# The Lives of Urban Women: A Survey of Help-Seeking Aboriginal and Non-Aboriginal Women in Montreal

Kahá:wi Jacobs Ph.D. and Kathryn Gill Ph.D.

Addictions Unit, McGill University Health Centre
1547 Pine Avenue W., Montreal, Quebec H3G 1B3

and

Division of Social & Transcultural Psychiatry,
Department of Psychiatry, McGill University

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# Table of Contents

**List of Tables**



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## Participatory Research Practices in the Lives of Urban Women Study

Participatory-action research practices are not yet seen as central elements of mainstream social research, but it is expanding in the context of Aboriginal research. This is largely attributable to the efforts of the Kahnawake Schools Diabetes Prevention Project (KSDPP) which outlined methods of the participatory approach to research in Aboriginal communities. This approach was used in the current study to give urban Aboriginal people a voice in the research process. Those with direct experience in providing services to women in the city collaborated with the authors on the development, analysis and dissemination of this project. Development of the research program was an interactive process, which involved meetings with community partners to define the issues, develop the research questions, and examine various interview tools and questionnaires.

The executive directors of the Native Women's Shelter of Montreal (NWSM) (Jean Stevenson and later Nakuset Marci Shapiro) and its staff had different levels of involvement at all stages of the Lives of Urban Women study. A focus group was held with the staff to identify important issues for women accessing services in the city. Issues regarding urban women that required further understanding and data included child care, addiction, mental health, and difficulties navigating available services in the city. The issues were carefully considered by the team and several were included in the final design, and the interview package. Thus, this project is the result of a joint inquiry by front-line service providers and academic researchers working together to investigate several complex interrelated issues affecting urban women.

**Acknowledgements**

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We would like to thank the individuals who contributed their time, hard work, and dedication to this project. The following research assistants (listed in alphabetical order) participated in various capacities such as the literature review, the survey design, as well as the data collection and analysis:

Ms. Leandra Hallis
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Ms. Christina Paquette

Our thanks go out to the directors and staff of the organizations who opened their doors to this research. They include the Native Women's Shelter of Montreal (NWSM), Native Friendship Centre of Montreal (NFCM), Chez Doris, L'Arret Source, La Dauphinelle, Le Parados, L'Abris Despoire, and Le Carrefour.

A debt of gratitude is paid to the women who participated in this study. Without their trust and cooperation, this project would not have been possible. We offer them our sincerest thanks and appreciation for sharing their stories with us. We wish them and their families all the best for the future.

*Niawen.*
*Thank you.*

Kahá:wi Jacobs Ph.D.
Kathryn Gill Ph.D.

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# Overview
## Description of the Project

The current study explored the physical and mental health of urban Aboriginal and non-Aboriginal women seeking shelter and social services in Montreal. It is a follow-up to a study conducted by Jacobs and Gill (2002a, 2002b) which explored physical and mental health within a sample of male and female Aboriginal peoples living in the Greater Montreal region. The sample included individuals across many socioeconomic strata, from street dwellers and social service users to college/university students and working professionals. Study results revealed that urban Aboriginal people were experiencing a number of difficulties related to their family and social lives, substance use, and mental health. These results in part prompted further exploration of the medical, family, social, and psychological lives of urban help-seeking women. The sample collected in the current study comprises women who were accessing services in the city to address any number of health, social, legal, and psychological/emotional problems or to meet basic needs for housing, food, and security.

Interviews were conducted in English and French with 172 Aboriginal and non-Aboriginal women, aged 16 years and older who were seeking help at one of the eight participating service organizations. They included the Native Women's Shelter of Montreal (NWSM), Native Friendship Centre of Montreal (NFCM), Chez Doris, L'Arret Source, La Dauphinelle, Le Parados, L'Abris Despoire, and Le Carrefour. Research assistants made personal visits to organizations, and bilingual printed notices and information about the study were posted in public areas at each location. Informed consent was obtained prior to interviewing.

The interviews collected information on sociodemographics (age, gender, education, income, employment status), medical problems, legal status, family and social relationships, psychological problems, and drug and alcohol use. Participants were asked to identify any problems they were experiencing, the number of days they had problems and to rate how troubled or bothered they were by these problems in the past 30 days on a scale of 0 (not at all) to 4 (extremely). In addition, they were asked to indicate their perceived need for treatment or counselling using the same rating scale. Additional information was also collected on women's physical health (pregnancy, possession of identifications needed to access medical services), mental health (recent symptoms of depression), family history (number of children, child care, and psychological, drug, and alcohol problems in the family), lifetime physical and sexual abuse, and childhood experiences of sexual abuse, neglect, and punishment.

## Summary of Findings and Conclusions

Analysis revealed that the majority of women interviewed for this study were single, in their mid-thirties, and they had lived in the city for an average of 16.3 years. They also comprised an economically disadvantaged group, with low levels of employment in the past three years and a high dependency on social assistance. All women were accessing largely female-targeted services in the city to meet the need for social services and basic necessities including shelter, meals, and food vouchers. The two largest ethnocultural groups were Aboriginals (predominantly Inuit, followed by Cree, Mohawk, Innu, and Mi'kmaq) and non-Aboriginals (primarily Caucasian).

Half of the women interviewed were experiencing chronic medical problems, and more than two-thirds had sought help for a medical problem in the previous year. While non-Aboriginal women largely sought care from a general practitioner, Aboriginal women were more likely to seek medical attention from hospitals or clinics. The two main reasons for not seeking medical care were 1) a desire to solve the problem on their own, and 2) believing the problem would get better by itself. One-quarter of those who did not seek care were unsure where to go for help. Although Aboriginal women were more likely to have children, both groups reported having few dependents with them in the city. Aboriginal women reported higher rates of pregnancies over their lifetime and before the age of 18.

The majority (91.3%) experienced some form of psychological distress in their lifetimes including anxiety and depression. Fully half of the women had attempted suicide and reported a current drug or alcohol problem. Aboriginal and non-Aboriginal women were equally likely to have ever sought treatment for a psychological or substance abuse problem. Analysis of abuse variables indicated that Aboriginal women were more likely than non-Aboriginal women to have been physically abused in their lifetimes. There was an association between higher rates of teen pregnancies among Aboriginal women, and rates of lifetime physical abuse. Studies have shown that the peak rates of physical violence against women usually occur among young women aged 15 to 24 years old. Previous research also indicates that teenage pregnancy is a risk factor for physical abuse among pregnant women, and adolescent mothers in particular.

There were no ethnocultural differences in lifetime history of sexual abuse. Further analysis indicated that women with a history of childhood sexual abuse (CSA) reported the highest rates of problems with parents and family history of psychological problems. They were significantly more likely than others to report lifetime suicidal ideation and suicidal attempts. Those with a history of CSA were also more likely to have been raised in home environments characterized by violence, family discord, and child neglect. It is important to note that significant ethnocultural differences emerged in a number of these experiences. Even when controlling for socioeconomic factors between the two ethnocultural groups, Aboriginal women with a history of childhood sexual abuse were more likely to have witnessed physical and sexual abuse in their homes as children, to have a family history of psychological problems, and to have a history of suicide attempts and psychological treatment.

Overall, these study results demonstrate that many of the urban women in this sample were suffering multiple forms of psychological distress while dealing with daily stresses of living in the city and navigating health and social services. This study also shed light on the interrelatedness of early life experiences with psychological distress. Future research among Aboriginal and non-Aboriginal women in Canada should focus on exploring the characteristics and consequences of living in multi-problem families situated in all levels of socioeconomic status. It also needs to explore the factors that allow females to survive toxic environments characterized by parental substance abuse, family violence, neglect, and verbal/physical abuse. Future studies in this area might ascertain what specific familial, cultural or community protective factors there are against the development of adverse physical and mental health outcomes for women, and under what circumstances they protect against psychological distress.

# Introduction

## Urban Aboriginals

An ever increasing number of Aboriginal people are moving into Canada's major metropolitan areas. According to the 2001 Aboriginal Peoples Survey, the total non-reserve Aboriginal population in Canada numbered 713,000 (Statistics Canada, 2003). First Nations comprise the largest group (358,000), followed by Metis (295,000), and Inuit (46,000). The majority of these individuals (68%) were living in urban areas (Statistics Canada, 2003).

