City Research Online

City St George's, University of London

Citation: Kyrimi, S. (2021). "The drugs were a response to my life": An exploration of the experiences of problematic drug use of women survivors of childhood sexual abuse who are in recovery. (Unpublished Doctoral thesis, City, University of London)

This is the accepted version of the paper.

This version of the publication may differ from the final published version. To cite this item please consult the publisher's version.

Permanent repository link: https://openaccess.city.ac.uk/id/eprint/29524/

Copyright and Reuse: Copyright and Moral Rights remain with the author(s) and/or copyright holders. Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge, unless otherwise indicated, provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way. For full details of reuse please refer to City Research Online policy.

City Research Online: http://openaccess.city.ac.uk/ publications@citystgeorges.ac.uk

“Maybe I’ve been chasing the highs but looking for human connection”: The process of relating for adult survivors of childhood trauma who are in recovery from problematic drug use

Styliani Kyrimi

Portfolio submitted in fulfilment of Professional Doctorate
in Counselling Psychology (DPsych)

Department of Psychology
City University of London

November 2021

Dedication

To the memory of my beloved father.

And to the survivors; the ones who were, the ones who are, and the ones who will be.

“The attempt to escape from pain is what creates more pain”

— Gabor Maté

Table of Contents

Acknowledgements 11

Declaration 12

Glossary of Abbreviations 13

Preface 14

Personal Reflections 14

Overview of the Portfolio 15

Part A: Research 15

Part B: Client Study 16

Part C: Journal Article 17

References 19

Part A: Research 21

"The drugs were a response to my life": An exploration of the experiences of problematic drug use of women survivors of childhood sexual abuse who are in recovery

Abstract 22

1. Chapter One: Introduction & Literature Review 23

1.1. Introduction 24

1.2. Definitions and Literature Review 25

1.2.1. Problematic Drug Use (PDU) 25

1.2.1.1. Definition of PDU and Related Diagnoses *26*

1.2.1.2. Prevalence Estimates of PDU *27*

1.2.1.3. Aetiology of PDU *28*

1.2.1.4. Women and PDU *31*

1.2.2. Childhood Sexual Abuse (CSA) 32

1.2.2.1. Adverse Childhood Experiences (ACEs) *32*

1.2.2.2. Women, ACEs, and PDU *33*

1.2.2.3. Definition of CSA *35*

1.2.2.4. Prevalence Estimates of CSA *36*

1.2.2.5. Long-term Effects of CSA *36*

1.2.3. Trauma-Informed Care (TIC) 39
1.2.3.1. Definition of Trauma and Related Diagnoses *39*
1.2.3.2. Definition of TIC *41*
1.2.3.3. Implications of TIC in Research, Practice, and Policy *42*
1.2.4. Feminist Theory 45
1.2.4.1. Definition of Feminist Theory *45*
1.2.4.2. Implications of Feminist Theory in Research, Practice, and Policy *46*
1.2.5. The Role of Qualitative Research in Formulating PDU 47
1.2.6. Summary Review of Literature Findings 48
1.3. The Present Study 49
1.3.1. Rationale 49
1.3.2. Research Questions 50
1.3.3. Relevance to Counselling Psychology 50

2. Chapter Two: Methodology 52
2.1. Overview 53
2.2 Research Aim 53
2.2.1. Research Questions 53
2.3. Rational for Chosen Research Paradigm 54
2.4. Philosophical Underpinnings of Research Paradigm 55
2.4.1. Constructivist Research Paradigm 55
2.4.2. Critical Realism Ontology 55
2.4.3. Relativism Epistemology 56
2.4.4. Feminist Standpoint Epistemology 56
2.5. Rationale for using IPA 58
2.6. Philosophical Underpinnings of IPA 58
2.6.1. Phenomenology 59
2.6.2. Hermeneutics 60
2.6.3. Idiography 60
2.6.4. Key Elements of IPA 61
2.7. Philosophical Alignment of IPA and Research Paradigm 62
2.8. Epistemic Reflexivity 62
2.9. Research Design and Procedures 63
2.9.1. Research Sample 63
2.9.2. Participant Inclusion and Exclusion Criteria 63

2.9.2.1. Inclusion Criteria *64*
2.9.2.2. Exclusion Criteria *64*
2.9.3. Recruitment 65
2.9.3.1. Background of Participants *66*
2.9.3.2. Challenges in Recruitment *68*
2.9.3.3. Risk and Safeguarding Considerations *68*
2.9.4. Data Collection and Storage 68
2.9.4.1. Semi-Structured Interviews *68*
2.9.4.2. Interview Schedule *69*
2.9.4.3. Pilot Interview *69*
2.9.4.4. Recording and Transcription *70*
2.9.4.5. Data Storage *70*
2.9.5. Analytical Strategy 70
2.9.5.1. Steps 1 and 2 – Familiarising with the Text and Initial Noting *71*
2.9.5.2. Step 3 – Emergent Themes *71*
2.9.5.3. Step 4 - Generating Superordinate Themes *72*
2.9.5.4. Steps 5 and 6 – Moving to the Next Cases and Looking for a Pattern across Cases *72*
2.9.5.5. Interpretation *72*
2.10. Validity and Quality 73
2.10.1. Sensitivity to Context 73
2.10.2. Commitment and Rigour 74
2.10.3. Transparency and Coherence 74
2.10.4. Impact and Importance 74
2.10.5. IPA specific criteria 75
2.10.6. Ten Key Issues in Critical Appraisal of Qualitative Research 75
2.11. Ethics 76
2.11.1. Ethical Approval 76
2.11.2. Ethical Considerations 76
2.11.2.1. Risk *76*
2.11.2.2. Screening *76*
2.11.2.3. Consent *77*
2.11.2.4. Debriefing *77*
2.11.2.5. Confidentiality *77*
2.11.2.6. Interviewer Role *78*
2.11.2.7. Trauma Informed Approach on Participation *78*
2.11.2.8. Reflexivity in Data Analysis *78*

2.12. Personal Reflexivity.....79

3. Chapter Three: Analysis.....82
3.1. Overview.....83
3.1.1. Overview of Themes.....84
3.2. Superordinate Theme 1: The Good, the Bad, and the Useful.....84
3.2.1. Subtheme 1: The Need for a Getaway Car.....85
3.2.2. Subtheme 2: From Friend to Foe.....86
3.3. Superordinate Theme 2: Because of You.....89
3.3.1. Subtheme 1: Somewhere I Belong.....90
3.3.2. Subtheme 2: Longing to Connect.....92
3.3.3. Subtheme 4: "'A Greater Capacity for Care'".....96
3.4. Superordinate Theme 3: Living in the Shadow.....100
3.4.1. Subtheme 1: Taking the Blame.....100
3.4.2. Subtheme 2: An "Unavoidable" Impact.....103
3.5. Superordinate Theme 4: Moving Forward.....105
3.5.1. Subtheme 1: Negotiating Identities.....106
3.5.2. Subtheme 2: Reclaiming Control.....108
3.6. Summary of Themes.....111

4. Chapter Four: Discussion.....112
4.1. Overview.....113
4.2. Synthesis of Findings.....113
4.2.1. Connection.....113
4.2.1.1. An overwhelming feeling of disconnection.....*113*
4.2.1.2. Striving for connection at all costs.....*114*
4.2.1.3. The importance of meaningful connections in recovery.....*115*
4.3. Discussion of Themes.....117
4.3.1. The Good, the Bad, and the Useful.....117
4.3.1.1. 'Self-medication'.....*117*
4.3.1.2. Escaping as a trauma response.....*118*
4.3.1.3. PDU as a gender-based coping mechanism.....*119*
4.3.2. Because of You.....120
4.3.2.1. The normalisation of PDU.....*120*
4.3.2.2. Disconnection as a trauma response.....*121*

4.3.2.3. Recovery through internalising interpersonal care *123*
4.3.2.4. Motherhood *124*
4.3.3. Living in the Shadow 124
4.3.3.1. PDU as a response to childhood trauma *124*
4.3.3.2. Emotional regulation and executive function in trauma survivors *126*
4.3.3.3. Shame and self-blame *127*
4.3.3.4. PDU as self-destructiveness *128*
4.3.4. Moving Forward 130
4.3.4.1. Self-development *130*
4.3.4.2. Self-empowerment via helping others *131*
4.4. Critical Evaluation of the Study 132
4.4.1. Strengths and Limitations 132
4.4.2. Epistemological Reflexivity 134
4.4.3. Research Evaluation 134
4.5. Professional Implications 135
4.5.1. Relevance to Counselling Psychology 135
4.5.2. Service Design and Treatment Provision 136
4.5.3. Future Research 138
4.6. Personal Reflexivity 140
5. Conclusion 142

References 143
Appendices 190
Appendix A: Recruitment Flyer 190
Appendix B: Participant Information Sheet 192
Appendix C: Screening Phone Call Guidance 196
Appendix D: Interview Schedule 197
Appendix E: Transcript Extract - Initial Coding 198
Appendix F: Table of Emergent Themes 200
Appendix G: Final Themes Table 202
Appendix H: Ethical Approval 207
Appendix I: Informed Consent Form 208
Appendix J: Participant Debriefing Sheet 210

Part B: Client Study/Process Report 213

"Beggars can't be choosers": The struggle to relate to the self and others and the therapeutic relationship as a vehicle for change

1. Introduction 214
2. Case Study 215
2.1. Setting and Referral 215
2.2. Client Profile 215
2.3. Presenting Problem 216
2.4. Theoretical Framework 216
2.5. Assessment and Reformulation Stage 217
2.6. Case Formulation and Reformulation Letter 218
2.7. Contract and Treatment Plan 220
2.8. Therapy: Recognition and Revision Stages 220
2.9. Therapeutic Outcome and Ending 221
3. Process Report 222
3.1. Overview 222
3.2. Lead in to the Session 223
3.3. Transcript and Commentary 223
3.4. Session Ending and Evaluation 229
4. Reflective Discussion 229
References 230
Appendices 233
Appendix A: Reformulation Letter 233
Appendix B: Sequential Diagrammatic Reformulation (SDR) 236
Appendix C: Therapist Goodbye Letter 237
Appendix D: Client Goodbye Letter 240

Part C: Journal Article 242

"It was absolutely unavoidable": The impact of trauma on problematic drug use for women survivors of childhood sexual abuse

Title Page 243
Abstract 244
Introduction 244

Present Study....246
Methods....247
Participants....247
Data Collection and Analysis....248
Results....248
An “Unavoidable” Impact....248
Summary of Findings....252
Discussion....252
Implications for Service Design and Treatment Provision....255
Conclusion....256
References....258
Appendix: Guidelines for Submission....266

Acknowledgements

I am deeply grateful to have had so many wonderful and supportive people alongside me throughout this process.

To the women who participated in the research, thank you for allowing me, and now others, to be a part of your journey. Your bravery and eagerness to share your experiences is to be admired. You told me how your courage to do so derived from your wish to help others, and I hope I was able to honour this wish.

To my research supervisor Dr Jacqui Farrants, your support was invaluable. Calm and always insightful, you helped me feel anchored and focused on my work, even though this has been an admittedly turbulent journey; one that at times I felt would see no end. Your consistent guidance and belief in my ability to successfully see the work through kept fuelling my motivation when it was most needed.

To my sister Argy, my editor in chief. Because of you I always find the strength to keep going. Your presence is one I can always depend on, even in the most challenging of times.

To my dear friends, Athina, Elli, and Varsha, you have helped me more than you know. You generously offered me your support and your guidance, and no problem was too small or big for you to extend your help. Even though you faced challenges of your own, you were always there for me, and without you this journey would not have been the same.

To my dad, to whom I am already the “best psychologist in the world”. Your unconditional admiration of my drive and my abilities has been an infinite source of strength.

To my partner, who helped me manage throughout unprecedented difficulty. I am forever grateful.

To everyone else who accompanied me throughout this journey these past four years. To my family, my friends, and my colleagues, thank you for waiting patiently for me to finish the doctorate so you can join me in celebration. Your unlimited enthusiasm and undeniable belief that this day would come, never failed to encourage me and put a smile on my face.

Declaration

I hereby declare that the work presented in this portfolio is entirely my own, under the supervision of Dr. Jacqui Farrants.

Moreover, I grant powers of discretion to the University Librarian to allow the thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Glossary of Abbreviations

ACE – Adverse Childhood Experience

C-PTSD – Complex Post-Traumatic Stress Disorder

CSA – Childhood Sexual Abuse

PDU – Problematic Drug Use

PTSD – Post-Traumatic Stress Disorder

SM – Substance Misuse

SUD – Substance Use Disorder

TIC – Trauma-Informed Care

Preface

Personal Reflections

My aim in this section is to present the various components of this portfolio – a piece of original qualitative research, a clinical client study, and a publishable journal article – while also providing my personal reflections on the process of its composition, particularly emphasising the common underlying themes that weave these components together. I also reflexively discuss how this process has shaped me both on a professional and personal level, as I'm balancing on the verge that separates my trainee identity from the identity of the qualified Counselling Psychologist. This shift in identity is externally specified by the successful completion of my doctoral training, while the internal process is not defined by a specific moment in time. Every experience I gathered throughout these past four years of my training as a researcher and a practitioner, as well as a person, has been a yellow brick[1] paving my professional road. I embarked on this journey thinking of the fulfilment I would experience when I would reach the destination, ready to overcome the challenges I would come across in the process. Reflecting on my original mindset now, I realise that the journey itself was the fulfilling experience, and like another Ithaka[2], I value the destination because if not for it, I wouldn't have embarked on this journey.

As a trainee Counselling Psychologist, I have been formulating my worldview as to the fundamental components that contribute to human suffering and the processes that help manage and alleviate it. Both in clinical practice, and in the research process, I was interested in the impact that childhood traumatic experiences have on people. This includes the way in which they shape one's lifeworld and ability to connect with themselves and others, as well as the means with which one attempts to mediate the effect of trauma, and the way in which this shapes one's life. I was also interested in the therapeutic effect of relating to others, and the positive impact that secure and safe interpersonal connections could have in providing corrective emotional experiences (Alexander, 1950; Alexander & French, 1946). The experience of interpersonal relating can become therapeutic once

[1] The term "yellow brick" is a variation of the term "yellow brick road", which refers to a course of action a person takes in order to achieve good things. The saying originates from the 1939 movie "The Wizard of Oz" where Dorothy and her friends followed the yellow brick road to Emerald City (Oxford Learner's Dictionaries, 2021).

[2] In its literal sense, "Ithaka" refers to the home island of Ancient Greek king Odysseus, which he returned to after 20 years of war and hardship, as mentioned in Homer's 8th century BCE epic poem "Odyssey" (Homer, 1919). In its metaphorical sense, "Ithaka" refers to a significant lifegoal that initiates a journey of personal growth and learning, as mentioned in C. P. Cavafy's 1911 poem "Ithaka" (Cavafy, 1975).

internalised, resulting in the alleviation of distress and in the promotion of long-term wellbeing. In addressing Problematic Drug Use (PDU) in women survivors of Childhood Sexual Abuse (CSA) I have sought to shed light on the impact of childhood trauma in shaping women's ability to relate to themselves and others, and in the role of PDU in mediating and perpetuating this impact. I have also decided to incorporate a feminist standpoint by creating a platform for women to define their own experience, rather than be defined "with reference to man", as the "Other" to the "Subject" that is he (de Beauvoir, 1973, p. xxii). In the client case study, I have chosen to demonstrate how the therapeutic relationship can bring relational difficulties induced by childhood trauma in the awareness, and the ways in which the therapeutic relationship can become a transformative experience and a vehicle for change. In the publishable journal article, I have attempted to incorporate a trauma-informed understanding of PDU and highlight the importance of a gender-specific understanding of PDU treatment provision.

This portfolio demonstrates my efforts of the past four years as a trainee Counselling Psychologist, which exhibit my theoretical and clinical learning. On reflection, I acknowledge that it represents other parts of myself too, which are more longstanding and personal. It represents my interest, influenced by my life-experience as a woman, on the effects of systemic, and systematic, patriarchal oppression on women, as well as my values of supporting the voiceless regain their voice and power. In addition, my interest in the effects of childhood trauma on human suffering and the means with which people attempt to mediate this, is also rooted in personal experience. Thus, this portfolio is influenced by the same components that construct who I am, and strive to be, as a professional and a person.

Overview of Portfolio

Part A: Research

The first part of the portfolio is a piece of original qualitative research titled **"The drugs were a response to my life": An exploration of the experiences of problematic drug use of women survivors of childhood sexual abuse who are in recovery.** This study aims to explore how women survivors of CSA experienced PDU, assuming that PDU was perceived to had been influenced by their CSA experiences. The exploration of this topic is aligned with the trauma-informed narrative of PDU that "rather than choice, chance or genetic predetermination, it is childhood adversity that creates the susceptibility for addiction" (Maté, 2012, p. 56). The title that I chose for this research is a direct quote from one of the participants, highlighting how the women who participated in this study perceived an

impactful connection between their CSA and PDU experiences. The study also aims to respond to the claims of feminist researchers that psychological and social research is largely androcentric (Magnusson & Marecek, 2017), especially in the substance misuse field (Wincup, 2016), and researchers have a duty of increasing representation of marginalised populations in mainstream research and enrich pre-established theories and understandings of social and psychological processes (Wigginton & Lafrance, 2019).

In the *Introduction and Literature Review* chapter I explore the existing research body and discuss how quantitative research has framed Adverse Childhood Experiences (ACEs), which include CSA, as risk factors for the development of PDU. I also discuss the research evidence that ACEs are more prevalent in girls than in boys (NICE, 2014) and that women face gender-specific struggles in accessing treatment for PDU (UNODC, 2004). This, in combination with the limited qualitative studies on how women experience PDU, suggests that more studies are needed for an in-depth exploration of these experiences, in order to enhance our current insights and knowledge. Thus, I employed Interpretative Phenomenological Analysis (IPA) as an appropriate method (Smith et al., 2009) in collecting qualitative data that enhance our understanding of the subjective meaning-making of an individual's lived experiences. The data was collected through individual semi-structured interviews (50-90 mins long) with six women CSA survivors who are in recovery from PDU. The four superordinate themes that emerged through IPA are: **"The good, the bad, and the useful"**, **"Because of you"**, **"Living in the shadow"**, and **"Moving forward"**. In the *Analysis* chapter I present these, accompanied with direct participant quotes in an attempt to describe phenomenologically the lived experiences of participants. Following the analysis, in the *Discussion* chapter I enhance the insights provided by the findings by discussing them according to the existing relevant literature. I also discuss the relevance of these findings to the field of Counselling Psychology, as well as their implications for service design and treatment provision.

Part B: Client Study

The second part of the portfolio is a clinical client study and process report titled **"Beggars can't be choosers": The struggle to relate to the self and others and the therapeutic relationship as a vehicle for change**. In this client study I present a clinical piece of work from my third-year counselling psychology training. The title that I chose for this research is a direct quote from the client, highlighting her self-view in the context of relationships. The client presented with a comorbid Bipolar Disorder Type II and Borderline Personality Disorder (BPD) and was offered twenty-four sessions of Cognitive Analytic Therapy (CAT; Ryle, 1975; 1985). I chose to present this clinical piece of work in the portfolio as it shares the theme of

the impact of childhood trauma on mental health and wellbeing, and how this affects the person's ability for interpersonal and intrapersonal connection. It also captures how the therapeutic relationship can provide a supportive environment to explore these relational difficulties, a corrective emotional experience for the client, and ultimately facilitating change.

The choice of CAT is relevant to this portfolio as it is based on the theoretical integration of cognitive and analytic understandings of the mind, which suggest that childhood experiences develop specific templates of relating that are carried into adulthood in the interpersonal and intrapersonal communication (Gomez, 1997; Ogden, 1983; Ryle, 1985). During therapy my client was able to utilise the therapeutic relationship and explore her maladaptive patterns of relating to herself and others. The power of the therapeutic relationship in creating a corrective emotional interpersonal connection was internalised and she was able to create new and more adaptive patterns of relating to herself and others.

Part C: Journal Article

The third part of the portfolio is a publishable journal article titled **"It was absolutely unavoidable": The impact of trauma on problematic drug use for women survivors of childhood sexual abuse.** I plan to submit this article to the *Journal of Psychoactive Drugs*, which describes its focus on "drug abuse, dependence, addiction, rehabilitation and research, hallucinogens, psychotherapy and counselling of individuals and families" (Journal of Psychoactive Drugs, 2021). Throughout the *Literature Review* and *Discussion* chapters of the research, I have referenced papers published in this journal, and thus this choice seemed relevant and appropriate to the aims of my research. I initially thought of publishing to *Feminism & Psychology*, in line with the feminist epistemology of the paper, aiming to add to the current debate of the role of feminism in psychological research (Feminism & Psychology, 2021). However, I decided to publish in a journal that does not self-define as "feminist" in an attempt to take feminist research out of feminist-only spaces, and into a wider audience. Research on PDU is traditionally androcentric, thus the incorporation of a feminist research paper in a journal that specialises in PDU, would interrupt the patriarchal power imbalance by allowing for female representation and public dissemination of the findings.

In this article I have highlighted the findings that represent the impact of CSA on psychological distress, and the role of drugs in alleviating this, in a misdirected attempt to promote wellbeing. I discuss these findings in relation to gender, since women are underrepresented as clients for substance misuse treatment, and therefore treatment provision does not incorporate the particular needs of women (Covington, 2008). This results in the majority of women either accessing inefficient treatment or refusing to access

treatment. Additionally, I discuss these findings in relation to trauma, as substance misuse treatment, in its majority, does not incorporate a trauma-informed lens, resulting in the provision of ineffective treatment for trauma survivors (SAMHSA, 2019). I propose a trauma-informed approach to service design and provision, as well as clinical practice.

References

Alexander, F. G. (1950). Analysis of the therapeutic factors in psychoanalytic treatment. *The Psychoanalytic Quarterly, 19,* 482–500.

Alexander, F. G., & French, T. M. (1946). *Psychoanalytic therapy: Principles and applications*. New York: Ronald.

Cavafy, C. P. (1975). Ithaka. In *C.P. Cavafy: Collected Poems* (E. Keeley & P. Sherrard, Trans.), Princeton University Press.

Covington S. S. (2008). Women and addiction: a trauma-informed approach. *Journal of Psychoactive Drugs, 5*, 377–385.

de Beauvoir, S. (1973). *The second sex*. New York: Vintage Books.

Feminism & Psychology. (2021, November 22). *Feminism & Psychology.* https://journals.sagepub.com/home/fap

Gomez, L. (1997). *An Introduction to Object Relations*. New York University Press.

Homer. (1919). *The Odyssey*. London : New York :W. Heinemann; G.P. Putnam's sons.

Journal of Psychoactive Drugs. (2021, November 22). *Journal of Psychoactive Drugs.* https://www.tandfonline.com/toc/ujpd20/current

Magnusson, E., & Marecek, J. (2017). Feminisms, psychologies, and the study of social life. In B. Gough (Ed.), *The Palgrave Handbook of Critical Social Psychology* (pp. 17–35). London, UK: Springer Nature.

Maté, G. (2012). Addiction: Childhood Trauma, Stress and the Biology of Addiction. *Journal of Restorative Medicine, 1(1),* 56–63.

NICE (2014). Domestic Violence and Abuse: How Health Services, Social Care and the Organisations they work with can respond effectively. *Public Health Guidance, 50.*

Ogden, T. H. (1983). The concept of internal object relations. *International Journal of Psycho-Analysis, 64,* 227-241.

Oxford Learner's Dictionaries. (2021, November 19). *the Yellow Brick Road.* Oxford University Press. https://www.oxfordlearnersdictionaries.com/definition/english/the-yellow-brick-road

Ryle, A. (1975). *Frames and Cages: The Repertory Grid Approach to Human Understanding.* International Universities Press.

Ryle, A. (1985). Cognitive theory, object relations and the self. *British Journal of Medical Psychology, 58(1),* 1-7.

SAMHSA. (2019). *National Survey on Drug Use and Health: Detailed Tables*, United States, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis:*

Theory, method and research. London: Sage.

UNODC. (2004), *Substance abuse treatment and care for women: case studies and lessons learned*, United Nations: New York.

Wigginton, B., & Lafrance, M. N. (2019a). Doing critical feminist research: A Feminism & Psychology reader. *Feminism & Psychology, 29(4),* 534-552.

Wincup, E. (2016), Gender, recovery and contemporary UK drug policy. *Drugs and Alcohol Today, 16(1),* 39-48.

Part A: Research

“The drugs were a response to my life”: An exploration of the experiences of problematic drug use of women survivors of childhood sexual abuse who are in recovery

Styliani Kyrimi

Abstract

Women make up 25% of clients entering treatment for Problematic Drug Use (PDU; EMCDDA, 2008a). Treatment provision and PDU research are largely androcentric (Wincup, 2016), resulting in the underrepresentation of women and mirroring the oppressive societal power dynamics between the sexes (Langdridge & Hagger-Johnson, 2009). The majority of trauma-informed PDU research is quantitative, focusing on identifying Adverse Childhood Experiences (ACEs) as risk factors for PDU (SAMHSA, 2019), without exploring the subjective meaning-making of this relationship. The aim of this qualitative study is to fill this gap in knowledge from a feminist standpoint and offer insight into the experiences of PDU of women Childhood Sexual Abuse (CSA) survivors, in relation to their childhood trauma. The data was collected through individual, semi-structured interviews of six women CSA survivors, in recovery, describing how they experienced PDU. Interpretative Phenomenological Analysis (IPA) shed light on the following superordinate themes: 'The Good, the Bad, and the Useful', 'Because of You', 'Living in the Shadow', 'Moving Forward'. The narratives within these themes revealed the negative and positive effects of PDU, the dynamic relationship between participants, others, and PDU, the impact of trauma, and the process of identity formation and reclaiming control in recovery. The relevance of these findings for Counselling Psychology and their implications for service design, treatment provision, and future research are discussed.

Keywords: problematic drug use, recovery, childhood trauma, childhood sexual abuse, women, qualitative research, interpretative phenomenological analysis

1. Chapter 1: Introduction & Literature Review

1.1. Introduction

In Europe women make up a quarter of the people who have developed Problematic Drug Use (PDU), and serious health and psychosocial problems, due to PDU. Approximately 25% of clients entering Substance Misuse (SM) treatment, and 20% of deaths directly related to PDU, are women (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA], 2005, 2006, 2008a). This has influenced the provision of SM services, which are predominantly designed based on the needs of men. Additionally, women are underrepresented in the majority of PDU research, and therefore, policies that are informed by research outcomes systematically neglect the particular needs of women (EMCDDA, 2008b). According to Feminist Theory, this underrepresentation of women in research, policy, and treatment provision is mirroring the oppressive societal power dynamics between the sexes (Harding & Norberg, 2005; Jordan & Hartling, 2002; Langdridge & Hagger-Johnson, 2009). Research has a crucial role in either sustaining or dismantling this power imbalance. Taking into consideration that men and women are socialised differently in a patriarchal system (Covington, 2008; Wincup, 2016), researching the particular psychosocial needs of women engaging in PDU is thought to play a fundamental role in designing effective policies and treatment programmes (EMCDDA, 2000b; Wincup, 2016). Contrary to quantitative research, qualitative research focuses on exploring in-depth the subjective experiences of the population of interest, and therefore has gained popularity in the field of PDU research (Agar, 2002; Rhodes & Moore, 2001), especially when it is regarding underrepresented populations (EMCDDA, 2000b; 2005; 2008b; Thom, 2010).

Moreover, the majority of PDU research is quantitative with a focus on prevalence and aetiology (EMCDDA, 2000b; Martin & Stenner, 2004). The research body suggests the prevalence of Adverse Childhood Experiences (ACEs) in individuals who engage in PDU (Maté, 2008; 2012). Similarly, research on ACEs, and especially Childhood Sexual Abuse (CSA) suggest an increased risk for the development of PDU in adolescence and adulthood (Hamburger et al., 2008; Kilpatrick et al., 2000; Simantov et al., 2000). Nowadays, a big part of the scientific community has reached a consensus that adverse experiences are a significant factor contributing to the development of PDU and addiction (Maté, 2012; Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). Therefore, as professional understanding progresses, the design and dissemination of research that incorporates a trauma-informed understanding into policy and service provision, is considered fundamental (Goodman, 2017).

The aforementioned theoretical lenses of feminism and trauma have influenced the design of this research. The conceptualisation of the research focus has been based on the

principles of feminism; that there is an inherent power imbalance, in the current societal structure, between the sexes that results in women be overlooked as non-essential and non-equal in society (Langdridge & Hagger-Johnson, 2009), and the principles of psychological trauma; that early childhood trauma deeply influences the construction of how people view and experience themselves, the world, and the interaction between them and others (van der Kolk, 2014). These lenses have informed and influenced the approach to the review of the relevant literature, the approach to the analysis, as well as the discussion of the findings and their applications.

In this chapter I introduce the four definitions on which the research is based; (a) PDU and recovery, (b) CSA, (c) Trauma-Informed Care (TIC), and (d) Feminist Theory. As the focus of this research is on the experiences of PDU of women CSA survivors who are in recovery, the literature review is divided into these four definitions, allowing for an exploration of the components of PDU and CSA, from a trauma-informed perspective, while also incorporating a feminist lens. Along with their definitions, I will review the research on prevalence estimates of the PDU, ACEs, and CSA phenomena, and I will present the evidence of TIC and Feminist Theory in psychological research, as well as their implementation in service design and treatment provision. I will also review the literature as it corresponds to the aforementioned definitions. The literature that was chosen to be presented is a mix of theories and research projects of well-established findings, as well as newer studies from the past decade. These allow for a presentation of the most recent understanding of the above phenomena, capturing the latest findings, and advancements, in the aforementioned fields. In addition, prevalence estimates are presented from the most recent prevalence studies, in order to construct an accurate view of the current phenomena. Finally, I will provide research suggestions on the importance of qualitative research in the formulation of PDU, and I will conclude with presenting the rationale for the present study, the research questions, and the relevance of the study to the field of Counselling Psychology.

1.2. Definitions and Literature Review

1.2.1. Problematic Drug Use (PDU)

In this section, I establish the definition of PDU for this study. I continue with presenting prevalence estimates of PDU in Europe, the UK, and globally. The European and UK prevalence estimates were considered relevant to the study, as this study's sample derived from the European and UK population. The global prevalence estimates were considered relevant due to the fact that they were similar to the findings from Europe and the UK, supporting the idea of PDU as a global issue. Next, I present findings on the aetiology of PDU, and findings on women's experiences of PDU. Throughout this section I critically

review the meaningful gaps of quantitative research, and the role of qualitative research in filling them.

1.2.1.1. Definition of PDU and Related Diagnoses

There are currently two official classification manuals that include diagnostic categories relating to PDU. The International Classification of Diseases (ICD) defines harmful use based on "evidence that substance use is causing physical or psychological harm" (p.56), and drug dependence "if three or more indicators of dependence are present for at least one month within the past year" (WHO, 1993, p. 57). The most recent version, ICD-10, includes a diagnostic category for "Mental and behavioural disorders due to psychoactive substance use" (WHO, 2004, p. 48). Similarly, the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) includes the diagnostic category of Substance Use Disorder (SUD), which includes 11 criteria grouped under impaired control, social impairment, risky use, and pharmacological dependence. Severity of the disorder is categorised on a continuum of mild, moderate, and severe, based on the number of criteria present (APA, 2013).

The term PDU has been adjusted to include the consumption of non-illicit substances (i.e. solvents [organic compounds that produce effects similar to alcohol or anaesthetics when their vapours are inhaled], prescription medication, steroids, and others), whose use fits the criteria of ICD-10 or DSM-5. Although PDU does not necessarily equate addiction, a problematic use of substances, as defined by the ICD-10 and DSM-5, resembles the phenomenology of addiction as described by the neuropsychological perspective (Hall-Flavin & Hofmann, 2003; Miller & Gold, 1993); this includes: (a) compulsive engagement and/or preoccupation with the behaviour, (b) impaired control over the behaviour, (c) persistent engagement with the behaviour (including relapse) even though there is clear evidence of harm, and (d) dissatisfaction, irritability, or intense craving to engage with the behaviour, when the object (i.e. drug) is not immediately available (Maté, 2008; NIDA, 1999). For the purposes of this study, I will be using a definition of PDU that is inclusive of the biopsychosocial framework. By doing so, I am taking into consideration the physical or psychological harm of PDU as perceived by participants, rather than the extrinsically attributed definitions of professional bodies. In addition, when defining the term 'in recovery' I will adhere to the philosophical underpinnings of Interpretative Phenomenological Analysis and construct the definition from the participants' own understanding of what 'in recovery' is for them. For the participants, 'in recovery' was defined by the long-term psychosocial efforts they have made to abstain from PDU. Thus, 'in recovery' encompasses the active efforts to

build a life that increases their well-being in terms of physical health, mental health, and social and relational circumstances.

1.2.1.2. Prevalence Estimates of PDU

In the UK, the most recent report from the Office for National Statistics (ONS, 2020a) states that 2.1% of adults were classified as frequent drug users (i.e. use of the drug more than once a month in the last year), and in young adults the percentage is higher at 4.3%. In addition, men were found to be twice as likely to engage in PDU than women, across all drugs. The findings also suggest a correlation between alcohol consumption and drug use, with adults who reported drinking 3 or more times per week to be twice as likely to engage in PDU (14.9%) than adults who reported drinking less, or not at all (5.1%). Household income was also found to have a correlation with PDU, with 14.8% of adults living with an annual income of £10,400 or lower engaging in PDU, whereas that percentage reduced by half, or more, for adults living with a higher annual income. A study by the same organisation on personal wellbeing, for the same time period, shows a correlation between life satisfaction and PDU, with PDU reported in 23.3% of participants who scored low on satisfaction. This is a significantly higher percentage than the 13.2% for medium satisfaction, 11.7% for high satisfaction, and 4.8% for very high life satisfaction (ONS, 2020b). These findings suggest a positive correlation between (a) alcohol consumption and PDU, and negative correlations between (b) age and PDU, (c) income and PDU, and (d) life satisfaction and PDU (ONS, 2020a).

In the European Union, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) produces an annual report on drug use prevalence. Their most recent report (EMCDDA, 2021) suggests that: (a) men are almost 3 times more likely than women to engage in PDU, (b) cannabis is the most prevalent substance, (c) there is a negative correlation between age and PDU, where young adults (aged 16 – 34) engage in PDU more than twice than older adults (aged 35 – 64), (d) men with problematic PDU are between 3 and 6 times more likely than women to request and receive treatment, (e) approximately only 30-50% of women who are engaging in problematic PDU request and enter treatment, (f) opioids have the highest prevalence in treatment requests, and (g) opioids pose the greatest risk to life (EMCDDA, 2021).

Finally, the United Nations Office on Drugs and Crime (UNODC) produces frequent reports on global PDU prevalence. The World Drug Report (UNODC, 2021) presents similar findings to the aforementioned; men are more likely to engage in PDU than women, there is a negative correlation between age and PDU, cannabis is the most commonly used drug, and

opioids present the highest risk to life. In more detail, the findings suggest that 5.4% of the global population had engaged in PDU in 2018 (UNODC, 2020a), and almost 13% of which are estimated to suffer from a drug use disorder to the extent that they experience dependence and require treatment. In addition, UNODC estimates that globally the prevalence of men engaging in PDU is higher than women, with an estimation of only 33% of people who engage in PDU being women (UNODC, 2015). In Europe, US, Australia, and New Zealand the gap of PDU between genders has started to close, with 0.69 women engaging in PDU for every 1 man in 2010, but 0.77 women for every 1 man in 2019 (SAMHSA, 2019).

1.2.1.3. Aetiology of PDU

According to SAMHSA (2019), risk factors are "characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes" (p. 1), whereas protective factors are "characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact" (p. 1). In order to gain further understanding on the aetiology of PDU, I have reviewed the literature that suggests risk factors that are predisposing, precipitating, and perpetuating PDU, on a familial, social, and individual level. The focus of the review will be on factors that influence the development of PDU in adolescence and young adulthood since that is the most prevalent age of onset for problematic PDU. The research body in epidemiology and aetiology is quantitative, as the purpose of the study is to highlight correlations between different factors and PDU. Therefore I have presented findings only from quantitative research.

