psychiatric population, with a more thorough reporting through the use of Substance Abuse Subtle Screening Inventory (SASSI) and treatment related to detoxification. With the shift away from substance use it seems that the charting and reporting also suffered. Additionally, there were several cases in which the patient refused to answer questions, was unable to due to psychosis, or was under the influence of varying substances. As a result of the data difficulties, it is believed that the rates of substance use, most likely for the reasons stated above were underreported. Had this not been the case the results may have been more in line with the intended hypotheses. With the correct occurrence of substance use, the rates would have been higher and therefore the correct picture of sexual abuse increasing substance use would have been portrayed. However, with the current limited data, it appears that no relationship exists, which may have been due to a lack of accurate data. In this case it is
believed that the data did not tell the whole story and that much more is going on under the surface.

As previous research has established, and this one serves to reinforce, it is necessary to address the sexual abuse history of inpatients due to the high percentage of individuals suffering from co-morbidity. Despite the null findings in this study, the need for a holistic approach which addresses CSA, revictimization, and substance use is necessary for treatment to be successful and complete. More research is needed within the psychiatric population to determine what relationships exist between these factors and how best to serve these individuals.
REFERENCES


APPENDIX

PATIENT INFORMATION

ID number:

Age:

Gender:

Admitting Diagnoses:

Race:

History of Previous Mental Health Treatment:

<table>
<thead>
<tr>
<th>Facility</th>
<th># of Times</th>
<th>Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>UVMC ABH</td>
<td></td>
<td></td>
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<tr>
<td></td>
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<td></td>
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</tbody>
</table>

Notes:

Substance Abuse History:

<table>
<thead>
<tr>
<th>Positive</th>
<th>Use</th>
<th>Type</th>
<th># of times per week</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nicotine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcohol</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Cocaine</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Methamphetamine</td>
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<td></td>
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<tr>
<td></td>
<td>Marijuana</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Heroine</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Hallucinogens</td>
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<tr>
<td></td>
<td>Opiates</td>
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</tr>
<tr>
<td></td>
<td>Benzodiazepines</td>
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</tbody>
</table>

Notes:
Urine Drug Screen

History of Drug/Alcohol Treatment:

Family History of Mental Health or Drug/Alcohol Problems:

History of childhood sexual abuse:

Adult sexual abuse:

Impulse Control:

Good    Fair    Limited    Impaired

Insight:

Good    Fair    Limited    Impaired

Intelligence:

Unknown    Below Average    Average    Above Average

Any other Relevant History (as related to abuse or significant trauma):