Montreal is a large Canadian city with a diverse multiethnic population numbering 3,287,645 (Statistics Canada, 1996c). Size estimates of Aboriginal people residing in the Montreal area have varied over the years, from 45,230 (Statistics Canada, 1991) to 9,965 (Statistics Canada, 1996a), and 11,090 (Statistics Canada, 2001a). This population includes status and non-status Native (including Cree, Mohawk, Innu, Mi'kmaq, Attikamekw, Naskapi, Ojibway, Malecite and Algonquin), Inuit, and Métis people. The word Aboriginal used in this report thus refers to a heterogenous ethnocultural group from a particular geographic area, who are differentiated linguistically, culturally, historically, and politically.

Movement from reserve to city is motivated by any number of factors relating to home (e.g. lack of adequate housing, isolation) and community (e.g. lack of educational and employment opportunities, low standard of living) (LaPrairie 1994; David 1993; Kastes 1993). In a study of 202 male and female Aboriginals in Montreal, in addition to seeking a higher education and exploring better employment opportunities, migration to the city was motivated by the desire to live with families or spouses, or to escape family/social problems on the reserve (Jacobs and Gill, 2002). There is evidence that multiple generations of Aboriginal families have been living in Canada's urban areas (RCAP 1993; Dagenbach & Simpson 1992), and that most are women (55.8% female versus 44.2% male) (Gill 1995). Previous literature also indicated that Montreal's urban Aboriginals were predominantly female, Inuit, and had drug or alcohol problems (Zambrowsky, 1986).

## Physical and Mental Health Issues

Little has been written about the physical and mental health of Canada's urban Aboriginals. Existing literature has shown that urban Aboriginal peoples in Canada are experiencing a number of physical and mental health problems (e.g., Jacobs and Gill, 2002; LaPrairie, 1996 Macmillan, 1996). Compared to the general population, some studies have shown that Aboriginal peoples are at higher risk of death from alcoholism and homicide (MacMillan, 1996). According to older figures collected by Health and Welfare Canada (Aboriginal Health in Canada, 1992) alcohol and other substances of abuse were major contributing factors to the high death rate due to injuries (both intentional and unintentional). In one study, LaPrairie (1994) found that the lives of inner city Aboriginals in Regina, Edmonton, Vancouver and Montreal were "characterized by despondency and hopelessness and...hard-core alcohol problems" as well

as poor education, unemployment and victimization as children. In a more recent study by Jacobs and Gill (2002), a number of mental health problems were related to substance abuse among a sample of urban Aboriginal males and females. For instance, one-third of those interviewed reported that they had a current substance abuse problem and that there were high levels of problem drug or alcohol use by their parents. In particular, compared to non-substance abusers, substance abusers were more likely to report that their mothers had a drug or alcohol problem at some point in their lives that did or should have led to treatment. Substance abusers also reported significantly higher levels of emotional distress (depression, suicide attempts) and physical/emotional abuse than non-abusers.

Numerous mental health factors are interrelated including history of depression, drug or alcohol abuse, and aggressive behaviour (LeMaster, Beals, Movins & Manson, 2004; Shaughnessy, Doshi, Jones, 2004). A higher likelihood of attempting suicide among depressed individuals is particularly well established in the literature (Goldstein, Birmaher, Axelson et al., 2005; Ystgaard, Hestetun, Loeb & Mehlum, 2004). Substance abuse is also associated with higher likelihood of suicidal behaviour (Galaif, Sussman, Newcomb & Locke, 2007; Ilgen, Harris, Moos & Tiet, 2007; Jacobs & Gill, 2002; Sher, Sperling, Stanley et al., 2007). Strong relationships between mental health problems and current drug/alcohol abuse have also been found among urban Aboriginals (Jacobs and Gill, 2002). Compared to non-substance abusers, substance abusers reported significantly higher lifetime rates of suicidal ideation (40.5% versus 61.2%), and suicide attempts (22.9% versus 50.7%).

Relatively little is known about rates of mental health problems for Aboriginal peoples living in urban communities, how rates differ from those in the general population, or in individuals within the same socioeconomic and geographic region. One of the major goals of the current study was to explore similarities and differences in the health and mental health status of Aboriginal and non-Aboriginal women. The study sample consists of socioeconomically disadvantaged Aboriginal and non-Aboriginal women seeking social and basic needs services in one of Canada's largest metropolitan areas.

**Access to Services in Urban Environments**

There is a consensus in the literature that urban Aboriginal people's needs for services related to health, mental health, alcohol/drug abuse, education, employment and housing are not being adequately or appropriately met (Clatworthy et al., 1987; Gill and Jacobs, 2000; LaPrairie, 1994; Petawabano et al., 1994). Many of the Aboriginal women surveyed in one study, including those who had been in the city up to ten years, had been unable to take advantage of even the few social, educational and legal services available (Zambrowsky, 1986). In addition, Aboriginal individuals who do receive services are disproportionately represented within the category of "dual diagnosis", i.e. suffering a mix of mental illness and substance abuse. Peters, writing from Vancouver in 1987, noted that "Canadian Indians [in urban communities] under-utilize [mental health] services in relation to their numbers in the population, and [there is] an over-representation of substance abuse problems among those who seek treatment." The First People's Urban Circle (1993) (FPUC) interviewed urban Aboriginals in nine Canadian cities, finding that

Aboriginal people in Montreal had a higher unemployment rate, were more likely than other urban Aboriginals to have experienced racial discrimination, and were less likely to say that services such as subsidized housing, health care, welfare and other social services, family counselling and police services were available."(FPUC, 1993).

Access to health care is still a pressing issue for urban Aboriginals. Nearly half of the urban Aboriginal respondents (43.3%) in the study by Jacobs and Gill (2002a) experienced a significant emotional problem in the past 12 months that required treatment. However, less than half sought treatment from a professional. In the same study, a number of barriers to drug/alcohol treatment were documented. Beyond clients' ambivalence towards entering a treatment program, barriers to treatment were largely structural and political. Structural barriers included lengthy waiting lists and application forms requiring English literacy, lack of child care services, and lack of Native-tailored treatment programs in the city. Governmental issues of jurisdiction also interfered with securing the funding and transportation to send individuals to treatment in other areas of Quebec. Another goal of the present study was to explore similarities and differences in the need for and access to medical and mental health services in the city between Aboriginal and non-Aboriginal women.

### Description of the Study

This research project was designed to explore the family, social, economic, and psychological lives of urban help-seeking women. Characteristics of health and well-being, and service seeking were explored in a sample of 172 women. All study participants were using the services of any one of the eight organizations who agreed to participate in this research. They included the Native Women's Shelter of Montreal (NWSM), the Native Friendship Centre of Montreal (NFCM), Chez Doris, L'Arret Source, La Dauphinelle, Le Parados, L'Abris Despoire, and Le Carrefour. The services offered by these organizations include social & mental health services/information/referrals, clothing, food vouchers, meals, temporary housing, legal consultation.

An important focus of this study was to examine associations between family and social relationships and physical and mental health. The two largest ethnocultural groups in the sample were Aboriginal and non-Aboriginal. These groups were compared on a number of factors including history of medical problems, psychological problems, substance abuse, and treatment seeking. History of adverse experiences was also explored in relation to current mental health, including physical and sexual abuse, and childhood neglect.

## Methodology and Procedures

### Participants and Research Sites

Study participants were women of varying ethnocultural backgrounds seeking services in Montreal. All women, aged 16 years and older who were seeking help with any number of health, social, legal, and psychological/emotional or basic needs (housing, food vouchers, meals) problems at one of the eight participating service organizations were eligible to participate in the study. They were recruited from drop-in centres, social service agencies, and shelter

organizations on the island of Montreal.

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

The two remaining research sites were Chez Doris and the Native Friendship Centre of Montreal (NFCM). These drop-in social service centres are major interaction points for Non-Aboriginal (Chez Doris) and Aboriginal women (NFCM, Chez Doris) within the urban community. With the exception of temporary residence, these centres provide the same types of services offered at the women's shelters. The NFCM and Chez Doris are information and referral centres located in the East and West of Montreal respectively. They provide a wide array of services to women in the city. They provide social services including aid with employment issues, obtaining legal identification including Native status cards and Inuit beneficiary numbers, low-cost housing, legal consultations, and provide resource information and referrals for physical and mental health care in the city. In addition to these services, they also provide more fundamental services such as food and clothing depots, and daily lunches. Daily social events are organized including arts and crafts, and workshops on various issues of personal development.