Research suggests that familial risk factors for the development of PDU resemble some of the ACEs (Enoch, 2011; Jadidi & Nakhaee, 2014; Naqavi, et al., 2011; Roy, 2018; Whitesell et al., 2013) as identified by the ACE study (Felitti & Anda, 2009). These include (a) physical and sexual abuse (Hamburger et al., 2008; Kilpatrick et al., 2000; Simantov et al., 2000), (b) emotional abuse (Tonmyr et al., 2010), (c) emotional neglect (Abdelrahman et al., 1998; Chen et al., 2011; Hill et al., 2005; Frisher et al., 2007; Solis et al., 2012), (d) parental separation (Whitesell et al., 2013), (d) exposure to domestic violence (Kilpatrick et al., 2000), and (f) parental substance use (Biederman et al., 2000; Korhonen et al., 2008; Rhodes et al., 2003). In addition, familial relationships are considered a risk factor (Whitesell et al., 2013). Research also suggests that there is a stronger positive correlation for girls between difficult parent-child relationships and PDU, than it is for boys (Grogan-Kaylor et al., 2008; Piko & Balazs, 2012; Skeer et al., 2011). Researchers hypothesise that this difference is due to the different coping strategies employed by the two sexes in managing stress, where girls

have a tendency to engage in a more avoidant and non-confrontational way that may increase symptoms of depression and PDU, and boys are more confrontational (Boppre & Boyer, 2021; Kort-Butler, 2009). According to feminist theory the two genders are socialised differently, especially in terms of power and conflict, and therefore these differences may be the result of patriarchal defined gender stereotypes (Covington, 2008; Kort-Butler, 2009). These findings can instigate the design of qualitative research, as the explanation attributed to gender differences in PDU is based on professionals' understandings of the phenomena, rather than the understanding of the people who experience it. Thus, research designed to explore the meaning-making of men and women who have experienced the aforementioned risk factors, regarding their PDU, will enlighten our understanding of these quantitative findings.

In terms of social risk factors for PDU, research has identified: (a) deviant peer relationships (Dodge et al., 2009; Duncan et al., 1994; Musher-Eizenman et al., 2003; Simons-Morton et al., 2001; Snedker et al., 2009; Trucco et al., 2011; Tucker et al., 2011; Whitesell et al., 2013), (b) popularity and peer pressure (Brooke et al., 1990; Diego et al., 2003; Goode, 2007; Grand et al., 2001; Guo et al., 2001; Kandel, 1985; Jadidi & Nakhaee, 2014; Rhodes et al., 2003; Scherrer et al., 2012; Simons-Morton et al., 2001; Trucco et al., 2011; Tucker et al., 2011; Whitesell et al., 2013), (c) bullying (Finkelhor et al., 2005; Frauenglass et al., 1997; Kaltiala-Heino et al., 2000; Nansel et al., 2001; Stuber & Good, 1998; Tharp-Taylor et al., 2009; Thornberry et al., 1993; Walker-Barnes & Mason, 2004; Whitesell et al., 2013), and (d) the socioeconomic disadvantage of the community (Goode, 2007; Jadidi & Nakhaee, 2014; UNODC, 2020b; WHO, 2020b). As deviant peer relationships the researchers define the individual or group association with peers that engage with PDU. Research suggests a significant association between socialisation in deviant relationships, including susceptibility to peer pressure, and difficult parent-child relationship (i.e. presence of abuse and neglect; Brown, 2002; Dodge et al., 2009; Jadidi & Nakhaee, 2014; Nakhaee & Jadidi, 2009; Rhodes et al., 2003; Simons-Morton et al., 2001; Velleman, et al., 2005). Further research suggests that instability in the community environment has also an effect on deviant socialisation, especially because the lack of socioeconomic privilege increases the probability of the presence of other risk factors (Snedker et al., 2009). Although the understanding of these correlational relationships is robust, quantitative research does not allow for an understanding of how adolescents experience their PDU in relation to these social phenomena. Thus, qualitative research would promote our understanding of the processes that link these factors to PDU.

Moreover, bullying has been found to have an implicit effect on PDU, since bullying is suggested to increase probability of the development of depression, anxiety, and other psychosocial problems (Kaltiala-Heino et al., 2000; Nansel et al., 2001). Further research suggests that girls, rather than boys, are more probable to engage in PDU primarily for emotional management (Simantov et al., 2000). On a community level, research suggests that poverty and violence, income inequality, community disorganisation and low social capital, normalisation of PDU in the community, and drug availability, are also positively corelated with PDU (Hawkins, et al., 2002; Herting & Guest, 1995; Roy, 2018; WHO, 2020b). Qualitative research designs would complement these findings and promote our understanding of how adolescents experience their PDU in light of these social influences.

Furthermore, individual risk factors for PDU have been identified by research as relating to mental health, especially to the diagnosis of depression (APA, 2013), which is associated with increase drug use especially in the instances where no other pharmacological or psychosocial intervention is present (Birmaher et al., 1996; Clark et al., 2011; Libby et al., 2005; Rao et al., 1999; Taylor, 2011; Wu et al., 2008). The link between depression, PDU, and the brain's reward system (i.e. dopamine production) has been suggested by several studies (Belujon & Grace, 2017; Brady & Sinha, 2005; Naranjo et al., 2011; Rao et al., 1999;). Researchers hypothesise that this link may provide some grounds for the theory of 'self-medication' (Center for Substance Abuse Treatment, 2014; Khantzian, 1985). In other words, low dopamine in the brain is making the person more likely to seek out to increase dopamine production through PDU (Belujon & Grace, 2017). As research shows, this is a short-term solution since PDU tends to decrease dopamine production in the long-term, thus PDU that was used as a 'self-treatment' is perpetuating and magnifying the issue, making the person more prone to engage with PDU in the future, in order to manage (Belujon & Grace, 2017; NIDA, 2004; Whitesell et al., 2013). This conclusion of quantitative studies promotes the voices and meaning-making of professionals on PDU, allowing little space for the meaning-making of people with these lived experiences. Qualitative research could complement the aforementioned studies and potentially strengthen professionals' meaning-making and highlight aspects of the experience which had not been previously considered.

According to the above studies, in order to design effective prevention and treatment programmes that focus on interventions regarding minimising risk factors and maximising protective factors, we need to enhance our in-depth understanding of how PDU is experienced in relation to these factors. Thus, the role of qualitative research would be of outmost importance in complementing the research body and facilitating the applicability of findings in practice.

1.2.1.4. Women and PDU

A subject that is of particular interest to this research project is literature that involves the experiences of women who engage in PDU. Researchers believe that women are underrepresented in PDU prevalence figures. This claim is supported by a snowball survey conducted in Belgium, which found a much higher percentage of women with problematic PDU than the one identified by official treatment data (EMCDDA, 2008b). A major factor for this underrepresentation is thought to be motherhood, as European data suggests that between 18-75% of women in SM treatment have at least one child. Thus, preoccupation with childcare, which by patriarchal gender norms falls largely on the mother (Brady & Ashley, 2005), and fear around being labelled an 'unfit' mother and risk involvement of social services and removal of the children (EMCDDA, 2000b) might be a barrier to accessing treatment. Qualitative research from a global sample of women who engaged in PDU showed that women have specific reasons behind their treatment struggles, including: (a) shame and stigma, (b) physical and sexual abuse, (c) relationship issues regarding fear of losing children, fear of losing a partner, or needing a partner's permission to obtain treatment, (d) treatment issues, such as lack of services for women, not understanding women's treatment, long waiting lists, and lack of childcare services, and (e) systemic issues, including lack of financial resources, lack of clean/sober housing, and poorly coordinated services (UNODC, 2004).

Qualitative research on women's experiences of PDU, highlights five key issues, including: (a) confusion and desperation that mothers experience when their own children develop drug problems, (b) deprivation and abuse that characterises the lives of many women who go on to develop drug problems, (c) difficulties faced by women who engage in PDU and are attempting to fulfil societal roles as mothers (d) the difficulty of women who engage in PDU in prison, a population that is evidenced to be amongst the most vulnerable subgroup of all women, and (e) stigma, policies and practices that make it generally difficult for women to access treatment (EMCDDA, 2008b). In addition, findings suggest a high prevalence in physical and emotional neglect, and physical and sexual abuse in childhood in their sample, which they interpreted as increasing the vulnerability of women in engaging with PDU (EMCDDA, 2008b). Further findings suggested that women portrayed their PDU as a coping mechanism. The same study also describes that although childhood neglect is a risk factor for both men and women, due to patriarchal gender roles girls are burdened more by domestic responsibilities, and therefore are under more stress (EMCDDA, 2008b; Wincup, 2016). Although this piece of qualitative research complements the body of quantitative research by allowing for an insight of the lifeworld of women who engage in PDU, it does not incorporate the phenomenon of CSA or other ACES into the design; it does not allow for the

development of a trauma-informed understanding of these experiences. Recognising the input of traumatic experiences in women's lives will allow for the development of more effective treatment approaches (Elliott et al., 2005). Therefore, further research on women's experiences of PDU, which incorporate within their aim the inclusion of CSA experiences, or other ACEs, could promote our understanding of these phenomena even further.

1.2.2. Childhood Sexual Abuse (CSA)

In this section I will discuss the wider definition of CSA, which includes a presentation of the concept of ACEs, in order to discuss how CSA falls within the wider context of childhood adversity. The studies presented, which describe the nature of ACEs and the difficulties in adulthood that are linked to them, are well-established quantitative studies that have been replicated over the past twenty-five years. Additionally, in more recent years, qualitative studies have been employed in the research of ACEs. I will discuss these, aiming to explore the meaning-making of ACEs, and the importance of exploring this meaning for women. I will also provide the operational definition of CSA for this study and I will present quantitative research on the prevalence of CSA using that definition, in order to construct an understanding of prevalence rates. Finally, I will present both quantitative and qualitative studies, critically evaluating the findings of the long-term effects of CSA. The studies chosen include either mixed gender samples or women only samples, as this is most relevant to the sample of this research project. Throughout this section I critically review the meaningful omissions of quantitative research and the role of qualitative research in complementing them.

1.2.2.1. Adverse Childhood Experiences (ACEs)

In order to better understand the phenomenon of CSA, we need to first address the wider context of ACEs and how it was developed through research. The ACEs study originated in San Diego at the Kaiser Permanente's Health Appraisal Clinic from 1995 to 1997, it included 17,000 participants, and its main purpose was to find connections between physical health conditions and ACEs (Anda et al., 2009). Overall, ten childhood experiences were categorised as adverse, including: physical, emotional, and sexual abuse, physical and emotional neglect, exposure to domestic violence, household substance abuse, household mental illness, parental separation (or divorce), and having an incarcerated household member (Felitti & Anda, 2009).

Quantitative research suggests a strong positive correlation between ACEs and physical health, mental health, health behaviours, sexual behaviours, and social problems (Anda, 2009; Chang et al., 2019; Cunningham et al., 2014; Dong et al., 2003, 2004; Dube et al.,

2009; Edwards et al., 2007; Felitti & Anda, 2009; Felitti et al., 2019; Ford et al., 2011; Hillis et al., 2004; Karatekin, 2019; Shonkoff & Garner, 2012). Regarding depression and suicide risk, research findings show that in women, 54% of people with a current diagnosis of depression and 58% of suicide attempts are linked to ACEs (Felitti & Anda, 2009; Felitti et al. 2019). In addition, research findings show that health related behaviours such as alcohol abuse and PDU, have a significantly increased risk in appearing in people with ACEs (Dube et al., 2003, 2006; Felitti et al., 2019; Fuller-Thompson et al., 2016; Strine et al., 2012). Systematic metanalysis of studies on ACEs and health outcomes suggest that having multiple ACEs is a major risk factor for interpersonal violence, self-harm (i.e. violence directed towards the self), mental health difficulties and diagnoses (i.e. Post-Traumatic Stress Disorder [PTSD], Complex Post-Traumatic Stress Disorder [C-PTSD], depression, anxiety), alcohol use, and PDU (Hughes et al., 2017).

More recently, qualitative studies aimed to complement the aforementioned quantitative research. Qualitative research aimed to investigate the impact of various ACEs, as perceived by the people who experienced them (LaNoue et al., 2019). Findings suggest that CSA and emotional abuse were rated as the most impactful ACEs. In addition, perceived impact was found to be predictive of health outcomes in adulthood, above the presence of the ACE alone (LaNoue et al., 2019). This study suggests that experiences of CSA, ranked as one of the most impactful ACEs, would be of particular interest and relevance when exploring adult health outcomes, such as PDU.

1.2.2.2. Women, ACEs, and PDU

Specific research on women and ACEs suggests that ACEs are more prevalent in girls than in boys. Thus research and clinical considerations of the impact of ACEs in women's lives is of particular importance (Almuneef et al., 2017; Bebbington et al., 2011; Boppre & Boyer, 2021; Giano et al., 2020; Haahr-Pedersen et al., 2020; Khalifeh et al., 2013; NICE, 2014; Radford et al., 2013). An extensive body of research supports the premise that women tend to respond to ACEs, in particular victimisation and abuse, through the process of internalisation (i.e. engaging in behaviours that attack themselves rather than externalised violence towards others; Bevilacqua et al., 2021; Boppre & Boyer, 2021; Covington, 2003; Haahr-Pedersen et al., 2020; Keirns et al., 2021; Kort-Butler, 2009). Quantitative studies suggest that symptoms of this internalisation include mental health difficulties (such as depression, anxiety, and PTSD), substance abuse, self-harm, and an overall low distress tolerance threshold (Ali et al., 2015; Anumba et al., 2012; Bowles et al., 2012; Broidy et al., 2018; DeHart et al., 2014; Jones et al., 2014, Jones et al., 2018a, 2018b; McClellan et al.,

1997; McDaniels-Wilson & Belknap, 2008; Payne et al., 2007; Salisbury & Van Voorhis, 2009; Scott et al., 2014, 2015; Verona et al., 2015; 2016).

The research body indicates that substance abuse among women is rooted more often in psychosocial problems and traumatic life events, compared to men (Brady & Ashley, 2005). Quantitative research findings show a significant association between CSA and substance abuse in women (Boughner & Frewen, 2016; Cohen et al., 2009; Khoury et al., 2010; Logan et al., 2002; McHugo et al., 2005; Sartor et al., 2013), and in mixed samples (Afifi et al., 2008, 2012; Fuller-Thompson et al., 2016; Kessler et al., 1997; MacMillan et al., 2001; Molnar et al., 2001; Tonmyr & Shields, 2017; Tonmyr et al., 2010; Wu et al., 2010). Further quantitative research findings show that women survivors of CSA are in an increased risk of developing polysubstance abuse (Shin et al., 2010), and CSA in women accounts for a more psychosocially complex client presentation in SM treatment with a lower likelihood for successful treatment outcomes (Boles et al., 2005; Brandon et al., 2012; Cohen & Hien, 2006; Sacks et al., 2008). These findings have also been replicated for participants who are mothers (Canfield et al., 2017; 2021; Gilchrist & Taylor, 2009, Minnes et al., 2008, Tsantefski et al., 2014). Moreover, research suggests the concept of 'self-medication' with alcohol and drugs as more likely for women with ACEs (Brady & Ashley, 2005; Clay et al., 2000; Harris & Fallot, 2001; Miranda et al., 2002; Teusch, 2001), and for women subjected to domestic violence, who tend to use drugs and/or alcohol to cope with the abuse (Gilchrist et al., 2019; Testa et al., 2012). Further qualitative investigation would allow for an in-depth understanding of ACEs, and PDU in women, in an attempt to improve the design of services and treatment programmes.

Boppre and Boyer (2021) aimed to contribute to the research body with a qualitative study, which included a feminist standpoint, exploring the role of ACEs as understood by women who engage with the criminal justice system. Findings suggest that the primary reason of women's involvement with the criminal justice system was ACEs, and that the indirect pathways were primarily reinforced by substance abuse, with 50% of the women identifying substance abuse as their primary reason for engaging with the criminal justice system (Boppre & Boyer, 2021). The findings reflect three reasons for women's engagement with substance abuse: (a) coping/self-medication (Bowles et al., 2012; Broidy et al., 2018; DeHart, 2008; Jones et al., 2018b; McClellan et al., 1997; Salisbury & Van Voorhis, 2009; Scott et al., 2015), (b) escaping insecure households to use with friends or partners (Bloom et al., 2003; Bowles et al., 2012; Chesney-Lind, 1989; Daly, 1992; DeHart, 2008; Gilfus, 1992; Simpson et al., 2008), and (c) familial influences (Bowles et al., 2012; Payne et al., 2007). These findings suggest that women incorporated a link between ACEs and substance

abuse in their understanding of their lives in relation to their involvement with the criminal justice system. In addition, the findings support that CSA is amongst the most impactful ACEs for substance abuse (Boppre & Boyer, 2021). Overall, the researchers suggest that substance abuse perpetuated by ACEs is the primary gendered pathway for women engaging with the criminal justice system, as it has been supported by previous research (Bowles et al., 2012; Broidy et al., 2018; DeHart, 2008; Salisbury & Van Voorhis, 2009; Smith, 2017; Widom et al., 2018). This qualitative study suggests that further research on the meaning-making of PDU of women with ACEs could provide further insight into the perceived role of drugs and ACEs in their lives. This could be especially true if specific ACEs are explored, and different subsets of women are to be included in the sample.

1.2.2.3. Definition of CSA

Although CSA is a widespread phenomenon and a named threat to public health (Tonmy & Shields, 2016), different studies have adopted different definitions of the term (Barth et al., 2013; Stoltenborgh et al., 2011; Matthews & Collin-Vezina, 2019; Sumner et al., 2015). CSA may encompass a variety of sexually abusive acts towards children, and therefore it is important to provide an operational definition for research, knowledge formation, and dissemination of information purposes. The use of different definitions of CSA prevalence, aetiology, and sequelae in research has led to substantial variance in the findings, which poses problems in identifying and tracing the phenomenon over time, across ages, genders, and cultures (Matthews & Collin-Vezina, 2019). The World Health Organisation (WHO, 2006a, p.10) describe CSA as:

> *[…] the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are—by virtue of their age or stage of development—in a position of responsibility, trust, or power over the victim.*

A definition of CSA that defines the acts as 'unwanted physical contact' has been suggested to be the "clearest and least restrictive definition [of CSA]" (Violato & Genuis, 1993, p. 37), and has been adopted by multiple researchers in the development of screening instruments (Dube et al., 2005; Dunne et al., 2009; Finkelhor et al., 2014; McGee et al., 2002; Zolotor et al., 2009). For the purpose of this research, in line with a constructivist paradigm and the phenomenological philosophy, participants were given the opportunity to self-identify as survivors of CSA based on the operational definition by WHO (2006a).

1.2.2.4. Prevalence Estimates of CSA

As discussed above, the variation in CSA definitions has created methodological issues, including sampling and data collection, which may affect the validity of prevalence estimates (Goldman & Padayachi, 2000). In addition, these estimates are largely calculated from retrospective accounts, which may be subject to recall bias (Murray et al., 2015). The WHO 2002 World Report on Violence and Health (Krug et al., 2002) suggests that the CSA cases that are reported to the authorities are more likely to be the ones that are physically violent and therefore require medical treatment, which does not allow for an accurate real-time estimate of less physically violent CSA cases. Research suggests that disclosure is affected by feelings of guilt, shame, perceived responsibility for the abuse, and low self-worth (Fontes, 2007; Goodman-Brown et al., 2003; Krug et al.,2002; Schönbucher et al., 2012), while further research suggests a negative correlation between severity of abuse and likelihood of disclosure (Pain & Jansesn, 2002). Research also suggests gender differences in disclosure of incidents of abuse, (Fontes & Plummer, 2010; Hillberg et al., 2011) which are affected by the social and cultural context, which shape perception of gender and sexuality.

Recent data from the World Health Organisation suggest global CSA prevalence as high as 26% (WHO, 2017), not accounting for the assumption that cases are underreported (Smith et al., 2000; Steine et al., 2017). In the ACEs study 28% of women and 16% of men reported contact sexual abuse (Bryant & Moran, 2020). Studies in the US, of a population-based sample, collected data through interviews from 34,000 adult participants, where 10% of them had contact experiences of CSA, of which 75% were women (Perez-Fuentes et al., 2013). Research on adolescents between the ages of 14-17, with a sample of 4549 participants, suggests that 27.3% of them have experienced CSA in their lifetime (Finkelhor et al., 2009). Meta-analysis that focused on global prevalence on mixed samples of more than 10,000 participants suggested a combined mean prevalence of CSA in 19.7% of females and 7.9% of males (Pereda et al., 2009). Similarly, another meta-analysis of approximately 10 million participants, suggested that CSA prevalence in females was 18% and in males 7.6% (Stoltenborgh et al., 2011). Between 30% and 50% of women survivors of CSA have experienced psychological difficulties that resulted in them seeking therapy (Balloon et al., 2001; Hetzel-Riggin et al., 2007).

1.2.2.5. Long-term Effects of CSA

CSA is an experience contained in childhood, but its effects can be long-term, long-lasting, and may impair the developmental process of the child, contributing to the impairment of the adult's functionality and quality of life. Studies have explored various long-term effects of

CSA on different aspects of the human experience including negative psychological (Fergusson et al., 2013; Noll et al., 2017), physical (Paras et al., 2009), sociological (McLean et al., 2013), and behavioural (Papalia et al., 2017; Singh et al., 2014) consequences. Quantitative research findings suggest that severity of the CSA experience is positively corelated with a greater risk of the development of psychological adjustment difficulties and psychopathology, especially depression, PTSD, and C-PTSD (Briere & Runtz, 1987; Bulik et al., 2001; Cahill et al., 1991; Dinwiddie et al.,2000; Dorahy et al., 2015; Ducrocq et al., 2011; Fergusson et al., 1996; Finkelhor, 1987; Kendler et al., 2000; Kilpatrick et al., 1986; 2000; Mullen et al.,1993; Palic et al., 2016; Romans et al., 1994; 1995; Spaccarelli, 1994; Spaccarelli & Kim,1995). Review of prevalence rates of PTSD amongst survivors of CSA suggests that the diagnosis is prevalent in 20%-75% of the cases, while most severe abuse was positively corelated with higher risk of developing PTSD (Shaaf & McCanne, 1998).

Moreover, studies show that even when PTSD criteria are not fully met, the trauma symptoms can have a significant interference with functioning in interpersonal relationships (Bateman et al., 2013; Davis et al., 2001), general distress (Felitti et al., 1998; Jonas et al., 2011; Marshall et al., 2010), and substance use (Covington, 2008; Fallot & Harris, 2002; Jonas et al., 2011; Najavits, 2009; Norman et al., 2007). It is suggested that trauma-responses can increase risk of substance use problems even if diagnostic criteria are not met (Norman et al., 2007). Studies suggest that CSA survivors tend to experience difficulties in building trusting relationships with romantic partners (Godbout et al., 2009), as well as experience difficulties with parenting their children (Wright et al., 2005). In addition, research conducted on identifying correlational relationship between C-PTSD diagnosis and different types of traumatic events, indicates that a history of CSA is one of the three most prevalent experiences in individuals with C-PTSD. The other two experiences are being adult refugees and ex-prisoners of war, and military veterans and mental health workers (Palic et al., 2016). Quantitative clinical studies of homogenous populations for eating disorders, substance abuse, and PDU, have shown consistent findings of high prevalence of CSA in these populations compared to the general population (Briere & Runtz,1988; Bushnell et al.,1992; Mullen et al.,1993; Romans et al.,1995; Fergusson et al.,1996; Ussher, 1995; Wonderlich et al., 1997). Thus, qualitative research would allow for an expansion of our understanding of how survivors of CSA make sense of their adult difficulties in relation to their childhood experiences of adversity.

Further research findings suggest a positive correlation between CSA and behavioural disorders and substance abuse (Balloon et al., 2001; Briere & Elliot, 2003; Cicchetti & Toth, 2005; Collishaw et al., 2007; Hetzel-Riggin et al., 2007; Hyman & Williams, 2001; Saathoff-

Wells et al., 2005), especially in women (Najavits et al., 1997). Some studies have found a specific association of CSA with substance misuse (Wilsnack et al., 1997) and dependence (Galaif et al., 2001), whereas others failed to replicate this significant relationship between specifically CSA and substance misuse problems in women (Fassler et al., 2005). These inconclusive findings highlight the importance of mediating variables of the effect of CSA on substance misuse problems, including resilience (Benyard & Williams, 2007; Walsh et al., 2009) and severity of abuse (Bulik et al., 2001). One of the main protective factors regarding the development of psychopathology, as suggested by quantitative research, is support in the family environment, and in particular whether the abuse was terminated upon disclosure (Bulik et al., 2001; Hyman et al., 2003; Morrison et al., 2018; Romans et al., 1995; Spaccarelli & Kim,1995). Further qualitative studies, examining circumstances of disclosure, suggest that participants were less likely to disclose to parents when the parent-child relationship was not perceived as trusting and when the child perceived disclosure as a burden to the parent (Schönbucher et al., 2012). Moreover, qualitative studies discuss the importance placed by survivors in receiving parental emotional support. (Schönbucher et al., 2014). These findings suggest that the severity of the impact of childhood adversity does not operate in isolation, and therefore qualitative research could illuminate the meaning-making of survivors of CSA regarding the interaction of different risk and protective factors.

Qualitative research indicates the concept of 'escaping', both physically and mentally, as a perceived attempt to manage the effects of CSA (Darlington, 1997; Jeong & Cha, 2019). The process of escaping has been conceptualised in research through behaviours including substance abuse, dissociation, and suicide attempts (Foster & Hagedorn, 2014; Ligiéro et al., 2009; Phanichrat & Townshend, 2010; Singh et al., 2013; Vilenica et al., 2013). Research suggests that maladaptive attempts of coping in the short-term, such as substance misuse, may jeopardise the long-term process of healing (Filipas & Ullman, 2006). A meta-ethnography of eight qualitative studies, between 2007 and 2017, on the process of healing, analysed the experiences of a majority female sample (Jeong & Cha, 2019). The findings support previous research on the association of reduced negative outcomes of CSA and healing with (a) disclosure, (b) dissociating from the memories (i.e. mental escaping), (c) creating a comfort zone in order to find peace, (d) engagement in on-going self-reflective activities to promote identity development, (e) creating comfort by sharing and connecting with other CSA survivors, and (f) accepting CSA as a part of their life history in order to move forward (Anderson & Hiersteiner, 2008; Arias & Johnson, 2013; Foster & Hagedorn, 2014; Jeong & Cha, 2019; Ligiéro et al., 2009; Phanichrat & Townshend, 2010; Singh et al., 2010, 2013; Vilenica et al., 2013). The researchers suggest that the findings support the model of healing as suggested by Draucker et al. (2011), the

psychological model of account-making (i.e. finding meaning in the experience and develop their self-identity through that; Draucker & Martsolf, 2008; Easton, 2013; Grossman et al., 2006), and the concept of resilience (i.e. the ability to adapt and overcome in the face of adversity; Domhardt et al., 2015; McClure et al., 2008). Qualitative research on coping, healing, and resilience is of particular relevance to this research project as participants are in recovery and these processes may be included in their narratives.

It is evident from the aforementioned studies that the severity and effects of CSA can be conceptualised by the characteristics of the abuse itself in relation to other protective and risk factors. This suggests that a 'CSA psychopathology profile cannot be easily generalised as the combination of factors is unique to the individual (Bulik et al., 2001; Kendler et al.,2000). This assumption highlights the importance of qualitative research in relation to CSA experiences, in order to gain meaningful and in-depth understanding of these individual and subjective processes, and of any specific phenomena that correlate with CSA (i.e. PDU).

1.2.3. Trauma-Informed Care (TIC)

In this section I establish a definition of trauma, and move on to describe Trauma-Informed Care (TIC). I then continue with discussing trauma related diagnoses and their prevalence in women, and specifically in women who engage in PDU. This is particularly relevant to this study as it allows for the development of a premise where trauma has a high prevalence in women who engage in PDU, and therefore should be taken into consideration in understanding individuals' PDU experience in treatment provision. Then I am presenting professional suggestions regarding the application of TIC in research, clinical practice, and policy design, in order to facilitate treatment outcomes. Specific emphasis is being placed on the efficacy of this for women, as this is relevant to the focus of this study. Since TIC is a fairly new concept in social science research and practice, the studies presented are mostly within the past decade, with a few exceptions of less recent studies that draw important links between trauma as a contributing factor to treatment outcomes. Furthermore, I discuss the current state of TIC research and implementation and identify research suggestions to develop our understanding. Throughout this section I critically review the meaningful gaps of quantitative research and the role of qualitative research in managing them.

1.2.3.1. Definition of Trauma and Related Diagnoses

Trauma is defined as the negative psychological implications following ACEs, or exposure to events that are perceived as threatening to the physical or mental integrity of the person.

The most commonly referenced definition is that of the Substance Abuse and Mental Health Services Administration (SAMHSA):

> *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual wellbeing.* (SAMHSA, 2014)

In the definition of trauma, contributions have been made by the American Psychiatric Association via the DSM, and the World Health Organisation via the ICD, through their clear definition of diagnostic criteria that related to the presentation and implications of traumatic stress. The DSM-5 includes a category of Trauma and Stressor-Related Disorders, across the lifespan, which include PTSD, Acute Stress Disorder (ASD), and Adjustment Disorder (AD; APA, 2013). Similarly, the ICD-10 includes a category of Reaction to Severe Stress and Adjustment Disorders, which includes Acute Stress Reaction (ASR), PTSD, and AD (WHO, 2004). In addition to the above, clinical practice and qualitative research with trauma survivors has enriched our understanding of the manifestation of trauma in individuals' lives, beyond diagnoses (Boom & Farragher, 2011; Guarino et al., 2009).

Research and clinical practice suggest that individuals who have experienced multiple, prolonged, and repeated traumas in childhood, especially in the context of important interpersonal relationships, might not fit into the aforementioned diagnostic categories (Herman, 1992). These unique characteristics have been given the proposed name of C-PTSD (Covington, 2008; Ford, 2013; Ford et al., 2009), and although diagnostically recognised by the revised version of the ICD (ICD-11; WHO, 2018) are not yet recognised by the DSM-5 (APA, 2013). Studies suggest that a presentation of C-PTSD can be especially severe if: (a) the traumatic events happened early in life, (b) the trauma was caused by a parent or caregiver, (c) the person experienced the trauma for a long time, (d) the person was alone during the trauma, and (e) there's still contact with the person responsible for the trauma (NHS, 2018). These criteria for C-PTSD severity are very similar to the criteria for CSA severity, as discussed in the section *Long-term Effects of CSA* (Bulik et al., 2001). Thus, the fact that separate bodies of research for CSA and C-PTSD seem to reach similar conclusions in terms of the nature of the traumatic stress effects on the individual, (Auxéméry, 2012; Hyland et al., 2017; Wagenmans et al., 2018) suggests the possibility of high C-PTSD prevalence in survivors of CSA. The gaining popularity of C-PTSD as differential diagnosis to PTSD has given rise to a new wave of research aiming to

highlight the differences of C-PTSD and PTSD (Cloitre, et al., 2014; Courtois & Ford, 2009; Karatzias, 2017). As suggested above, cases who fall under the term C-PTSD are often characterised by a more enduring presentation of symptoms, and a level of impaired functionality that cannot be attributed to the diagnostic criteria of PTSD (Hyland et al., 2018).

1.2.3.2. Definition of TIC

CSA, and ACEs overall, are considered to contribute to the creation of a 'trauma environment' for the development of children (Chapman et al., 2007), and therefore may possibly affect their lives all through adulthood, in what is described in research as 'trauma' or 'traumatic stress' (Piotrowski, 2020), as discussed in the section *Long-term Effects of CSA*. Over the past two decades there have been major developments in the research of trauma and traumatic stress, especially in the fields of developmental neuroscience, clinical psychology, psychiatry, genetics, and immune response (Huber- Lang et al., 2018; Lupien et al., 2009; McCrory et al., 2010; van der Kolk, 2014). Research studies have allowed for an understanding of how trauma survivors think, feel, and behave (Levine, 2010; Perry, 2009), with emphasis on the fact that they are more vulnerable to becoming distressed or retraumatised in interactions where there is an inherent power imbalance, such as healthcare settings (Cadman et al., 2012; Coles & Jones, 2009; Leeners et al., 2007; Reeves, 2015; Robohm & Buttenheim, 1996; Sweeney et al., 2019)

Trauma-Informed Care (TIC) is an example of how trauma-related research has informed treatment provision. This approach aims to reduce traumatic stress for survivors engaging with healthcare provision, in an attempt to increase efficient delivery and positive outcomes (Asmussen et al., 2020; Piotrowski, 2020; Sweeney et al., 2016). TIC includes "the explicit recognition of and deliberate effort to understand the impact of past traumatic events, such as ACEs." (Piotrowski, 2020, p309). One of the most well-known and broadly used definitions of TIC has been defined SAMHSA:

> *[TIC] includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. TIC involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services.* (SAMHSA, 2014, pp. 7–8)

This definition is expressed in 10 principles that underline the implementation of TIC in research and practice: (1) resilience and strengths-based perspective, (2) acknowledging that change is a process, (3) safety, (4) trustworthiness and transparency, (5) collaboration and mutuality, (6) empowerment, (7) voice and choice, (8) peer support and mutual self-help, (9) inclusiveness and shared purpose, and (10) sensitivity to cultural, historic, and gender issues (SAMHSA, 2014). These principles are of particular relevance to this study since the qualitative design incorporates change as a process, trustworthiness and transparency, empowerment, voice and choice, and inclusiveness and shared purpose. In addition, the sample of choice, and the feminist viewpoint expresses sensitivity to gender issues.

The shift in focus from pathologizing to contextualising (Hales et al., 2019) rejects the premise of only treating symptomatology in behavioural health settings, such as SM treatment services, and allows for the placement of symptoms within a greater context that involves client's trauma history (Fallot & Harris, 2009; Harris & Fallot, 2001). The research body supports this assumption as consistent findings from quantitative studies suggest that past trauma has a significant effect on treatment outcomes (Driessen et al., 2008; Najavits et al., 2007) and on clients' overall ability to engage with the treatment process (Amaro et al., 2007; Claus & Kindleberger, 2002). Taking into consideration the quantitative studies on trauma prevalence in clients who engage with PDU, this research aims to promote the subjective meaning-making of women who have experienced both PDU and CSA. This in turn will allow the 'affected' to align, or reject professional understanding of the importance of TIC for PDU treatment.

1.2.3.3. Implications of TIC in Research, Practice, and Policy

This paradigm shift that occurred with the introduction of the term TIC has enhanced the conceptualisation, delivery, and evaluation of policies, service provision, and individual practice (Asmussen et al., 2020; Piotrowski, 2020). In terms of research, TIC has influenced the implementation of research protocols (SAMHSA, 2015a), as it has broadened the spectrum in which we identify phenomena for research and the ways in which we design our methodologies. TIC is of particular relevance to this study, as the investigation of PDU experiences is conducted through the lens of CSA, aiming to increase awareness of how women make sense of their PDU and CSA experiences, in order to enhance the body of research that supports the efficiency of trauma-informed practice and policy design.

In policy design and service provision we might see an implicit or explicit perpetuation or recreation of conditions that might resemble traumatic histories and activate difficult

emotions for clients with these histories (Brady & Ashley, 2005; Reeves, 2015). This process is also called 're-traumatisation' (SAMHSA, 2014) since survivors of trauma are more vulnerable to triggers of feelings of unsafety. Studies suggest that survivors of CSA in particular, tend to carry somaticized memories of trauma (van der Kolk, 2014; van Loon et al., 2004). In his book 'In the Realm of Hungry Ghosts', Maté (2008) describes the need for trauma-informed approaches of engaging clients with treatment for drug addiction. He describes a study conducted in 1999 that compared the effects of two methods of engaging clients in treatment, employed both by professionals and families. The outcomes of the study suggest that 64% of participants engaged with treatment when a 'nurturing and compassionate' approach was implemented, a number that is more than double to the 30% of engagement from participants who were met with a confrontational approach. He concludes that "Contrary to a popular misconception, confrontational 'tough love' is likely to fail" (Maté, 2008, p. 378). These confrontational models, used in traditional therapeutic communities (Brady & Ashley, 2005), are thought to present a gendered barrier to treatment, especially due to the high prevalence of trauma for women service users (Copeland, 1997). As aforementioned, a non-TIC approach is likely to 're-enact' traumatic experiences and trigger distress, leading to re-traumatisation, especially due to the inherent power imbalances between clients and practitioners (Brady & Ashley, 2005).

Further research has studied the implementation of TIC in the context of addiction treatment, where prevalence of trauma is high (Brown et al., 2013; Elliott et al., 2005; Finkelstein et al., 2004; Frisman et al., 2008; Harris & Fallot, 2001) especially in gender-responsive treatment settings for women (Covington, 2008; Tompkins & Neale, 2018) and integrated treatment programmes for mothers (Neo et al., 2021). Women who enter SM treatment report emotional, physical, and sexual abuse in adulthood and childhood, as well as chronic history of SM, experiences of sex-work, incarceration, and enduring psychosocial problems of compromised personal support networks (Hammersley et al., 2016; McKeganey et al., 2005). Findings indicate a higher percentage of treatment adherence and a higher percentage of positive treatment outcomes for clients in trauma-informed treatment programmes (Brown et al., 2013; Hales et al., 2018; Neo et al., 2021). These results are supported by the assumption that fewer, or no experiences of re-traumatisation and an understanding of holistic needs allow for an increased quality in the therapeutic or caring relationship between clients and professionals, which increases the likelihood of treatment adherence (Piotrowski, 2020; Neo et al., 2021; Tompkins & Neale, 2018).

The results of a 12-month follow-up RCT study that was conducted with over two thousand women service users in SM treatment, half receiving TIC and the rest the usual treatment,

suggest that TIC had an improvement for mental health but not for SM. Thus, researchers suggest an integration of substance abuse, mental health, and TIC in treatment, since this integration showed significant improvement in symptoms (Morrissey et al., 2005). Additionally, a qualitative study on the implementation of a TIC protocol in a women-only residential rehabilitation setting found that incorporating a TIC protocol in SM treatment offered a valuable approach, but not guaranteeing recovery outcomes as measured by most services (i.e. abstinence). Researchers suggested that the complex issues of women, who have experienced trauma and re-traumatisation, need to be taken into consideration not only in modifying mainstream service provision, but also in how treatment outcomes are measured (Tompkins & Neale, 2018). Thus, qualitative research on trauma survivors who engage in PDU would provide valuable insight in informing service design and revising outcome measures.

Covington (2008) suggests that the consideration of both gender issues and trauma histories is of outmost importance when designing SM treatment protocols, and therefore she proposes gender-responsive treatment in the face of the Women's Integrated Treatment (WIT) model. The proposal of the model is based on the body of research that stresses the importance of acknowledging gender specific needs in treatment design (Bloom et al., 2003; Grella, 1999; Grella et al., 2000; Orwin et al., 2001). This is especially true as she suggests women are socialised differently than men and therefore have different needs and experiences than them. She also argues about further discrimination against women, as 'gender neutral' programmes are actually male-based, since the majority of research in substance abuse and PDU is androcentric (Covington, 2008). The aforementioned studies of RCTs and focus groups provide us with supportive findings for the implementation of a treatment model that incorporates both trauma and gender for women with substance abuse issues, and for women with experiences of incarceration (Bond & Messina, 2007; Messina & Grella, 2008). This suggestion is very relevant to the current study because it is based on similar principles: substance abuse, ACEs, TIC, and gender. Thus, this study can enhance our understanding of how women survivors experience PDU and whether they agree with the importance of these principles.

Although there is a large body of research, and knowledge from clinical practice, supporting the further exploration and implementation of TIC, there is also criticism of the current research body. The application of TIC is a recent practice and therefore systematic reviews evaluating the results of the approach are only preliminary, as most lack a comparison group (Bailey et al., 2019; Berger, 2019; Bunting et al., 2019; Thomas et al., 2019). Therefore, rigour appeared to be an issue when reviewing studies (Maynard et al., 2019), especially

regarding the reduction of trauma symptoms (Champine et al., 2019). Another issue that was identified was that the TIC protocol includes mainly theory on the effects of ACEs, without necessarily identifying specific skills that would help practitioners translate this knowledge into practice (Alessi & Kahn, 2019). A number of studies evaluating the efficacy of TIC suggest that the results are inconclusive, since they are not able to identify whether any positive outcomes where due to TIC or other factors, especially since there is no specific standardised-skill protocol that was implemented across services (Atwool, 2019; Sweeney et al., 2018; Jankowski et al., 2019). Findings from quantitative studies could gain in validity if there is a clear universal TIC-skills practice in place to be evaluated (Asmussen et al., 2020). Qualitative studies could support this by incorporating the subjective experiences of service users in the development of a TIC protocol, and in its implementation and evaluation.

1.2.4. Feminist Theory

1.2.4.1. Definition of Feminist Theory

> *She is defined and differentiated with reference to man and not he with reference to her; she is the incidental, the inessential as opposed to the essential. He is the Subject, he is the Absolute — she is the Other.* (de Beauvoir, 1973, xxii)

Feminist Theory explores topics of discrimination (Rotosky & Riggle, 2002; Szymanski, 2005; 2006), objectification, oppression (Brown, 1994), patriarchy (Gilligan, 1977; Lerman, 1990), stereotyping, and others. Central to these subjects is the concept of power, and therefore power inequality, its manifestation in society, and the implication it has for individuals and systems. The power dynamics of a patriarchal society can account for the negative impact they have on the oppressed group (Parritt, 2016). Intersectional Feminist Theory has contributed to the study of how different parts of the identity, including gender, race, socioeconomic background, and others, intersect and create different layers of social oppression and privilege (Carbado et al., 2014; Crenshaw, 1989; Davis, 1974). According to feminist theory, the possibility of healing from the impact of oppression comes from dismantling it and reaching an egalitarian status quo (Brannon, 2016; Szymanski, 2005). This will allow for affirmation of experiences, and the development of positively impactful structures and role models (Szymanski et al., 2008). Along these lines of gender empowerment, the present study aims to facilitate the prevalence of women's voices in a predominantly androcentric field (Covington, 2008; Thom, 2010; Wincup, 2016).

1.2.4.2. Implications of Feminist Theory in Research, Practice, and Policy

Feminist theorists and researchers suggest that research can discriminate against, or empower specific social groups, as socio-political policies and health institutions do, because research helps shape the practices of these institutions (Harding & Norberg, 2005; Oakley, 1998; Wincup, 2016). Hence, Feminist Theory can have multiple implications for research, practice, and policy. In particular, feminist researchers have consistently discussed how the quality of research projects can be evaluated through the practical implications they have to improve the quality of women's lives (Harding & Norberg, 2005). Feminist researchers in the field of social sciences have discussed that research is largely androcentric, where men were regarded to be the 'norm' and women were by default regarded as irrelevant, or 'deficient', for understanding the human experience (Crawford & Marecek, 1989; Hare-Mustin & Marecek, 1990; Magnusson & Marecek, 2017; Tavris, 1993; Wigginton & Lafrance, 2019). The androcentrism of psychological and social research has influenced some researchers to incorporate a critical feminist lens into their research topics and designs, in order to increase representation of marginalised populations in mainstream research, and enrich pre-established theories and understandings of social and psychological processes (Gilligan, 1982; Hare-Mustin & Marecek, 1988, 1990; Oakley, 1998; Smith, 1987, 1991; Tavris, 1993; Wigginton & Lafrance, 2019). In addition, closing the gap of this inequality between researchers and participants is central to the idea of feminist inspired research (Allen, 1998; 1999; Caputi, 2013; Hartsock, 1983; 1996; Oakley, 1998; Yeatmann, 1997; Young, 1992). In an effort to do that, feminist standpoint theory in research aims to (a) take the interests of the oppressed into consideration when representing the world; (b) facilitate the understanding of the oppressed regarding their problems; and (c) have a utilitarian value for the oppressed in aims to improve their condition (Harding, 1991; Hartsock, 1996). Based on these premises, the present study is centred around women's experiences, allowing for women's subjective meaning-making to inform mainstream understanding.

A review of contemporary UK drug policy (Wincup, 2016) suggests that without recognising the points of similarity and differences between female and male drug users it is impossible to develop gender-responsive policies. In her review, she highlights intersectionality as an important variable, since PDU can be part of individual, socioeconomic, and cultural structures of inequality (Stevens, 2011). In investigating the Recovery Agenda from a feminist lens, she highlights the need for qualitative research in understanding the differences of meaning making between men and women (Thom, 2010; Wincup, 2016). The concepts of 'wellbeing' and 'citizenship' are central in PDU recovery. These are perceived as gendered concepts that further promote oppressive patriarchal roles and values for women

(Wincup, 2016). In order to approach them from a feminist standpoint, we need to recognise the structural constraints that diminish and undermine wellbeing and citizenship for women (Lister, 1997). The way they are defined by UK drug policy puts the responsibility solely on the individual, without considering the patriarchal constraints of women. Therefore, women are measured on the same expectations as men, even though they are expected to fulfil different roles and are given less resources (Wincup, 2016). Incorporating a feminist lens in the present study may be impactful for women in various levels, including the representation and the diversification of knowledge, which in turn will influence the shaping of more inclusive theories that will inform non-discriminatory policies, and service provision. In that way, the gap of power inequality will start to bridge. In line with Thom's (2010) suggestion of needing more evidence on women's journeys, this qualitative study aims to add to the pre-existing research body by exploring women's lived experiences of PDU.

1.2.5. The Role of Qualitative Research in Formulating PDU

Research in the field of PDU has been mainly quantitative, exploring the aetiology of PDU (EMCDDA, 2021; NIDA, 2021; ONS, 2020a; SAMHSA, 2021; UNODC, 2021). In the process, quantitative studies have linked ACEs and CSA with a higher risk in engagement with problematic PDU in adolescence and adulthood (Briere & Runtz,1988; Mullen et al.,1993; Romans et al.,1995; Fergusson et al.,1996), especially in women (Najavits et al., 1997). As a consequence, the scientific community has consistently tried to shape the phenomenology of PDU as it is observed by professionals, neglecting to place sufficient emphasis on the meaning of PDU as it is experienced by individuals.

Due to professional ethics in human research (Mandal et al., 2011), it would be unethical to employ experimental designs to get a clear picture of the exact cause and effect relationship between ACEs and PDU, and therefore quantitative studies can only provide us with correlations between risk factors and PDU and the role of protective factors in mediating this relationship (SAMHSA, 2019). Thus, the employment of a qualitative design seems necessary and fundamental in developing our understanding of the perceived function of PDU (Carlson et al., 1995; EMCDDA, 2000b). The role of qualitative research is therefore to focus on the meanings, the perceptions, and the characteristics that participants attribute to drugs and PDU, in an attempt to gain an in-depth understanding of the 'lifeworld' of participants (Smith et al., 2009) and 'the world of drugs' (EMCDDA, 2000b). Overall, there are multiple advantages of qualitative research for PDU that will allow for a deeper understanding of how it is precipitated and experienced, which in turn can inform the development and design of policy, prevention programmes, and treatment provision. The main roles of qualitative research in the topic of PDU are to reach and research hidden

populations, understand the experience and meaning of PDU, understand the social context of PDU, inform the design of quantitative research, complement and question the findings of quantitative research, and inform the development of effective interventions and policies (EMCDDA, 2000b).

The research topic of PDU is not a topic of only academic and theoretical interest. Millions of people around the world are affected by problems created due to their engagement with PDU (UNODC, 2021). Therefore the clinical and real-world applications of research findings are at the core of the aims of the research body. From the development of fair and effective policy, to the development of impactful and efficient prevention and treatment programmes, meaningfully applicable findings in PDU research are crucial. The way to do this is through getting the populations' own views (Morrison et al., 2002), thus, qualitative research has been perceived by the scientific community as an indispensable complement to quantitative studies (Bourgois, 2002; Martin & Stenner, 2004; McKeganey, 1995).

1.2.6. Summary Review of Literature Findings

The literature that has been presented and reviewed in this chapter represents the four standpoints of PDU, CSA, Trauma-Informed Care, and Feminism. Thus, an integrated review of the strengths and weaknesses of their findings is instrumental in building a picture of the current research landscape of the PDU phenomenon as it manifests in women CSA survivors. The overall findings of the aforementioned quantitative research suggest that women are at statistical disadvantage in experiencing ACEs, and CSA specifically. In addition, the aforementioned research significantly links ACEs and CSA to mental health difficulties, psychiatric diagnoses, and damaging health behaviours, including substance use. Girls are also statistically more likely to engage in avoidance-based behaviours in order to cope with emotional difficulties, rather than confrontational-based behaviours. Substance use has been conceptualised by research as an avoidance-based behaviour. Even though the above connections have been made separately, there is very limited research focus on women's substance use. This underrepresentation is critiqued by feminist researchers as a perpetuation of the power imbalance that overlooks women in both research and society. The current qualitative research has not integrated the concept of childhood trauma, CSA, or ACEs in the exploration of the lived experiences of women who use substances. The lack of integration of these phenomena in substance use research overlooks their potential influence on our understanding of substance misuse. Thus, the trauma narrative is not given a platform to unveil instrumental parts of the PDU experience.

Moreover, the reviewed qualitative research suggests that women are in a disadvantage when trying to access treatment services for substance use, as they are concerned with societal stigmas around women's roles, especially motherhood. Additionally, evidence-based treatment services are designed based on research with predominantly male participants, which results in an omission of any specific needs that women may have. Research on the experiences of women with PDU suggests that the majority of the sample have multifaceted needs, including mental health and traumatic histories. Findings from research on Trauma and Trauma-Informed Care suggests that people with traumatic histories, including the diagnoses of PTSD and C-PTSD require specialist care in order to avoid re-traumatisation and increase treatment access and adherence, while also increasing positive treatment outcomes. Thus, integrating trauma-informed care is relevant in the conceptualisation of appropriate treatment provision for women.

1.3. The Present Study

1.3.1. Rationale

As previously discussed, research on PDU has been in its majority androcentric. Consequentially, SM service provision has been designed based on findings from male participants, catering to their needs. The majority of the PDU research body is comprised of quantitative studies (EMCDDA, 2000b; Martin & Stenner, 2004). Thus, there is a research need in understanding in-depth the experiences of people who engage in PDU through a qualitative paradigm, in order to enrich our understanding of their worldview. Although there is a quantitative body of research suggesting a positive correlation between CSA and mental health difficulties, which are in turn positively corelated with PDU (Palic et al., 2016), there is insufficient understanding on the individuals' subjective meaning-making. This is also mirrored in SM treatment provision, where the design and treatment provision of SM services in the UK is not trauma-informed. Research suggests that TIC supports client retainment in treatment and increases the probability of achieving treatment goals. Gaining an in-depth understanding of the experience of PDU from CSA survivors , will allow for a trauma-informed understanding of PDU, which in turn will support the appropriate implementation of TIC within SM services. This will promote both the wellbeing of the service users, as well as the quality of work for professionals and organisation, as they will see an increase in providing efficient treatment.

Taking into consideration the intersectional notion of feminism and how it is expressed in feminist theories (Carbado et al., 2014; Crenshaw, 1991; Davis, 1974) we can assume that a person's oppression via social power inequality is magnified by the number of oppressed groups they belong to (Allen, 1998; 1999). Thus, women who are survivors of CSA,

experience mental health difficulties, and engage in PDU, are in the intersection of oppression in various levels. In addition, considering women's underrepresentation in PDU research and SM treatment provision, there is an added system of oppression as a barrier to treatment request and provision for women. Therefore, creating a platform where women are given a voice through the opportunity of expressing their experiences, will allow for a dismantle of oppression (a) via representation in research, and (b) via the request for the provision of trauma-informed and gender-responsive prevention and treatment programmes.

1.3.2. Research Questions

RQ1: How do women survivors of CSA experience PDU?

RQ2: How do women survivors of CSA make meaning of their PDU in relation to their trauma?

1.3.3. Relevance to Counselling Psychology

As mentioned above, policies regarding PDU and SM services are mostly informed by quantitative epidemiological studies, and therefore the field of Counselling Psychology has not been as prevalent in SM research and practice (Martin et al., 2016). Introducing a trauma-informed understanding of PDU, and therefore shifting the focus from the behaviour (i.e. the content) to the historical and current psychosocial aspects of PDU (i.e. the process) allows for Counselling Psychology to come at the forefront of PDU research and treatment practice. This study can enrich existing quantitative findings that support a correlation between CSA and PDU (Hamburger et al., 2008; Kilpatrick et al., 2000; Simantov et al., 2000), complement existing qualitative studies (Boppre & Boyer, 2021) and contribute to our understanding of how Counselling Psychology can influence the development of policies, SM services, and trauma-informed interventions, in order to enrich the field of PDU prevention and treatment provision. This can promote the role of Counselling Psychologists in informing commissioning decisions, as well as their role in SM treatment services overall, including leadership and clinical positions. Additionally, enriching our understanding of trauma and PDU can contribute to the development of various professionals including psychiatrists, psychologists, psychotherapists, social workers, recovery workers, specialist nurses, and other practitioners/service providers.

Finally, the choice of a qualitative paradigm, and more particularly of IPA, allows this study to focus on the experiences of participants, a practice that is in line with the values of Counselling Psychology, as defined by the British Psychological Society (BPS, 2021b) including creativity, compassion, collaboration, and ethical and reflective practice. The present research may encourage Counselling Psychologists and other mental health

practitioners to enhance their understanding of PDU and view it as relevant to the field of mental health (Maté, 2008). The introduction of a trauma-informed psychological formulation creates a direct link between Counselling Psychology and PDU and strengthens the argument that Counselling Psychology can help the majority learn from the 'other', in order to promote diversity, represent vulnerable populations and minorities, and advocate for a more inclusive practice, as well as a more inclusive society (Parritt, 2016).

2. Chapter 2: Methodology

2.1. Overview

This chapter aims to discuss a number of principles relating to methodology and procedures. I start by defining the research aims and research questions, so that all following methodological discussions can be rooted in these. I proceed to introduce the chosen research design and discuss the rationale for this choice, before presenting the philosophical underpinnings of IPA and discuss the reasons behind its suitability in addressing the aims and research questions, based on its philosophical underpinnings. Up next, there is an outline presentation of the exact procedures that were followed and the ethical considerations that were considered when designing them. The analytical design is being discussed, and the process of reflexivity is addressed, both from an epistemological and personal standpoint. The final section is dedicated to exploring the validity and quality of the research design, with reference to specific criteria for the evaluation of qualitative research.

2.2 Research Aim

There is a body of quantitative research exploring the comorbidity and correlation of ACEs, and substance use in adulthood, with an emphasis on identifying risk and protective factors for its development (SAMHSA, 2019). Some of these studies concentrate on CSA and PDU, thus further research is needed to explore the nature of PDU, as experienced by CSA survivors. This will allow us to look at these experiences in depth and inform our understanding of them, beyond their quantitative comorbidity. In addition, the research is highly androcentric, with men making the majority of most research samples (Fine & Gordon, 1989; Tavris, 1993). Studies in a variety of subjects suggest that there can be gender differences when exploring meaning-making of experiences, and therefore there is a risk of missing those if gender is not accounted for in samples (Thom, 2010). Hence, studies who account for women's experiences are needed to enrich women's representation in research that informs our understanding of phenomena, and the actions that are taken from these understandings. The aim of this research study is to embark into an in-depth exploration of the lived experiences that women survivors of Childhood Sexual Abuse (CSA) have of Problematic Drug Use (PDU). At the core of the study is the aim to capture the subjective meaning-making of women's experiences of PDU, in their own words, including any perceived relationship between CSA and PDU.

2.2.1. Research Questions

RQ1: How do women survivors of CSA experience PDU?

RQ2: How do women survivors of CSA make meaning of their PDU in relation to their trauma?

2.3. Rationale for Chosen Research Paradigm

The two research paradigms, quantitative and qualitative, have one core difference rooted in their assumptions around the nature of human experience and knowledge (Bhati, Hoyt & Huffman, 2014). These assumptions inform the way each paradigm approaches the investigation of phenomena, which in turn informs the formation of research questions, the nature of data they seek to gather, the manner in which the data is analysed, and finally, the nature of the conclusions they aim to reach. The quantitative paradigm aims to explore and define relationships between phenomena as they are observed from the outside, influenced by a positivistic investigation and employing methods of a hypothetico-deductive nature (McGrath & Johnson, 2003). Therefore, the quantitative methods aim to quantify data, and by defining certain phenomena as variables they aim to explore the causal, or correlational, relationship between them (Pontoretto, 2005). This is usually achieved by using large samples that aim to confirm a hypothesis regarding that relationship, embracing a nomothetic, generalisable, and universal perspective. The qualitative paradigm aims to explore the experiential nature of psychological phenomena as they are experienced by people, often incorporating the words participants use to describe their lived experiences, in order to enhance the understanding of the subjective meaning-making (Willig, 2013). In doing so, qualitative methods usually include a much smaller sample than quantitative, aiming to enhance the idiographic perspective (Pontoretto, 2005).

Taking into consideration the above understandings of both paradigms, and comparing them to the research aims, it is evident that a qualitative paradigm would best facilitate the exploration of the research questions. A qualitative paradigm would allow for the voices of participants to be expressed freely and openly, a practice that is of particular importance when the population under investigation (i.e. women) has been historically under-represented in psychology and social science research (Covington, 2008; Hays-Gilpin & Whitley 1998; Jordan & Hartling, 2002; Langdridge & Hagger-Johnson, 2009; Stacey & Thorne, 1985). In addition, Stanley and Wise (1983) suggest that only qualitative methods allow for the acceptance of women's reports of their experiences in their own terms. This is because qualitative methods allow for the manifestation of feminist values that avoid replicating the power dynamics between researchers and participants that could occur in a researcher-led or discipline-led quantitative design (Oakley, 1998). Consequently, the use of qualitative methods would allow for a deeper understanding of the phenomenon of interest as it is experienced by women survivors of CSA.

Moreover, a qualitative study would enrich and compliment the current quantitative body of research that has focused on establishing a correlational relationship between trauma and

addiction, providing the depth of understanding that hasn't been sufficiently captured yet (EMDCCA, 2000b).

2.4. Philosophical Underpinnings of Research Paradigm

2.4.1. Constructivist Research Paradigm

Defining the ontological and epistemological positions of the research is of outmost importance, as it will allow us to gain a significant understanding of the outlook with which the study sets out to answer the research questions, as well as the outcomes themselves (Gregor, 2006). The qualitative research paradigm of the study aims to produce knowledge about the nature of the lived experience of women survivors of CSA, in an attempt to understand their subjective meaning-making of their PDU experiences. The present research is consistent with a constructivist paradigm that adheres to the scientific notion of a reality that exists independently of human consciousness and experience (Levers, 2013), and the only way of accessing knowledge of this reality is after it is "filtered through the lenses of language, gender, social class, race, and ethnicity" (Denzin & Lincoln, 2005, p. 21). According to Crotty (1998), in a constructivist paradigm, meaning is created through the interaction between what is under interpretation and the interpreter. In other words, the interaction between the women's narratives of a phenomenon and the researcher, who although being separate from the phenomenon, cannot be entirely objective. Therefore, society influences both parties of the meaning-making interaction, the interpreted and the interpreter, who is aware of these influences and the way they inform their observations and interpretations. This has as an outcome for the researcher to not attempt to discover the Truth, but rather conceptualise any findings as a product of a construction that is ultimately influenced by its situation in society (Levers, 2013).

The addition of a feminist lens onto the constructivism paradigm suggests the importance of taking into consideration the influence of power and gender, which are "integral elements in processes of construction" (Locher & Prügl, 2001, p. 111). The feminist lens is relevant in this study as both power and gender can be perceived as integral parts of the phenomenon of interest.

2.4.2. Critical Realism Ontology

Etymologically the term 'ontology' is derived from Greek, where the word «ών» (on) meaning 'being' and the word «λόγος» (logos) meaning 'speech of' or 'study of' are combined (Merriam-Webster). Therefore, ontology's definition is 'the study of what is' or in other words, 'the study of being' (Crotty, 1998, p.10). Ontology "raises basic questions about the nature of reality and the nature of the human being in the world" (Denzin & Lincoln, 2005, p.183), and

is attempting to answer the debate of whether the existence of reality is independent of human existence, or whether human consciousness is the only medium through which reality exists (Levers, 2013).

The ontological position I'm adopting for this study is that of the critical realist. This perspective suggests that reality's existence is not dependent on the human mind. Whether human consciousness is able to directly comprehend, or experience, reality, is independent of its existence (Levers, 2013). An important aspect of critical realism is that ontological existence does not equate or depend on epistemological awareness. In other words, there is a belief that the human mind cannot access but fragments and glimpses of the independent existence of the world (Letourneau & Allen, 2006). The ontological position of critical realism is fitting with the purpose of this study as it is aligned with the identification of phenomena, and the development of an understanding of the whole, by the descriptions of glimpses from its parts (Bergen, Wells, & Owen, 2010). In line with the qualitative paradigm, in the critical realism perspective, Truth is achieved by reasoning rather than pure observation (Clark, MacIntyre, & Cruickshank, 2007).

2.4.3. Relativist Epistemology

Etymologically, the term 'epistemology' is derived from Greek, where the word «επίστασθαι» (epistasthe) meaning 'to know' and the word «επιστήμη» (epistēmē) meaning 'knowledge' (or 'science' in modern Greek), are combined with the word «λόγος» (logos) meaning 'speech of' or 'study of' (Merriam-Webster). Therefore, epistemology's definition is 'the study of knowledge' or 'the study of knowing', in other words, "a way of understanding and explaining how I know what I know" (Crotty, 1998, p.3). According to Willig (2013) qualitative research allows for a spectrum of epistemological positions, ranging from 'Naive Realist' to 'Radical Relativist'. The position of 'Naive Realist' position suggests that the research data can accurately represent a universal Truth, while the 'Radical Relativist' position rejects the concept of one universal Truth and embraces the historical, cultural, social, and linguistic construction of a subjective reality. The epistemological position I adopt for this study is between critical realism and radical relativism; accepting the existence of an external reality, while understanding that it is impossible to attain a universal understanding of it that remains unaffected by individual reflections and interpretations (Levers, 2013).

2.4.4. Feminist Standpoint Epistemology

Feminist Standpoint Theory enriches the epistemological position of relativism by introducing another layer of attaining knowledge. Feminist epistemology introduces the importance of exploring 'who' can know, or who is the knower (Anderson, 2011; Haraway, 1988),

investigating how gender, and other social experiences, influence the process of 'knowing'. This exploration rejects the notion that there can be a detached and neutral knower who can objectively and value-free pursue and represent reality (Smith, 1991). Moreover, it is important to acknowledge the influence of the social context of the researcher (i.e. the knower) in forming the research questions, designing the study, collecting and analysing the data, and ultimately producing the knowledge (Naples, 2007). This notion rejects the claim that there can ever be a purely positivist-realist scientific design as all research is conducted by unavoidably biased humans (Haraway, 1988; Harding, 1992; Hesse-Biber, 2012; Riger, 1992).

Smith (1987) suggests that women experience a division in consciousness, in that they experience life through the female lens, but the only conceptual categories to make sense and identify these experiences are solely male. To address this, Feminist Standpoint Theory suggests the understanding of phenomena, by exploring how they are experienced by people who don't belong to the dominant group (Wigginton & Lafrance, 2019b). Harding (1996) clarifies:

> *The point here is not that every poor or otherwise marginalised person already can or does 'see the truth', but rather that discourses oppositional to the dominant ones can arise as marginalised groups begin to articulate their histories, needs, and desires 'for themselves' instead of only in the ways encouraged by their 'masters' favoured conceptual frameworks.* (pp. 445–6)

This epistemological framework suggests that researchers sharing the standpoint of the population under investigation (i.e. woman researcher studying the experiences of women), are better equipped to understand and interpret the world view that is expressed through the participants and the data (Colins, 2000). Harding (2008) argued that researchers of dominant groups investigating phenomena relating to non-dominant groups are particularly inadequately equipped to reflexively identify oppressive features and biases of their own world view. Research on women's underrepresentation in the sciences shows that theories produced from a feminist standpoint epistemology have been more empirically adequate, than similar research produced by non-feminist researchers (Rolin, 2006; Wylie, 2009). Important additions to the Feminist Standpoint Theory, also, suggest that feminist standpoint epistemology is intersectional and therefore gender is not the only attribute that can influence the production of knowledge. The way to a theory of feminist intersectionality was led by African American scholars who in addition to gender, included race, sexuality,

disability, age, and social class, in their feminist epistemological process (Collins, 1990; Crenshaw, 1991).

In summary, feminist standpoint epistemology suggests that epistemological authority lies with the experiences gained through specific societal perspectives, and access to the deeper levels of societal knowledge lies with the groups that have been most systematically oppressed (Anderson, 2011).

2.5. Rationale for using IPA

Interpretive Phenomenological Analysis is designed to explore the experiences of participants and the meaning the attribute to them, while at the same time identifying key themes that characterise these experiences (Smith, 1996; Smith & Osborn, 2003). For this study, IPA was considered and chosen as the most suitable method for a variety of reasons. In accordance with the aims of the study, IPA's main purpose is to explore the links that exist between people's description of their experiences, their behaviours, and their cognitions (Smith, 1996). Additionally, IPA has been described as a useful research method in the fields of applied psychology and mental health, as it adheres to the realist ontology (Scotland, 2012). Other qualitative methods, which have methodological resemblance to IPA, were considered, such as grounded theory (Willig, 2008), discourse analysis (Kaplan & Grabe, 2002), and narrative analysis (Linde, 1993), but their fundamental focus diverted from the aim of the study, which is to gain an understanding of the experience of PDU from the perspective of women survivors of CSA. IPA provides the opportunity to not only understand in-depth the experiences of participants, but also for participants' own subjective meaning-making to emerge in the data collection process. In this respect, IPA allows for the emergence of data similar to the ones that surface during the psychotherapeutic process. Thus, IPA can create a bridge between the research and clinical processes and their often diverse meaning-making and data collection standpoints. Quantitative methods were discarded as an inappropriate research medium, due to their emphasis on causal relationships, objective measurement, and generalisability, which are not in accordance with the aim of the study.

2.6. Philosophical Underpinnings of IPA

The Interpretive Phenomenological Analysis (IPA) approach is a qualitative approach to research, which aspires to "gain a better understanding of the nature and quality of phenomenon as they present themselves" (Willig, 2008, p, 56), and its theoretical roots lie within critical realism (Bhaskar, 1978) and the social cognition paradigm (Fiske & Taylor, 1991). Through IPA researchers are presented with the opportunity to explore the views,

understandings, perceptions, and experiences of participants (Brocki & Wearden, 2006), by making use of qualitative data that have been gathered through interviews, or other media (Smith & Osborn, 2003). IPA enhances and emphasises the subjective meaning that people attribute to their lived experience, while also acknowledging the situational and social aspects that have influenced this meaning-making (Willig, 2013). It has been suggested that the fundamental aim of IPA is to gain an 'insider understanding' of the phenomenon that is being studied, through recognising the instrumental role the researcher holds as an instrument of analysis (Smith et al., 1999). The researcher's subjective beliefs are not necessarily regarded as biases, but as an important component in the analytical processes of making sense of the participants' experiences, through the process of interpretative activity (Smith & Eatough, 2007). The process of interpretative activity is described by Smith and Eatough (2007) as a process of 'double hermeneutics', where the participants have initially made sense of their experiences, and then, as a second process, the researcher is called to make sense of the participants' attempts to make sense of their experiences.

The IPA approach was initially developed for undertaking experiential research in psychology by Jonathan Smith (1996). Since then, the methodology has gained grown popularity within the field, especially in the UK (Biggerstaff & Thompson, 2008), as it is one of the main chosen methodologies for qualitative research in the fields of both counselling and clinical psychology. Since its development, IPA's popularity has also grown in other disciplines, becoming a well-established methodology in other human-centred fields, including the social and health sciences (Smith et al., 2009). The three main philosophical pillars underpinning the theory of IPA are phenomenology, hermeneutics, and idiography (Smith et al., 2009). In the following sections I explore the bases of phenomenology, the role of hermeneutics, and the influence of idiography, finishing with a description of the key elements of the IPA methodological framework.

2.6.1. Phenomenology

Phenomenology studies the ways in which events are incorporated in experiences, while attributing emphasis on the things that are by principle meaningful and contribute to a person's lived experience (Smith et al., 2009). The two philosophically historical phases from which phenomenology derives are the transcendental and the existential, or hermeneutic (Smith et al., 2009). Grounded on the philosophical ideas of Husserl is transcendental phenomenology, which is based on Husserl's focus on the perception of the world through conscious acts and experience (Langdridge, 2008; Brocki, & Wearden, 2006; Smith, et al., 2009). According to Husserl (Smith et al., 2009) the core of transcendental phenomenology includes the effort of identifying the fundamental variables of the experience, through the

process of methodological reductions. He suggested that phenomenology explores in detail the human experience by putting emphasis on allowing individuals to identify the fundamental variables of their experience of a particular phenomenon. Husserl (1970) supported the idea that when these fundamental variables have been acknowledged, they could transcend the individual's particular circumstances and could be used to inform the experiences of others as well (Smith et al., 2009). Husserl argued that in order for the experience to be examined, individuals would need to employ, through reflexivity around their inner experiences, a phenomenological attitude (Smith et al., 2009). For this phenomenological attitude to be achieved, Husserl (1970) supported the idea that people need to identify and isolate their assumptions that relate to history, culture, and context as to remove the disruption of preconceptions and assumptions, with the ultimate aim to get to the essence of the lived experience (Smith et al., 2009).

2.6.2. Hermeneutics

The ideas of Husserl were further developed by philosophers such as Merleau-Ponty, Heidegger, and Sartre, who spoke about the theory of hermeneutics, or in other words, the theory of interpretation (Langdridge, 2008). Fundamental to the theory of hermeneutics is human nature and existence, while the way in which phenomenology influenced the theory keeps hermeneutics rooted in understanding the appearance of events through phenomenological methods (Smith & Eatough, 2007). Nevertheless, hermeneutics is inspired and developed from phenomenology but has a fundamental distinction, which is the incorporation of the context of the person that is having the experience, in the meaning-making process (Langdridge, 2008). In other words, Merleau-Ponty (1945-1962), Heidegger (1927-1962), and Sartre (1943-2013) supported the idea that transcendent phenomenology lacked the consideration of the context of the person that lives and makes sense of the experience (Langdridge, 2008). The way hermeneutic thinking has influenced IPA is evident in IPA's focus of eliciting meaning and processes, instead of events and their causes (Smith & Eatough, 2007).

2.6.3. Idiography

Finally, alongside phenomenology and hermeneutics, the third school of thought that has influenced IPA is idiography, which has as a main focus the development of systemic and detailed analysis, as well as the specific (Smith et al., 2009). At the core of idiography is the analysis and understanding of a specific phenomenon, by a specific individual, in a specific context. This influences IPA's analysis by directing it towards the particular instead of on generalisations (Smith et al., 2009). Data analysis in idiography most commonly refers to a detailed development of a single case that could stand on its own, or of many cases that

make up a larger study, which in turn may be cautiously developed into valid and reliable generalisations (Smith et al., 2009; Smith & Eatough, 2007). The process of idiographic analysis therefore facilitates the understanding and development of general themes that are not necessarily related to the understanding of the individual experiencing the phenomenon, while also allowing for an exploration of the individual narrative of the specific person's experience (Smith & Eatough, 2007). The possibility of this twofold interpretation becomes realistic through acknowledging that an individual has the ability to offer insight on their involvement in the phenomenon as well as their relationship to it (Smith et al., 2009).

2.6.4. Key Elements of IPA

The main focus of IPA is to consider each participant's account. This leads to studies that have smaller samples, allowing for a more detailed and in-depth analysis of each participant's narrative (Pietkiewicz & Smith, 2014). The word 'small' in terms of sampling is deliberately vague, because the number of participants depends on the aims of the researcher; is their aim to present a case study or a more general account of a specific group/population? Although there is no strict rule as to the number of participants included in each study, Smith et al. (2009) recommend a sample size between 4-10 interviews for a professional doctoral level research study. Due to the small sample size, sampling usually tends to aim on homogeneity across participants. Typically, psychological similarities and differences are analysed within a group that has been defined based on certain predetermined characteristics, ergo random sampling would not promote that purpose because of the vast range of different characteristics in the larger population. In IPA, we aim for purposive sampling (Willig, 2013), which allows for the researcher to define the group they wish to interview based on pre-determined characteristics, for which the phenomenon that is under investigation has specific relevance and significance (Pietkiewicz & Smith, 2014).