**Recruitment**

Research assistants made weekly visits to the participating service organizations to recruit subjects. Researchers were introduced by staff to all clients during group meetings at shelters, and in common rooms at the two service centres. The researchers gave brief bilingual descriptions of the study to clients, outlining the aim to interview women using health and social services in the city. It was explained that information gathered in the interviews would lead to a greater understanding of the issues or problems they were experiencing. Participating in the project would provide them the opportunity to voice their opinions and concerns in a confidential environment. Bilingual printed notices and information about the study were posted in public areas at each site. The procedure for enrolment in the study consisted of the following steps: 1) obtaining informed consent; 2) conducting the initial interview to collect information on sociodemographics, medical history, legal history, drug/alcohol use, family/social relationships, and psychological problems; 3) collecting additional measures with self-report instruments. Interviews were conducted on site from Spring 2002 to Autumn 2005.

## Detailed Procedures

### 1) Information and Informed Consent

The sample of urban help-seeking women were invited to participate in a project designed to gather information on issues or problems they may have faced while accessing social services in the city. It was explained to subjects that the study was designed to gather information about the life experiences of women using social services in the city, with regard to family and social relationships, medical history, legal history, drug and alcohol use, and violence. In the process of obtaining informed consent, study participants were informed that 1) they were under no obligation to participate in the study, and participation or refusal would not affect their access to services, 2) they could decline to answer any of the questions in the interview, 3) should they decide, they could withdraw from the study at any point during the interview, 4) the initial interview would last approximately 1½ hours, 5) they may be invited to participate in a second follow-up interview, but they could decline further participation in the study.

### 2) Conducting the Initial Interview

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

### 3) Self-Report Questionnaires

Two bilingual self-reports were also used in the interview. The Beck Depression Inventory (BDI) (Beck & Steer, 1987; Bourque & Beaudette, 1982), and the Child Abuse and Trauma Scale (CATS) (Sanders & Becker-Lausen, 1995), were used to collect additional mental health and abuse related information including a) recent symptoms of depression, b) sexual experiences before the age of 18, and c) sexual abuse, neglect, and punishment, during childhood.

### 4) Second Interview

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

**5) Conducting the Second Interview**

The second interview, also conducted in the subject's preferred language (English or French), collected information on family and social relationships during childhood. This included experiences of care (e.g. supervision, neglect, parental antipathy) and abuse (physical, sexual, psychological) before the age of seventeen using the Childhood Experiences of Care and Abuse (CECA) interview (Bifulco, Brown & Harris, 1994; Tousignant, Habimana, Biron, Malo, Sidoli-LeBlanc & Bendris, 1999). Study participants who completed this interview were remunerated with an additional $20.00 in gift certificates.

## Measures

**Substance Abuse and Psychological Problems:** Information on substance use (e.g., alcohol, cannabis, cocaine, hallucinogens, etc.) and psychopathology (e.g., depression, anxiety, suicidal ideation, etc.) was collected using the fifth version of the Addiction Severity Index (ASI) in French (RISQ, 1996) and English (McLellan et al., 1990). The ASI is a validated, semi-structured interview designed to collect information in seven domains including medical history, employment, psychological status, legal status, family/social relations (including lifetime history of physical, sexual abuse) and substance abuse. Information is gathered on subjects' lifetime and recent (past 30 days) status in these seven areas. Within each domain, a number of items relating to recent problem severity are weighted to create a composite severity score. Composite scores range from 0 (no significant problem) to 1 (extreme problem). The psychometric properties of the ASI have been found to be excellent with high interrater reliabilities for all composite scores (Alterman, Brown, Zaballero & McKay, 1994). The drug and alcohol subscales have been shown to have interrater reliability ranging from 0.86 - 0.96 and test-retest reliabilities of 0.92. The ASI has been widely employed in Quebec, and had been recommended by the Le Comite-Conjoint MSSS-Reseau sur la selection d'instruments d'evaluation de la clientele, Quebec (Boivin, 1990). This structured interview has been previously employed within many diverse ethnic populations including Aboriginal people (e.g., Jacobs & Gill, 2002a; Jacobs & Gill 2002b).

**Psychological Distress:** The Beck Depression Inventory (BDI) is a 21-item self-report that rates the severity of cognitive, affective, somatic, and vegetative symptoms of depression on a four-point scale from neutral to severe. The total score can range from 0 to 63, reflecting the overall level of depression experienced in the week prior to the test (Beck & Steer, 1987). The BDI has been used extensively in clinical and non-clinical samples. The psychometric properties of the BDI are good, with internal consistencies ranging from 0.86 (in clinical samples) and 0.81 (in non-clinical non-clinical samples) (Beck, Steer & Carbin, 1988). Bilingual versions of this instrument were used, in French (Bourque & Beaudette, 1982) and English (Beck & Steer, 1987).

**Childhood Physical/Sexual Abuse and Neglect:** Information on childhood physical, sexual and emotional abuse was collected using French and English versions of the Child Abuse and Trauma

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

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

The CECA interviews were tape recorded and relevant data was filled onto CECA schedules and rating sheets. Portions of the data were transcribed verbatim, including sections on parental neglect, antipathy, and child physical and sexual abuse. Sections of the narrative text were filled onto the mini rating schedules A and B of the CECA, and severity ratings were assigned following the criteria established for the CECA by Bifulco (2002). This instrument has excellent inter-rater reliability for physical abuse (0.82), sexual abuse (1.00), and relationship to perpetrator (0.98).

## Results

### Sociodemographics, Family/Social Characteristics, and Legal Status

A total of 172 women were interviewed for this study. Overall sample results are presented alongside comparisons between Aboriginal (Native, Inuit and Metis) and non-Aboriginal women[1]. Comparisons were made to determine whether there were differences in sociodemographics (e.g., age, education, employment status), medical status, psychological status, substance abuse problems, and histories of abuse. The sample breakdown was 48.3% Aboriginal (n= 83), and 51.7% non-Aboriginal (n= 89) women. The majority of Aboriginal women chose to complete the interview in English (88%), and the language of choice for more than two-thirds of non-Aboriginal women was French (65.2%). Inuit women comprised the largest part of the Aboriginal group (31.1%), followed by Cree (25.3%), Mohawk (8.4%), and Innu (8.4%) women. Most had status/beneficiary numbers (84.4%).

Sociodemographic characteristics of the general sample are provided in Table 1. The overall sample comprised women in their late thirties. While Aboriginal women were more likely to have children (Aboriginal 2.7 ± 0.2, non-Aboriginal 1.2 ± 0.2; t (162) = 5.6, p= 0.0001), both groups reported few dependents. Among women with children, there were no differences in likelihood of having at least one child in foster care or adopted out of family (Aboriginal 21.3%, non-Aboriginal 30.6%). Non-Aboriginal women had the potential for stronger family support systems while in the city since they reported having more family members living in the greater Montreal area than non-Aboriginal women. Non-Aboriginal women had also lived in Montreal longer than Aboriginal women (Aboriginal 7.1 ± 1.4 years, non-Aboriginal 24.6 ± 1.9 years. This suggests that Aboriginal women may have more recently migrated to the city. The majority of both groups were residing in a shelter at the time of interview, and were using these services for similar reasons, primarily for temporary shelter. Despite the high rate of current residence in a shelter, most women had been living with a partner or alone in the past three years.

Characteristics of family and social relationships are presented in Table 2. Aboriginal and non-Aboriginal women were alike in terms of marital status; both groups were equally likely to have ever been married or in a common-law relationship, and to be satisfied with their marital status. Women were as likely to have lived with family or lived alone in the past year, and most women were satisfied with those arrangements. Many reported having good relationships with their families in their lifetimes, with little conflict in the past 30 days.