The most common data collection method of a qualitative methodology, such as IPA, is the use of semi-structured interviews. This popularity stems from the ease with which semi-structured interview data is arranged, compared to other data collection forms. From the compatibility they have with various analytic methods, in-depth semi-structured interviews, allow for the collection of data that can be analysed by IPA researchers who aspire to analyse the subjective meaning-making of participants. Through semi-structured interviews, participants have an opportunity to provide a rich and detailed personal account of their narrative, including their thoughts and feeling about the phenomena they lived through (Smith et al., 2009). Semi-structured interviewing allows for both researchers and participants to engage in a dialogue that is not restricted by the initial interview questions,

since these are altered depending on the direction towards which the participant takes their narrative, while the researcher has the opportunity to probe towards interesting topics that may come up during the interview (Smith, 2008). In IPA there is a requirement for rich and subjective data, therefore the participants need this opportunity to speak freely about the ways they understand their lived experiences, in a reflective and lengthy manner (Smith et al., 2009). Although IPA researchers might use an interview schedule to include some predetermined topics deriving from the research questions, semi-structured interviews' use of open-ended questions allow for flexibility to accommodate the unanticipated twists and turns a participant's account might take (Tod, 2006).

Finally, an important purpose of IPA interviews is to try and indirectly approach the research subject, gaining information regarding the research question(s), which might be ineffective to gather if asked directly (Smith et al., 2009). As aforementioned, an interview schedule is usually in place to prompt around the research subject, but in no way does it direct the course of the interview, which is mainly led by the participant. Usually, the questions that are included in the schedule are asked in an order that seems more natural, suitable, and appropriate for each participant, given that the nature of the research question(s) might be sensitive for participants.

2.7. Philosophical Alignment of IPA and Research Paradigm

Since the philosophical underpinnings of IPA are aligned with my ontological position of critical realism and my epistemological positions of relativism, the methodological choices for this research are consistent with both the selected qualitative paradigm and the selected philosophical standpoint.

2.8. Epistemic Reflexivity

The concept of reflexivity describes the reflective process in which researchers engage as to become aware of their own cognitive, emotional, and behavioural reactions and responses (Anderson, 2008; Hughes, 2014). In qualitative research, this process is particularly important in upholding the quality and validity of the research because it promotes transparency regarding the design, data collection, and analysis of the findings. (Finlay & Ballinger, 2006). The role of the researcher needs to be acknowledged and reflected upon in the write-up of the research, as it is considered a core characteristic of good qualitative research (Henwood & Pidgeon, 1992). Reflexivity allows the researcher to reflect upon their own assumptions, thoughts, and expectations (Finlay, 1998), which are informed by their worldview. It is therefore a valuable process to continue throughout the research (Gilgum, 2006).

The constructivist paradigm, and the phenomenological principle that underline this research, highlight the need for reflexivity. As aforementioned, Husserl's founding principle of phenomenological inquiry suggests that experiences need to be investigated as they are (i.e. as expressed by participants). Researchers, therefore, need to approach their analysis reflexively, by engaging in the practice of 'bracketing', which requires them to 'bracket' their own assumptions about the phenomena, in order to allow themselves to understand them as they are, rather than reactively perceive them biased by their own world view (Willig, 2013). In a constructivist paradigm the epistemic focus is on the principle that the phenomena and the interpreter affect the interpretation 'with equal force' (Levers, 2013). Thus, the researcher's reflexivity will allow for a more in-depth understanding of the meaning-making process.

The feminist standpoint epistemology that informs this research suggests that science operates as a part of the social order (Wigginton & Lafrance, 2019b), and challenges the notion of a "god view" of science that suggests the researcher is "seeing everything from nowhere" (Haraway, 1988, p.581). All knowledge is socially situated, and the existence of a neutral observer/interpreter is rejected (Haraway, 1988). The process of reflexivity, from a feminist standpoint, takes into consideration the personal identities, values, and politics of the researcher that influence them to construct knowledge about the 'other' (Fine, 1994; Magnusson & Marecek, 2012). I will discuss more about the process of reflexivity as it has informed my research practice in the section *Personal Reflexivity* at the end of the chapter and in the *Discussion* chapter of the study.

2.9. Research Design and Procedures

2.9.1. Research Sample

The six participants who were recruited for the study were women survivors of childhood sexual abuse, who self-identified as having a history of problematic drug use. Although I work as a trainee counselling psychologist with women survivors of abuse and women with substance misuse difficulties, none of the participants were recruited from any of the services I work at, which meant that I had no previous encounter with them in any capacity, therapeutic or otherwise.

2.9.2. Participant Inclusion and Exclusion Criteria

In IPA we are looking to include a homogenous sample in order to ensure that the focus of the exploration is only one phenomenon (Smith & Osborn, 2007) and in order to reach meaningful depths with the analysis (Smith et al., 2009). As aforementioned, the participants included in the study were women survivors of CSA who self-reported past PDU. The nature

of IPA highlights the importance of subjective meaning-making, thus I wanted to allow for participants to self-identify as CSA survivors, rather than use professional-led criteria to describe their experiences during the recruitment stage. For that reason I didn't use any standardised instruments to identify whether participants met the criteria for Substance Use Disorder as defined by the DSM-5 (APA, 2013), or the ICD-10 (WHO, 2004). Similarly, there was no pre-screening of participants with standardised instruments, like the CTQ-SF (Bernstein et al., 2003) to identify the existence and severity of the CSA experiences.

In line with the research aims and the ethical considerations as described by the British Psychological Society (BPS, 2021a), the following criteria were set to ensure homogeneity of sample and participant safety:

2.9.2.1. Inclusion Criteria

1. Self-identify as a woman and be above 18 years of age.
2. Self-report as having a history of CSA
3. Self-report as having a history of problematic PDU
4. Have been abstinent from PDU for a minimum of 12 months
5. Currently engaging with talking therapy or have engaged for a minimum of three months in talking therapy addressing their CSA and PDU
6. Ability to express themselves in the English language

The inclusion criteria 1-3 relate to the aims and purpose of the study, which explores the experiences of the specific phenomenon of PDU from women's survivors of CSA. The inclusion criteria 4-5 were put in place as a safeguarding measure in order to minimise the probability of adverse effects of participation, which may trigger a lapse in PDU (criterion 4). In addition, ensuring that participants have had some support around their experiences, rather than disclosing potentially traumatic and triggering events for the first time during the interview, was important to ensure participants' ability to engage with the process, as well as their safety (criterion 5). The inclusion criterion 6 was to ensure that participants would be able to give an in-depth account of their experiences without being limited by language skills.

2.9.2.2. Exclusion Criteria

1. A severe and enduring mental health diagnosis which might have an impact on memory/cognitive functioning
2. Presentations of current suicidal ideation or self-harm, or within the past 3 months

Both exclusion criteria were put in place to ensure two things: (a) participants' ability to give an account of their experience, and (b) as a safeguarding measure to minimise risk or distress to participants, which could arise from discussing potentially traumatic and emotionally triggering events. The six inclusion and two exclusion criteria were clarified to participants verbally prior to giving their consent to participate in the study. All participants who showed interest in the study verified verbally that they meet the inclusion criteria and none of them reported meeting the exclusion criteria.

2.9.3. Recruitment

IPA calls for a homogenous sample of fewer than twelve participants (Alase, 2017), but the final number is dependent on context and on the subjective recruitment process of each study (Schulz & Grimes, 2005). For this project six participants were recruited through flyers (Appendix A). Various establishments for survivors of CSA and for substance misuse, which were considered appropriate (i.e. counselling centres, support groups, support charities), were contacted to ask for permission to leave hard copies of the flyers on their premises. According to ethics guidelines for internet-mediated research (BPS, 2021c) women's and CSA survivor charities The Women's Trust and National Association for People Abused in Childhood (NAPAC) were approached and asked to upload the flyer on their online platforms (website and social media). A one-page website was created specifically for the purpose of uploading the research flyer, because some of the organisations that advertised the research online required a URL to be provided to them to accompany the photo of the flyer.

Individuals indicated their interest in participation either by sending an email to the researcher or by filling in the contact form on the research website. After individuals made first contact, they were sent the Participant Information Sheet (Appendix B) and were encouraged to allow themselves a minimum of 24 hours to decide whether they wished to continue with participation and arrange a screening phone call. The Screening Phone-Call (Appendix C) was arranged a minimum of 48 hours and a maximum of one week after individuals were sent the Participant Information Sheet, during which the interview time/date was arranged. The medium via which the interview would be conducted was discussed with participants who were given a choice of an in-person interview (this was an option for only one of the six participants due to the pandemic restrictions), a phone call, or a video call. The participant who was given the option for an in-person interview chose that, all the other participants chose phone call. All communication, apart from the Screening Phone-Call and the interview, took place through my university e-mail account. I called participants on the pre-arranged time for both the Screening Phone-Call and the interview, which were conducted from my work phone with an undisclosed caller ID.

2.9.3.1. Background of Participants

During the interview participants discussed parts of their history that could contribute meaningfully to understanding their perspectives, providing important insight onto the intersectionality and complexity of their experiences. Based on this information, the below narrative account of their pseudonym profiles was formed:

Table 1. Narrative Account of Participants' Pseudonym Profiles

Sarah
Sarah is a British woman of Turkish origin, in her late 40s. She is single, unemployed, and lives alone supported by government benefits. Sarah has one daughter in her late 20s and a granddaughter under the age of ten, for whom she cares for frequently. She disclosed having a diagnosis of Dissociative Identity Disorder (DID), depression, anxiety, and relational difficulties. She also takes medication for her mental health and is participating in open-ended counselling for survivors of CSA. Sarah described that her CSA experiences started around the age of five and lasted until her early adolescence. Perpetrators include her mother, father, grandparents and uncles from both sides of the family, and her older brother. She also disclosed experiences of emotional abuse, physical abuse, verbal abuse, emotional neglect, and substance misuse in the family environment. Her PDU started in her early adolescence and it included mainly cannabis and powder cocaine use initiated and perpetuated by peers and romantic partners. She has been abstinent for more than fifteen years. Sarah also disclosed repeated experiences of domestic violence in her adult relationships.
Tania
Tania is an English woman in her late 40s. She is a primary school teacher, single, and lives alone. Tania described chronic difficulties with her mental health including depression, anxiety, and relational difficulties, but did not disclose any official diagnoses or taking any medication. Tania described that her experiences of CSA started at the age of three after her maternal grandfather's funeral, and the perpetrator was her mother. She said that her mother would sexually abuse her throughout her life, even as an adult, with the last episode being at the age of twenty eight. Tania's family is described as socioeconomically privileged and includes an older sister, and a mother and a father, both of whom have been deceased for more than ten years. She also disclosed that the CSA would follow episodes of physical abuse by her mother. Her PDU started at the age of six when her father taught her to inhale glue as a means of managing her emotional frustration after an incident of CSA that he reportedly was unaware of. Her substance abuse continued with inhaling other solvents and drinking alcohol. She has been abstinent for more than ten years and expressed receiving support from substance misuse services and mutual aid to do so. She also described having had psychotherapy in the past.
Leyla
Leyla is an American woman of Scottish origin, in her early 50s. She has studied psychology, is an ex-counsellor in forensic settings, currently unemployed, and lives alone. She is divorced from an abusive marriage with an ex-client of hers, and has one adult daughter. Leyla described chronic difficulties with depression, self-harm, suicidal ideation, relational difficulties, chronic psychosomatic pain, ADHD, and PTSD, for which she is taking medication. Leyla mentioned experiences of CSA but did not disclose her relationship to the perpetrator or the duration of these experiences. Leyla disclosed enduring episodes of emotional abuse and neglect from her mother and father that started in childhood and continue to this day. She also expressed that her parents did not believe her or support her when she disclosed her experiences of CSA and have been consistently unsupportive about her mental health and PDU difficulties. Her PDU started with cannabis in adolescence and escalated to occasional powder cocaine use. Leyla described that when she was

away from her parents at university her PDU was infrequent and was not experienced as problematic. After university when she was back with her parents she described frequent and problematic drug use of powder and crack cocaine and alcohol. She has been abstinent for more than twenty years with professional help. Leyla has had psychotherapy for her mental health but believes that she never experienced adequate support that integrated her PDU and mental health.

Simone

Simone is a White British woman in her early 30s. She is a mental health nurse living with her long-term partner. Simone described past difficulties with depression, self-harm, suicidal ideation, anxiety, emotional volatility, and relational difficulties. She mentioned experiences of CSA from one perpetrator that started at the age of twelve. The thirty six year old man reportedly approached her to be the nanny to his children and they started what was thought to be a romantic relationship for four years. Simone described that her only family was her mother, who was emotionally abusive and neglectful and she believes this made her susceptible to entering a CSA interaction with this man. She described that for years she thought this was a relationship and was heart-broken when he broke up with her to enter a CSA relationship with a younger girl. Simone disclosed that when she started psychotherapy a few years ago she was able to reflect on the CSA nature of her interaction with him and reported him to the police. Her PDU started with cannabis and was initiated by her abuser. After the end of their interaction she described feeling empty and engaging with cocaine use to manage her emotions. She described PDU to be a very frequent practice in the financially deprived area she grew up. She has been abstinent for over a year with professional help and believes that her profession has helped her achieve and maintain abstinence.

Monica

Monica is a Scottish woman in her early 50s. She did not disclose her employment status or living situation. Monica has three adult children. She did not disclose mental health difficulties other than an enduring sense of emotional disconnection throughout her life, before engaging in psychotherapy. Monica described that her experiences of CSA started in early childhood and the perpetrator was her father. She discussed how she knew her father sexually abused her sisters too, and her uncles sexually abused their daughters. Monica disclosed that one of her cousins committed suicide, which she believes to be related to her CSA experiences. Her PDU started very early in life and included stimulants but not opiates. She said that using and trafficking drugs was popular and highly esteemed in her financially deprived community. She also disclosed that all her family members abused substances and her mother and brother passed away from heroin use. When her children were young she described moving away from her family to save them from CSA and that is when she decided to stop her PDU. She has been abstinent for more than twenty years.

Ella

Ella is a British woman of Polish decent in her early 60s. She is divorced, unemployed and living alone. She disclosed enduring difficulties with depression, anxiety, relationships, and chronic physical pain. Her experiences of CSA started at the age of five at the children's home she was sent to live by her father, after her mother passed away. The perpetrator was one of the men employed to care for the children. Later in life she realised that her older sister shared the same CSA experiences with her. Ella described that she also experienced emotional and physical neglect. Her PDU started at her early 20s when her husband initiated her to stimulants as a means to have fun at their evening outings. Ella has four estranged children from her marriage. She described that her PDU, volatile marriage, and engagement with sex work has affected her relationship with her children. Ella discussed getting help with her PDU as a means of showing good behaviour with the court when she was given criminal charges for drug trafficking. During her period of incarceration she engaged with SM treatment and has been abstinent since, except for cannabis, which she considers medication for her chronic psychical pain.

2.9.3.2. Challenges in Recruitment

In the first few months that the flyer was advertised, recruitment was very slow. Only the first participant was recruited through a printed flyer left at a counselling service in autumn of 2019, before lockdown measures were employed and in person communication ceased. The majority of individuals interested in participation came from the online presence of the flyer when it was uploaded by The Women's Trust and NAPAC on their social media, in spring of 2020.

2.9.3.3. Risk and Safeguarding Considerations

Some of the inclusion and exclusion criteria were put in place in order to keep safeguarding at the forefront of recruitment and ensure participants' wellbeing. In addition, the extra step of the screening phone call was put in place in order to ensure participants' suitability for the study in terms of risk and safeguarding. Both as a practitioner and a researcher it is important to "always evaluate the extent to which simply talking about sensitive issues might constitute 'harm' for any particular participant group'' (Smith et al., 2009, p.53).

The one interview that was conducted in person took place at the counselling centre in which the participant was attending therapy during working hours, where the counselling centre staff could help if anything out of the ordinary occurred. For the following, telephone interviews, participants were given crisis helpline information in case the interview process caused them distress.

2.9.4. Data Collection and Storage

2.9.4.1. Semi-Structured Interviews

In IPA the focus is the subjective lived experiences of participants, who are invited to give an in-depth account of them (Smith et al., 2009). In order to align my data collection method with that focus, and integrate the idiographic principle of IPA, I chose to use semi-structured interviews to explore the research question (Langdridge, 2007). The framework of semi-structured interviews allows for the development of a coherent narrative, relevant to the research question, while having flexible enough boundaries to allow for the unpredictable directions and unique depths that participants' narratives may take (Smith et al., 2009).

The data was therefore collected through one-to-one semi-structured interviews. One interview was in person and the other five interviews were over the phone, abiding by lockdown measures that restricted in person contact. All interviews lasted from 50 minutes to 90 minutes, including a quick check in the beginning of the process for any questions and paperwork, but excluding extra debriefing time at the end. The interviews followed a trauma-

informed conversational style to build rapport and an environment of safety to allow participants to express their narratives.

2.9.4.2. Interview Schedule

When attempting to collect data for a research project, it is important to abide by two main principles: (a) the data needs to be consistent with the chosen methodology's epistemological position, and (b) the data need to follow a scientific process of replicability (Giorgi, 2010). In IPA the focus is for the researcher to engage with the participants 'lifeworld' in order to produce a rich interpretation of the subjective experience (Smith et al., 2009). The conversation nature of the interview suggests that the IPA research process considers both interviewer and participant to be active participants, both contributing to the final product of the narrative.

In order to abide by both IPA's epistemological position, and the scientific value of replicability of findings, I constructed an interview schedule (Appendix D) as a guidance to ensure consistency across interviews. The questions included in the interview schedule aimed to invite participants to provide in-depth accounts of their experiences, while containing the interview within the scope of the research questions. The interview schedule included 5 open ended questions that acted more like general themes, inviting participants to address certain aspects of their experience and recount it on a descriptive level, which then allowed for them to expand on it, taking unique depths and directions. Each question was followed by prompts, only when needed, to assist participants to provide a more analytic and explorative account. In addition to these five questions, I endeavoured to follow the narrative that each participant provided, and sometimes refrained from asking the questions in the order they were designed, allowing for each participant's train of thought to manifest freely. When asking explorative and supplementary questions in order to allow for expansion on a phenomenon that was already addressed by participants, I was mindful to maintain an empathically curious stance in order to avoid leading the discussion and distorting it from my subjective understanding.

2.9.4.3. Pilot Interview

The development of the interview schedule was followed by a pilot interview. The purpose of which was to assess the interview schedule in practice and modify or adjust it as needed, especially in terms of being open-ended, non-directive, and allowing for a natural narrative progression. One participant who met all participation criteria was recruited solely for the pilot interview, making it a useful experience that provided a good opportunity to practice interview reflexivity. The pilot interview was not recorded and therefore no data was

collected as the participant had only consented to be interviewed to support with the development of the semi-structured questions and help me rehearse my interview style. Because of this specific aim, the interview was shorter than the data collection interviews and the participant was encouraged to provide feedback to both the questions and my interview style throughout. This differentiated the focus of the pilot interview to the aim of the data collection interviews. During the pilot I had the opportunity to become mindful of my potential contributions to the narrative, in terms of interruptions, interpretations, and misdirection, as well as practise maintaining the focus of the interview to the research question. The experience of the pilot interview allowed me to rehearse being a 'naïve' and 'curious' listener (Smith et al., 2009), and to embrace the person-centred Rogerian conditions (Rogers, 1957) and a trauma-informed approach (SAMHSA, 2014).

2.9.4.4. Recording and Transcription

As per IPA data collection requirements, all interviews were recorded to allow for a verbatim transcription, in line with the methodological aim of interpreting the meaning of the accurate participant account (Smith et al., 2009). In line with Willig's (2013) criticism of IPA's overreliance on language to carry narrative validity, I strived to include some non-linguistic verbal cues into the transcripts. However, due to the majority of interviews being over the phone, I was unable to include non-verbal behaviours into the transcript for five out of the six interviews.

2.9.4.5. Data Storage

As per the British Psychological Society's Code of Human Research Ethics (BPS, 2021a) all written and recorded identifying information, including personal and biographical information, signed informed consent forms, recordings, and transcripts were stored in separate password protected electronic folders to protect participants' identities. All recordings were immediately transferred to their corresponding computer folder and deleted from the recording device. The transcripts are going to be kept in the password protected folders for five years after the publication of the study, and then will be deleted.

2.9.5. Analytical Strategy

The analytical strategy employed to process the data was based on Smith et al. (2009) heuristic framework. This includes six steps based on the philosophical underpinnings of IPA, which are described below.

2.9.5.1. Steps 1 and 2 – Familiarising with the Text and Initial Noting

In my process instead of following the first two steps sequentially, I integrated them. This included immersing in the raw data by re-listening and re-reading them and making initial notes from as early as the transcriptions process. I then followed the transcript line by line and started coding by commenting on the data systematically. Four different coding strategies were used to categorise the data, which were colour coded for easier identification when re-reading the transcripts, an example of which can be found in Appendix E:

- Descriptive comments (in blue) included descriptions of what participants have said, especially captured in particular keywords that gave unique insight onto participants' lifeworld.
- Linguistic comments (in orange) highlighted particular linguistic manifestations, including pauses, repetitions, laughter, sighs, etc.
- Conceptual comments (in purple) focused on my curious stance in understanding the transcript. This process involved engaging with a double hermeneutic, where I strived to make sense of the participants' meaning-making of their experiences. Since my own understanding and worldview was employed in this process, my personal and professional understanding of phenomena influenced the emerging interpretations. At this stage it was particularly important to engage reflexively with the analytical process and focus on keeping my interpretations grounded in the transcript (Smith et al., 2009).
- De-contextualisation comments (in green) attempted to include further descriptions of the transcript by de-contextualising each line from the rest of the narrative.

2.9.5.2. Step 3 – Emergent Themes

Following the coding of step two, step three focused on the development of emergent themes for each interview. This process included the reduction of the volume of detail, while preserving the meaning of the connections and patterns that emerged from the initial notes. At this stage it was particularly helpful and important to have preserved congruency and comprehension between the transcript and my explanatory comments, since the emergent themes developed from the commentary rather than the transcript itself. This process was continuously developing as the emergent themes were constantly being reshaped as I progressed to re-read my initial comments in an attempt to identify all observed emergent themes, including all different aspects of the participant's account. The emergent themes were noted in red onto the transcript itself, as noted in the Appendix E, in red capital letters, and then organised in a table (Appendix F) to facilitate further synthesis.

2.9.5.3. Step 4 - Generating Superordinate Themes

When emergent themes were generated as they emerged sequentially within the transcript, the next step involved finding connections and patterns amongst themes, in order to group them under a larger superordinate theme. The focus of grouping was on the process of illumination that each theme offered onto the experiences of PDU. The patterns and connection between emergent themes and the development of superordinate themes were explored through the following processes:

- Abstraction – grouping emergent themes under one superordinate theme
- Subsumption – an emergent theme becomes a superordinate theme as it allows for other emergent themes to group under it
- Polarisation – emergent themes grouped based on their opposite relationships
- Contextualisation – grouping of emergent themes based on their relationships with context and narrative
- Numeration – frequencies amongst themes are observed
- Function – identifying the functions of the themes in the transcript, based on the experiential aspect

2.9.5.4. Steps 5 and 6 – Moving to the Next Cases and Looking for a Pattern across Cases

As with stages one and two, stages five and six were not necessarily followed strictly sequentially. The above strategies between steps one and four were applied to the analysis of each transcript thoroughly and systematically. Grounded on IPA's idiographic nature, for transcripts two to six, I had to bracket any thoughts and ideas that emerged from previous analyses and treat each transcript as an independent account in its own terms. Finally, patterns across cases were starting to emerge and I was able to start identifying how themes from one transcript were illuminating and complimenting themes of other transcripts. This process was complex and required a lot of synthesis in order to finalise the Sub-themes under the superordinate themes, as portrayed in the final themes table (Appendix G).

2.9.5.5. Interpretation

The role of interpretation in the creation of the final superordinate themes and the grouping of Sub-themes was two-fold. In accordance with the two approaches for understanding meaning (Langdridge, 2007), that of empathic and that of suspicious understanding, IPA can include two levels of interpretation. Empathic interpretation adheres more to the process of entering a participant's world as it is and interpret from that standpoint, whereas suspicious interpretation aims to critically investigate the participant's account in order to gain insight on its meaning and nature (Eatough & Smith, 2008). Both levels of interpretation are valuable in

creating meaningful themes in IPA (Willig, 2017). Suspicious interpretation that is based on pre-existing knowledge allows for the embellishment and validation of this knowledge, whereas empathic interpretation allows for the discovery and exploration of novel concepts in order to broaden pre-existing knowledge (Willig, 2017). The process of reflexivity is important at the stage of suspicious interpretation, in order to be mindful in abiding to the process of clarification and enrichment of the narrative, rather than imposing meaning by silencing the voices of participants (Larkin et al., 2006).

2.10. Validity and Quality

Qualitative research has incited substantial discussions around the assessment of validity and quality. Even the concepts of validity and quality themselves have been challenged as impossible to assess due to the infinite data interpretations, influenced by the ontological position that underlines qualitative research (Forshaw, 2007). Although I personally resonate with said philosophical position, I value the benefits of espousing a systematic evaluative approach to the research process.

IPA's epistemological position suggests that there is a subjectivity on the concepts of truth and reality, influenced by the individual's worldview. This subjective perspective on reality is shaped by the individual's surroundings, such as culture, and socioeconomic and historical context (Yardley, 2008). In order to evaluate qualitative research the criteria need to be consistent with the specific methodology (Madill et al., 2000). Willig (2012) suggested that the main focus of these criteria would be to evaluate whether the research contributes meaningful knowledge based on its aims. For this study Yardley's (2000) guidelines were chosen based on their pluralistic attitude for assessing qualitative research. Smith et al. (2009) have also been known to recommend Yardley's approach, basing their recommendation on fundamental advantages, such as the fact that the nature of this approach's criteria is broad in range and supply with the opportunity to establish quality in a variety of ways. The four main principles presented by Yardley (2000) include sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

2.10.1. Sensitivity to Context

According to Yardley (2000) in order for qualitative research to be considered good, or appropriate, it should be able to demonstrate sensitivity to context. This criterion was incorporated in the research design through involving myself with reading and assessing relevant literature and taking into consideration the sociocultural and historic context, including "normative, ideological, historical, linguistic and socioeconomic influences on the beliefs, objectives, expectations and talk of all participants (including those of the

investigator)" (Yardley, 2000, p.220). Moreover, the design of the research process itself can exhibit sensitivity to context (Smith et al., 2009). In this chapter we see this criterion being met in my choice to engage in IPA, in line with my epistemological position and in addressing the research questions, adhering to the principle of idiography of lived experiences that underpins IPA.

2.10.2. Commitment and Rigour

In order to meet the criterion of commitment and rigour, I designed and implemented all stages of the research with a rigorous attention to detail, commitment to transparency, and a thorough and committed demonstration of a coherent rationale throughout each stage of the process (Shinebourne, 2011; Smith et al., 2009; Yardley, 2000). Commitment and rigour are therefore demonstrated in every stage, from recruiting a homogenous sample and collecting data through semi-structure interviews, to sensitively and carefully taking the time to analyse the transcripts in a phenomenological way, attempting to capture the participants' voices, while also keeping in mind an interpretative IPA stance.

2.10.3. Transparency and Coherence

The criterion of transparency and coherence is being met by committing to present to the reader a coherent and transparent description of all the steps of the study, in order to ensure transparency regarding decision making and rationale (Smith et al., 2009; Yardley, 2008). In addition, I adhere to a reflective practice throughout, to increase transparency of the potential impact of my own subjective experience in all stages, and especially on the analytic process.

2.10.4. Impact and Importance

The criterion of impact and importance refers to how meaningful, impactful, memorable, and important the reader might find this piece of research (Smith et al., 2009; Yardley, 2000). This research aims to contribute in a meaningful and impactful way in our understanding of PDU experiences of women survivors of CSA, in order to inform further research and promote more service-user led clinical understanding and practice. Because this premise would "probably only be judged in the eye of the beholder" (Finlay, 2011, p.256), when I was in the initial stages of the research proposal, I presented a summary of the research aims to non-participants who belonged to the population (i.e. women survivors of CSA with experiences of PDU) and there was a consensus regarding the impact and importance of the research. All participants declared a similar sentiment, unprompted, when applying to participate. In an attempt to increase impact and importance for the participants, the opportunity to receive a copy of the final paper was offered to them. All but one participants

expressed that they would like to receive a copy of the final results and I agreed to contact them via email to send them a link to the final published document once the project is successfully accepted by the university.

2.10.5. IPA Specific Criteria

As aforementioned, the quality and validity criteria need to be adjusted to the specific methodological approach (Madill et al., 2000; Reicher, 2000; Willig, 2013). Therefore, in addition to Yardley's pluralistic criteria, I have included Smith's (2011) IPA-specific criteria:

- The research adheres to the philosophical underpinnings of IPA
- Transparency is employed throughout to ensure the reader understands the research process
- Coherency, plausibility, and being interesting are core analytical aims
- Each of the themes is supported and evidenced by a sufficient sample of the participants in order to allow for the different voices to be heard.

2.10.6. Ten Key Issues in Critical Appraisal of Qualitative Research

Another perspective through which we can approach the critical appraisal of qualitative research focuses on the importance of evaluating methodological aspects (Dixon-Woods et al., 2004). Below are the ten questions proposed by Treloar et al. (2000) designed to facilitate such an appraisal.

Table 2. The Ten Key Issues in Critical Appraisal of Qualitative Research (Treloar et al., 2000).

Is the purpose of the study clearly stated?
Is an appropriate rationale provided for using a qualitative approach?
Do the researchers clearly outline the conceptual framework (if any) within which they are working?
Do the researchers demonstrate an understanding of the ethical implications of their study?
Is the sampling strategy appropriate and will the sample represent the target group?
Does the research provide information about data collection procedures and how they were derived?
Do the researchers describe the procedures for keeping data organised and retrievable?
What methods of data analysis are used and are they appropriate to address the study purpose?
Does the researcher address the threats to reliability and validity in data collection, analysis, and interpretation?
Is there a clear progression from research question to conclusions drawn from data?

2.11. Ethics

2.11.1. Ethical Approval

Ethical approval for this research was granted by City University of London (Appendix H). Due to the nature and level of risk negotiated in the ethics application, the first submission in January of 2019 was declined, and the form had to be resubmitted twice, due to various amendments on inclusion criteria, screening process, and debriefing safeguarding procedures before it was granted ethical approval in June of the same year.

2.11.2. Ethical Considerations

My role in this research was that of a trainee Counselling Psychologist, which guided my adherence to the Code of Ethics and Conduct (BPS, 2018), the Standard of Proficiency for Practitioner Psychologists (HCPC, 2015) and the HCPC 'Guidance on Conduct and Ethics for Students' (2016). My ethical principles as a researcher guided me throughout the research process, emphasising scientific value, respect for the autonomy and individuality of participants, social responsibility, and ensuring the maximisation of participation benefits with an aim for minimisation of any adverse experiences to participants (BPS, 2021a). Below I discuss the ethical consideration that are especially relevant to this piece of research.

2.11.2.1. Risk

There are studies indicating an increased risk for emotional volatility and distress (Hughes et al., 2017), self-harm, suicide, and risky behaviours (Felitti & Anda, 2009; Felitti et al. 2019) in CSA survivors. Similar risks are presented for people who are currently engaging in PDU, while people recently abstinent from PDU have a higher risk of lapsing or relapsing (EMCDDA, 2021). As a result, there was a great emphasis in setting appropriate inclusion and exclusion criteria, and in having a thorough screening and debriefing process, to minimise possible harm from participation.

2.11.2.2. Screening

In the screening process I employed my experience as a practitioner assessing clients in clinical settings. The screening process included a screening phone call, during which I aimed to ensure participants met the inclusion criteria and didn't meet any of the exclusion criteria. During the screening questions around the participation criteria acted as a discussion guide, rather than as close-ended questions, in order to make sure participants understood the full extent of each criterion in order to give informed answers. Therefore, the screening process resembled a short semi-structured interview that allowed for my professional assessment of participants' fit to participate, rather than a closed-question questionnaire.

2.11.2.3. Consent

The research questions include a recollection of potentially traumatic and emotionally distressing experiences during the interview. In order to ensure that participants could give their informed consent in participation they were provided with Participant Information Sheet (Appendix B) and Informed Consent Form (Appendix I) prior to the interview. This allowed participants to know more about the research and what it would entail. In addition, participants were encouraged verbally to read the forms and reach out to the researcher with any questions or worries regarding participation, prior to the interview. Participants were also informed that they could withdraw participation if any worries persisted, at any moment up until before the analysis stage.

2.11.2.4. Debriefing

In the process of semi-structured interviews on a deeply personal and potentially distressing nature, there is the possibility for unpredicted self-disclosure from participants, as well as unexpected and not previously thought of narratives (Fassinger, 2005). In order to ensure harm minimisation and containment, participants were offered verbal debriefing in addition to the Participant Debriefing Sheet (Appendix J), which included a more elaborate discussion of the aims of the study, signposting for mental health crisis/distress, and further reading on the subject.

2.11.2.5. Confidentiality

All written and recorded identifying information, including personal and biographical information, were changed and anonymised. The participants were assigned pseudonyms and their profiles were altered to ensure anonymity and confidentiality. Participants were informed in the beginning of the screening phone call the parameters in which I would have to break confidentiality, which included the BPS's Practice Guidelines (BPS, 2017) for safeguarding. These include any information disclosed that would suggest a current risk to the participant's life, or the life of another. Participants were told that if such an issue was to arise and urgent help was needed, I would support them with giving them information regarding the appropriate steps to follow. This included guidance on presenting to A&E or calling 111 if in imminent risk to themselves (NHS, 2021b), or calling 101 to raise a safeguarding concern of another, as per NHS guidelines (NHS, 2021a). They were also informed that I would break confidentiality and call the above lines myself if they expressed inability or unwillingness to do so themselves.

2.11.2.6. Interviewer Role

As a trainee Counselling Psychologist, my interaction with members of the population from which I recruited has been mainly that of the practitioner/therapist. During the recruitment and interview process I was very mindful that the interviewer's role can be very different from that of the therapist, in order to avoid a 'quasi-therapeutic relationship' (Willig, 2013). In addition to being self-reflective in the 'here and now' during the interviews in an attempt to bracket any emerging personal/emotional responses, I discussed these in personal therapy and peer supervision with other trainee Counselling Psychologists who shared a similar research journey.

2.11.2.7. Trauma Informed Approach on Participation

The participants' wellbeing was kept in mind throughout the research process, in defining the participation criteria, screen, interviewing, and receiving appropriate debriefing. I was aware of the potential emotional distress incited by the interview process, and therefore was mindful to assess and reflect on the participants' mental and emotional state before, during, and after the interviews. In line with a trauma informed approach (SAMHSA, 2014) I made sure that participants understood both the nature of the study, as well as the potential directions these might take, especially around disclosing traumatic and emotionally distressing information. This allowed for a minimisation of being unpleasantly surprised about certain topics of discussion. Similarly, participants were told that they could skip any questions that might be too uncomfortable for them to answer, and share as much or as little information as they felt comfortable with. In an effort to minimise the distress of disclosure, participants were not prompted to give explicit details of events. During the interview I remained aware of the participants' emotional responses to the topics of discussion so that I could provide containment and minimise risk of adverse interview experience.

2.11.2.8. Reflexivity in Data Analysis

The primary focus of qualitative research is meaning-making and therefore the analysis process is a product of the integration of both participants' and researcher's engagement with the narrative. On the one hand, participants choose the ways in which they will give their accounts, and on the other, the researcher engages in a double-hermeneutic process in their attempt to interpret the data. Therefore, there needs to be sufficient acknowledgment of the contribution of the researcher's own mind in the meaning-making process. I have addressed the nature and process of epistemological reflexivity above when discussing the philosophical standpoints of qualitative research and IPA. Below, I will also address personal reflexivity, as this process also contributes largely to the analytical process. Furthermore, I will use the opportunity to explore reflexivity again in the *Discussion* chapter of the portfolio,

in an effort to give a general account of the impact my role as a researcher had on the study overall, from the stages of research proposal until the final stages of interpreting and discussing the data.

2.12. Personal Reflexivity

In a constructivist qualitative paradigm, the researcher cannot be perceived as a detached observer of knowledge, but rather as its socially situated co-interpreter along with the participants. Therefore, it was important for me to practice reflexivity on many different levels when I embarked on this research journey. I started by reflecting on the reasons behind choosing this research topic and that opened the door to many more layers of reflections, where the answer to each level created another question that spurred a process of deeper self-reflection. At the end of this spiral of questions I found the constructs of my values and my identity, as they have been formed by my own meaning-making of experiencing myself in the social system. For that reason, part of my reflexivity is identifying and defining the parts of myself that on the one hand form my interest, and on the other may prevent me from abiding to the phenomenological values of IPA.

My personal axiology is very closely aligned with how I perceive and interpret the values of two disciplines, Counselling Psychology and Feminism. The values of Counselling Psychology, as defined by the British Psychological Society (BPS, 2021b), are that of creativity, compassion, collaboration, and ethical and reflective practice, in an attempt to promote equality, fairness, and social justice, in order to influence the design and delivery of policies, always with the ultimate goal of striving to meet the needs of the people. Feminist values centre around the promotion of gender equality by acknowledging both the individual and collective implications of female oppression in a patriarchal society (Brown, 1994; Gilligan, 1977; Lerman, 1990; Rotosky & Riggle, 2002; Szymanski, 2005; 2006). My choices, both as a practitioner and a researcher, have been influenced by these two disciplines.

Moreover, I identify as a woman and have constructed my identity through that lens. As I affiliate with the concept that gender is a social construct with no intrinsic value (as Simone de Beauvoir [1973] put it, “one is not born, but rather becomes, [a] woman” p. xxii), my meaning-making of my womanhood stems from my interactions within a patriarchal system, which is inherently oppressive (Beasley, 1999; Brunell & Burkett, 2019; Hawkesworth, 2006; Lengermann & Niebrugge, 2010; Mendus, 1995). Thus, even the ones who loved and cared for me were benevolently exposing me to sexist and misogynistic ideas and behaviour that shaped the way I view myself, as well as others: the ones belonging to the dominant group (men), and the ones belonging to the systemically oppressed group due to their affiliation

with my gender. That lens through which I view the world has systematically highlighted in my mind ways in which women are undervalued, underrepresented, and underserved in different aspects of society.

My research interest emerged from my experiences in clinical practice. A large part of my training has been in SM services. During that time, I noticed two main challenges for service users: (a) complex and enduring mental health difficulties, especially the ones relating to childhood trauma were not integrated in treatment provision, and (b) service delivery was rarely able to collaboratively tailor to the particular needs of women service users, that related both to their mental health and gender. When I took these two characteristics into account, during a service audit I did, a large number of women with a history of trauma, were returning service users, rarely making significant changes, who frequently disengaged from treatment. They presented with increased complexity in terms of risk and safeguarding, and multiagency involvement, including challenges around their mental and physical health, as well as social and financial situation. Thus, I considered the potential benefit of a phenomenological interpretation of this population's experiences, in an attempt to strive towards abolishing gender oppression in our understanding of PDU in women, and in an attempt to incorporate a more trauma-focused understanding of women survivors of CSA, both of which could inform not only individual clinical practice, but also policy and systemic service design. Moreover, I anticipated that being a woman would enhance my 'hermeneutic reflection', i.e. my empathic interpretation of the phenomena as they are presented to me (Shaw, 2010), while also adhering by the principles of feminist standpoint epistemology of knowledge created by women for women (Smith, 1987).

Upon conducting this research there was an added layer of complexity that required more attention to reflexivity. In October 2020 I started working at a SM service. Suddenly my experiences from that population were not limited to my interviews, as they continued through my work. Therefore, I needed to be aware of both how my worldview and professional experience, could interfere with participants' accounts. I risked skewing their narratives based on my personal and professional understanding of trauma, PDU, addiction, and gender-based discrimination. My main reflection was that of meta-discrimination, i.e. by silencing my participants I risked repeating the silencing and discrimination they have experienced in and out of services, which would be both unethical and potentially damaging to them. Thus, I remained committed to practice reflexively throughout the research process, in order to preserve the authenticity of the participants' unique experiences and strive towards their empowerment by giving their voice a platform for representation.

The aforementioned reflexive attitude was operationalised through the use of various resources, including personal therapy and peer support group/supervision. The interview material was very rich in detail, especially details of physical and mental hardship that the participants experienced since childhood. Through the process of listening and analysing the participants' narratives I experienced difficult emotions of sadness and anger. I felt angry at the people who contributed to their adverse experiences, and deeply saddened at their intense and prolonged hardship. Even though in my clinical practice I had come across similar experiences from clients, I never felt 'used to' or 'desensitised' to the stories of abuse and adversity. Thus, I used my personal therapy throughout the time of conducting the interviews and analysing the findings to process my own emotional responses and receive support, in order to continue with the research without allowing my own experience from the narratives to shadow the participants' lived experiences. Similarly, I participated in a peer support group/supervision with two of my peers from the programme. These two people were also close friends who had clinical experiences that included working with populations who have experienced abuse and adversity, similar to the backgrounds of my clients. The relationship between us and their clinical experience with similar populations made them a great support system for me to express and process my emotional responses to the interview material.

3. Chapter 3: Analysis

3.1. Overview

This chapter aims to capture the collective and shared experiences of women, and the idiographic nature of these individual experiences, by highlighting the different superordinate themes (Appendix G). The focus of this chapter is the interpretative element of the analysis, which includes links between the women's narratives. Following the IPA analytic process (see *Methodology*) four superordinate themes were identified that are aligned with the research questions, which are comprised of nine subthemes. The themes will be illustrated through quotes that intensify, expand, and elaborate their understanding. These superordinate themes are: **"The good, the bad, and the useful"**, **"Because of you"**, **"Living in the shadow"**, and **"Moving forward"**. They are presented in the diagram below with their corresponding subthemes:

This chapter guides the reader through the themes that are most prevalent across cases, which are also most closely attempting to answer the research questions. The progression of the analysis disclosed the multifaceted nature of participants' experiences by highlighting the different layers that contributed to the development of their stories. When looking at the four themes we can identify that they correspond to four different areas of participants' lives: the effects of PDU, the input of relating with others, the impact of trauma, and identity construction and empowerment. These four superordinate themes are present in the

experiences of all six women, while there are variations in how each theme manifests in the different narratives.

3.1.1. Overview of Themes

The first superordinate theme titled **"The good, the bad, and the useful"** is centred around PDU and its utilitarian value. This is the first theme presented in the analysis as it gives a good baseline understanding of the different facets of the drug taking experience; what is described as the 'good' effects (i.e. pleasant feelings), the 'bad' effects (i.e. the long-term negative impact on functionality), and the 'useful' (i.e. the psychological functions facilitated by PDU). The second theme titled **"Because of you"** is centred around relating and the influence others had in participants' PDU. It describes the impact of social relationships as setting a status quo for drugs, the difficulties in relating and the role of PDU in promoting connections, as well as the positive impact that relationships had on instigating the recovery journey. The third theme titled **"Living in the shadow"** explores how participants' lives were influenced by experiences of CSA and childhood maltreatment. When discussing these the focus is on CSA, but other forms of trauma were introduced to the narrative. Participants discuss the psychological effects of CSA and draw direct links between these experiences and PDU. The fourth theme titled **"Moving forward"** explores a process of identity construction influenced by experience of CSA and PDU. This includes attempts to integrate different parts of their identity in order to be able to feel in control of their lives and move forward in recovery. A state of feeling out of control was attributed to feeling disempowered by CSA and re-victimised by PDU, while reclaiming control included efforts to take personal responsibility and feelings of empowerment.

3.2. Superordinate Theme 1: The Good, the Bad, and the Useful

The first superordinate theme captures the participants' experiences of the effects of drugs on their physical and mental functioning. Participants described PDU as a medium to manage emotional difficulties, either through drug-induced euphoria or through drug-induced emotional withdrawal from distressing emotions. The language and experiences in participants' accounts bear several similarities across narratives, even though each woman used different drugs, in different quantities, under different circumstances, and with a different frequency. Their narratives emphasise the operational value of PDU, and they demonstrate its changing state from 'good' in the short-term, to 'bad' in the long-term. Two subthemes are identified within this theme: **"The need for a getaway car"** and **"From friend to foe"**.

3.2.1. Subtheme 1: The Need for a Getaway Car

In this subtheme, participants described how drugs were experienced as an integral part of their emotional functionality. PDU was conceptualised in the narratives as a vehicle that facilitated escape from negative thoughts and emotions. The need for an escape suggests the magnitude of the perceived negative effect of these emotions. Leyla made a distinction between PDU for enjoyment and PDU as a medium for escape and suggested that being able to escape on demand gave her a sense of control over herself. She also drew parallels between other behaviours that were providing her with a similar emotional escape, and she illustrated how these are similar to PDU:

> *"I wanted to be in control so it would be one-night stands […] looking back that is another escape and I believe also that is um self-harming behaviour now looking back on it. So, yeah and any, any chance to escape I did […] in New York, you know mar.juana, cocaine once in a while wasn't really escape cause I, it was an er.joyment, I-I liked it [laughs] but now that I was put back in this shitty thing, thing, you know life uh, right back in the thick of it, escape was very, very important. Especially 'cause I lived with my parents when I first moved back so yeah, so now drugs became a problem and drink and sex and uh, whatever else now became a problem."* [Leyla:466-470]

In addition, Leyla mentioned isolation and distressing memories to be prominent in her life, and drugs were described as the means with which she would cope with these:

> *"And to escape. I don't, so, so I don't have to think and feel this loneliness and this isolation and these memories."* [Leyla:716-718]

Similarly, Simone mentioned her life being empty and that PDU became the experience that filled that void:

> *"I escaped my reality with, my reality was full of nothing, you know in… in… in essence, it, my reality was, there was no connections, there were no, no meaning, no purpose and drugs provided that for me."* [Simone:426-429]

Along the same lines, Tania mentioned how her CSA experiences affected her mental health in a way that made her feel stuck and through PDU she was able to escape this vicious cycle and cope with the symptoms she was experiencing. She also made direct mentions to PDU masking what she experienced as emotional pain:

"[...] stuck in that um, cycle of-of uh, kind of flashbacks and um, and then, then to use whatever [short laugh] to help uh, to try and cope with that." [Tania:38-40]

And

"How it made me feel is like very um, dreamy and um, I didn't feel the uh, the uh, emotional pain I was feeling or the, yeah. Just took me away from all of that." [Tania:103-105]

Tania's use of the word "dreamy" reflects the process of escaping reality into a dream-like state. Dreams are pleasant, otherwise they would be nightmares, further highlighting the discrepancy between the unpleasant reality and the pleasant state of intoxication.

In summary, for participants PDU was an instrumental component of their process of managing difficult emotions and coping with the adverse effects of CSA and other experiences of maltreatment. In their narratives participants emphasised PDU's operational value of escaping, which suggests a high level of difficulty in navigating and tolerating their lives without the effect of drugs. These difficult emotions seem to derive from the participants' exposure to traumatic events. The emotional difficulties, which were dominating their reality, are presented as a vicious cycle in which participants were stuck, and PDU is presented as the most effective solution to help them cope and promote their wellbeing. Overall, PDU seemed like an efficient and effevctive solution, at the time.

3.2.2. Subtheme 2: From Friend to Foe

In this subtheme participants proceeded to describe the ways in which they experienced the shift of PDU from beneficial to catastrophic. Sarah described that, despite initially thinking otherwise, drugs actually made her feel worse rather than helping her get better:

"Yeah, yeah, that's it, I was not getting better…" [Sarah:463]

And

"I felt terrible […] with the effect of drugs. […] 'cos it's bad, isn't it? […] They make you worse." [Sarah:319-326]

Simone too mentioned feeling worse from using stimulants. Her experiences centred around the negative effects that coming off of the influence had on her mental health, and how this increased her risk to herself, with self-harm and suicidal ideation being prominent parts of her life. She highlighted that this occurred especially when she felt lonely after taking drugs with others:

"[…] the stimulants, they made me feel worse, after I had a lovely evening you know, I'd have a great evening with, with the drugs and with my friends and then 2 or 3 hours later I would feel like death um, you know and because I, I was quite suicidal um, you know for, for a long time in my life um, engaged in self harm quite a lot um, and you know having the come down, having the period of, of um, after the drugs had worn off and everybody had gone home, feeling that bad." [Simone: 312-321]

And

"[…] they [drugs] didn't do me, my mental health any favours." [Simone:327-328]

Similarly, Leyla described how during the time she was smoking crack cocaine she experienced a very big dip in her mental health that escalated into a suicide attempt:

"I tried to commit suicide." [Leyla:808]

In the previous theme, Leyla described PDU as a behaviour that allowed her to take control of her life by escaping difficult emotions. In this subtheme, she described opposite feelings of being out of control due to smoking crack cocaine. This experience is described as shocking because the drugs, which she knew and trusted in the past to help her, were now contributing to destroying her life:

"I smoked crack cocaine for three months um, and that almost completely, it was only for three months but it almost completely destroyed my life." [Leyla:120-122]

And

"[…] that was so scary and so um, how quick it happened and um, you know I wasn't prepared for it because you know crack is just cocaine and I've used cocaine off and on for, for such, many years at that point so you know [exhales] I wasn't expecting the, the chemical reaction or whatever that takes place […] devastate me financially and take away my, the person that I was or, for, or contribute to, to stealing my soul." [Leyla:876-883]

Leyla mentioned having her "soul stolen" and herself "taken away" by PDU, which further represents this sense of being out of control. The analogy of drugs stealing her soul suggests that she perceived them to maliciously and deviously taking away from her the essence of who she was. In other words, she was robbed of the good parts of her identity that made her

whole, leaving her empty and unrecognisable. Similarly, Simone described the false promises that drugs made to her by allowing her only to see her life in the moment, inhibiting her ability to view herself in a timeline. Like water running from a leaking pipe, slowly but steadily ruining the carpet, drugs were leaking into other areas of life, running her ability to make life plans. Simone explained that inevitably "living for the moment" meant that she was living for the next time she could use drugs.

> *"Yeah um, drugs give you a very um, myth, you know, you can only feel what's in front of you um, and by, by taking the drugs you perceive it, […] but you're not able to see the bigger picture and what it's doing to everything else around you um, and you know, […] I-I've been given opportunities and drugs have ruined them, […] drugs were leaking into my bigger picture um, they, they were making me you know, just live for, for the moment and, and live for, for, by live for the moment what I mean is live for the next time I can get my hands on drugs um, you know it's a very near-sighted thing."* [Simone:490-503]

Simone's use of the word "myth" reflects the unrealistic narrative promised by drugs, a narrative that can never come into fruition. A "myth" is something desirable, and yet unattainable, suggesting a constant feeling of disappointment that she wasn't getting the experience she was aiming for. Ella mentioned that the realisation that drugs were negatively affecting her life came when she recognised that they were the reason she didn't have a good relationship with her children. She described that although she had pleasant experiences with PDU, what was important to her eventually were her relationship with her children, and losing them brought up a range of difficult emotions:

> *"I was really sad and desperate and broken and empty […] I realised that I was empty of myself regardless of all the experiences because my, it was my children who were my life and the, the drugs I realised had a, absolutely affected my relationship with my children and my behaviours which I, I really wasn't, I wasn't ignorant you know but kind of, well, that's the way it's always been and isn't everyone like that, you know."* [Ella:275-285]

Ella also described that although she knew drugs could be bad for her, she failed to calculate the devastating effects of PDU. This happened because she was using drugs for many years and was socialising with people who did the same, thus PDU was normalised to her. Monica also mentioned being aware of the devastating effects of drugs. She described heroin as having positive effects, which were significantly outweighed by its negative impact. Her

perception of heroin as a one-way deadly street came from her mother's death due to a heroin overdose. She experienced this death as a life-saving experience for her because it stopped her from getting addicted to heroin:

> *"I knew that at that point, although I really wanted, to me, what seemed to be the benefits of heroin at that time, I was also very aware that there's no coming back for me personally when I started using heroin, I was never ever, I would never ever come back. […] probably because I see my mother dying of heroin use."* [Monica:283-290]

And

> *"I think in hindsight, I knew that heroin was death, I think that was a lifesaving thought for me because I think if I had back in 10 years and if I had just used heroin, I would be dead."* [Monica:794-796]

In summary, participants reached a consensus that in the long-term, the negative impact of PDU overshadowed the positive short-term effects. Yet, none of the participants described this realisation as the reason for stopping PDU. Participants describe these experiences almost as if the drugs deceived them by introducing themselves as a friend, who would help them cope, but that friend later became demanding, overpowering, and controlling. This deceiving nature of PDU, described almost like a trojan horse, had a negative impact on many different aspects of participants' lives; from physical health and death to their ability to engage with other people, and with meaningful long-term life plans.

3.3. Superordinate Theme 2: Because of You

The second superordinate theme captures the dynamic relationship between participants, drugs, and others. It includes the participants' need to belong in a social group and their longing to connect with others and with parts of themselves. In their narratives, drugs were described as the medium that was used to facilitate these experiences of connection. Participants' accounts include experiences of relationships that centred around PDU that lead to an increased sense of loneliness and isolation. Two participants also expressed experiences of PDU that helped them connect to withdrawn parts of themselves. As their narratives progressed, participants described experiences of the positive impact that their relationships with others had in instigating their engagement with recovery. In order to explore this superordinate theme, I present the subthemes of ***"Somewhere I belong"***, ***"Longing to connect"***, and ***"'A greater capacity for care'"***.

3.3.1. Subtheme 1: Somewhere I Belong

In this subtheme, participants explained the process in which PDU was an integral component of their sense of belonging to a social group. Sarah described a process of normalisation of drugs through socialising with other drug users, which allowed her to engage with PDU.

> *"I just felt like, everyone was doing it."* [Sarah:114]

And

> *"I think I was always around it so that means I thought it was normal."* [Sarah:431]

Simone explained how she experienced drugs as a fundamental part of her socialisation. She mentioned that engaging with PDU as a medium to increase her sense of belonging to a social group was a priority for her. For Simone, social engagement was a synonym to taking drugs:

> *"[…] if at that time you would have asked me where I would rather be, my choice would have been to take, I would rather be in my house taking drugs. I would rather be out in a nightclub. I would rather be drinking, socialising, that, that was my, you know it came, socialising came as a, a whole picture and, and, and the socialising didn't come without drugs or alcohol you know, they were, they were one and the same things. If I said that I was socialising that was drugs, taking drugs, drinking you know, and I didn't perceive socialising to be anything but."* [Simone:513-521]

Simone also described her drug-taking behaviour as a social identity, emphasising the role that her socioeconomic circumstances had on this perception. In her experience, using drugs signified her sense of belonging to the social group she grew up in, since other people from her area defined themselves through their PDU. Simone highlights the difficulties that come with living in poverty, having limited options in life, and how drugs provided an escape from the "poor" identity by replacing it with the identity of the drug user. She explained that socialising in that environment convinced her that she must inherently belong to the social identity that came with PDU:

> *"[…] taking drugs is an identity […] I'm talking about the kind of people who were brought up around drugs. You know I come from um, you know a really poor background. […] drugs were a way of life that… that… that was people's*

identity because they're so, you know, so desolate that the drugs is their only escape from, from their reality um, and, and it does become their identity um, and I just blended in with that, that just you know because I was always kind of socialised around that environment it… it… it made me believe that… that… that's who I was." [Simone:287-299]

Similar to Simone, Monica emphasised that her PDU experience was affected by the socioeconomic environment she grew up in. She spoke about drugs being "everywhere" in her surroundings growing up in a socioeconomically deprived area, which further promoted their normalisation. Monica mentioned that a few people from her neighbourhood and her family also engaged in selling drugs, and criminal activity, which further normalised the presence and consumption of drugs. Her experience was especially influenced by the fact that she did not feel the people in her area, and inevitably her, were encouraged to engage with life through education or any activity that would allow them to build a future. Thus, she felt that budling a life around drugs was her only option:

"Because it was there, it was available easily, very easily available, I had all kinds about me […] my best cousins are drug dealers uh, we lived in a flat with people upstairs were drug dealers, the people I met, this was everywhere, there was so much violence […] you could see real gangsters and there's been a lot of gun violence and so much whereas I was able to access it socially easily there was no, we were not encouraged to start free education, we were not encouraged to get up and get a job and that, that we were not encouraged to really have a future […] and that just seemed to be everybody else was doing it so why not? [Monica:406-416]

And

"Everybody was, everybody was doing it." [Monica:434]

And

"[…] it was very much a normal part of life where we grew up." [Monica:661-662]

Monica, also, mentioned that drugs played an important role in how she experienced social and financial status. Due to the limited socioeconomic opportunities in her area, the people who were selling drugs were the most financially privileged. This, in combination with the poverty that she experienced, promoted an idea in her adolescent mind that selling and using drugs is not only normal, but also admirable and desirable, especially if she wanted to belong amongst the admired and the achieved:

> *"Very normal, very, very normal, very, very normal it was. We admired drug dealers because drug dealers were the only people that had money everybody else was really poor, really poor in such an area and the drug dealers had money and drug dealers had power and they had nice cars and that appealed to the outside that they had a lot of things because they had a lot of people coming and going so they were very, in that environment as a 14, 15, 16 year old."* [Monica:418-425]

Monica's repeated use of the word "normal" and the phrase "really poor" indicate the emphasis that she wants to place on these two aspects of her experience. Repetition suggests a conscious choice of words and a wish to be fully understood on the realities of her experience. Through repetition she aims to highlight that she is not using these words lightly, and wishes to paint a realistic picture that conveys the full essence of her experiences.

In summary, this subtheme sheds light into how the systemic and systematic normalisation of drugs had various implications for participants. They described their experiences of being exposed to a normalised, or even 'glamourised', lifestyle of PDU. This influenced their experiences and shaped their understanding around the implications of engaging in PDU as a means to achieve a sense of belonging to their families and their communities. From the narratives it seems that participants were looking in others for cues on how they could develop a sense of self by primarily developing a sense of belonging in a social group.

3.3.2. Subtheme 2: Longing to Connect

In this subtheme participants express their need for interpersonal connection, and how this need was shaped and perpetuated by PDU. Tania described how her father was emotionally withdrawn when she was growing up, and the only times she felt a warm connection with him was when they were inhaling glue together:

> *"Yeah, I mean it's, it felt like a kind of shared almost like a warm [laughs] um, experience [inhaling glue] which we, he kinda struggled to do mostly. It wasn't, you know, he wasn't abusive, but he did struggle to um, show the affection or emotions so it felt like something we were sharing that's um, at the time."* [Tania:461-465]

Tania's use of the word "warm" to describe her interaction with her father, reflects on the nurturing aspect of their relationship that was facilitated by PDU. Her laugh indicates feelings

of uncomfortableness from understanding the dissonance that a warm and nurturing experience with her father had to be facilitated by PDU. Simone mentioned that feeling isolated and disconnected was largely due to her CSA experiences. She described how she felt a sense of connection to her abuser, and when the abuse ended, she felt isolated and alone, disconnected from everyone, which left her needs for interpersonal connection unmet:

> *"[…] and although abuse and manipulation was hard when it's all you know um, and it's kind of all you've had to fill your emotions or to fill your need and want and desire for connection um, and that goes away. You start to feel empty."* [Simone:621-625]

And

> *"[…] lonely, I felt lonely um, and I felt, I felt empty."* [Simone:615]

In her narrative Simone explained drugs were there to help her manage feelings of emptiness by allowing her to connect with others. She expressed that being under the influence and feeling connected with drugs created a sense that she is also connected with others who take drugs with her. She described that she did not experience human connection apart from when she used drugs with others, and although she expressed that these relationships were only based on a common drug-taking behaviour, at the time they felt more than that. This left her with intense feelings of loneliness when she wasn't engaging in PDU, which made her preoccupied with seeking the next time she would be able to take drugs and connect with others:

> *"when you take drugs and you take them with other people, the… the… the same chemicals um, you begin, begin to feel like that you have a connection with somebody um, and something you know, that you've, you've got the connection with the drug and you've got the connection with the people that are taking the drugs with you and I suppose […] seeking connection um, and I have no connection apart from substances. I have no, I've had nothing that aligned with me."* [Simone:415-426]

And

> *"[…] those connections felt like real friendships, […] it meant that every time I wasn't on drugs, I was thinking about how maybe I could next get to be taking drugs to fill that void."* [Simone:452-456]

Ella also described that because of the PDU she was able to feel connected in relationships and experience intense feelings of being in love. She emphasised how great this was for her, at the same time mentioning that this greatness was short-lived:

> *"[…] so who wouldn't want to take the drug that makes you with other people and gives you a great social life and makes you fall in love all over again and it was great [exhales] at the time."* [Ella:527-529]

Ella exhales deeply when describing the short-lived connections, facilitated by PDU. This reflects her disappointment, or even sadness, that this effect didn't last. Similarly, Leyla experienced using cocaine as her only avenue in which to experience interpersonal connection. She described these connections as very intense because cocaine disinhibited her and allowed her to share intimate moments with others, something that she expressed she would never do when not using drugs. Leyla placed emphasis on how unique and important this intimacy was for her at the time, calling these interactions "almost therapeutic":

> *"Oh, that's when I connected uh, is when I, using cocaine because it, it's like a truth serum. […] we got into some really deep stuff and so it was almost like therapeutic, and that's the only time I would ever do that. I wouldn't do that sober or normally to any, anyone you know so uh, that was, that was part of it, […] that allowed an intimate connection with these people who […] I wouldn't have wanted to engage in or, or ever had the chance to engage in with them otherwise so um, yeah."* [Leyla:536-547]

Leyla's use of the phrase "truth serum" indicates the effect drugs had on her ability to connect with herself. Drugs took control of her mind, the way a truth serum would do, and she was forced into connecting with her true thoughts and emotions. This lack of self-control is what allowed her to connect with others, implying that when she was in control of herself she wouldn't consciously connect with them. She describes the connection as a positive experience, which she was too inhibited to seek when sober. Monica described how she had supressed the difficult emotions she experienced in childhood, which made her feel disconnected from other people. She explained how being emotionally withdrawn made her feel that her relationships were not genuine, since no one actually knew her "real" self. Thus, PDU played an integral part in promoting and sustaining these connections, as Monica equated her need to feel connected to others to her need to take drugs:

> *"I was probably, I disconnected with the others."* [Monica:115-116]

And

> *"[…] every connection that I tried to have, I had suppressed so much emotion. I realised that I was more than who I thought, that everything was a lie, that I wasn't being honest as I genuinely felt with, with myself or with anybody. […] nobody genuinely knew who I was because I had kept that inside for so many years."* [Monica:590-594]

And

> *"I don't know maybe, maybe I've been chasing the highs but looking for human connection."* [Monica:568-570]

Monica's use of the word "chasing" indicates her active efforts to acquire connection. This word also suggests that she never quite acquired it, as "chasing" reflects a continuous effort, rather than an achieved goal. Further to the interpersonal connections, Monica described that through PDU she was able to achieve intrapersonal connection. She mentioned that only when she was under the influence of drugs she experienced sincere connection to her emotional world, and only when engaging in PDU was she able to express her sincere thoughts and emotions to others:

> *"On drugs is when I emotionally connected with myself, where I had a real emotional connection where I could feel what I genuinely felt at that point and time and prior to that, I've never voiced what I felt, always kept my true feelings quiet and with drugs I just voiced my true feelings, so drugs could bring me to actually genuine emotionally connect with myself and to express my genuine emotions in that moment in time."* [Monica: 570-576]

Along the same lines, Ella mentioned that she used drugs in order to achieve intrapersonal connection. She directly mentioned that the only times when she was able to face the difficult feelings that she was fostering, which derived from the abuse she experienced in childhood, was when she was engaging in PDU. She explained that on some level she was aware that these difficult memories existed and assumed that this is the reason she used drugs, as a way to retrieve and process them:

> *"Drugs help me connect to myself that's, that's… that's what I was using to connect to myself"* [Ella:168-170]

And

> *"[…] so the drug […] facilitated me being able to look at that ["painful memories'] because it was so disorganised and unconnected and frightening,*

it was just, I didn't want to look at it, it was old emotions that I, I obviously knew I had but couldn't process." [Ella:377-382]

In summary, this subtheme highlights how PDU was experienced as a facilitator of connections for participants. These connections were experienced as unique and valuable parts of participants' lives at the time. In this theme we see the facilitation of both interpersonal connections, where participants were able to experience "togetherness", and also intrapersonal connections, where participants were able to experience their emotional world. These connections had a conditional nature as they were only occurring due to drugs. Thus, PDU positively reinforced the participants to continue using drugs as a way of not losing this ability to connect. Participants also mentioned the impact that CSA and other childhood maltreatment had on their ability to become connected to themselves and others, and highlighted how PDU was experienced as the only avenue to mend this disconnection.

3.3.3. Subtheme 3: "'A Greater Capacity for Care'"

This subtheme captures the influence that relationships had on the participants' decision to move away from PDU and engage with recovery. Sarah expressed that what helped her stop using drugs was her daughter, and the fact that she needed to not engage with the PDU lifestyle in order to look after her properly. In her narrative she described this as a conscious decision to prioritise her daughter's needs over PDU, and expressed explicitly that she wouldn't have stopped if she didn't have to take care of her daughter:

"I stopped you know what I mean 'cos of my daughter." [Sarah-58-59]

And

"I have my daughter to look after." [Sarah:397]

And

"If it wasn't for [my daughter] I wouldn't have stopped here. […] I decided to put my daughter first, didn't I?" [Sarah:672-675]

Sarah also mentioned that she didn't manage to engage with recovery until a few years after her daughter's birth, which still brings up feelings of guilt for her. She feels that she let her daughter down because she was using drugs while her daughter was a young child, a process that she doesn't want to repeat with her grandchildren. For Sarah having a relationship with her grandchildren without the involvement of drugs is almost like a second chance in being a good mother and a good caregiver, and therefore this keeps her motivated with recovery:

"I would never do drugs again in my life, […] Maybe it's a good thing I'm not getting stoned, […] I don't really want to let my grandchildren down, already done it with my daughter." [Sarah:153-158]

Similarly, Monica mentioned how disengaging from PDU was a difficult journey that signified her becoming a better person. She also emphasised that as a better person she wished to provide for her children a better life than the one she had, since in her own childhood she was exposed to drugs and abuse. This prospect for a better life for her children motivated her to engage with recovery:

"I went to so much trouble myself to be a better person but also to be a better mum to my kids […] I wanted my kids to have a better life." [Monica:199-205]

And

"I just especially want my kids having a [silence] a good life. I just want them to have a better life." [Monica:363-366]

Monica's silence before the phrase "good life" conveys her hurt regarding her own life that was not good. She then changes and says "better life", highlighting the comparison she made between hers and her children's quality of life. Monica discussed feeling proud and successful to have managed to raise her children in an environment that was drastically different than the one she grew up in. She expressed that both her and her children are better off without drugs being a part of their life. Monica drew parallels between her upbringing and her adult difficulties and mentioned that her children are able to be healthy and emotionally connect to themselves without using drugs, contrary to what she used to do. She also expressed that doing so was a very difficult task for her, as it would have been much easier to keep repeating previously learned patterns of relating and behaving:

"[…] my children and I know that it, at the end of the day we are better off because my children are grown up, have very, very different lives that I grew up with and they are grown up have, happy, healthy, well-rounded individuals [exhaling] who have emotions and they acknowledge their emotions and, and I feel that's, that's a success for me, that's a success for me because as I said it would've been easier to do what I knew, it was harder where I am and to learn new behaviours and to teach new behaviours." [Monica:860-867]

Monica repeats the words "emotions" and "success", suggesting that these are important components of her experience. Being able to experience her emotional world has been a

significant part of her journey. Achieving that, not only for herself but also for her children, was experienced as an immeasurable success. Along the same lines, Simone mentioned her professional role as a mental health nurse to have instigated her recovery. Through her job Simone was in a place where she was caring for others with mental health difficulties. This experience exposed her to people with whom she shared similar past and current difficulties. Her professional role allowed her to express care, empathy, and forgiveness to her patients for things that she was not able to care, empathise, or forgive in herself. Simone discussed how she started drawing links between her patients' and her own experiences, which made her realise that if she had the capacity to care about others who are like her, she can start practicing self-care as well. Her professional experience allowed her to understand that if others are worthy of acceptance and stability, then she is deserving of it too. This thought is described as instrumental in her decision to practice self-care by removing PDU from her life:

> *"I am a training mental health nurse as well um, and that helped me a lot um, so I suppose um, […] you start to look over people who were maybe being in the situation that you're in um, and you have more empathy, more forgiveness um, you know a, a, a greater capacity for care because it's somebody else and then you realise that, that you are that person […] and you start to realise that, that you're deserving of, of, of that, you know that understanding and that stability um, and that grasp of, of, of um, you know of everything that's gone on."* [Simone:222-240]

Simone's use of the phrase "greater capacity" reflects her understanding of the low capacity of self-care she used to have. Being able to care for others she discovered that she indeed had the ability to provide more care than the one she was giving herself, which allowed her to reflect on her life-choices. For Tania the turning point in her PDU came when she engaged with professional help for her alcohol difficulties. Before being told by a professional that her use of solvents is a substance misuse issue, she did not consider her inhaling solvents to be problematic, as it had been a part of her life for a very long time and it had become part of her daily routine. When she was exposed with the information of the validity and severity of her PDU she mentioned being surprised and shocked, and the support and information from the recovery worker influenced her decision to engage with recovery:

> *"Um, I uh, I was 34 um, when I was working with um it was an alcohol and drug prcject um, and the drug worker there, um, she came, she, she so I went through a list of um, drugs uh, solvents. She, she did some research and went through a list of solvents um, that I'd pretty much tried all of them at some*

point in my life on there and that's, it was that day I was like oh my God. So that, that was, that ended up being um, uh clean you know, since then." [Tania:113-119]

And

"I didn't even really know that the solvent use was a problem for some […] until I had someone explain to me and read it and this is what happens, and me go, oh yeah, that's what I do kind of thing." [Tania:177-181]

Along similar lines, Ella described that if not for her engagement with the criminal justice system, she would have never attempted to stop her PDU. She described that the drive and motivation for recovery needed to come from someone else. The external source, which incited her turning point, was when she faced prison time for a drug related crime. Ella mentioned that she was fearful of an unfavourable sentence, and in an attempt to show the court that she had remorse for her offence and willingness to be reformed, she engaged with recovery:

"I wouldn't have given up drugs and that I said that also at the time. I had to have someone to drive me to that action to, to motivate me to do that for myself and that motivation although I still had the punitive measure, the punitive measure was of a far less harsh degree than I believe I would've experienced if I was still in addiction when I went to jail." [Ella:1380-1385]

In summary, this subtheme captures the ways in which others acted as a tacit 'wake-up call' for participants, prompting a turning point in their PDU lifestyle. These others came in different roles in participants lives, including children, patients, and professionals. Participants experienced a sense of fear around how things would be if they were to keep using drugs, which allowed them to make an effort for a different future that wouldn't include PDU. Participants who adopted a caregiving role, either due to motherhood or due to their professional capacity, were exposed to the reality of the poor care they received as children, and the way in which engaging with PDU was perpetuating the same low standard of self-care. When caring for others, participants had a chance to assess and decide whether they wanted to continue the same cycle of providing poor self-care, or whether they wanted to take steps towards change. This provided the opportunity of experiencing a turning point in their lives and allowed them to use this inspiration and motivation from others to pursue recovery.

3.4. Superordinate Theme 3: Living in the Shadow

The third superordinate theme depicts the impact of CSA and other childhood maltreatment on participants' lives, as they perceived and experienced it. Even though the experiences of CSA were contained in childhood, participants described the impact of CSA as a long casting shadow that covered many areas of their lives, perpetuated by their PDU. It includes narratives of women experiencing criticism and self-blame around the choices they made and the lives they led when using drugs. It also includes an overall understanding from participants that their CSA and childhood maltreatment had an explicit effect on their mental health and their PDU difficulties. These experiences are explored in the two subthemes ***"Taking the blame"*** and ***"An 'unavoidable' impact"***.