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

**Table 1: Selected Socio-demographics Stratified by Ethnocultural Background (n=172)**

| | Overall (n= 172) | Aboriginal (n=83) | Non-Aboriginal (n=89) |
|---|---|---|---|
| **Age (± SEM)** | 38.8 ± 0.9 | 37.7 ± 1.1 | 39.9 ± 1.4 |
| **Number of Dependents (± SEM)** | 0.8 ± 0.08 | 0.7 ± 0.2 | 0.3 ± 0.07 |
| **Mother Tongue** | | | |
| Native | 31.4% | 62.7% | 0.0% |
| English | 25.6% | 27.7% | 23.6% |
| French | 37.2% | 9.6% | 62.9% |
| Other | 7.0% | 0.0% | 13.5% |
| **Religion** | | | |
| Native Spirituality | 1.4% | 2.8% | 0.0% |
| Protestant | 16.3% | 26.4% | 30.0% |
| Catholic | 6.4% | 8.3% | 16.7% |
| Other | 20.9% | 33.3% | 40.0% |
| None | 11.6% | 27.8% | 0.0% |
| **Number Family Members in Montreal (± SEM)** | 2.7 ± 0.3 | 1.8 ± 0.25 | 3.5 ± 0.56* |
| **Number Years Lived in Montreal (±SEM)** | 16.33 ± 1.4 | 7.1 ± 1.4 | 24.6 ± 1.9* |
| **Living in a Shelter** | 72.1% | 78.3% | 66.3% |
| **Why in Shelter** | | | |
| Temporary housing | 43.0% | 48.8% | 38.6% |
| Fleeing abusive relationship | 18.6% | 19.5% | 18.2% |
| Counselling/Support/Other | 9.3% | 9.8% | 9.1% |

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

**Table 2: Family/Social Characteristics Stratified by Ethnocultural Background (n=172)**

| | Overall (n= 172) | Aboriginal (n=83) | Non-Aboriginal (n=89) |
|---|---|---|---|
| **Marital Status** | | | |
| Never Married/Common-law | 54.1% | 50.6% | 57.3% |
| Ever Married/Common-law | 45.9% | 49.4% | 42.7% |

| Table 2: Family/Social Characteristics Stratified by Ethnocultural Background (n=172) | | | |
|---|---|---|---|
| **Satisfied with Marital Status** | 68.0% | 74.4% | 65.1% |
| **Living Arrangements (past 3 years)** | | | |
| Partner/Family | 47.7% | 57.3% | 40.7% |
| Alone/Nothing stable | 50.0% | 42.7% | 59.3% |
| **Satisfied with Living Arrangements** | 55.2% | 64.2% | 50.0% |
| **Reported a Close Relationship With... (in Lifetime)** | | | |
| Mother | 49.4% | 52.5% | 50.6% |
| Father | 36.0% | 36.7% | 40.2% |
| Siblings | 61.0% | 71.8% | 62.8% |
| Children | 54.1% | 89.4% | 75.6% |
| **Reported Problems Getting Along With... (Past 30 Days)** | | | |
| Mother | 12.8% | 12.7% | 14.3% |
| Father | 7.0% | 6.4% | 9.0% |
| Siblings | 14.0% | 19.5% | 11.5% |
| Children | 4.1% | 1.5% | 13.6% |

Groups were compared using Student's t-tests and Chi-square analysis.
There were no significant differences between ethnocultural groups on these variables.

Indicators of socioeconomic status are presented in Table 3. The majority of women were socioeconomically disadvantaged. The mean years of education for the sample was 11 years, the majority were unemployed, and relying on social assistance as their primary source of financial support. Aboriginal and non-Aboriginal women were comparable socioeconomically. While non-Aboriginal women received on average 1.5 more years of formal education, there were no significant differences between Aboriginal and non-Aboriginal women in patterns of employment in the past three years. More than half reported that they had experiences troubles due to lack of money in the past year (see Table 4). Overall, the women in this study sample did not report many legal problems, and there were no ethnocultural differences in rates of charges or likelihood of being on probation or parole at the time of interview (see Table 5).

**Table 3: Indicators of Socioeconomic Status Stratified by Ethnocultural Background (n=172)**

| | **Overall (n= 172)** | **Aboriginal (n=83)** | **Non-Aboriginal (n=89)** |
|---|---|---|---|

**Table 3: Indicators of Socioeconomic Status Stratified by Ethnocultural Background (n=172)**

| | | | |
|---|---|---|---|
| **Number Years of Education (± SEM)** | 11.1 ± 0.2 | 10.3 ± 0.31 | 11.8 ± 0.39* |
| **Number Months of Training or Technical School (± SEM)** | 5.5 ± 0.8 | 4.8 ± 0.9 | 6.1 ± 1.3 |
| **Employment Pattern (past 3 years)** | | | |
| Employed | 32.6% | 35.4% | 30.3% |
| Unemployed or Student/Retired | 66.9% | 64.6% | 69.7% |
| **Currently on Welfare** | 65.1% | 61.0% | 69.7% |
| **Monthly Income (± SEM)** | $596.63 ± 28.34 | $573.57 ± 45.33 | $618.10 ± 34.93 |
| **Days Experienced Employment Problems (Past 30) (± SEM)** | 4.4 ± 0.7 | 5.3 ± 1.2 | 3.6 ± 0.9 |
| **Mean ASI Employment Composite Severity score (± SEM)†** | 0.9 ± 0.01 | 0.9 ± 0.2 | 0.9 ± 0.2 |
| **Has a Driver's License** | 14.5% | 14.6% | 14.6% |
| **Has a Car to Drive** | 5.8% | 4.9% | 6.7% |

Groups were compared using Student's t-tests and Chi-square analysis.

* significant differences between groups $p < 0.05$, corrected for multiple comparisons.

†ASI – Addiction Severity Index composite scores range from 0 to 1.0, with higher scores indicating greater problem severity.

**Table 4: Recent Events Stratified by Ethnocultural Background (n=172)**

| | Overall (n= 172) | Aboriginal (n=83) | Non-Aboriginal (n=89) |
|---|---|---|---|
| **Experienced in the Past Year** | | | |
| Troubles due to lack of money | 55.8% | 53.1% | 60.9% |
| Illness or death in the family | 39.0% | 46.8% | 35.3% |
| Troubles with housing | 59.3% | 56.8% | 64.4% |
| Troubles with prejudice or discrimination | 28.5% | 37.0% | 25.3% |
| Difficulties at work or school | 24.4% | 13.8% | 35.6%* |
| Problems with government agencies | 30.8% | 33.3% | 29.9% |
| Troubles due to language differences | 18.6% | 25.9% | 13.8% |
| Troubles with the police or law | 20.9% | 23.5% | 19.5% |
| Victim of a crime or assault | 41.9% | 50.6% | 35.6% |

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

**Table 5: Legal Status Stratified by Ethnocultural Background (n=172)**

| | Overall (n= 172) | Aboriginal (n=83) | Non-Aboriginal (n=89) |
|---|---|---|---|
| **Mean Number of Charges in Lifetime (± SEM)** | | | |
| B&E | 0.29 ± 0.16 | 0.05 ± 0.2 | 0.13 ± 0.6 |
| Shoplifting | 0.09 ± 0.03 | 0.4 ± 0.3 | 0.1 ± 0.08 |
| Assault | 0.5 ± 0.14 | 0.8 ± 0.25 | 0.2 ± 0.12 |
| Disorderly Conduct | 0.4 ± 0.09 | 0.6 ± 0.16 | 0.2 ± 0.08 |
| **Number of Convictions in Lifetime** | 0.9 ± 0.3 | 1.1 ± 0.5 | 0.7 ± 0.3 |
| **Number Months Spent in Jail in Lifetime** | 1.2 ± 0.4 | 1.4 ± 0.6 | 0.9 ± 0.5 |
| **Currently On Probation or Parole** | 6.4% | 8.6% | 4.7% |
| **Currently Awaiting Charges** | 11.0% | 14.8% | 8.0% |

Groups were compared using Student's t-tests and Chi-square analysis.
There were no significant differences between ethnocultural groups on these variables.

## Physical Health

Results of statistical tests for health variables are presented in Table 6. In terms of child bearing, overall results indicate a mean of three pregnancies for the general sample, and more than one-third had a pregnancy before the age of eighteen. Ethnocultural differences emerged in this respect, as Aboriginal women reported more pregnancies over their lifetimes [t (162) = 3.27, p= 0.001] and more pregnancies before the age of eighteen [$\chi^2$ (1) = 8.59, p= 0.003], compared to non-Aboriginal women. The women experienced a number of medical problems in the past year, including pain in extremities or chest and insomnia. An ethnocultural difference emerged in the experience of fatigue, with non-Aboriginal women reporting higher rates than Aboriginal women [$\chi^2$ (1) = 6.78, p= 0.009]. They did not differ in rates of chronic medical problems, or in the likelihood of seeking care from a medical practitioner for a health problem. Among those who needed medical care in the past year, one difference in help-seeking was found. Non-Aboriginal women were more likely to have sought care from a general practitioner, while Aboriginals largely sought care from hospitals or clinics [Aboriginals: GP 25%, hospital 75%, non-Aboriginals GP 52.6%, hospital 47.4%; $\chi^2$ (1) = 9.07, p= 0.003].

For women who reported experiencing health problems in the past year but did not seek medical care (n= 46), the most cited reasons for not seeking help were: wanting to solve the problem on her own (66.7%), believing the problem would get better by itself (52.2%), had sought care in the past but it did not help (37.0%), thought help wouldn't do any good (33.3%), and being unsure where to go for help (26.1%). Some women were missing the identification

required to access health and social services in the city. In all, 77.3% had a social insurance card, 85.5% had a medicare card, and 69.2% had a copy of their birth certificate. For Aboriginal women, 61.2% had a status card (for Natives), or documentation of a beneficiary number (for Inuit); these forms of identification are necessary for access to specialized services such as Native drug/alcohol treatment centres and federal non-insured health benefits. In addition to questions on medical status, Aboriginal women were asked if they would like to have access to a medical centre that would provide services exclusively to Aboriginal peoples. The majority of Aboriginal women (70.3%) were in favour of having this option.