3.4.1. Subtheme 1: Taking the Blame

This subtheme captures participants' experiences of criticism and self-blame as perpetuated by their drug-taking behaviour. Leyla described how she internalised her parents' opinion that she was to blame for the CSA, as she was to blame for being a bad person for engaging with PDU. This internalised blame left her feeling that she needed to maintain a "drug addict" identity, which perpetuated her engagement with drugs and, to this day, affects her self-image. Leyla explained feeling unlovable by her parents because of the CSA and PDU, and this interfered with her ability to be understanding and have self-compassion towards the reasons that precipitated and perpetuated her PDU, leaving her stuck in a self-critical narrative:

> *"I viewed myself as I'm just a piece of shit, drug addict […] nothing happened to me, nothing's wrong with me um, I just want, I'm such a disgusting person that I just wanna get high to get high. There is no other reason for it. There's, there's no understanding, no empathy, no acknowledgment, no um, regret or apologetic behaviour for how they [parents] contributed and still contribute to the way I feel about myself."* [Leyla:725-732]

And

> *"It was just 'cos I was um, I, I just a simple drug addict, selfish um, irresponsible."* [Leyla:659-660]

And

> *"I was now doing and believing the judgments and criticisms that my parents had been saying all along […] you know in my mind, and they didn't love me because of it."* [Leyla:745-748]

And

> *"If I'm the black sheep and such this horrible person who my mother loves to gossip and make stories and lies about me to, you know I, I might as well just live up to that, that label, you know?"* [Leyla:653-656]

Leyla chose words to describe herself that are charged with very strong negative connotations. This choice of words reflects the depth of self-loathing she fostered, and the further distress this caused her. She mentions that her mother viewed her through a very critical lens, which suggests that she internalised her mother's criticism, feeling at the same time completely rejected by her, while also affiliating with her and engaging in self-rejection. Similarly, Tania expressed how even now in recovery she feels that going back into a self-critical mindset is almost an automatic process for her. She described that her self-critical thoughts can be invalidating of her CSA experiences, calling herself "odd", and invalidating all the difficulties she endured that contributed to her PDU. She mentioned that preventing this automatic thinking is a conscious process:

> *"Now, even now it's, I can be really easy to turn it all back on myself, definitely um, and think oh, when I was selfishly something I was, I was sniffing or I was uh, maybe I imagined all these things or I was a very odd child or I had this or I had that and it was, yeah it can be very easy. I have to work very hard to kind of go you know, hang on a minute [laughs] let's stop here and kind of think about this."* [Tania:721-728]

Simone drew links between the negative emotional impact her CSA had on her, and how PDU was a way to alleviate herself from it. She mentioned that the CSA left her with negative beliefs about herself, especially regarding low self-worth, and recognised that, even though "artificial", drugs were helping her feel better:

> *"Yeah, it was, I wouldn't say it was bad, I would say it was guilt um, it was um, a feeling of inadequacy. A feeling of um, not being good enough um, not, just not being enough, not, not just good enough, enough um, as a person, as, as um, as a human, you know, the, the, the drugs gave me the artificial chemicals um, gave me a feeling of fulfilment and you know."* [Simone:410-415]

Simone also described that she still has to consciously try to stop the self-blaming thoughts regarding herself and the life choices she made when using drugs. She mentioned that this is particularly difficult since engaging with self-blame and self-criticism is something she has done for many years:

> *"[…] it's still an ongoing journey […] not criticising myself for the things that I've been and for the behaviours that, that I've, that I've done in the past years, there's things that I've done in the past um, I-I have spent a lot of time blaming myself."* [Simone:389-393]

Ella's experiences of blame and criticism involve her relationship with her children. She described that her experiences of childhood abuse had an impact on her mental health and an impact on her PDU, which resulted in her not being able to mother her children effectively. She explained that her daughters explicitly blamed her for the way she mothered them and have cut ties with her because of that. Ella described how she feels her difficulty to be a good enough mother to her children stemmed from the fact that she wasn't able to effectively manage her own difficulties, including her chronic engagement with PDU:

> *"I'm not a person who done anything to physically hurt my children um, but I realise also how they must be feeling, their own, unresolved issues where I wasn't able to help them with because I didn't know how to resolve my own issues and kept needing love."* [Ella:827-831]

And

> *"My youngest […] and my oldest daughter […], have not spoken to me for 8 years because they wrote me a letter telling me I'm a disgusting person and I shouldn't have inflicted what I did on their lives […] they felt that I wasn't paying enough attention to them […] they obviously have resentments because of the life I was leading."* [Ella:812-821]

Ella's use of the phrase "kept needing love" reflects an implicit criticism towards her need to be loved. This conveys her understanding that love is something that you get specific amounts of, for a specific time, and to "keep needing" it suggests a level of greed and selfishness.

In summary, this subtheme illustrates experiences of blame, shame and rejection, as well as self-loathing and disgust, as they relate to the life choices participants made when they were using drugs. These experiences are both external, affiliating with the thoughts and opinions of others, and internal, expressing participants own thoughts of low self-worth. Participants described intense experiences of blame and criticism that they internalised and repeated to themselves in a habitual way. Although they are currently in recovery and have created a more compassionate understanding of their past difficulties, participants explained that engaging with self-criticism is a long-term, on-going process that takes conscious effort to

stop. Participants also described how their relationships with others have been stigmatised by criticism regarding the times of their life when they used drugs.

3.4.2. Subtheme 2: An "Unavoidable" Impact

This subtheme portrays how participants make sense of the relationship between their PDU, and their experiences of CSA. Understanding, or even defining, a causal relationship between CSA and PDU can be a very subjective and personal process. Participants placed emphasis on how PDU was influenced by their CSA and childhood maltreatment experiences. Monica expressed that she acknowledges that her experiences of CSA and growing up in an environment, where drugs were normalised and praised, had a direct impact on the choices she made. She described that experiencing CSA is equal to being damaged, and therefore disempowered and unable to make different life choices:

> *"[…] my childhood experiences have actually had an impact on me. […] these things were normal to me and that it was normal for me […] to make those choices."* [Monica:67-72]

And

> *"Personally, I believe that it doesn't matter if it's one time [CSA] or a thousand times, the damage is done."* [Monica:113-114]

Monica expressed this deterministic view of the impact of her childhood on her PDU by the use of the world "unavoidable", signifying her experience of lack of choice when it came to her engagement with drugs:

> *"I think it was unavoidable that I was gonna use drugs between the environment that I grew up in and then the area that we grew up in and then my childhood experiences and I think it was absolutely unavoidable that I was gonna use drugs… […] I wish it hadn't happened um, but I think it was absolutely unavoidable. I think it was absolutely unavoidable."* [Monica:784-794]

Monica's repetitive use of the phrase "absolutely unavoidable" conveys her strong conviction that her life experiences predetermined her PDU. Her deterministic viewpoint indicates that she didn't feel able to intervene with her life-plan, as her experiences were externally controlled. On a very similar note, Ella mentioned lack of personal agency when it came to her engagement with PDU, as she described that in her understanding there is a cause-and-effect relationships between her experiences of childhood abuse and her drug use, which

does not allow for personal choice. She explained that PDU was a way of responding to the difficulties of her life, and without these difficulties she would not have resorted to PDU:

> *"I do understand the cause between my addictions and, and what my, my life experiences and I've had some very extreme adverse life experiences that sort of made me, I know that I wouldn't have used drugs if I had a different life."* [Ella:44-47]

And

> *"[…] all my drug use was dealing with my childhood."* [Ella:395-396]

And

> *"The drugs were a response to my life."* [Ella:308-309]

Simone mentioned that she believes there is a relationship between her CSA and PDU. In both experiences she felt out of control and this for her made the two experiences very similar to each other. She described that if she were to re-engage with PDU once she was in recovery this would make her feel out of control and like her abuser had still power over her:

> *"I suppose the drugs and, and, and the abuse are very um, you know they're one and the same thing um, I feel like they're both kind of tied to one another um, and by going back to drugs or by allowing myself to relax or become you know, engaged in, in, in cocaine or any drug again, it would've kinda felt like he [abuser] had a bit of a win over me."* [Simone:209-214]

In her narrative Leyla also expressed that other people who share her CSA experiences would use drugs, like she did, to escape from the emotional impact of the abuse:

> *"[…] the main thing for people that in my opinion, people are using substances when they've been abused in any way as a child, for exactly the, the reasons I did; to escape."* [Leyla:1031-1034]

Monica also described her understanding that her brother, who shares her experiences of CSA and other childhood maltreatment, is misusing heroin and alcohol, similarly to how she was misusing drugs. She mentioned that his experiences led him to lead a very dysfunctional life, and unlike her, he hasn't been able to detangle himself from this lifestyle. Monica expressed feeling lucky that despite the abuse she was able to manage her difficulties and take herself out the PDU lifestyle. These feelings are influenced by the fact that others

around her, who have been through similar experiences, ended up either stuck in the lifestyle or dead:

> *"My brother was also being abused, and my brother became a heroin addict. […] he still lives that, that completely dysfunctional life and […] he, he's always had an addiction of some sort um, and that it's just that he's not a heroin addict, he's an alcohol addict um, but he's still very much lives a very, very dysfunctional life."* [Monica:292-301]

And

> *"I've been luckier than some and how that is I don't know but I have been because I have two other cousins that was abused have committed suicide and you just think ah, so I just feel lucky, I feel lucky compared to a lot of people."* [Monica:870-873]

Simone also mentioned that another girl, who was abused by the same abuser, experiences drug addiction issues that are severely affecting her life. In her understanding, this girl must have gone through a similar journey as Simone, where her PDU derived directly from the CSA:

> *"[…] the girl that he went on to after me um, she is, she is addicted to crack um, you know she, she's got a really bad crack habit. […] I know that, that her drug use came from him."* [Simone:745-750]

In summary, this subtheme highlights the participants' perceptions of how they experienced the relationship between PDU and CSA. Participants described their PDU as an inevitable outcome of their CSA experiences, especially as PDU served the purpose of managing emotional difficulties that derived from the CSA. Their narratives suggest a deterministic approach to how childhood trauma will leave a lasting impact that can only be managed by the use of drugs. Participants extended this understanding not only to their own experiences, but also to the experiences of other people who have had similar life experiences to them. This parallel between theirs and others' lives suggests a level of confidence that there is a cause-and-effect relationship between CSA and PDU.

3.5. Superordinate Theme 4: Moving Forward

The fourth, and final, superordinate theme depicts the personal journey that participants embarked to develop a sense of identity, which was influenced by various experiences. It also entails their engagement with the recovery process as it relates to experiences of regaining control over themselves and their lives. Participants' accounts of the identity

development process included experiences of viewing themselves through different lenses, including the lens of CSA and PDU. As their stories progressed participants described uncovering different parts of themselves, and the choices they made to strengthen some of these parts, while leaving others in the past, in order to move forward. The concept of feeling "out of control" while using drugs, and of regaining control through engaging with recovery was pertinent across narratives. This superordinate theme is comprised of two subthemes: **"Negotiating identities"** and **"Reclaiming control"**.

3.5.1. Subtheme 1: Negotiating Identities

This subtheme depicts participants' experiences of identity development, as this was informed by various factors, including their experiences of CSA, PDU, interpersonal relationships, and life choices. Simone expressed that there was a time in her life when she self-defined through her drug-taking behaviour:

> *"[…] taking drugs was a big… was part of my identity."* [Simone:83]

She described that the drug user identity kept her stagnated in the identity of the abuse victim, which maintained the experience of CSA at the forefront of her mind. She mentioned that the abuse victim identity was one that protected her from reflecting on her life choices and accepting agency and personal responsibility for her life. Simone explained that hanging onto the victim identity allowed her to attribute her PDU and other negative emotions and behaviours to her victimhood. This absolved her from the responsibility of making any active changes to improve her life, and stopped her from even attempting to change:

> *"[…] when I was using the drugs um, I was still, I still felt like a victim um, I still felt like um, the abuse um, was, it was very still very real, very much a part of me, very um, [exhales] […] I used it as an identity […] the abuse was my armour […] It was my excuse for the drugs, it was my excuse when I was unemployed, it was my excuse for being an angry person, being a sad person."* [Simone:179-188]

In Leyla's narrative she expressed the idea of opposite identities. She described that for years she upheld a facade to the public, the identity of a well off, professional, and functioning person. She explained that this was outweighed by the other part of herself, the one that incorporated negative attributes and was using drugs:

"Even though I had this one persona of being a very intelligent good therapist at uh, uh very, you know secure and well-known prison, um, that was one part and then after that was the second personality where I would go and do my… [drugs]" [Leyla:496-500]

On reflection, Leyla described that she never affiliated with the drug addict identity because she conceptualised herself through other lenses, especially that of the childhood maltreatment victim. These identities include trauma-related psychiatric diagnoses:

"I wouldn't consider myself um, an, an addict in that respect but I would consider myself um, an escapist and uh, a risk taker, impulsive which it, it goes along with my PTSD or CPTSD diagnosis you know." [Leyla:114-117]

Ella explained that she experienced her identity as a drug addict to be one that caused her difficulties with others. She described herself as a person who wouldn't harm others, an attribute that she felt was not incorporated in the drug addict identity when she engaged with the criminal justice system:

"I've never been an angel, but I've never been a bad person and I've never harmed people you know, I've never, I don't cause harm and I you know, although I did some criminal things when I was younger, and I have been to jail for drugs [...] the only trouble I get in with the police is that I'm a drug addict." [Ella:616-621]

Simone explained that she started questioning and negotiating her identity only when she was able to perceive herself as someone who could embody identities other that the drug user and the abuse victim. In her experience there was a time when she felt she had to decide which identity would dominate her life choices, and this came through her professional role. Simone's choice to become a mental health nurse and to engage in a caregiving role came into contradiction with the uncaring nature of PDU, and this contradiction was the catalyst for leaving the drug user identity behind:

"Do I take drugs, do I sniff cocaine or am I a nurse, um you know? That, that it really did help me that I had to make a decision." [Simone:244-246]

And

"[…] it was finding something else and that being an option that, that, that pulled me away from, from, from the identity of being a drug user." [Simone:300-302]

Monica described that her engagement with the identity navigation process was instigated by comparing herself to the people that she was socialising with. She explained that growing around violence and PDU she never questioned whether this was fitting who she is as a person. It was only after reflecting on the incongruence between who her real self is and the identity she had adopted from her environment, that she was able to make a conscious choice and reject the violent, abusive, drug user identity:

"I didn't need, that's not me, that's just not who I am, I don't want it, I don't want to give it to other people, and I don't want it, I don't want to fight with people." [Monica:652-654]

In summary, this subtheme depicts the participants' experiences of negotiating different parts of themselves in order to form a congruent identity. This exploration process allowed them to view themselves through different lenses, as well as engage in a reflective process to shape their self-concept, their values, their wishes and goals, and their perception of agency over their lives. Through this process participants were able to make conscious choices regarding who they want to be in the future and decide which parts of themselves are not serving this vision and need to be left behind.

3.5.2. Subtheme 2: Reclaiming Control

This subtheme incorporates the process participants went through to reclaim control over their lives when they decided to move forward and away from PDU. Monica discussed how a part of her recovery journey was accepting personal responsibility for her life choices. She explained how when she was using drugs she defaulted into deflecting responsibility to drugs and other people, and for her, change was possible when she acknowledged that her behaviour was in her control:

"I would have to ... take responsibility you know, […] it's not the drugs, it's not anyone else's fault that is your choice to behave like that and you need to sort that so I did come round and to accept and there's a point about it my actions and reactions um, and acknowledge them and where I can, I've changed for." [Monica:756-762]

Ella expressed that her motivation to engage with recovery was tied to her wish to change her life completely. She described that it became apparent to her that being autonomous and able to be in control of her thoughts, emotions, and behaviours was an important value of hers, and PDU was getting in the way of living her life based on this value:

> *"[...] the motivation was to see if I could turn my life around massively […] I did get clean and I went to, to a programme of abstinence so I stopped using drugs immediately."* [Ella:313-317]

And

> *"I've always tried to change my life to be fully autonomous and you can't be doing that on drugs or drink, you have to be able to speak from your own mind mouth and heart so, so that's what I've learned as well."* [Ella:627-630]

In Simone's experience, recovery is an empowering process that allowed her to stop feeling like a disempowered victim. She described that her life felt like a car that someone else was driving, first her abuser and then the drugs. Through recovery she felt that she was able to be her own driver, in control of the direction her life would take. Simone explained that when her abuser was released from prison this was an opportunity to reflect on how far she had come in her recovery, feeling empowered enough to remain in control of her life and keep moving forward:

> *"When I came out of the drug use […] I was no longer a victim. I started to feel like I was in control of my own life now I'm you know, it's me at the steering wheel. […] I suppose in June when he came um, out [of prison] I was, I was, I was already in the driver's seat and I was very much empowered to um, to… to keep moving forward. […] I wasn't gonna let him come out of prison and stick in my driver's seat, it just wasn't gonna happen."* [Simone:189-209]

Simone also explained that through recovery she had an opportunity to progress as a person and develop copying strategies alternative to PDU, to the extent that she didn't feel she needed drugs to cope. She described that stopping PDU allowed her to let go of the painful impact of the CSA. She explained that part of this process dependent on her acknowledging and understanding the circumstances of her life events. This led to her letting go of self-blame and increase her self-compassion and self-forgiveness, which she described as invaluable components of moving forward:

"I feel like since stopping the drug use, I have, I wanna use the word progressed um, as a person. Um, I've been able to let go of the abuse a lot more and develop my own coping strategy a lot better without, without using drugs." [Simone:86-90]

And

"I have um, you know worked really hard on, on gaining the understanding that, that um you know that forgiving yourself is, is the key to kind of moving forward […] you're not to blame […] you're not a bad person […] it was just the situation at the time […] trying to teach that [kindness] to myself as well." [Simone:393-405]

In her narrative Tania emphasised that an important part of feeling empowered in recovery was using her life experience in order to help others who go through similar difficulties as her. She expressed the importance of using her voice to raise awareness about CSA and PDU issues, which would help others similarly to how she did in the past:

"[...] in my recovery um, uh, especially when I sort was more stable in myself, it's just become something I've wanted to speak out about and just uh, raise awareness of and help other people." [Tania:34-37]

And

"[…] if I see an opportunity to um, [exhales] to, to speak out and tell my story and, and help other people, then that's what I'll do kind of thing." [Tania:42-44]

Similarly, Leyla discussed that sharing her story to help others is something she finds very important. She explained that people, who went through the same difficulties as her, need to be better understood in order to be helped, and she expressed that using her voice to contribute to this understanding is invaluable to her:

"I'm a little nervous but I think it's important [the research participation]." [Leyla:62-63]

And

"I want to assist and participate in anything that can help people like me uh, in the future because we need better uh, treatment options and we need to better understand […] we need anything to help you know get, get the ball rolling so it's, it's eventually it's better and more helpful for, for you know people in the future." [Leyla:65-70]

On a similar note, Leyla discussed that through helping others she would be able to help herself. She explained that although she is in recovery she still feels 'broken' by her past experiences of CSA and PDU. Leyla mentioned that using her voice to help others is fundamental in the recovery and healing process, and she expressed gratitude for being given the opportunity to feel empowered through her participation:

> *"[…] this is how I'm gonna heal this [by sharing her story and helping others], […] that is gonna eventually put me back together and heal my soul. I feel it. […] This is the key for substance abuse, for everything. So, I'm grateful, so grateful that you um, picked me [laughs] to participate."* [Leyla:1052-1058]

In summary, this subtheme covers participants' experiences of reclaiming control of their choices and moving forward in their lives, away from PDU. Participants described a self-reflective process that allowed them to acknowledge their personal responsibility and accept agency over their lives. Their experiences of feeling empowered include the opportunity to share their stories and use their voices to raise awareness, help others, and ultimately take control of their narrative by turning it from hurtful to helpful. Participants' accounts suggest that this process is not a one-off decision, but rather requires continuous effort and engagement with behaviours and choices that are aligned with their values. Participants expressed that the process of reclaiming control and feeling empowered is opposite of being victimised, which is described as a passive role that lacks all sense of control. Thus, this empowering process of their journey is apparently the ultimate act of rebellion against their traumatic past.

3.6. Summary of Themes

The findings are clustered into four superordinate themes, each theme reflecting one significant component of the PDU experience. The superordinate theme **"The good, the bad and the useful"** conveys the impact of drugs on participants wellbeing, from pleasant and useful in the short-term, to negative and devastating in the long-term. The superordinate theme **"Because of you"** reflects the influence other people had, as both risk and protective factors for PDU. The superordinate theme **"Living in the shadow"** expresses the long-term negative impact of CSA, on participants' wellbeing . Finally, the superordinate theme **"Moving forward"** emphasises the importance of self-empowerment in participants' ability to regain control, and changing the trajectory of their lives. Combined, the four superordinate themes construct an integrated understanding of participants' experiences of PDU.

4. Chapter 4: Discussion

4.1. Overview

This chapter presents the key findings and conclusions that emerged from the analysis, while assessing and discussing them in relation to the existing literature. I have endeavoured to do this separately for each superordinate theme: **"The good, the bad, and the useful"**, **"Because of you"**, **"Living in the shadow"**, **"Moving forward"**. Next, I critically discuss the strengths, limitations, and quality of the study, and provide suggestions for future research. I conclude with the professional implications of the findings, including relevance to the field of Counselling Psychology and suggestions for clinical practice and service design.

4.2. Synthesis of Findings

4.2.1. Connection

4.2.1.1. An overwhelming feeling of disconnection

The participants had very different experiences of CSA and overall childhood adversity from each other, and yet all of them described these experience to have made them feel an intense sense of disconnection with themselves and others. This feeling of being disconnected from themselves and others was experienced in various ways by each participant.

Leyla described that she used drugs to *"escape [...] so I don't have to think and feel this loneliness and this isolation and these memories."*. She described that she experienced herself as two completely opposite people, where *"I had this one persona of being a very intelligent good therapist [...] that was one part and then after that was the second personality where I would go and do my… [drugs]"*.

Tania described feeling *"stuck in that um, cycle of"* being disconnected from her emotions and then suddenly having *"flashbacks and um, and then, then to use whatever [...] to help uh, to try and cope with that."*.

Simone spoke about her *"reality"* having *"no connections, there were no, no meaning, no purpose"* and feeling *"lonely"* and *"empty"*. She also described this sense of intrapersonal disconnection manifesting through *"blaming*" and *"criticising"* herself and *"a feeling of [...] just not being enough[...] as a person, [...] as a human"* and that *"the drugs gave me the artificial chemicals um, gave me a feeling of fulfilment"*. She also discussed the *"emptiness"* that she felt when the abuse stopped because *"although abuse and manipulation was hard when it's all you know um, and it's kind of all you've had to fill your emotions or to fill your need and want and desire for connection um, and that goes away. You start to feel empty."*.

Ella spoke of her experience of intrapersonal disconnection through feeling *"really sad and desperate and broken and empty"*. She also experienced interpersonal disconnection in her relationship with her children because she feels her "*unresolved issues where I wasn't able to help them with because I didn't know how to resolve my own issues and kept needing love.".*

Monica described a very explicit sense of disconnection *"with the others"* and how this was due to her *"childhood experiences"* that *"had an impact"* on her. She expressed that *"it doesn't matter if it's one time [CSA] or a thousand times, the damage is done."*. As an adult she later realised that in *"every connection that I tried to have, I had suppressed so much emotion"* and that *"everything was a lie, that I wasn't being honest as I genuinely felt with, with myself or with anybody. […] nobody genuinely knew who I was because I had kept that inside for so many years."*

4.2.1.2. Striving for connection at all costs

The participants described various ways in which they strived to feel connected to themselves and others. Even though their circumstances differed, all of them described their engagement with PDU as a way to build a sense of self and connect with others. Achieving these short-lived connections seemed so significant, that participants were willing to jeopardise their long-term wellbeing in the hopes that they would feel momentarily connected through PDU.

Sarah described feeling very isolated and using drugs in order to engage with others because *"I just felt like, everyone was doing it."*.

Simone expressed that her main priority was to engage in *"socialising"* and *"socialising didn't come without drugs or alcohol [...] they were one and the same things. If I said that I was socialising that was drugs, taking drugs, drinking you know, and I didn't perceive socialising to be anything but."*. She also spoke about drugs promoting a sense of connection with other people because *"you begin to feel like that you have a connection with somebody [...] you've got the connection with the drug and you've got the connection with the people that are taking the drugs with you"*. She went on to describe that she was *"seeking connection*" because she had *"no connection apart from substances [...] nothing that aligned with me."*. She described that although she strived for these connections through drug use, this was not a sustainable way of living as *"drugs give you a very um, myth, you know, you can only feel what's in front of you um, and by, by taking the drugs you perceive it, […] but you're not able to see the bigger picture and what it's doing to everything else around you."*. Although she

realises now that she's in recovery this process of drug-induced interpersonal connections, she claimed that *"[…] those connections felt like real friendships, […] it meant that every time I wasn't on drugs, I was thinking about how maybe I could next get to be taking drugs to fill that void."*.

Monica also explicitly described that *"maybe I've been chasing the highs but looking for human connection."*. She expressed her sense of disconnection and her deep need to seek out connection. She said that *"on drugs is when I emotionally connected with myself, where I had a real emotional connection [...] so drugs could bring me to actually genuine emotionally connect with myself and to express my genuine emotions in that moment in time."*. This experience strengthened her PDU behaviour as she strived to connect to herself and her emotional world.

Tania described that her father was the one who taught her how to inhale solvents the first time when she was six years old. This experience was very important for her because *"it felt like a kind of shared almost like a warm [...] experience [...] he did struggle to um, show the affection or emotions so it felt like something we were sharing that's um, at the time."*. This solidified her understanding that drug use was the way to connect with herself and others.

Leyla also described the importance of drug use in facilitating connections for her because *"it's like a truth serum. […] we got into some really deep stuff and so it was almost like therapeutic"*. For her connecting with others was really challenging, as she describe she *"wouldn't do that sober or normally [...] that allowed an intimate connection"*.

Ella expressed that it was obvious to her, at the time, that taking drugs was important in promoting interpersonal connections. As she said, *"who wouldn't want to take the drug that makes you with other people and gives you a great social life and makes you fall in love all over again"*. She also describe how the *"drugs help me connect to myself that's, that's… that's what I was using to connect to myself"* and that *"the drug […] facilitated me being able to look at that ["painful memories'] because it was so disorganised and unconnected and frightening, it was just, I didn't want to look at it, it was old emotions that I, I obviously knew I had but couldn't process."*.

4.2.1.3. The importance of meaningful connections in recovery

Participants described how through different life events they found the opportunity to develop meaningful connections with others, and how this allowed them to start connecting to their different parts of themselves, which promoted their recovery and overall well-being.

Sarah spoke of the importance that her family connections had in her recovery. She explained that *"If it wasn't for [my daughter] I wouldn't have stopped here. […] I decided to put my daughter first, didn't I?"*.

Similarly, Monica placed emphasis on her connections with her children and how she *"went to so much trouble myself to be a better person but also to be a better mum to my kids […] I wanted my kids to have a better life."*. Monica also explained that giving her children *"very different lives"* than the one she grew up in is a *"success"* for her because *"it would've been easier to do what I knew, it was harder where I am and to learn new behaviours and to teach new behaviours."*. She also described that she started connecting with herself more in recovery and that she realised *"I didn't need, that's not me, that's just not who I am, I don't want it, I don't want to give it to other people, and I don't want it, I don't want to fight with people."*.

Simone is not a mother, and yet through her caregiving role of being a mental health nurse she started to meaningfully connect to her patients because she explained that this allowed her to have *"more empathy, more forgiveness um, you know a, a, a greater capacity for care because it's somebody else and then you realise that, that you are that person […] and you start to realise that, that you're deserving of, of, of that, you know that understanding and that stability"*. She was able to internalise the connections and the care she gave to others, which allowed her to successfully embark in her recovery journey.

Ella discussed that in order for her to meaningfully connect with herself she had to move away from PDU as she *"tried to change my life to be fully autonomous and you can't be doing that on drugs or drink, you have to be able to speak from your own mind mouth and heart"*.

Tania spoke about her journey of connecting with herself in recovery, feeling *"more stable"* in herself and how this facilitated her to *"speak out"*, *"tell her story"* and openly discuss her past with PDU because she wanted to *"raise awareness of and help other people."*.

Similarly, Leyla spoke of wanting to share her story in order to make a meaningful impact and *"help people"* because she feels that *"is how I'm gonna heal this [by sharing her story and helping others], […] that is gonna eventually put me back together and heal my soul. I feel it. […] This is the key for substance abuse, for everything."*. Thus, meaningfully connecting to others that share her story is instrumental in her recovery journey.

4.3. Discussion of Themes

4.3.1. The Good, the Bad, and the Useful

4.3.1.1. 'Self-medication'

Participants described PDU as a medium that allowed them to escape experiencing difficult emotions, thoughts, and memories. PDU is thus conceptualised as a solution to their mental health struggles. The current quantitative research body has established that mental health, especially a diagnosis of depression (APA, 2013; Birmaher et al., 1996; Clark et al., 2011; Libby et al., 2005; Rao et al., 1999; Taylor, 2011; Wu et al., 2008), is associated with increased PDU, especially in the instances where no other pharmacological, or psychosocial, intervention is present. In their narratives, participants did not describe receiving support for their mental health outside of PDU, and some of them explicitly mentioned that PDU was the only means with which they could 'feel better'. Quantitative studies have suggested a link between PDU, depression, and the brain's reward system (i.e. dopamine production; Belujon & Grace, 2017; Brady & Sinha, 2005; Naranjo et al., 2011; Rao et al., 1999), which supports the theory of 'self-medication' (Center for Substance Abuse Treatment, 2014; Khantzian, 1985). In other words, low dopamine in the brain is making the person more likely to seek out to increase dopamine production through PDU (Belujon & Grace, 2017). As participants described, the positive effects were short-lived, and they soon found themselves devastated by the effects of drugs on their mental health and overall wellbeing. The current research body agrees with that. As neuropsychological findings show, PDU is a short-term solution since PDU tends to decrease dopamine production in the long-term, and therefore PDU that was used as a 'self-treatment' is perpetuating and magnifying the issue, making the person more prone to engage with PDU in order to manage (Belujon & Grace, 2017; NIDA, 2004; Whitesell et al., 2013). Similarly, psychological research suggests that attempts of coping in the short-term, such as substance misuse, may jeopardise the long-term process of healing (Filipas & Ullman, 2006). In their qualitative study of the experiences of men who engaged with PDU and have experiences of trauma, Georgsdottir et al. (2021) corroborate the short-lived positive effects of PDU and its long-term negative impact.

Similar to the findings of the present study, quantitative research on 410 adolescents found that 'coping with difficulty' was the primary reason for perpetuating PDU, with an emphasis on 'escaping reality' (Titus et al., 2007). Additionally, individuals with comorbid drug addiction and mental health difficulties, reported that PDU becomes the vehicle with which they cope with daily life (Ai et al., 2016; Choudhary et al., 2011; Ertl et al., 2016; Greger et al., 2015; Jansen et al., 2016; Tripodi & PettusDavis, 2013; Widom, 2014). Further findings suggest that PDU can also act as a way to regulate negative affect (Axelrod et al., 2011; Ham & Hope, 2003; Kassel et al., 2007; Kober & Bolling, 2014; McNally et al., 2003), a medium for

temporary empowerment (Kougiali et al., 2012), a solution to life problems (Kemp, 2019), and a way to escape from difficulties when other means of coping are not available (Wallace et al., 2016). Along these lines, Lancaster et al. (2020) conceptualised addiction as 'self-destructive self-nurturing'. All participants in the present study emphasised that their motive for PDU was to cope with mental health difficulties. Thus, findings suggest that PDU is actually a maladaptive attempt to promote wellbeing, highlighting individuals' drive to seek resolution from their trauma symptoms.

4.3.1.2. Escaping as a trauma response

A few participants made explicit references to their history of CSA as the reason for their mental health difficulties, and thus the reason they needed to escape. They described experiencing significant distress, which they perceived as intolerable, which made mental escaping a vital managing process. They felt trapped in a reality where they had no agency over, feeling out of control and disempowered in changing it, and escaping was the only perceived solution. Qualitative research indicates the concept of 'escaping', both physically and mentally, as a perceived attempt to manage the effects of CSA (Darlington, 1997; Jeong & Cha, 2019). Escaping has been conceptualised in research through various behaviours including substance abuse (Foster & Hagedorn, 2014; Ligiéro et al., 2009; Phanichrat & Townshend, 2010; Singh et al., 2013; Vilenica et al., 2013). Findings from a meta-ethnography of eight qualitative studies of a majority female sample, corroborates the notion that dissociating from the memories (i.e. mental escaping) is an attempt to promote post-CSA wellbeing (Jeong & Cha, 2019). Other studies suggest that PDU is a common coping mechanism for survivors of childhood trauma (Ai et al., 2016; Sanders et al., 2018). Further findings suggest that drugs are perceived by childhood trauma survivors as a remedy for distress, calming the mind, and escaping reality (Georgsdottir et al., 2021), which then becomes habitual and an inseparable part of coping with life (Ertl et al., 2018). Quantitative studies show a high correlation between ACE scores and substance dependence as a means to alleviate trauma-related symptoms (Allem et al., 2015; Douglas, et al., 2010). Prevalence studies suggest that 80%-90% of people who abuse drugs have experienced traumatic experience before the onset of problematic PDU (Barrett et al., 2015; Farley et al., 2004). Several studies on individuals with a SUD diagnosis have found that the need to cope with unpleasant emotions is a more frequent trigger for PDU for people with a comorbid PTSD diagnosis, than for individuals with no PTSD comorbidity (Staiger et al., 2009; Waldrop et al., 2007). Along the same lines, further research suggests that 'emotional numbing', which is a process prevalent in PTSD (Elhai & Palmieri, 2011; Yufik & Simms, 2010), includes engagement in avoidance behaviours (incl. PDU) in efforts to escape trauma-related emotions (Hassija et al., 2012). Ross et al. (2019) suggest a trauma-informed treatment

approach to PDU, in order to manage the primary motive of PDU in trauma survivors, which is avoidance of internal conflicts arising from traumatic experiences. In the present study, participants reflected on a fleeting, yet imperative, sense of control provided by drugs, emphasising their sense of being out-of-control in their everyday lives. This further highlights participants' drive to feel empowered in the midst of trauma symptoms.

Studies on women who engage with substance misuse, show that using drugs, as a way to manage emotions, is more prevalent in women with ACEs (Brady & Ashley, 2005; Clay et al., 2000; Harris & Fallot, 2001; Miranda et al., 2002; Teusch, 2001). Research on the copying styles of women suggests that women survivors of CSA were more likely to adopt avoidance-based copying styles than women with no CSA history (Gibson & Leitenberg, 2001). Mixed sample quantitative studies indicate that CSA survivors are more likely to engage in PDU (Kendall-Tackett et al., 2000), than individuals with no such history. Further quantitative studies show that female CSA survivors are 10 times more likely to disclose drug addiction (past or current; Briere & Runtz, 1989). Women CSA survivors who engage in PDU report using drugs in attempts to regulate trauma-related distress (Jarvis et al., 1998), which suggests that negative affect is a significant motivator for PDU in women survivors of CSA (Baker et al., 2004). These findings were replicated by Gil-Rivas et al., (2009) with women in a residential SM treatment service, and by Asberg & Renk (2012) and Boppre & Boyer (2021) with incarcerated women. These findings are also similar to the ones from the present study, with all participants suggesting trauma-related symptoms to be at the root of their distress, leaving them hopeless and desperate to seek relief via any available means.

4.3.1.3. PDU as a gender-based coping mechanism

Participants in the present study were women, and although all described using drugs as an avoidance coping mechanism, they didn't make any specific reference to their gender in making them more susceptible to PDU. On the other hand, the research body suggests that girls are more probable to engage in PDU primarily for emotional management, than boys (Simantov et al., 2000). Researchers hypothesise that this difference may be due to the different coping strategies employed by the two sexes in managing stress, where girls have a tendency in engaging in a more avoidant and non-confrontational way that may increase symptoms of depression and PDU, whereas boys are more confrontational (Boppre & Boyer, 2021; Kort-Butler, 2009). According to feminist theory the two genders are socialised differently, especially in terms of power and conflict, and therefore these differences may be the result of patriarchal defined parameters (Covington, 2008; Kort-Butler, 2009). Further findings suggested that women portrayed their PDU as a coping mechanism, and although childhood neglect is a risk factor for both men and women, due to patriarchal gender roles,

girls are burdened more by domestic responsibilities, and therefore are under more stress (EMCDDA, 2008b; Wincup, 2016). Research exploring similarities in experience of drug addicted women, and all women who experience patriarchal oppression, suggest that PDU might be a way of managing this social oppression (Mason, 1991). Nelson-Zlupko et al. (1995) further suggest that women often use substances to reduce, or numb, what seems to be insoluble social stressors. Based on the argument that pleasure is a "deep sense of personal and social satisfaction based on emotional and physical wellbeing", (Ettorre, 1992, p.146) and that "women use substances as a means to search for pleasure and manage patriarchal pain" (p.153), it is suggested that PDU might be for women an ill-adaptive way to enhance wellbeing, especially in light of individual and systemic trauma (Ettorre, 2004; Wincup, 2001).