**Mental Health and Abuse History**

Information on levels of psychological distress is presented in Tables 7 and 8. Compared to non-Aboriginal women, Aboriginal women reported lower rates of recent depression [$\chi^2$ (1) = 6.94, p=0.008]. They were less likely to have been prescribed medication to treat a psychological or emotional problem in the past month [$\chi^2$ (1) = 12.04, p= 0.001] and over their lifetimes [$\chi^2$ (1) = 5.54, p= 0.019]. Aboriginal women had a lower mean ASI psychological composite severity score [t (163) = -2.57, p= 0.011] than non-Aboriginal women. There were no between group differences in rates of lifetime depression or anxiety, and they were equally likely to seek treatment for a psychological/emotional problem in their lifetimes.

Characteristics of drug and alcohol use are presented in Table 9. Substance abuse is a problem for more than half of the sample, and more than a third had been treated for a drug or alcohol problem in the past. Aboriginal women were not more likely than non-Aboriginal women to have a current substance abuse problem. However, Aboriginal women were more likely to be current cigarette smokers [$\chi^2$ (1) = 17.16, p= 0.0001], to have used cannabis in the past month [t (165) = 3.94, p= 0.0001], and to have spent more money on alcohol in the past month [t (162) = 2.50, p= 0.01]. Compared to other women, Aboriginal women also used cannabis for more years [t (164) = 3.90, p= 0.0001], and were more likely to have been treated for a drug or alcohol problem in the past [$\chi^2$ (1) = 5.89, p= 0.015]. Mean ASI alcohol and drug composite severity scores showed no differences between Aboriginal and non-Aboriginal women, however it was evident that many were experiencing drug or alcohol related problems.

**Table 6: Physical Health Stratified by Ethnocultural Background (n=172)**

| | Overall (n= 172) | Aboriginal (n=83) | Non-Aboriginal (n=89) |
|---|---|---|---|
| **# Pregnancies in Lifetime (± SEM)** | 3.4 ± 0.2 | 4.2 ± 0.3 | 2.7 ± 0.3* |
| **Had a Teen Pregnancy (<18 years of age)** | 37.8% | 54.2% | 31.0%* |
| **In the Past Year Experienced** | | | |
| Pain in legs, arms, stomach | 66.3% | 62.2% | 70.8% |
| Chest pains | 37.2% | 40.2% | 34.8% |
| Fatigue | 74.4% | 65.9% | 83.1%* |
| Insomnia | 64.5% | 61.7% | 68.5% |
| **Has a chronic medical problem** | 55.2% | 52.4% | 58.4% |
| **Months Since Last Checkup (± SEM)** | 8.7 ± 1.8 | 6.4 ± 1.2 | 10.7 ± 3.3 |
| **Sought help for medical problems in the past year** | 66.9% | 74.4% | 67.1% |
| **Currently Taking Medication for a Medical Problem** | 36.6% | 30.5% | 42.7% |
| **Number Days Medical Problems in Past 30 (± SEM)** | 16.6 ± 1.0 | 15.1 ± 1.5 | 18.0 ± 1.4 |
| **Number Times Hospitalized in Lifetime (± SEM)** | 4.5 ± 0.5 | 4.1 ± 0.5 | 4.8 ± 0.8 |
| **Years Since Last Hospitalization (± SEM)** | 8.5 ± 0.9 | 7.1 ± 1.2 | 9.9 ± 1.4 |
| **Mean ASI Medical Composite Severity score (± SEM)†** | 0.5 ± 0.02 | 0.5 ± 0.04 | 0.6 ± 0.04 |

Groups were compared using Student's t-tests and Chi-square analysis.

* significant differences between groups $p < 0.05$, corrected for multiple comparisons.

†ASI – Addiction Severity Index composite scores range from 0 to 1.0, with higher scores indicating greater problem severity.

Nearly three-quarters of this sample of women reported lifetime histories of physical abuse, sexual abuse, and emotional abuse (see Table 10). Results of chi square analysis of abuse data indicated that Aboriginal and non-Aboriginal women were equally likely to have recently experienced physical or sexual abuse. They were also equally likely to have been sexually or emotionally abused in their lifetimes. However, Aboriginal women were significantly more likely to have been physically abused in their lifetimes compared to their non-Aboriginal counterparts (Aboriginal 91.5%, non-Aboriginal 76.7%; $\chi^2$ (1), 6.74, $p<0.009$). Aboriginal women did not have significantly higher rates of child/teen sexual abuse or neglect/living in a negative home atmosphere according to analyses of mean scores on the CATS neglect (Aboriginal 1.8 ± 0.1; non-Aboriginal 1.9 ± 0.09) and sexual abuse subscales (Aboriginal 1.2 ± 0.1; non-Aboriginal 0.9 ± 0.9).

**Table 7: Psychological Distress in Past 30 Days Stratified by Ethnocultural Background (n=172)**

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

Groups were compared using Student's t-tests and Chi-square analysis.

* significant differences between groups $p< 0.05$, corrected for multiple comparisons.

†ASI – Addiction Severity Index composite scores range from 0 to 1.0, with higher scores indicating greater problem severity.

**Table 8: Lifetime Psychological Distress Stratified by Ethnocultural Background (n=172)**

| | Overall (n= 172) | Aboriginal (n=83) | Non-Aboriginal (n=89) |
|---|---|---|---|
| **Experienced in Lifetime** | | | |
| Any Psychological Problems | 91.3% | 93.9% | 92.0% |
| Depression | 75.6% | 78.0% | 75.9% |
| Anxiety | 73.8% | 73.2% | 77.0% |
| Thoughts of Suicide | 68.0% | 70.7% | 67.8% |
| Attempted Suicide | 54.1% | 59.8% | 50.6% |
| **Ever Prescribed Medication for a Psychological problem** | 57.0% | 48.8% | 66.7%* |
| **Ever Sought Help for a Psychological Problem** | 68.0% | 62.2% | 75.9% |
| **Family History of Psychological Problems** | 51.7% | 47.3% | 63.5% |

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

**Table 9: Drug/Alcohol Use Stratified by Ethnocultural Background (n= 172)**

| | Overall (n= 172) | Aboriginal (n=83) | Non-Aboriginal (n=89) |
|---|---|---|---|
| **Currently Smokes Cigarettes** | 65.7% | 81.7% | 51.7%* |
| **Current Substance Abuse Problem** | 52.3% | 57.8% | 49.4% |
| **Ever Tx for Drug/Alcohol Problem** | 37.8% | 48.1% | 29.9%* |
| **Number of Days Used in Past 30 Days (± SEM)** | | | |
| Alcohol (any use) | 3.4 ± 0.6 | 4.4 ± 0.9 | 2.4 ± 0.6 |
| Cannabis | 3.4 ± 0.6 | 6.0 ± 1.2 | 1.1 ± 0.5* |
| Cocaine | 1.4 ± 0.4 | 1.6 ± 0.7 | 1.1 ± 0.5 |
| **Amount of Money Spent on Alcohol (Past 30 Days)** | $67.17 ± 17.91 | $114.10 ± $35.97 | $25.63 ± $9.52* |
| **Amount of Money Spent on Drugs (Past 30 Days)** | $63.85 ± 16.86 | $92.44 ± $30.21 | $38.23 ± $16.72 |
| **Number of Years Used in Lifetime (± SEM)** | | | |
| Alcohol (any use) | 14.8 ± 0.9 | 14.8 ± 1.1 | 14.8 ± 1.4 |
| Cannabis | 5.4 ± 0.6 | 7.9 ± 1.0 | 3.1 ± 0.7* |
| Cocaine | 2.6 ± 0.4 | 2.7 ± 0.6 | 2.6 ± 0.6 |
| **Mean ASI Alcohol Composite Severity score (± SEM)†** | 0.13 ± 0.02 | 0.17 ± 0.22 | 0.19 ± 0.02 |
| **Mean ASI Drug Composite Severity score (± SEM)†** | 0.07 ± 0.008 | 0.07 ± 0.01 | 0.06 ± 0.01 |
| **Family History of Drug or Alcohol Problems** | 63.4% | 79.2% | 56.5%* |

Groups were compared using Student's t-tests and Chi-square analysis.

* significant differences between groups $p < 0.05$, corrected for multiple comparisons.

†ASI – Addiction Severity Index composite scores range from 0 to 1.0, with higher scores indicating greater problem severity.

**Table 10: History of Abuse Stratified by Ethnocultural Background (n=172)**

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

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

**History of Childhood Sexual Abuse**

In the interest of exploring factors associated with a history of childhood sexual abuse, the next series of analyses were designed to further explore relationships between the experience of sexual abuse during childhood and physical/mental health status. All further analyses were performed on the total study sample divided into two groups; NA - never abused in childhood (n=48) or CSA - experienced childhood sexual abuse (n= 112). This child sexual abuse variable was created by combining 4 items on the CATS: 1) Before you were 14, did you engage in any sexual activity with an adult?, 2) Were there traumatic or upsetting sexual experiences when you were child or teenager that you couldn't speak to adults about, 3) Did you have a traumatic sexual experience as a child or teenager?, and 4) Did your relationship with your parents ever involve a sexual experience? A positive response to any of these items indicated a history of child sexual abuse. The groups were formed irrespective of women's ethnocultural background.

Analyses revealed that women with and without histories of CSA were comparable on primary sociodemographic characteristics. The two groups were similar in ethnocultural background (NA: Aboriginal 47.9%, non-Aboriginal 52.1%; CSA: Aboriginal 46.4%, non-Aboriginal 53.6%). They were also comparable in age (NA 39.6 $\pm$ 2.0 years, CSA 38.8 $\pm$ 1.1 years), marital history (ever married/common-law: NA 45.8%, CSA 46.4%), and usual living arrangement in the past three years (with partner/family NA 45.8%, CSA 50.5%). Additionally, neither abuse group had significantly higher levels of education (NA 10.3 $\pm$ 0.5, CSA 11.6 $\pm$ 0.3), and were equally likely to be unemployed and receiving welfare as their primary source of income (NA 54.2%, CSA 69.4%).

**Family and Social Relationships Among Women With and Without CSA**

Characteristics of family and social relationships are presented in Table 11. Women in the CSA group were significantly more likely to have experienced problems with their parents in their lifetimes [$\chi^2$ (1) = 17.92, p=0.0001]. While neither group was more likely to report that a parent ever had a drug or alcohol problem, individuals in the CSA group were significantly more likely to report that one or both parents had experienced a psychological problem in their lifetimes [$\chi^2$ (1) = 6.91, p=0.009]. A two-way chi square analysis of family history of psychological problems by ethnocultural background and history of CSA revealed between abuse group differences for Aboriginal women only. Compared to those never abused, Aboriginal women who were sexually abused as children were significantly more likely to report that one or both parents had a psychological problem [$\chi^2$ (1) = 5.01, p= 0.025].

**Adverse Childhood Experiences**

Table 12 presents results of selected adverse childhood experiences (ACEs) by the two groups. Analyses determined that women in the CSA group had significantly higher means scores on the CATS neglect/negative home environment [t (158)= -6.86, p= 0.0001] and punishment [t (158)= -3.56, p= 0.0001] subscales. The CSA group was also significantly more likely to live with verbally abusive parents [$\chi^2$ (1) = 23.28, p=0.0001], have witnessed physical violence [$\chi^2$ (1) = 16.33, p=0.0001], and sexual abuse [$\chi^2$ (1) = 11.43, p=0.001] perpetrated against other family members. Compared to the NA group, the CSA group were also more likely to have had a fear of being sexually abused when either parent was intoxicated [$\chi^2$ (1) = 16.38, p=0.0001]. Significance remained for Aboriginal women only for witnessing both physical (NA 26.1%, CSA 80.8%, $\chi^2$ (1) = 20.67, p=0.0001) and sexual (NA 8.7%, CSA 44.2%, $\chi^2$ (1) = 9.06, p=0.006) mistreatment of another family member. One third (33.9%) of all women with a history of CSA reported that their relationships with their parents had involved a sexual experience.

**Table 11: Selected Family Characteristics Stratified by History of Childhood Sexual Abuse (n=160)†**

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

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

**Table 12: Selected Adverse Childhood Experiences Stratified by History of Childhood Sexual Abuse (n=160)†**

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

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

## Physical and Mental Health Among Women With and Without CSA

Characteristics of physical health are presented in Table 13. Rates of medical problems and help-seeking were comparable across abuse groups. For example, there were no significant differences in the experience of acute or chronic medical problems, as more than half of both groups reported a chronic medical problem (NA 52.1%, CSA 55.9%), and most had sought help for a medical problem in the past year (NA 63.6%, CSA 74.8%). In terms of childbearing, there were no differences between groups in number of lifetime pregnancies, abortions or miscarriages. However, significant differences between groups were found in history of teenage pregnancy. The rate of teenage pregnancy in the CSA group was nearly double that of the NA group [$\chi^2$ (1) = 6.39, p= 0.01].

Statistical analyses of recent mental health variables are presented in Table 14. The CSA group reported higher rates of experiencing any psychological problems compared to the NA group [$\chi^2$ (1) = 16.90, p= 0.009]. However, there were no significant differences between abuse groups on individual indicators of psychological distress (including depression, anxiety, and suicidal ideation) in the past month. There were no differences in severity of current psychological distress between the NA and CSA groups, indicated by similar mean scores on the ASI psychological composite severity score.

Rates of lifetime psychological distress stratified by childhood abuse are presented in Table 15. While there were no differences in lifetime rates of depression or anxiety, the CSA group reported higher rates of suicidal ideation [$\chi^2$ (1) = 9.65, p=0.002] and attempted suicide [$\chi^2$ (1) = 19.12, p=0.003]. The CSA group were also significantly more likely to have sought treatment for a psychological problem in their lifetimes [$\chi^2$ (1) = 10.48, p=0.001]. Two-way chi square analyses of lifetime suicidal ideation, suicide attempts, and psychological treatment seeking by history of CSA and ethnocultural background produced varying results. Significant differences in lifetime suicidal ideation by abuse groups remained significant for non-Aboriginal women only. Compared to others, non-Aboriginal women who were sexually abused as children were significantly more likely to report they had seriously contemplated suicide in their lifetimes (NA 48.0%, CSA 75.0%, c2 (1) = 5.82, p=0.016). Ethnocultural differences were also found in lifetime rates of attempted suicide and psychological treatment seeking. Significant differences between abuse groups remained for Aboriginal women only, with Aboriginal women in the CSA group reporting significantly higher rates of lifetime suicide attempts (NA 39.1%, CSA 71.2%, $\chi^2$ (1) = 6.89, p=0.009) and ever being treated for a psychological problem (NA 34.8%, CSA 75.0%, $\chi^2$ (1) = 11.02, p=0.001).

The next section provides further results stratified by childhood sexual experiences based on information collected in the second interview of this study.

**Table 13: Selected Physical Health Characteristics Stratified by History of Childhood Sexual Abuse (n=161)†**

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

Groups were compared using Independent Samples t-tests and ANOVA.

* significant differences between groups $p < 0.05$, corrected for multiple comparisons.

†Twelve study subject failed to complete the CATS sexual abuse questions.

‡ASI – Addiction Severity Index composite scores range from 0 to 1.0, with higher scores indicating greater problem severity.

**Table 14: Recent Psychological Distress Stratified by History of Childhood Sexual Abuse (n=161)†**

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

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

**Table 15: Lifetime Psychological Distress Stratified by History of Childhood Sexual Abuse (n=161)†**

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

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

## Results: Second Interview

### Participants Versus Non-Participants

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

There were no differences between women who did and did not decide to participate in the second interview across a wide array of variables including sociodemographics, ethnicity, or mental health status. For example, Aboriginal and non-Aboriginal women were equally likely to participate in the second interview (47.2% and 58.2% respectively). There were no differences between participants and non-participants in terms of age, marital status, living arrangements, or history of lifetime physical abuse (Non-Participants 94.3%, Participants 92.7%) and sexual abuse (Non-Participants 83.1%, Participants 76.4%). In terms of psychological status, women from both groups were experiencing high levels of psychological distress in the past month including depression (non-participants 44.9%, participants 43.6%), anxiety (non-participants 53.9%, participants 54.5%) and suicidal ideation (non-participants 29.2%, participants 29.1%). They also reported similar rates of depressive symptomatology in the previous week, indicated by mean scores on the Beck Depression Inventory (non-participants $21.2 \pm 1.3$, participants $18.4 \pm 1.4$).