4.3.2. Because of You

4.3.2.1. The normalisation of PDU

Participants placed emphasis on the influence that others had on their decision to commence and continue engagement with PDU. Their descriptions highlight the importance of socialising in an environment where PDU was not only the norm, but also the desirable. This was especially true in terms of creating a social identity and a sense of belonging in their own families, friend groups, and communities. Quantitative research suggests that familial risk factors for the development of PDU include parental substance use (Korhonen et al., 2008; Rhodes et al., 2003), deviant peer relationships (Dodge et al., 2009; Snedker et al., 2009; Trucco et al., 2011; Tucker et al., 2011; Whitesell et al., 2013), and popularity and peer pressure (Diego et al., 2003; Goode, 2007; Jadidi & Nakhaee, 2014; Scherrer et al., 2012; Simons-Morton et al., 2001; Whitesell et al., 2013). In a study of 410 adolescents, findings suggest that 41% of participants started PDU due to the normalisation of drugs (i.e. everyone around them was using drugs) and due to the desire to be accepted by their peers (Titus et al., 2007). Further research on adolescents corroborates the importance of familial influences, including history of SM in the family (Sarangi et al., 2008) and peer influence (Atkinson et al., 2001; Barrett & Turner, 2006; Koposov et al., 2002; Wills et al., 2001). Gopiram & Kishore, (2014) qualitative research findings on incarcerated women also suggested familial influences to be a fundamental contributing factor in the development of PDU (Boppre and Boyer, 2021). Qualitative research on men generated similar findings, with participants revealing that belonging to a social group was the main reason for both instigation and maintenance of PDU (Georgsdottir et al., 2021). Research on social identity suggests that in these scenarios the individual assumes the characteristics of the social group and the group's attributes are adopted as the individual's personality traits (Dingle et al., 2015). Qualitative research on individuals diagnosed with schizophrenia yielded similar

findings, highlighting the need to belong to a peer group (Asher & Gask, 2010). These findings are in line with the narratives of four out of six participants of the present study, reflecting the need to adapt to a social identity. The urge to belong and be accepted left participants feeling like they had no choice but to engage in PDU.

A few participants also placed emphasis on the low socioeconomic circumstances of their family and community. They described that this contributed to the normalisation of drugs, as drugs were a predominant activity, both as leisure and as a way of generating income. Drugs are described as increasing an individual's social status and there is a sense of glamourisation of the PDU lifestyle. Participants described that they felt their life prospects were very limited due to their socioeconomic status, thus drug-related activity was perceived as the only viable option. In their narratives, poverty, drugs, and violence are intertwined. Findings from the Office for National Statistics (ONS, 2020a) show that there is a strong negative correlation between household income and PDU. Research suggests that socioeconomic disadvantage of the community (Goode, 2007; Jadidi & Nakhaee, 2014; UNODC, 2020b; WHO, 2020b) is considered a risk factor for PDU. Instability in the community environment is also shown to have an effect on deviant socialisation, especially because the lack of socioeconomic privilege increases the likelihood of other risk factors being present (Snedker et al., 2009). On a community level, research suggests that poverty and violence, income inequality, community disorganisation and low social capital, normalisation of PDU in the community, and drug availability, are also positively corelated with PDU (Hawkins, et al., 2002; Herting & Guest, 1995; Roy, 2018; WHO, 2020b). Findings from the present study emphasise the effect that normalisation and social identity had on participants' experiences of PDU. The precipitation of PDU was not framed as a conscious decision. In order to make a decision, one needs to choose amongst alternatives, and participants described no other viable choices in their communities. Using drugs was the predominant lifestyle, erasing in participants' minds the possibility for any alternative lifestyles to exist.

4.3.2.2. Disconnection as a trauma response

The difficulty in connecting with themselves and others was a predominant theme in participants' experiences. They conceptualised PDU as the only means with which they were able to have the interpersonal and intrapersonal connections they were missing from their lives. Participants described a sense of deep loneliness and isolation that left them longing for connection, which became a primary motivator in maintaining their PDU. Relationships built on PDU were perceived as meaningful, intimate, and sincere, signifying the overall poor quality of close relationships in participants' lives. In retrospect, and having left the PDU

lifestyle behind, all participants were able to reflect on the lack of fulfilment in these relationships.

Studies suggest that CSA survivors tend to experience difficulties in building trusting relationships with romantic partners (Godbout et al., 2009), as well as experience difficulties with parenting (Wright et al., 2005). The C-PTSD symptoms, as described by the NHS, include "Adults with C-PTSD may lose their trust in people and feel separated from others." (NHS, 2018), which is in line with the disconnection described by participants. The trauma-informed 'stages-of-recovery framework' similarly assumes that traumatic experiences result in disconnection from the self and others (Herman, 1992). Research on 303 women survivors of early-life interpersonal trauma, generated similar findings. These suggested that emotional avoidance was predominant in the sample, resulting in interpersonal disconnection, including limited social support-seeking, low emotional disclosure to others, impaired communication, and difficulty engaging in prosocial activities (Hassija et al., 2015). Moreover, a study of 300 participants, conducted based on principles of Schema Therapy (Temple, 2003; Young, 1999), found that interpersonal styles of relating are associated with childhood trauma (Kaya Tezel et al., 2015). Findings suggested that CSA is associated with the emotionally avoidant interpersonal style, highlighting the impact CSA has on interpersonal disconnection in adulthood.

In their proposal of a developmental trauma model of psychopathology, Schimmenti & Caretti (2016) grounded their design in psychoanalytic, developmental, and affective neuroscience research. In this model they suggested that the key in understanding psychological disorders, rooted in traumatic experiences, is understanding the purpose of dissociation. They discussed that developmental trauma affects the individual on an emotional and cognitive level, to the extent that they become intolerable. In their view, dissociation is actually an attempt to self-protection, since by mentally disconnecting the different parts of the self, intense affect, deriving from abuse or neglect, is more efficiently managed. This model can provide an explanation of the intrapersonal disconnection described by participants, who then engaged in PDU as a means of connecting in a safer, more controlled manner. Additionally, Birrell et al., (2017) proposed that traumatic events, rooted in betrayal (i.e. CSA from a familial person), can be even more devastating than life-threating events, as they distort the individual's perception of reality, and damage their ability to trust in themselves and others. In their study they found that chronic disconnections are at the source of individual's suffering. Findings from the present study reflect participants' skewed criteria for assessing intimacy and closeness in relationships, which were influenced by their

experience of childhood trauma. Thus, when living in complete disconnection, the 'artificial' connections facilitated by PDU were perceived as good enough, and even desirable.

4.3.2.3. Recovery through internalising interpersonal care

Participants discussed how their experiences of meaningful relationships with others, instigated a process of self-reflection that led to their decision to engage with recovery. This was presented in two different types of relationships: when participants became someone's caregiver, including motherhood, and in relationships with professionals. As mentioned above, Birrell et al. (2017) emphasised the negative impact of chronic disconnection. Their findings suggested that this intrapersonal disconnection can be repaired through creating meaningful and authentic interpersonal connections. Similarly, a study by Leenerts (1999) suggests that abusive childhood relationships create a barrier to self-care. Findings show that by engaging with experiences of interpersonal care, especially in healthcare settings, individuals are able to internalise this through self-care. In trauma-informed psychotherapy it is suggested that forming safe and meaningful relationships with others is a significant aspect of recovery (Herman, 1992; Lebowitz et al., 1992). In a study by Tummala-Narra et al. (2007) findings corroborate this notion, suggesting that recovery from childhood interpersonal trauma includes the capacity to form meaningful relationships, personal self-care in the context of intimate relationships, the ability to extend safety to another in relationships, and a balanced sense of power in relationships.

In psychoanalytic theory this is portrayed in the concept of 'the corrective emotional experience' (Alexander & French, 1946). This experience is described to occur within the context of a therapeutic relationship, or in non-therapeutic interactions, where the individual has the opportunity to reexperience old emotional conflict, with a new, more positive ending. They suggested that once this happens then the individual perceives a possibility of a different reality, and therefore is hopeful and motivated to behave differently. Participants' experiences may be interpreted through this lens, as when they became the caregivers for others, through motherhood for Sarah, Leyla, Monica, and Ella, or in Simone's case, through her role as a mental health nurse, they had the opportunity to reflect on the lack of care they had experienced throughout their lives, a pattern that they perpetuated by engaging in PDU. Participants described that their wish to provide quality care to others was what motivated them to stop PDU and translate this into self-care as well. Simone suggested that providing an empathic and caring environment for patients, who had similar experiences to her, allowed her to reflect on the fact that she is does not extend this courtesy to herself. Thus, she described realising that she is deserving of the same quality of care she provides to others, which helped her decide to stop PDU. Findings indicate the reciprocal role of care

and its importance in PDU recovery, especially for individuals with very limited experiences of being cared for as children.

4.3.2.4. Motherhood

Four out of six participants are mothers, three of whom mentioned their children as important factors in their decision to stop PDU. They described their wish to provide their children with a better life than the one they had, which suggests a level of self-reflection regarding their own upbringing, their negative experiences of parenting, and their experiences of trauma and drugs growing up. Findings from a qualitative study with mothers who engage in PDU, suggest that peer support intervention (Berman et al., 2014) increases self-reflective capacity, which leads to women making more mindful choices as mothers. This includes 'staying sober for your child' (Puurunen & Vis, 2019). Qualitative findings from a study with twelve Native mothers in a Pacific Northwest tribe, in SM treatment, show that motherhood was a fundamental motivator both in seeking treatment and in successful recovery (Schultz et al., 2018). Similarly, a qualitative study of six mothers in recovery from drug abuse who had their children in foster placement, suggest that being able to parent their children effectively was an important motivator for abstinence (Carlson et al., 2006). The qualitative research body highlights the importance of a 'good mother construct' that defines the reasons why mothers seek SM treatment (Brownstein-Evans, 2001). These include the need to protect their children and the wish to become appropriate role models for them (Finkelstein, 1993; 1994). These are in line with findings from the present study, as participants explicitly mentioned their wish to give their children a 'better life'. Qualitative feminist research on mothers in SM treatment, suggests that being a 'good mother' is an important role for women. Researchers argued that this is influenced by internalised patriarchal gender stereotypes for women, which measure women's worth, and self-worth, based on family and motherhood. They describe that, for the participants, the idealised mother role was a protective factor for SM treatment and allowed them to negotiate the meaning of motherhood for them (Brownstein-Evans, 2001).

4.3.3. Living in the Shadow

4.3.3.1. PDU as a response to childhood trauma

Participants expressed with conviction that their experiences of CSA, and overall childhood trauma, caused their PDU. In their narratives they mentioned that the impact of CSA on PDU was unavoidable. This suggests that they felt they had no agency over their PDU, trapped in a predetermined narrative. Participants also described PDU as a response to their childhood trauma, proposing that their childhood created wounds that needed mending. In the quantitative research body, ACEs are considered risk factors for PDU development (Enoch,

2011; Roy, 2018; Whitesell et al., 2013), including physical and sexual abuse (Hamburger et al., 2008; Kilpatrick et al., 2000; Simantov et al., 2000). Further quantitative research findings suggest a positive correlation between CSA and substance abuse (Briere & Elliot, 2003; Cicchetti & Toth, 2005; Hetzel-Riggin et al., 2007), especially in women (Najavits et al., 1997). In a study by LaNoue et al. (2019) findings showed that CSA and emotional abuse rated as the most impactful ACEs on adult wellbeing, while perceived impact was found to be more significant than the presence of the ACE alone. Quantitative research highlights that the most prevalent response to ACEs is substance abuse (Jones et al., 2018; Salisbury & Van Voorhis, 2009). Clinical studies of homogenous populations for eating disorders, substance abuse, and PDU have shown consistent findings of high prevalence of CSA in these populations compared to the general population (Briere & Runtz,1988; Mullen et al.,1993; Romans et al.,1995; Fergusson et al.,1996; Wonderlich et al., 1997).

Quantitative research findings suggest that severity of the CSA experience is positively corelated with a greater risk for the development of psychological adjustment difficulties and psychopathology, especially depression, PTSD, and C-PTSD (Briere & Runtz, 1987; Ertl et al., 2018; Fergusson et al., 1996; Finkelhor, 1987; Kilpatrick et al., 1986; 2000; Palic et al., 2016; 1995; Spaccarelli, 1994; Spaccarelli & Kim,1995). A study by Palic et al. (2016) found that a history of CSA is one of the three most prevalent experiences in individuals with C-PTSD, which is thought to increase risk of substance use problems (Covington, 2008; Fallot & Harris, 2002; Jonas et al., 2011; Najavits, 2009; Norman et al., 2007). Similar results were replicated in a quantitative study of a mixed sample of 2,014 individuals. Findings suggest that exposure to childhood trauma increases the likelihood of trauma-related disorders, including PTSD and depression. Long-term trauma-related symptoms were found to lead to substance use as a way of managing these symptoms. The researchers emphasised the important relationship between trauma-exposure in childhood and substance use (Mandavia et al., 2016). The research body supports the idea that trauma symptoms, even when not meeting diagnostic criteria, can have a significant interference with psychological functioning, leading to mental distress (Felitti et al., 1998; Jonas et al., 2011; Marshall et al., 2010). Similarly, quantitative research on incarcerated adolescent girls suggests that sexual abuse increased PDU and alcohol misuse (Rich et al., 2016). In the present study, all participants described psychological distress in the form of distressing memories, suicidality, anxiety, emotional disconnection and dysregulation, and loneliness and isolation. Experiencing these symptoms left participants feeling out-of-control, which instigated anxiety and impacted on their overall wellbeing. Participants linked their psychological distress to their experiences of CSA, and framed PDU as a response to their life struggles.

A number of addictions theorists suggest that survivors of childhood trauma use substances as a copying mechanism to manage symptoms (Finkelstein et al., 2004). This hypothesis is corroborated by the participants in the present study, who described PDU as an unavoidable response to CSA. Participants conveyed a deterministic outlook on life, which further establishes their complete sense of disempowerment and lack of agency over their own lives. Quantitative studies suggest that a significant portion of women survivors of childhood trauma will develop an addiction to substances (Horwitz et al., 2001; Kendler et al., 2000). Findings show that women survivors of childhood trauma are 2–2.3 times at greater risk of developing drug problems and dependence, and 1.5–2.8 times at greater risk of developing alcohol problems (Newmann & Sallmann, 2004). The research body shows consistent overrepresentation of CSA survivors, amongst women who seek SM treatment (Hien et al., 2004; Linden et al., 2013; Moylan et al., 2001; Puurunen & Vis, 2019). Qualitative research, which studied the prevalence of mental illness, addiction, and trauma on 33 pregnant women and mothers, addicted to drugs and alcohol, found that all of the participants had experiences of CSA, with the majority reporting severe emotional and physical abuse in childhood (Linden et al., 2013). Researchers highlight the need for an intersectional approach in the treatment of addicted women, a proposal that was also suggested by from them findings of similar studies (Berman et al., 2014). Further quantitative research on substance misuse relapse, shows that severity of childhood trauma significantly predicted relapse in women, but not in men (Heffner et al., 2011). These findings were replicated in a study exploring relapse during a 90-day period following inpatient treatment, where results showed that severity of childhood trauma predicted cocaine relapse in women but not in men (Hyman et al., 2008). Researchers argued the importance of trauma-informed care for all individuals in SM treatment, and women in particular (Heffner et al., 2011), as women survivors of childhood trauma have a higher relapse risk.

4.3.3.2. Emotional regulation and executive function in trauma survivors

Participants described emotional difficulties and a poor quality of wellbeing, which they attributed to their childhood trauma. All participants explicitly stated that CSA does inevitable damage to the individual, which then affects other areas of life. Quantitative studies have explored the executive function of individuals with drug dependence. Executive function being the process through which individuals successfully engage in self-serving, independent, and purposive behaviour (Bridgett Oddi et al., 2013; Burgess, 2005; Lezak, 1995). Executive dysfunction is illustrated by inability to focus or maintain attention, disinhibition, disorganization, impulsivity, difficulties in working memory, problems with monitoring or regulating performance, the inability to plan future actions, poor reasoning ability, perseverance, having difficulties coping with conflicting demands, and a failure to

learn from mistakes (Anderson, 2008; Taşören, 2017). Findings show that ACEs of drug-dependent individuals are determinants of cognitive dysfunction (Narvaez et al., 2012). The research body shows an association of childhood maltreatment to emotional dysregulation (Cicchetti et al., 1991; Shields & Cicchetti, 1998), highlighting that CSA, compared to other forms of childhood maltreatment, is particularly disruptive in the development of normative regulatory processes (Harris et al., 2021; Putnam, 2003; Shipman et al., 2000). Researchers suggest that emotional dysregulation mediates childhood maltreatment to adverse psychosocial outcomes in adulthood (Cloitre et al., 2006; Heleniak et al., 2016; Jennissen et al., 2016; Messman-Moore & Bhuptani, 2017; Moretti & Craig, 2013). Quantitative studies suggest that PTSD symptoms and impaired function, of adult survivors of childhood maltreatment, are affected by emotional dysregulation (Burns et al., 2010; Cloitre et al., 2005; Lilly et al., 2014; Reffi et al., 2019). Overall, the evidence on the impact of trauma on executive dysfunction and emotional dysregulation, support the narrative of participants in the present study, who described CSA as a determinant of PDU.

4.3.3.3. Shame and self-blame

Participants expressed experiencing shame and self-blame for their CSA, their life-choices, and the behaviours they engaged with, including PDU. The way they viewed themselves was influenced by shame and they described intense feelings of disgust and self-loathing, all of which were internalised from interpersonal interactions with important others in close relationships. Consequently, their feelings of self-worth were very low, which perpetuated their PDU as a way to manage these difficult feelings, creating a vicious cycle. Participants mentioned that shifting from a self-critical to a self-compassionate lens, was a long-term and challenging process that required self-reflection and professional intervention. Two of the participants mentioned that they don't consider themselves completely out of this process, even now. This vicious cycle of shame was so ingrained in their cognitive and emotional patterns, that even now in recovery, having had therapy, participants described that it is very easy for them to go back into this maladaptive pattern. This is also indicated in the definition of C-PTSD that states "a child's development, including their behaviour and self-confidence, can be altered as they get older." (NHS, 2018).

Quantitative research suggests that the main protective factors regarding the development of psychopathology in CSA, is having support in the family environment, and in particular whether the abuse was terminated upon disclosure (Bulik et al., 2001; Morrison et al., 2018; Romans et al., 1995). Children are less likely to disclose to parents when the parent-child relationship was not perceived as trusting and when the child perceived disclosure as a burden to the parent (Schönbucher et al., 2012). Qualitative studies discuss the importance

placed by survivors in receiving parental emotional support. (Schönbucher et al., 2014). Participants in the present study mentioned extensively the lack of parental support they received, with most participants' experiences of CSA having been instigated by parents or parental figures, highlighting abuse within the caregiver-child relationship. Three of the participants made direct mention to perceiving their parents as unable to parent them effectively, resulting to emotional neglect. The other three made direct mentions to physical and emotional abuse by parents and other family members, resulting in feeling completely isolated and unsupported growing up.

In the literature, the opposite cognitive and emotional process to self-criticism, is self-compassion. Self-compassion is defined by a process where the individual accepts their emotional suffering and chooses to respond to painful experiences with a non-judgemental understanding and kindness (Neff, 2003a). Quantitative research evidence indicates that the practice of self-compassion can reduce psychological distress, improve mental health and psychological wellbeing, and promote social connectedness (Neff, 2003b; Neff et al., 2007; Neff & McGehee, 2010; Neff et al., 2008). In addictions treatment, Gabor Maté (2008) mentions the importance of professionals approaching clients with 'compassionate curiosity', rather than with 'tough love'. He suggests that the 'tough love' approach mimics the self-critical processes of individuals' traumatic past, as well as the ones taking place within them, whereas compassionate curiosity could instigate their process of self-compassion. Psychological theory suggests that the ability to view the self and others through a compassionate lens, is shaped by early childhood experiences with care figures (Bowlby, 1988; Gilbert, 2005; 2009; 2010). Theorists indicate that children who experience abuse and neglect within the caregiver-child relationship, develop increased sensitivity to threat and are deprived from the feelings of safety, resulting in an inhibited ability to develop self-compassion (Gilbert, 2014; Gilbert & Procter, 2006). This hypothesis is corroborated by research evidence on survivors of childhood maltreatment, who report low levels of self-compassion (Miron et al., 2014; 2016; Tanaka et al., 2011; Vettese et al., 2011). This understanding is in line with the experiences of CSA and other childhood maltreatment that participants experienced, which led them to an inescapable self-critical narrative governed by shame. Participants described believing and internalising the shaming narrative placed on them by others, which inevitably skewed their self-view.

4.3.3.4. PDU as self-destructiveness

All participants described that although the purpose of using drugs was to manage and escape their emotional difficulties, PDU exacerbated them and created new difficulties in the long-term. For participants, the negative consequences of drugs were not enough to support

them into deciding to stop PDU. They described the negative consequences as hurtful and devastating, but this wasn't a strong enough motivator for engaging with recovery. A body of quantitative and qualitative research supports the premise that women tend to respond to ACEs, in particular victimisation and abuse, through the process of internalisation (i.e. engaging in behaviours that attack themselves rather than violence towards others; Bevilacqua et al., 2021; Boppre & Boyer, 2021; Covington, 2003; Haahr-Pedersen et al., 2020; Keirns et al., 2021). Quantitative studies suggest that symptoms of this internalisation include substance abuse, self-harm, and an overall low distress tolerance threshold (Ali et al., 2015; Broidy et al., 2018; DeHart et al., 2014; Jones et al., 2014, Jones et al., 2018a, 2018b; Payne et al., 2007; Scott et al., 2014, 2015; Verona et al., 2015; 2016). Thus, participants' persistence in engaging with PDU, in spite of the negative impact, can be conceptualised as 'self-destructiveness'. On the other hand, drugs were conceptualised by participants as simultaneously helpful and destructive, and therefore their PDU was both self-nurturing and self-destructive. This raises the question of participants' perception of the different levels of psychological destruction they experienced. It can be assumed that the destructive impact of their trauma was so significant that, in comparison, the destructive impact of PDU was insignificant, highlighting PDU's positive value. When experiencing intense psychological distress from trauma, participants were not able to rationally assess the impact of PDU. Their evaluation criteria for destructiveness were significantly skewed, allowing for the distress-alleviating pros of drugs to overshadow any of their cons. This is also corroborated by participants accounts that instant relief of significant distress was very important, an effect drugs were able to provide successfully.

In psychological theory, the concept of 'dissociation', or 'avoidance coping', is a widely accepted process of emotional management (Platt et al., 2017). It is suggested that an adaptive function of dissociation, is the protection against disruptively overwhelming affect, associated with trauma (Freud, 1959), and especially shame (Kaufman, 1989; Lewis, 1971). Theory suggests four different cognitive, emotional, and behavioural methods of bypassing shame: avoidance, attack self, attack other, and withdraw (Nathanson, 1992). Gilbert and Proctor (2006) explored the concept in a study of compassion training for individuals who scored high in shame and self-criticism. Findings indicated that "control of internally aversive experiences can be via dissociation, substance misuse, cutting oneself, reminding oneself of one's faults and weaknesses or trying to rid oneself of 'bad things inside me'" (Gilbert & Proctor, 2006; p. 360). Childhood maltreatment in familial relationships can be framed as early-life high-betrayal trauma, and research evidence indicate that substance abuse, self-harm, and suicidality are common responses to interpersonal betrayal trauma (Bornovalova et al., 2013). High-betrayal trauma experienced in childhood (incl.CSA), threatens the

integrity of the social self, and promotes an unsafe environment with lack of personal agency in the world (Budden, 2009). Researchers hypothesised that individuals respond to this via attributing the reason for betrayal onto themselves, who they perceive as corrupt, shameful, and deserving of hurt, rather than onto the perpetrator (Herman, 1992; Platt & Freyd, 2012). This hypothesis supports the presence of self-blame (Ullman et al., 2008) and shame (Platt & Freyd, 2012) in survivors of childhood trauma, and provides a reasoning for the presence of self-destructive behaviours. Thus, survivors of CSA are likely to perceive themselves as shameful and deserving of hurt, which would explain why the negative impact of PDU did not motivate the participants in this study to stop using drugs. Findings from the present study regarding participants' self-blame and self-loathing complement the research body, by providing in-depth understanding of this process of internalised blame.

4.3.4. Moving Forward

4.3.4.1. Self-development

All participants are in recovery and therefore their narratives of PDU inevitably included experiences that led them into the decision to stop using drugs. One important element that allowed participants to move forward into recovery was a process of self-reflection regarding their traumatic past, and the role they had in perpetuating it. Participants described various experiences that instigated this self-reflective process of who they have been, and who they want to become. The process of change is described as leaving the 'out-of-control victim' and 'drug user' identity behind, in order to become in control and adopt different identities. This was experienced as a process of realising that they have agency over their own lives to choose differently. A meta-ethnography of eight qualitative studies, between 2007 and 2017, on the process of healing, analysed the experiences of a majority female sample (Jeong & Cha, 2019). The findings support previous research on the association of reduced negative outcomes of CSA and healing with engagement in on-going self-reflective activities to experience and develop their self-identity (Arias & Johnson, 2013; Jeong & Cha, 2019; Phanichrat & Townshend, 2010; Singh et al., 2010, 2013). Quantitative research on SM recovery suggests that individuals were more likely to engage with recovery if they perceived the PDU lifestyle to no longer fit their identity (Titus et al., 2007). Findings indicate that individuals experienced a conflict between the identity of the drug user and new identities that they valued, and hoping to change towards these was a major motivator for recovery. In a 90-day abstinence follow-up, researchers found that recovery motivation was linked to the discrepancy between PDU and the new self-standards that individuals had set for themselves (Downey et al., 2000). A similar study indicates that self-development activities, which positively influence mental and physical wellbeing, support the recovery process (Jha & Singh, 2020). Additionally, the development of personal goals and a sense of purpose,

were found to be motivators for abstinence (Kumpfer & Bluth 2004). In psychological trauma and PDU literature we come across the concept of resilience when discussing self-driven positive change (Benyard & Williams, 2007; Herman, 1998; Walsh et al., 2009. The American Psychological Association (2014) defines resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress" (p. 4). This concept encapsulates the experiences expressed by participants in the present study, who made a conscious decision to stop being passively affected by their life adversity, but rather adapt in an effort to take control of their lives and move forward. In the present study, participants' resilience is therefore reflected in their ability to escape their victimhood, which held them trapped in a cycle of self-victimisation through PDU, and embody new identities that empowered them and promoted their long-term wellbeing.

4.3.4.2. Self-empowerment via helping others

An unexpected theme of participants' experience with PDU occurred through self-reflection during the interview process. All participants expressed their wish to share their story in order to help others who are in similar positions. They discussed the importance of recognising the intricacies of the comorbid experience of CSA and PDU, as it is not widely recognised in society, and is not reflected in treatment options. Some participants expressed that they regularly attempt to engage with programmes where they get to help others and described finding fulfilment in this activity. One participant explicitly expressed that her own treatment was less than efficient because her mental health and childhood trauma were not integrated in her treatment in a way that would have been beneficial for her. She referred to Gabor Maté's understanding that addiction stems from trauma and expressed that this resonates with her lifeworld. Thus, she emphasised that she would like to keep contributing to this field in order to help develop non-judgemental and trauma-informed treatment programmes. Evidence on peer support in SM treatment suggest that it is a reciprocal process that benefits both the provider and receiver of help (SAMHSA, 2015). Understanding of the ways in which the helper is benefiting from helping, derive from the helper therapy principle (Scannell, 2021), and extensive research findings show that helping others provides a reduction in the helper's own problems (Davidson et al., 2005; Pagano et al., 2010; Riessman, 1965), as helping others is the most efficient way of helping oneself (Riessman, 1997). These findings reflect one participant's understanding of her own process of healing from the present study. She mentioned that she is certain that the only way to heal herself would be through helping others in similar positions as her, and she expressed deep gratitude that she was 'chosen' to participate in the study.

The findings of a qualitative study exploring the experience of recovery in SM peer support workers, offers a similar understanding. Participants in that study expressed that helping others had a positive influence in their own recovery, it allowed them to continue their connection with communities of support, it gave them a sense of purpose by being of service to others and provided them with a sense of accomplishment that boosted their self-confidence and promoted their wellbeing (Scannell, 2021). Findings from a study with Gambler's Anonymous suggest that peer support significantly promotes the recovery of the helpers (Hutchison et al., 2018). Another qualitative study with 178 Alcoholics Anonymous members in the USA, found similar themes. Individuals described that helping others allowed them to be reminded of their painful past in a productive way, reinforced their own motivation for recovery, allowed them to lose the sense of terminal uniqueness that made them feel defective and isolated, and promoted their relationship with their own self (Lederman & Menegatos, 2011).

4.4. Critical Evaluation of the Study

4.4.1. Strengths and Limitations

Following the exploration of the key findings, I endeavour to critically evaluate the study's strengths and limitations. One possible limitation prevalent in most qualitative studies is around sample size. The sample size in the present research is six participants and although this is within the suggested sample for IPA (Smith et al., 2009), it is a small enough size to raise critic regarding the generalisation/transfer of the findings from the quantitative research standpoint of generalisability and transferability. For qualitative research, generalisability and transferability can occur with findings from a homogenous sample that provides qualitatively rich and detailed data. The idiographic and phenomenological focus allows for a deeply meaningful understanding of phenomena that cannot be otherwise explored or strengthened via quantitative designs. The findings of this research strengthen the understanding of current theories on the effect and impact of early childhood trauma on the development of the self, emotional awareness and tolerance, and self-damaging behaviours as a mean of emotional management. Additionally, the findings support the idea that relating is instrumental in the process of psychological well-being, and the reciprocal connection between interpersonal and intrapersonal processes of relating. The findings of the study are valuable in uncovering aspects of the participants' experience that would be able to inform further quantitative and qualitative research on PDU in women survivors of childhood maltreatment. They can further inform policy, service design, and treatment provision for women survivors of CSA, and childhood maltreatment, who engage in PDU.

A limitation of this study is around the inclusion criteria. In aiming to create a homogenous sample, and informed by a feminist standpoint, I focused on women's experiences of PDU without considering other parts of their identity that might provide significant contributions to their meaning-making. From an intersectional feminist standpoint, it is important to recognise how the intersection of multiple systems of oppression (social, cultural, racial, etc.) shapes the identity and the worldview of participants. Thus, the findings may differ when accounting for different subgroups of women. On the other hand, research has a crucial role in either sustaining or dismantling the patriarchal power imbalance of the sexes. Along these lines, the present study successfully provides an important contribution of women's voices in a predominantly androcentric field. This promotes women's contribution in shaping the understanding of the PDU phenomenon, while illuminating their particular needs.

The participants who volunteered for the study are all in recovery, and therefore another limitation stems from the fact that the accounts of their experiences of PDU are in retrospect, potentially influenced by the positive outcome of their recovery journeys. On the other hand, retrospective accounts may allow for a clearer reflection on the experience, unclouded by current difficult emotions and drug-related life challenges. Additionally, as with every research with voluntary participation, I only had access to the narratives of the participants who were willing to share their experiences. Confounding variables that would prohibit women from participating might provide a different insight into the PDU experience, one that it would not be possible to capture, as these women would not volunteer for participation.

Another limitation was the way in which the aim of the study was communicated during the recruitment process. The inclusion criteria mandated that I advertise participation of women CSA survivors to speak about their PDU. This might have inferred to potential participants that I already held an understanding around the relationship between the two phenomena and therefore this might have biased their interview accounts. It is also possible that only women who held beliefs regarding a link between CSA and PDU, volunteered to participate, creating an unwanted bias in the pool of potential participants. This limitation is one that cannot be easily managed, as not disclosing the main inclusion criterion of CSA experiences would create potentially a vast pool of women interested in volunteering that would then have to be interviewed to identify whether or not they are CSA survivors. This would result to a very challenging recruitment process and a very large number of interested potential participants not going forward with participation.

4.4.2. Epistemological Reflexivity

The aim of the present study was to offer an insight into the experiences of PDU as they were perceived by women CSA survivors, and into their subjective meaning-making of the relationship between their PDU and experiences of trauma. The findings suggest that the research has fulfilled its aim, as they assist the reader in constructing an understanding of these experiences and the impact they had in women's lives. The knowledge from these findings emerged through a constructivist research paradigm (Crotty, 1998) that adopts a relativist epistemological position (Willig, 2013), incorporating a feminist epistemological standpoint (Haraway, 1988), and a critical realist ontological position (Levers, 2013). This epistemological position is a middle ground between critical realism and radical relativism (Willig, 2013) since it suggests that the data portrays the several realities of the lived experiences of PDU of women CSA survivors, incorporating the concept that gender influences the construction of these realities (Wigginton & Lafrance, 2019b). The epistemological position assumes that even if there is the existence of an objective external reality, it is impossible for the data to capture this, as both the participants and the researcher are affected by individual reflections and interpretations (Hesse-Biber, 2012). Thus, it is possible that by changing the context and the interviewer, would produce a varied set of these realities.

Since IPA is underpinned by phenomenology, the data are phenomenological (Willig, 2013) as they illustrate the quality of PDU experiences. Additionally, the interpretative aspect of IPA informs the data in relation to a wider sociocultural context that incorporates the researcher's standpoint (Denzin & Lincoln, 2005). Thus, the knowledge from the findings progresses from the phenomenological to the intersubjective, as it is co-constructed by the participant and the researcher (Crotty, 1998). The feminist standpoint epistemology suggests that this unavoidable process of double-hermeneutic (Smith et al., 2009), when it comes to the investigation of the experiences of non-dominant groups, is more empirically adequate when it is produced by feminist researchers, such as myself (Wylie, 2009).

4.4.3. Research Evaluation

In evaluating the present study, I implemented Yardley's (2000) four criteria and Treloar's (2000) ten key issues for critical appraisal of qualitative research. Quality and validity criteria need to be adjusted to the specific methodological approach (Madill et al., 2000; Reicher, 2000; Willig, 2013) and therefore I also applied Smith's (2011) IPA-specific criteria (see *Methodology* chapter). The present study is satisfactory based on these. Part of the importance of qualitative research also lies with its ability to evoke a debate in order to promote further expansion of knowledge (Forshaw, 2007). In line with this premise, this

research can influence readers to incite discussions around the role of CSA and childhood trauma in the development and perpetuation of PDU, and the role of trauma-informed care in SM treatment design and provision. Additionally, this research can instigate discussions around the role of female voices in shaping our understanding of what is currently an androcentric field, and the differences gender might signify in PDU. As this is a qualitative phenomenological research project, it has direct relevance to therapeutic practice as it can directly inform recommendations for improved training and clinical practice (Willig, 2013).

4.5. Professional Implications

4.5.1. Relevance to Counselling Psychology

Counselling Psychologists have attempted over the years to define the field of Counselling Psychology by identifying the ways in which it fits within the field of Psychology, and ways in which it complements other psychological and social science disciplines (Corrie & Callahan, 2000). Through this exploration, a definition that incorporates the scientific, academic, and practical application of the field, suggests that Counselling Psychology is the application of psychological knowledge to therapeutic practice (Strawbridge & Woolfe, 2010). The basic principles of the field of Counselling Psychology incorporate a humanistic and existential-phenomenological position that reinforces the exploration of subjective meaning-making, through the understanding of the beliefs and values, as these stem from the subjective experience (Galbraith, 2017). In addition, Counselling Psychology places special emphasis on relational dynamics integrated with a compassionately curious stance of understanding the human experience from multiple standpoints (Milton, 2010). This approach is argued to be a principal point of differentiating between Counselling Psychology and Clinical Psychology, as the latter has been argued to incorporate a less flexible position regarding the human experience (Galbraith, 2017). In accordance with the aforementioned attributes of the field of Counselling Psychology, the present research aimed to complement and expand on the existing quantitative and qualitative research body on the experiences of PDU of women CSA survivors. The decision to use IPA promoted this in-depth exploration (Smith et al., 2009), since IPA is aligned with the humanistic and phenomenological values and intersubjectivity that underlines Counselling Psychology.