Overall, there were no significant differences in sociodemographic, physical/sexual abuse, or psychological variables between groups, suggesting that those participants who completed the CECA interview did not represent a biased sample. The major reasons for non-completion were scheduling difficulties, subjects not showing up for appointments, subjects not having time to do the interview, and study drop-out. Efforts were made to reschedule appointments with women when initial plans to meet failed; confidential messages were left for them at the shelter/organization where they were contacted, and calls were made when subjects were able to provide phone numbers where they could be reached. Others were not interested in doing the second interview for reasons including not wishing to discuss their childhoods, or not wanting to be interviewed a second time.

### Severity of Childhood Sexual Abuse

In the CECA interview, subjects are asked the lead question: When you were a child or teenager did you ever have an unwanted sexual experience? Additional probes are used to collect information on timing/duration, and examples/descriptions of events. The CECA is an investigator-based interview, wherein the interviewer judges the severity ratings with consensus ratings within the research team to avoid bias in rating severity. The severity assigned to sexual abuse incidents is based on the subjects' descriptions of events and take into account the frequency, duration, and type of sexual mistreatment experienced by women before the age of seventeen. Severity rating also considers the individual's relationship to the perpetrator, as well as

age and status of the perpetrator (whether a family member or someone in authority), degree of sexual contact, and involvement of force or coercion (Bifulco et al., 1994). An individual's abuse experiences are assigned to one of four severity groups: 'little/none', 'some', 'moderate', and 'marked'.

For analytic purposes, these four groups were recoded into three childhood sexual abuse severity groups. The groups were never abused (NA), those who reported 'little - some' sexual abuse, or moderate abuse (MA), and those who experienced 'moderate- marked' levels of abuse, or severe abuse (SA). Results presented in Table 16 indicate that rates of parental antipathy, neglect, and physical abuse during childhood are high for all three CSA severity groups. The data suggest that those in the MA and SA groups experienced higher rates of adverse childhood events, with those in the SA group reporting the highest rates for most variables, including witnessing both physical and sexual mistreatment of another family member during childhood. While no significant group differences were found for either CATS neglect or punishment subscales, there was a significant difference in mean number of adverse childhood events (ACEs) [$F(2, 53) = 10.03$, $p < 0.0001$]. Compared to those in the NA and MA groups, the SA group reported the highest mean number of events. These study results provide further evidence that there is a clustering of early life family and home environment problems for individuals who have been sexually abused during childhood. The following section presents analysis of verbatim text of material tape recorded in the CECA interview.

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

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

Groups were compared using ANOVA for continuous variables.

* significant differences between groups $p < 0.05$, corrected for multiple comparisons.

Chi-square analysis could not be conducted due to low cell counts.

*p-values indicate statistical significance ($p<0.05$) after using a Bonferroni correction for multiple comparisons

**Women's Thoughts/Explanations for Childhood Abuse Experiences**

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

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

> *"Y'a pas choisit d'étre de méme. Mais j'pense qu'y avait pas ehh... c'est vraiment juste? Cause d'la maladie, tu sais? Qu'était p'étre en psychose.*

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

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

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

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

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

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

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

> *"I think its choice. .. I think its choice. They're reasoning human beings, you know, they can reason to get up in the morning, go to work, go to school, whatever, drive the car, right?" "I don't buy it "well they were abused, so that's why they're, they abused me" I don't buy it, I don't accept it, it's not a justification for me. I do believe that the fact that they were abused maybe made them, angry. Well I know what that is, I know what anger is, I'm angry.. but you can't use that to say "oh well, that happened to me, so I'm going to do it to somebody else."*

These narratives suggest that childhood sexual abuse may be more strongly associated with family and social factors, than with ethnocultural differences in this sub-sample of women. Individual women do not necessarily hypothesize a collective or historical explanation for their adverse experiences, but rather more local ones entrenched in home environments rife with family dysfunction and psychological problems.

## Methodological Considerations and Limitations

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

## General Discussion

The majority of this study sample were single women at severe economic disadvantage with low levels of formal education, low rates of employment, high dependency on welfare, and need for temporary shelter and other services. Aboriginal and non-Aboriginal study participants experienced similar socioeconomic disadvantages. They did not differ in rates of chronic medical problems, or in the likelihood of seeking care from a medical practitioner for a health problem. Compared to non-Aboriginal women however, Aboriginal women did have higher rates of lifetime pregnancies and teen pregnancies before the age of eighteen. The women in this sample experienced few legal problems, and a minority were on probation/parole or awaiting charges at the time of interview. While more than half (52.3%) of all women reported a current substance abuse problem, there were no ethnocultural differences in experiencing this problem. However, Aboriginal women were more likely than their non-Aboriginal counterparts to currently smoke cigarettes, have higher rates of current and lifetime cannabis use , and have been treated for a drug or alcohol problem in the past.

Differences were found in the experience of recent psychological distress among Aboriginal and non-Aboriginal women. For instance, non-Aboriginal women were more likely than Aboriginal women to report feeling depressed in the past 30 days. However, there were no between group differences in experiencing depressive symptomatology in the preceding week, expressed by similar mean scores on the Beck Depression Inventory (BDI). This may be attributable to cultural differences in defining depression, with Aboriginal women less likely to identify their feelings/experiences as symptoms of depression; a difference that was corrected by answering specific questions about symptoms of depression on the BDI. It is also possible that this difference reflected non-Aboriginal women's experience of more proximate life stressors, or a greater higher sensitivity to developing depression following negative events.

As a group, the women interviewed for this study reported high rates of lifetime psychological distress, with nearly three-quarters reporting serious anxiety (73.8%) and depression (75.6%). Lifetime rates of suicidal ideation and attempted suicides were similarly high (68% and 54.1% respectively). There were no ethnocultural differences in recent or lifetime anxiety, and lifetime depression. Initial results indicated no difference in rates of help seeking for psychological problems between Aboriginal and non-Aboriginal women. However differences emerged in two-way chi square analysis of psychological variables by ethnocultural background and history of CSA. While initial results showed that the mean ASI psychological composite severity scores were higher for non-Aboriginal women (suggesting that they were currently experiencing more severe mental health related problems), further analysis indicated that Aboriginal women with a history of CSA were significantly likely than their non-Aboriginal abused counterparts to seek mental health care in the city. This may be a function of a greater access to psychological services in the city, compared to what is currently available on reserve.

This study also explored physical and sexual abuse in relation to ethnocultural background and history of CSA. It should be noted that there are few in-depth cross-cultural comparisons of abuse characteristics and their long-term consequences for Native and non-Native

people. Aboriginal-focussed violence research in Canada is typically limited by small study samples and the under use of standardized instruments. According to the existing literature, physical and sexual violence are considered major problems for many Aboriginal people in Canada (e.g., Archibald, 2004; Dion Stout, Kipling & Stout, 2001; Muhajarine & D'Arcy, 1999; Ontario Native Women's Association (ONWA), 1989; Pauktuutit Inuit Women's Association, 2005; Royal Commission on Aboriginal Peoples (RCAP), 1997). For instance, a document prepared by the Ontario Native Women's Association indicated that 80% of a sample of urban and rural dwelling Aboriginal women (n= 104) who responded to a survey mailing had been abused (ONWA, 1989). It has been estimated that violence-related mortality (including domestic violence injuries and suicide) is three to five times higher for Aboriginal women, compared to women from all other ethnocultural backgrounds in Canada (Native Women's Association of Canada (NWAC), 2002). Rates of physical and sexual abuse also vary by women's health and socioeconomic status. Higher rates of abuse are commonly found among young women with lower socioeconomic status and fewer years of education than other women (Brems & Namyniuk, 2002; Field & Caetano, 2004; Flake, 2005; Heaman 2005; Kramer, Lorenzon & Mueller, 2003).

In the current study, Aboriginal women were more likely than non-Aboriginal women to have been physically abused in their lifetimes. This finding corroborates results from past General Social Surveys on violence against women in Canada (Statistics Canada, 2001; Statistics Canada, 2005). One report stated that Aboriginal women were nearly three times more likely to have been physically abused in their lifetimes (Statistics Canada, 2001). There is however two important differences between the results reported by Statistics Canada and those found in this study. First, the rates of physical abuse in this study are much higher than those found by Statistics Canada. Second, the difference in rates of physical abuse between Aboriginals and non-Aboriginals is less marked, possibly due to the fact that socioeconomic status (SES) was similar across the two groups. Studies have shown that the peak rates of physical violence usually occur among young women aged 15 to 24 years old (Curtis, Larsen, Helweg-Larsen, Bjerregaard, 2002). Previous research also indicates that teenage pregnancy is a risk factor for physical abuse among pregnant women in general (Fergusson, Horwood & Lynskey, 1997; Gessner & Perham-Hester, 1998; Harrykissoon, Rickert, & Wiemann, 2002; Rosen, 2004).

There was no ethnocultural difference in lifetime rates of sexual abuse. More than two-thirds of both Aboriginal and non-Aboriginal women in the sample had been sexually abused in their lifetimes (74.4% and 69.0% respectively). This finding contradicts existing evidence that Aboriginal women experience sexual abuse at two to three times higher rates than non-Aboriginal women (see Wahab & Olson, 2004). This may be due to the fact that women in the current study were of a similar socioeconomic status, while previous evidence compared rates of sexual violence among Aboriginals against national rates that represented persons from many socioeconomic strata. Women who were sexually abused in childhood also experienced more family-related problems than women who were never abused. They were more likely to have had serious relationship problems with their parents, and to report that one or both parents had experienced psychological problems in their lifetimes. Psychological problems included problem

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

This study also found that severity of child sexual abuse (based on frequency, duration, type of abuse experienced, and identity of the perpetrator) had a differential impact on the likelihood of problem family environments. Women who were severely sexually abused in childhood clearly experienced more adverse childhood events (ACEs) compared to women in the none or moderate abuse severity groups. This meant they were significantly more likely to have been neglected, physically abused, witnessed physical or sexual violence against other family members, and have a family history of substance abuse. It should be noted that the small sample size may have masked group differences in other mistreatment and psychological variables.

The link between the experience of childhood sexual abuse and troubled family environments has also been firmly established in the literature. Women with a history of CSA are more likely to have been raised in households characterized by parental drug or alcohol abuse and/or parental psychological problems including depression (Classen, Palesh & Aggarwal, 2005, Fergusson, Horwood & Lynskey, 1997; Dinwiddie et al., 2000; Kunitz et al., 1998; Scheutze & Das Eiden, 2005). In a longitudinal study of 520 women, Fergusson and Colleagues (1997) report that women with a history of CSA were more than twice as likely as women without a history of CSA to have had a parent with an alcohol problem (25.0% versus 10.9%) or problem drug use (42.9% versus 24.3%).

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

In terms of mental health, women who had been sexually abused during childhood fared worse than others on some indicators of psychological distress. There were no significant differences between abuse groups in rates of recent depression, anxiety, or suicidal ideation. The CSA group did however report significantly higher rates of experiencing any psychological problem in the past month. Women in the CSA group however, were significantly more likely than women in the NA group to have seriously contemplated suicide or attempted suicide in their lifetimes. They were also more likely to have sought treatment for a psychological problem in the past.

Study results also revealed that given similar histories of CSA, Aboriginal women in this study sample were significantly more likely to experience any form of psychological distress and to have ever attempted suicide. Previous research has shown strong relationships between suicidal behaviour and history of childhood sexual abuse (Evren & Evren, 2007; Favaro, Ferrara & Santonastaso, 2007; Joiner, Sachs-Ericsson, Wingate, et al., 2007). The association between CSA and suicide attempts is particularly true for adolescent females (Howard & Wang, 2005; Turner, Finkelhor & Ormrod, 2006) and women (Dube, Anda, Whitfield, Brown, Felitti, Dong & Giles, 2005; Ystgaard et al., 2004). A 3-fold increase in suicidal ideation and suicide attempts has been reported among sexually abused adolescent females (Martin, Bergen, Richardson, Roeger & Allison, 2004), and a 2-fold increase for attempted suicide among women with a history of childhood sexual abuse (Dube et al., 2005). However, there is no pre-existing research on the comparability of attempted suicides between Aboriginal and non-Aboriginal females sexually abused in childhood.

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

## Final Considerations

It is necessary to move towards an understanding of why problems such as family violence, child neglect, problem substance abuse, attempted suicides, and physical and sexual abuse persist in both urban and rural communities characterized by low-income families with low rates of formal education. These adverse life events are part of a larger phenomenon of psychological distress within multi-problem families. Considering that abuses are largely perpetrated within families and social environments rife with economic struggles, these abusive actions may be considered as a means of exerting control over others in difficult situations. The consequences of comorbid substance abuse problems only exacerbate the stress of living in poor communities. Aboriginal and non-Aboriginal women and children continue to suffer the most, as acts of physical and sexual abuse are often alcohol-related. Isolated incidents of maltreatment are

rare, and abused women will often experience multiple forms of abuse over the course of a lifetime.

This study shows that there are a number of issues for multiply disadvantaged individuals who live within environments characterized by poor family relationships, child neglect, and physical/sexual abuse. The participants suffered multiple forms of psychological distress while dealing with daily stresses of living in the city and navigating health and social services. Given the high rates of unemployment and reliance on social welfare system, these results also suggest that there is a sizeable subsection of the Canadian population who are dealing with coinciding socioeconomic, psychological, and emotional disadvantages. Future research should focus on exploring the characteristics of living in multi-problem families situated in all levels of socioeconomic status, and their psychological consequences. This is especially true for Aboriginal women, given that under similar socioeconomic conditions and history of childhood sexual abuse, they were significantly more likely to report certain adverse childhood experiences (i.e. witnessing physical and sexual violence in the home, parental history of psychological problems and suffer psychological distress in subsequent years (i.e. current psychological problems and a history of attempted suicide).

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

| | NA (n=48) | CSA (n=112) | Significance |
|---|---|---|---|
| **As a Child, Witnessed the Physical Mistreatment of Another Family Member** | | | |
| Aboriginal | 26.1% | 80.8% * | $\chi^2$ (1)= 20.67, p= 0.0001 |
| Non-Aboriginal | 54.2% | 68.3% | – |
| **As a Child, Witnessed the Sexual Mistreatment of Another Family Member** | | | |
| Aboriginal | 8.7% | 44.2%* | $\chi^2$ (1)= 9.06, p= 0.006 |
| Non-Aboriginal | 4.2% | 20.3% | – |
| **Parental History of Psychological Problems** | | | |
| Aboriginal | 25.0% | 58.3%* | $\chi^2$ (1)= 6.28, p= 0.025 |
| Non-Aboriginal | 52.0% | 67.2% | – |
| **Experienced Any Psychological Problems in Past Month** | | | |
| Aboriginal | 56.5% | 71.2% | – |
| Non-Aboriginal | 60.0% | 85.0%** | $\chi^2$ (1) = 6.35, p= 0.025 |
| **Ever Attempted Suicide** | | | |
| Aboriginal | 39.1% | 71.2%* | $\chi^2$ (1)= 6.89, p= 0.018 |
| Non-Aboriginal | 36.0% | 56.7% | – |

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

| | | | |
|---|---|---|---|
| **Ever Been Treated for a Psychological Problem** | | | |
| Aboriginal | 34.8% | 75.0%* | $\chi^2$ (1)= 11.02, p= 0.002 |
| Non-Aboriginal | 68.0% | 80.0% | – |

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

It is becoming increasingly important for future research to explore the effects of individual resources (e.g. social support, family relations) and cultural beliefs on women's ability to cope with the stress of living with memories of adverse events. Walters and Simoni (2002) for instance refer to 'traumatic stressors' in a discussion of culturally formed responses to negative life events. They suggest that Aboriginal women's ability to cope with adverse events is moderated by cultural identity and traditional healing. Women's positive cultural identification support healthy physical and mental health outcomes. There is increasing evidence of social and psychological resiliency among individuals with histories of adverse childhood experiences (Noll, 2005; Tyler, 2002; Wright, Fopma-Loy & Fischer, 2005). For instance, social support and suitable parental monitoring have been shown to reduce the risk for alcohol abuse in females with a history of childhood sexual abuse (see Hobfoll et al., 2002; Tyler, 2002). Having a supportive spouse has also been identified as a protective factor for depression (Wright et al., 2005).

This study shed light on the interrelatedness of early life experiences with psychological distress among a sample of help-seeking Aboriginal and non-Aboriginal women. Future research among Aboriginal and non-Aboriginal women in Canada's urban areas needs to explore the factors that allow females to survive environments characterized by parental substance abuse, family violence, neglect, and verbal abuse. We need to understand how urban Aboriginal and non-Aboriginal women successfully deal with traumatic events and co-occurring economic deprivation, and overcome adversity. Furthermore, future studies in this area should ascertain not only what specific protective factors there are against the development of adverse physical and mental health outcomes, but what specific components of family, community, or culture are protective, and under what circumstances they protect against psychological distress.

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