Counselling Psychology is argued to have a crucial role in researching and advocating for social justice (Douglas et al., 2016; Toporek et al., 2006; Moradi et al., 2010), as expressed by its defining aims of promoting equality, fairness, and social justice, in an attempt to strive to meet the needs of the people (BPS, 2021b). Thus, we can argue that the feminist epistemological lens, which is incorporated in the present study, is inherent to the research and practice of Counselling Psychology, since the feminist standpoint aims to dismantle both

individual and collective systems of oppression in an attempt to recognise social inequality and promote social justice. Practicing as a Counselling Psychologist requires the ability to formulate and intervene with social justice issues on an individual and systemic level (Toporek et al., 2006). It is, therefore, fundamental to have an increased competence in acknowledging and understanding various dynamics of systems of oppression, while also having an increased skillset in designing and implementing interventions and policies that dismantle these systems and promote systemic solutions. The present study promotes these aims as it focuses on enhancing the voices of women in an androcentric field. By doing so, it provides an opportunity to Counselling Psychologists, training institutions, and professional bodies to increase their awareness about these systems of oppression and gender-based privilege in a patriarchal society, while also igniting consideration around ways in which to dismantle gender-based oppression in research, practice, and ultimately, within society (Douglas et al., 2016).

4.5.2. Service Design and Treatment Provision

Millions of people around the world are affected by problems created due to their engagement with PDU (UNODC, 2021), thus it is important for research in this field to provide meaningful findings that can have clinical and real-world applications. The findings from this study express various viewpoints that could provide useful insight into service design and treatment provision. A fundamental component of participants' meaning-making includes their experience that PDU is 'a response' to CSA and other childhood trauma, and their conviction that past experiences unavoidably led to PDU. Trauma symptoms, including mental health and psychosocial difficulties, are the driving factor of distress, whereas PDU is the perceived solution to distress. This provides an in-depth understanding of the fact that survivors of childhood trauma would benefit from trauma-focused rather than behaviour-focused treatment. Incorporating the lifeworld of service users into service design allows for a person-centred formulation of their treatment needs. Thus, trauma-focused SM treatment provision, for this population, would allow for better client-engagement rates, more successful completions, and more efficient and holistic treatment. Currently, SM services in the UK do not incorporate significant input from mental health professionals who are trauma-specialists, including psychologists, psychotherapists, and counsellors. This results in low treatment-retention and successful completion rates for clients who present with trauma-related complexity. In addition, it would be beneficial for SM services to incorporate trauma and gender-sensitive training for staff, including CPD opportunities and workshops, in order to enhance the understanding of clients' needs, and allow for the provision of client-centred care. Seeing that empowerment, self-agency, and self-compassion, were important components of participants' recovery narrative, client-centred care would further empower

clients through personal responsibility, in a compassionate and non-judgemental therapeutic space.

Additionally, services could incorporate a trauma-informed assessment to capture the percentage of clients that would need trauma-specialist treatment, which would allow for more efficient allocation of resources. Another suggestion would be for services to include trauma-specialist teams, comprised of mental health professionals, to provide effective specialist care. Mapping specific treatment pathways for trauma survivors, would allow for the development of specific interventions to serve the particular needs of clients, and the development of forums for specialist supervision, case discussion, and consultation. These internal pathways could also include links and referral pathways with psychosocial-support services in the community, to ensure integrated care for survivors. Findings also reflect the importance of interpersonal connections in recovery. This can inform the development of peer support interventions, to promote the sense of community, connectedness, and healing properties of 'helping others'. Moreover, identifying that motherhood can be of particular importance in women's recovery, services could include specialist teams for pregnant women and mothers. Creating links with antenatal and perinatal services in the community, would also promote continuity of care.

In my current professional role at a SM service, I have identified these needs and helped develop an inter-agency perinatal MDT meeting to better support the particular needs of pregnant women and women with young children, as many of them have complex needs and histories of trauma. I have also developed and chair a specialist case consultation meeting, providing psychological and trauma-informed consultation to staff. In terms of training, I am delivering a service-wide introductory psychoeducational training and workshop on trauma-informed care to upskill staff. I am currently in the process of designing a more detailed trauma training, in order to enhance both the theoretical, and practical knowledge in the service, and improve quality of treatment provision. Mental health services are usually not accepting referrals for individuals who are currently engaging in PDU, and SM services do not have an in-house team of mental health professionals, to be able to offer psychotherapy routinely to clients who need it. Inspired by the findings of this study, where emphasis is placed on PDU being linked to mental health and trauma symptoms, I am liaising with NHS mental health services, aiming to develop inter-agency pathways to holistically support our shared clients. The collaborative working plan includes information sharing agreements between services, shared consultation and case discussion forums, the design of joint interventions, and co-location and outreach to increase treatment access to clients.

Overall, some of these changes can happen internally, within each SM service, while some of them require a systemic shift in our understanding of PDU and trauma. This shift would allow for the development of various specialist posts in SM services and would influence our approach to the client work, including number of clients in each caseload and minimum standards of care. Moreover, it would allow for a modification of how we measure service efficiency, quality, and treatment outcomes, which is a fundamental factor in funding decisions.

4.5.3. Future Research

The present research is an explorative study aiming to identify different aspects contributing to the experience of PDU in women CSA survivors. Future quantitative and qualitative research could expand on further investigating the different themes that emerged from this study. Specific research questions around each of the themes would allow for a deeper exploration of how each of these have been experienced and would allow for other facets related with each theme to manifest. The concept of childhood trauma and CSA as promoting disconnection with the self and others, and the ways in which engaging with PDU becomes the means with which connection is facilitated, can be of particular interest in understanding precipitating and perpetuating factors for PDU. Another theme of particular interest to women is the concept of motherhood and being a caregiver, and how engagement with these roles instigates the evaluation of the PDU impact, which promotes the process of internalisation of the care they give to others (i.e. children) by engaging with recovery.

Due to ethical considerations and limited resources, this study included only participants in recovery. This shapes a very specific lens of how women who have successfully disengaged with problematic PDU understand this in retrospect. Further research on populations with on-going engagement with PDU would allow for a more in-depth understanding of the experiences as they are perceived in the present, rather than retrospectively. Recovery was also a part of the participants narratives of PDU, as they were in recovery when the interviews were conducted. Future research with current problematic drug users could explore whether recovery, as a plan or a wish, manifests in their narratives of PDU or whether it is absent, as it is not part of their lived reality. This would enrich our understanding of the role that recovery holds in the PDU narratives of people who haven't engaged with it successfully.

Future research could also focus on the experiences of specific subgroups of the present population, especially ones that are more vulnerable and under-represented in research (i.e. pregnant women, dual diagnosis, sex-workers, rough sleepers/homeless, incarcerated

women, incarcerated mothers, etc). This would allow for a deeper understanding of the specific experiences, and subsequently needs, of these subgroups, and how they intertwine with childhood trauma and CSA. In this study the only characteristics that were design for homogeneity of sample were gender and experiences of CSA, and therefore other important parts of the participants' identities, could have contributed to shaping their experiences in a manner that is not captured in depth by this research. From a post-structural and intersectional feminist standpoint, although gender shapes and constrains women's experiences, it is not the only, or most prominent, part of their identity. Their lived experiences are also shaped and constrained by the intersection of race, culture, socioeconomic background, age, sexual orientation, education, mental health needs, past experiences of trauma, and others (Campbell & Ettorre, 2011; Campbell & Herzberg, 2017; Crenshaw, 1991; Hankivsky et al., 2009; Holmes, 2007; Ramazanoglu, 1989). A post-structural and intersectional feminist body of research suggests that women who engage in substance misuse can present with very diverse needs and experiences (Ettorre, 2004; Luck et al., 2004; Neal, 2004; Neal et al., 2014; Taylor, 1993). The literature reflects that sometimes the needs women share with men can outweigh in some respects the differences posed by gender (Neal, 2004; Neal et al., 2014; 2018). These findings suggest that depending on the topic of exploration in PDU research, gender may or may not be central to shaping the PDU experience.

Although participants made direct mentions to their CSA experiences and how they impacted their lives and PDU, all of the participants mentioned multiple other experiences of abuse and neglect as important and impactful, including emotional abuse and emotional neglect. This evidence suggests that different childhood maltreatment experiences cannot be neatly segregated and measured in isolation from each other, and even though this study attempted to explore CSA in particular, it is challenging to isolate CSA from all other incidents of childhood adversity. In addition, we could argue that measuring and researching participants' experiences in a vacuum is not only challenging, but also contradicting the purpose of qualitative research. Conducting qualitative research has at its core the aim of getting as close as possible to the lived experiences of phenomena and to the subjective meaning making of participants. In order to do so we need to bracket our professional theoretical understanding of childhood maltreatment categories and allow for the understanding of the lived experience as it is expressed by individuals. In order to manage that, future research could incorporate the input of experts-by-experience in the design of the research questions, the inclusion and exclusion criteria, and the design of the methodology.

4.6. Personal Reflexivity

The process of conducting qualitative research incorporates an understanding that the researcher brings their own lifeworld (Smith et al., 2009) and biases into the data analysis process (Willig, 2013). This might inevitably have an impact on the validity and reliability of the findings of the present research. In the *Methodology* chapter, my interest in this topic and my personal and professional position are clearly stated and explored in detail. I also mention my engagement with the data analysis through the process of recognising and 'bracketing' my preconceptions, biases, and existing knowledge, as they were shaped by my professional experiences working with survivors who misuse substances, and my personal feminist ideology. However, I need to acknowledge that despite my best efforts, my engagement with the literature and my current role in a SM service, might have contributed to my interpretation of the original data.

Reflecting on the research process, I feel grateful and fortunate to have been given the opportunity to explore this subject and interview the women who participated in the study. Their eagerness, openness, and bravery in sharing their life stories and experiences of CSA and PDU provided invaluable contributions to this research project and my professional development. Without their involvement, this study would never had come into fruition, and my professional understanding would not have been as in depth. Through immersing myself in their narratives I was able to further my understanding of PDU as it is experienced by women survivors of CSA, which promoted my ability to engage with this population both as a clinician and as a professional involved with the design of SM treatment provision. I wish to carry this knowledge with me in my continuous work with women survivors of childhood maltreatment.

Engaging with qualitative research, at this level, was a first-time experience for me, and as with most first-time challenging tasks, I was faced with anxiety and worry about my ability to engage successfully with the process. I was able to manage these, and promote my confidence as a researcher, through accessing my support system of supervision, peer supervision, and personal therapy. Throughout the process I encountered multiple moments where I felt overwhelmed by factors that impacted my planning and completion of the study, however, my support system helped me understand the feelings that were elicited in me and supported me in putting these into context. Prior to embarking on this research project, I did not anticipate the depth and width of emotions I would experience; from worry and hopelessness that I would not be able to complete the project, to feeling excited and deeply moved that I was able to give the participants a voice and contribute to promoting the understanding of their experiences.

My own expectations of how the research would unfold, were challenged a few times since I embarked on this journey. Prior to the interviews I anticipated that the women would view this opportunity as a service to me and the research, generously donating their time and life stories in helping me with the data collection. However, none of the participants expressed such feelings, as all of the women expressed deep gratitude to me for allowing them to share their stories. They described a wish to help others, professionals, and their peers, and as Leyla said to 'heal' themselves through sharing their stories, a wish that they felt was fulfilled via their participation. In addition, Tania, Leyla, and Simone mentioned a few times that their engagement with the interview process allowed them to reflect on aspects of their narrative and understand themselves in ways that they hadn't in therapy.

I was deeply moved by the participants' attitudes towards me, since at different points during the interviews all of them expressed worry about my wellbeing due to the vicarious trauma (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995) I could experience by listening to their narratives. This influenced some of them to give me advice on how to engage with self-care post-interview. This part of the interaction allowed me to reflect on the level of understanding that participants had of the impact that these experiences had on them, which urged them to prevent me from experiencing a similar impact. This experience prompted me to reflect on the different roles that participants and researchers engage with when they interact in the research process. Discussing difficult and sensitive concepts as professionals we sometimes omit reflecting on the impact that these have on our own emotional world. I was surprised and moved to be reminded by the women of my role as a person, in addition to the researcher role, and to receive their attempts to care for my well-being, especially since in my mind I was the one weighted with the responsibility of care in our interaction. Reflecting on that process I am reminded of the reciprocal element that underlies all human interactions and the multiple roles that people can embody even in professional relationships with explicit boundaries. I will surely treasure this reflection moving forward in my research and clinical practice, as it broadens my understanding of the relational process between professionals and clients/participants.

5. Conclusion

The present research study focused on the phenomenon of PDU as it was experienced by women survivors of CSA and as it was perceived in relation to their CSA history. In order to offer an in-depth understanding into the lived experiences of six women, the study employed IPA. The narratives of these women highlighted various aspects of their lives since childhood, and how these interacted with their PDU. Participants emphasised the role of PDU in initially promoting, and later inhibiting, their wellbeing. They also discussed the influence that relationships had, as risk factors in initiating and maintaining PDU, and as protective factors in promoting recovery. Overall, participants made meaning of their PDU in light of their CSA and other childhood trauma, which they understood as having an overarching impact in every area of their lives that was both managed and perpetuated by PDU. All participants were in recovery and therefore their PDU experiences conclude with descriptions of how they managed to form an identity away from 'victim' and 'drug user', and reclaim control over the trajectory of their lives, a process that empowered them to move forward. The findings of this research provide significant insight into the experiences of PDU of women with a history of trauma, allowing for the development of a trauma-informed understanding of women's PDU, while promoting the representation of women in a male-dominated research and clinical field (Ettorre, 2004). I hope this study can provide valuable contribution to the field of Counselling Psychology as it promotes an integrated understanding of childhood trauma and PDU (Maté, 2008), through the female lens (Covington, 2008).

References

Abdelrahman, A.I., Rodriguez, G., Ryan, J., French, J., & Weinbaum, D. (1999). The Epidemiology of Substance Use Among Middle School Students: The Impact of School, Familial, Community and Individual Risk Factors. *Journal of Child & Adolescent Substance Abuse, 8*, 55-75.

Ai, A., Lee, J., Solis, A., & Yap, C. (2016). Childhood abuse, religious involvement, and substance abuse among Latino- American men in the united states. *International Journal of Behavioral Medicine*, *23*(6), 764–775.

Afifi, T. O., Enns, M. W., Cox, B. J., Asmundson, G. J., Stein, M. B., & Sareen, J. (2008). Population attributable fractions of psychiatric disorders and suicide ideation and attempts associated with adverse childhood experiences. *American Journal of Public Health*, *98(5),* 946–952.

Afifi, T. O., Henriksen, C. A., Asmundson, G. J., & Sareen, J. (2012). Childhood maltreatment and substance use disorders among men and women in a nationally representative sample. *Canadian journal of psychiatry. Revue Canadienne de Psychiatrie*, *57(11),* 677–686.

Agar, M. (2002). How the drug field turned my beard grey. *International Journal of Drug Policy*, *13*, 249–258.

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies*, *5*(2), 9-19.

Alexander, F.G., & French, T.M. (1946). *Psychoanalytic therapy: Principles and applications.* New York: Ronald.

Ali, B., Seitz-Brown, C. J., & Daughters, S. B. (2015). The interacting effect of depressive symptoms, gender, and distress tolerance on substance use problems among residential treatment-seeking substance users. *Drug and Alcohol Dependence, 148,* 21–26.

Alessi, E. J., & Kahn, S. (2019). Using psychodynamic interventions to engage in trauma-informed practice. *Journal of Social Work Practice 33*, 27–39.

Allem, J., Soto, D. W., Baezconde-Garbanati, L., & Unger, J. B. (2015). Adverse childhood experiences and substance use among Hispanic emerging adults in Southern California. *Addictive Behaviors*, *50*, 199–204.

Allen, A. (1998). Rethinking Power. *Hypatia, 13*, 21–40.

Allen, A. (1999). *The Power of Feminist Theory: Domination, Resistance, Solidarity,* Boulder, CO: Westview Press.

Almuneef, M., El Choueiry, N., Saleheen, H. N., & Al-Eissa, M. (2017). Gender-based

disparities in the impact of adverse childhood experiences on adult health: findings from a national study in the Kingdom of Saudi Arabia. *International Journal for Equity in Health, 16(1).*

Amaro, H., Chernoff, M., Brown, V., Arevalo, S., & Gatz, M. (2007). Does integrated trauma-informed substance abuse treatment increase treatment retention? *Journal of Community Psychology*, *35*(7), 845–862.

Anda, R. (2009). *The health and social impact of growing up with adverse childhood experiences: The human economic costs of the status quo.* http://hdl.handle.net/11212/268

Anda, R. F., Dong, M., Brown, D. W. Felitti, V. F., Giles, W. H., Perry, G. S., Edwards, J. V. & Dube, S. R. (2009). The relationship of adverse childhood experiences to a history of premature death of family members. *BMC Public Health, 9(1),* 106.

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., Dube, S. R., & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256(3),* 174–186.

Anderson, E. (2011). Feminist epistemology and philosophy of science. *In Stanford Encyclopaedia of Philosophy Online.* Retrieved from https://plato.stanford.edu/entries/feminism-epistemology/

Anderson, K. M., & Hiersteiner, C. (2008). Recovering from childhood sexual abuse: Is a "storybook ending" possible? *American Journal of Family Therapy, 36,* 413–424.

Anderson, L. (2008). Reflexivity. In: Thorpe. R, Holt. R,. eds. *The Sage Dictionary of Qualitative Management Research.* (pp. 183-185). London: Sage.

Anderson, P. J. (2008). Towards a developmental model of executive function. In V. Anderson, R. Jacobs, & P. J. Anderson (Eds.), *Executive functions and the frontal lobes: A lifespan perspective* (pp. 3–22). New York, NY: Taylor & Francis.

Anumba, N., DeMatteo, D., & Heilbrun, K. (2012). Social functioning, victimization, and mental health among female offenders. *Criminal Justice and Behavior, 39,* 1204–1218.

APA. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association: Arlington, VA.

APA. (2014). *The road to resilience*. Washington, DC: American Psychological Association. Retrieved from http://www.apa.org/helpcenter/road-resilience.aspx.

Arias, B. J., & Johnson, C. V. (2013). Voices of healing and recovery from childhood sexual abuse. *Journal of Child Sexual Abuse, 22*, 822–841.

Asberg, K., & Renk, K. (2012). Substance Use Coping as a Mediator of the Relationship

Between Trauma Symptoms and Substance Use Consequences Among Incarcerated Females With Childhood Sexual Abuse Histories. *Substance Use & Misuse, 47(7),* 799-808.

Asher, C. J., & Gask, L. (2010). Reasons for illicit drug use in people with schizophrenia: Qualitative study. *BMC Psychiatry, 10(1),* 94.

Asmundson, G., Coons, M., Taylor, S., & Katz, J. (2002). PTSD and the experience of pain: research and clinical implications of shared vulnerability and mutual maintenance models. *Canadian Journal of Psychiatry, 47(10),* 930–937.

Asmussen, K., Fischer, F., Drayton, E., & McBride, T. (2020, February 26). Adverse childhood experiences: What we know, what we don't know, and what should happen next, Early Intervention Foundation. Retrieved August 29, 2021, from https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

Atkinson, J. S., Richard, A. J., & Carlson, J. W. (2001). The influence of peer, family, and school relationships in substance use among participants in a youth jobs program. *Journal of Child & Adolescent Substance Abuse*, *11*(1), 45–54.

Atwool, N. (2019). Challenges of operationalizing trauma-informed practice in child protection services in New Zealand. *Child & Family Social Work, 24(1),* 25–32.

Auxéméry Y. (2012). L'état de stress post-traumatique comme conséquence de l'interaction entre une susceptibilité génétique individuelle, un évènement traumatogène et un contexte social [Posttraumatic stress disorder (PTSD) as a consequence of the interaction between an individual genetic susceptibility, a traumatogenic event and a social context]. *L'Encephale*, *38(5),* 373–380.

Axelrod, S. R., Perepletchikova, F., Holtzman, K., & Sinha, R. (2011). Emotion regulation and substance use frequency in women with substance dependence and borderline personality disorder receiving dialectical behavior therapy. *The American Journal of Drug and Alcohol Abuse, 37,* 37–42.

Bailey, C., Klas, A., Cox, R., Bergmeier, H., Avery, J., & Skouteris, H. (2019). Systematic review of organisation-wide, trauma-informed care models in out-of-home care (Oo HC) settings. *Health & Social Care In The Community, 27(3),* e10–e22.

Baker, T. B., Piper, M. E., McCarthy, D. E., Majeskie, M. R., & Fiore, M. C. (2004). Addiction motivation reformulated: An affective processing model of negative reinforcement. *Psychological Review, 111*, 33–51.

Balloon, B., Courbasson, C., & Smith, P. (2001). Physical and sexual abuse issues among youths with substance abuse problems. *The Canadian Journal of Psychiatry, 46,* 617–621.

Banyard, V. L., & Williams, L. M. (2007). Women's voices on recovery: A multi-method study

of the complexity of recovery from child sexual abuse. *Child Abuse and Neglect, 31,* 275-290.

Barrett, A. E., & Turner, R. J. (2006). Family structure and substance use problems in adolescence and early adulthood: examining explanations for the relationship. *Addiction (Abingdon, England), 101(1),* 109–120.

Barrett, E. L., Teesson, M., Chapman, C., Slade, T., Carragher, N., & Mills, K. (2015). Substance use and mental health con- sequences of childhood trauma: An epidemiological investigation. *Drug & Alcohol Dependence, 146*, e217–e218.

Barth, J., Bermetz, L., Heim, E., Trelle, S., & Tonia, T. (2013). The current prevalence of child sexual abuse worldwide: A systematic review and meta-analysis. *International Journal of Public Health, 58,* 469–483.

Bateman, J., Henderson, C. & Kezelman, C. (2013). *Trauma-informed Care and Practice: Towards a Cultural Shift in Policy Reform across Mental Health and Human Services in Australia.* Mental Health Coordinating Council.

Beasley, Chris (1999). *What is Feminism?.* (pp. 3-11). New York: Sage.

Bebbington, P., Jonas, S., Kuipers, E., King, M., Cooper, C., Brugha, T. & Jenkins, R. (2011). Childhood sexual abuse and psychosis: Data from a cross-sectional national psychiatric survey in England. *The British Journal of Psychiatry, 199(1),* 29-37.

Becker, J. & Duffy, C. (2002). *Women drug users and drugs service provision: service-level responses to engagement and retention,* DPAS Briefing Paper 17, UK Home Office: London.

Belujon, P., & Grace, A. A. (2017). Dopamine System Dysregulation in Major Depressive Disorders. *The International Journal of Neuropsychopharmacology*, *20*(12), 1036–1046.

Bergen, M., Wells, J. S. G., & Owen, S. (2010). Relating realist metatheory to issues of gender and mental health. *Journal of Psychiatric and Mental Health Nursing*, *17*, 442-451.

Berger, E. (2019) Multi-tiered approaches to trauma-informed care in schools: A systematic review. *School Mental Health 11*, 650–664.

Berman, H., Mason, R., Hall, J., Rodger, S., Classen, C. C., Evans, M. K., Ross, L. E., Mulcahy, G. A., Carranza, L., & Al-Zoubi, F. (2014). Laboring to mother in the context of past trauma: the transition to motherhood. *Qualitative Health Research*, *24*(9), 1253–1264.

Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., Stokes, J., Handelsman, L., Medrano, M., Desmond, D., & Zule, W. (2003). Development and validation of a brief screening version of the Childhood Trauma Questionnaire. *Child abuse & neglect*, *27*(2), 169–190.

Bevilacqua, L., Kelly, Y., Heilmann, A., Priest, N., & Lacey, R. E. (2021). Adverse childhood experiences and trajectories of internalizing, externalizing, and prosocial behaviors from childhood to adolescence. *Child Abuse & Neglect, 112,* 104890.

Bhaskar, R. (1978). *A Realist Theory of Science*. Hassocks, West Sussex: Harvester Press.

Bhati, K.S., Hoyt, W.T., & Huffman, K.L. (2014). Integration or Assimilation? Locating qualitative research in psychology. *Qualitative Research in Psychology, 11,* 98–114.

Biederman, J., Faraone, S. V., Monuteaux, M. C., & Feighner, J. A. (2000). Patterns of alcohol and drug use in adolescents can be predicted by parental substance use disorders. *Pediatrics*, *106*(4), 792–797.

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology*, *5*(3), 214-224.

Birmaher, B., Ryan, N. D., Williamson, D. E., Brent, D. A., Kaufman, J., Dahl, R. E., Perel, J., & Nelson, B. (1996). Childhood and adolescent depression: a review of the past 10 years. Part I. *Journal of the American Academy of Child and Adolescent Psychiatry*, *35*(11), 1427–1439.

Birrell, P. J., Bernstein, R. E., & Freyd, J. J. (2017). With the fierce and loving embrace of another soul: Finding connection and meaning after the profound disconnection of betrayal trauma. In E. M. Altmaier (Ed.), *Reconstructing meaning after trauma: Theory, research, and practice* (pp. 29–43). Elsevier Academic Press.

Bloom, S. L. & Farragher, B. (2011). *Destroying sanctuary: the crisis in human services delivery systems.* New York: Oxford University Press.

Bloom, B., Owen, B., & Covington, S. (2003). *Gender-responsive strategies: Research, practice and guiding principles for women offenders*. Washington, DC: National Institute of Corrections, USDOJ.

Boles, S. M., Joshi, V., Grella, C., & Wellisch, J. (2005). Childhood Sexual Abuse Patterns, Psychosocial Correlates, and Treatment Outcomes Among Adults in Drug Abuse Treatment. *Journal of Child Sexual Abuse, 14(1),* 39–55.

Bond, K. & Messina, N. (2001). *Annual Report for the Enhancing Substance Abuse Treatment and HIV Prevention for Women Offenders.* Submitted to the National Institute on Drug Abuse, Rockville, MD.

Boppre, B., & Boyer, C. (2021). "The Traps Started During My Childhood": The Role of Substance Abuse in Women's Responses to Adverse Childhood Experiences (ACEs). *Journal of Aggression, Maltreatment & Trauma, 30(4),* 429–449.

Bornovalova, M. A., Huibregtse, B. M., Hicks, B. M., Keyes, M., McGue, M., & Iacono, W.

(2013). Tests of a direct effect of childhood abuse on adult borderline personality disorder traits: a longitudinal discordant twin design. *Journal of Abnormal Psychology*, *122*(1), 180–194.

Boughner, E., & Frewen, P. (2016). Gender differences in perceived causal relations between trauma-related symptoms and substance use disorders in online and outpatient samples. *Traumatology, 22*(4), 288–298.

Bourgois, P. (2002). Anthropology and epidemiology on drugs: The challenges of cross-methodological and theoretical dialogue. *International Journal of Drug Policy, 13,* 259–269.

Bowlby, J. (1988). *A secure base: Parent–Child attachment and healthy human development.* New York, NY: Basic Books.

Bowles, M. A., DeHart, D., & Webb, J. R. (2012). Family influences on female offenders' substance use: The role of adverse childhood events among incarcerated women. *Journal of Family Violence, 27*, 681–686.

BPS. (2017, August). *Practice Guidelines* (3rd Edition), British Psychological Society. Retrieved August 18, 2021, from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Practice%20Guidelines%20%28Third%20Edition%29.pdf

BPS. (2018, July). *Code of Ethics and Conduct*. British Psychological Society. Retrieved August 16, 2021, from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf

BPS. (2021a, April). *Code of Human Research Ethics*. British Psychological Society. Retrieved August 16, 2021, from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf

BPS. (2021b). *Division of Counselling Psychology*, British Psychological Society. Retrieved August 16, 2021, from https://www.bps.org.uk/member-microsites/division-counselling-psychology

BPS. (2021c, June). *Ethics Guidelines for Internet-mediated Research*. British Psychological Society. Retrieved August 18, 2021, from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Ethics%20Guidelines%20for%20Internet-mediated%20Research.pdf

Brady, K. T., & Sinha, R. (2005). Co-occurring mental and substance use disorders: the neurobiological effects of chronic stress. *The American Journal of Psychiatry*, *162*(8), 1483–1493.

Brady, T. M., & Ashley, O. S. (Eds.). (2005). *Women in substance abuse treatment: Results from the Alcohol and Drug Services Study (ADSS)* (DHHS Publication No. SMA 04-3968, Analytic Series A-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Brandon, M. S. P., Bailey, S., Belderson, P., Hawley, C., Ellis, C., & Megson, M. (2012). *New learning from serious case reviews: a two year report for 2009–2011,* The Stationery Office, London.

Brannon, L. (2016). *Gender: psychological perspectives*. Routledge.

Bridgett, D. J., Oddi, K. B., Laake, L. M., Murdock, K. W., & Bachmann, M. N. (2013). Integrating and differentiating aspects of self-regulation: Effortful control, executive functioning, and links to negative affectivity. *Emotion, 13(1),* 47–63.

Briere, J. & Elliot, D. M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse and Neglect, 27*, 1205–1222.

Briere, J. & Runtz, M. (1987). Post sexual abuse trauma: Data and implications for clinical practice. *Journal of Interpersonal Violence, 2,* 367-379.

Briere, J. & Runtz, M. (1988) Symptomatology associated with childhood sexual victimization in a nonclinical adult sample. *Child Abuse and Neglect, 12,* 51-59.

Briere, J., & Runtz, M. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence, 4*, 151–163.

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology & Health, 21*, 87-108.

Broidy, L., Payne, J., & Piquero, A. R. (2018). Making sense of heterogeneity in the influence of childhood abuse, mental health, and drug use on women's offending pathways. *Criminal Justice and Behavior, 45*, 1565–1587.

Brook, J. S., Brook, D. W., Gordon, A. S., Whiteman, M., & Cohen, P. (1990). The psychosocial etiology of adolescent drug use: a family interactional approach. *Genetic, Social, and General Psychology Monographs*, *116*(2), 111–267.

Brown, L. S. (1994). *Subversive dialogues: Theory in feminist therapy*. New York: Basic Books.

Brown R. T. (2002). Risk factors for substance abuse in adolescents. *Pediatric Clinics of North America*, *49*(2), 247–v.

Brown, V., Harris, M., & Fallot, R. (2013). Moving toward trauma-informed practice in addiction treatment: a collaborative model of inter-agency assessment. *Journal of Psychoactive Drugs, 45(5),* 386–393.

Brownstein-Evans, C. (2001). Negotiating the meaning of motherhood: Women in addiction

and recovery. *Journal of the Association for Research on Mothering, 3(1),* 161-171.

Brunell, L. & Burkett, E. Feminism. Encyclopaedia Britannica. Retrieved August 13, 2021, from https://www.britannica.com/topic/feminism

Bryant, J. K. & Moran, K. L. B. (2020). Adverse Childhood Experiences (ACEs): Implications for Counselors. *Winsconsin Counseling Journal, 33*, 32-47.

Budden A. (2009). The role of shame in posttraumatic stress disorder: a proposal for a socio-emotional model for DSM-V. *Social Science & Medicine (1982)*, *69*(7), 1032–1039.

Bulik, C. M., Prescott, C. A., & Kendler, K. S. (2001). Features of childhood sexual abuse and the development of psychiatric and substance use disorders. *British Journal of Psychiatry, 179*, 444-449.

Bunting, L., Montgomery, L., Mooney, S., MacDonald, M., Coulter, S., Hayes, D., & Davidson, G. (2019). Trauma informed child welfare systems – A rapid evidence review. *International Journal of Environmental Research and Public Health, 16(13),* 2365.

Burgess, P. W. (2005). Theory and methodology in executive function research. In P. Rabbitt (Ed.), *Methodology of frontal and executive function* (pp. 79–113). Hove, UK.: Psychology Press.

Burns, E. E., Jackson, J. L., & Harding, H. G. (2010). Child maltreatment, emotion regulation, and posttraumatic stress: The impact of emotional abuse. *Journal of Aggression, Maltreatment, & Trauma, 19(8),* 801–819.

Bushnell, J. A.,Wells, J. E. & Oakley-Browne, M. A. (1992) Long-term effects of intrafamilial sexual abuse in childhood. *Acta Psychiatrica Scandinavica, 85,*136-142.

Cadman, L., Waller, J., Ashdown-Barr, L., & Szarewski, A. (2012). Barriers to cervical screening in women who have experienced sexual abuse: an exploratory study: Table 1. *Journal of Family Planning and Reproductive Health Care, 38(4),* 214–220.

Cahill, C., Llewelyn, S. P., & Pearson, C. (1991). Long-term effects of sexual abuse which occurred in childhood: A review. *British Journal of Clinical Psychology, 30,* 117-130.

Canfield, M., Norton, S., Downs, J., & Gilchrist, G. (2021). Parental status and characteristics of women in substance use treatment services: Analysis of electronic patient records. *Journal of Substance Abuse Treatment, 127,* 108365.

Canfield, M., Radcliffe, P., Marlow, S., Boreham, M., & Gilchrist, G. (2017). Maternal substance use and child protection: a rapid evidence assessment of factors associated with loss of child care. *Child Abuse & Neglect, 70,* 11–27.

Caputi, M. (2013). *Feminism and Power: The Need for Critical Theory*, Lanham, MD: Lexington Books.

Carbado, D. W., Crenshaw, K. W., Mays, V. M., & Tomlinson, B. (2013). Intersectionality:

Mapping the Movements of a Theory. *Du Bois Review : Social Science Research on Race*, *10(2),* 303–312.

Carlson, B. E., Matto, H., Smith, C. A., & Eversman, M. (2006). A pilot study of reunification following drug abuse treatment: Recovering the mother role. *Journal of Drug Issues, 36(4),* 877–902.

Carlson, R. G., Siegal, H. A., & Falck R. S. (1995). Qualitative Research Methods in Drug and AIDS Prevention Research: An Overview. In E. Y. Lambert, R. S. Ashery, & R. H. Needle (Eds.), *Qualitative Methods in Drug Abuse and HIV Research.* (pp.6-26). National Institute on Drug Abuse: Rockville, MD.

Center for Substance Abuse Treatment. (2014). Chapter 3, Understanding the Impact of Trauma. In *Trauma-Informed Care in Behavioral Health Services*, (Treatment Improvement Protocol (TIP) Series, No. 57.). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved August 14, 2021, from https://www.ncbi.nlm.nih.gov/books/NBK207191/

Champine, R. B., Lang, J. M., Nelson, A. M., Hanson, R. F., & Tebes, J. K. (2019). Systems Measures of a Trauma- Informed Approach: A Systematic Review. *American Journal of Community Psychology, 64(3-4),* 418–437.

Chang, X., Jiang, X., Mkandarwire, T., & Shen, M. (2019). Associations between adverse childhood experiences and health outcomes in adults aged 18-59 years. *PloS one, 14(2),* e0211850.

Chapman, D. P., Dube, S. R., & Anda, R. F. (2007). Adverse childhood events as risk factors for negative mental health outcomes. *Psychiatric Annals, 37(5*), 359-364.

Chen, W., Propp, J., deLara, E. and Corvo, K., 2011. Child Neglect and Its Association With Subsequent Juvenile Drug and Alcohol Offence. *Child and Adolescent Social Work Journal*, 28(4), 273-290.

Chesney-Lind, M. (1989). Girls' crime and woman's place: Toward a feminist model of female delinquency. *Crime & Delinquency, 35*, 5–29.

Choudhary, E., Smith, M., & Bossarte, R. M. (2011). Depression, anxiety, and symptom profiles among female and male victims of sexual violence. *American Journal of Men's Health*, *6*(1), 28–36.

Cicchetti, D., Ganiban, J., & Barnett, D. (1991). Contributions from the study of high-risk populations to understanding the development of emotion regulation. In J. Garber & K. A. Dodge (Eds.), *The development of emotion regulation and dysregulation* (pp. 15–48). Cambridge University Press.

Cicchetti, D., & Toth, S. L. (2005). Child maltreatment. *Annual Review of Clinical Psychology, 1,* 409-438.

Clark, A. M., MacIntyre, P. D., & Cruickshank, J. (2007). A critical realist approach to

understanding and evaluating heart health programmes. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness, and Medicine*, *11*, 513-539.

Clark, H. K., Ringwalt, C. L., & Shamblen, S. R. (2011). Predicting adolescent substance use: the effects of depressed mood and positive expectancies. *Addictive Behaviors*, *36*(5), 488–493.

Claus, R. E., & Kindleberger, L. R. (2002). Engaging substance abusers after centralized assessment: Predictors of treatment entry and dropout. *Journal of Psychoactive Drugs, 34,* 25–31.

Clay, K. M., Olsheski, J. A., & Clay, S. W. (2000). Alcohol use disorders in female survivors of childhood sexual abuse. *Alcoholism Treatment Quarterly, 18(4),* 19–29.

Cloitre, M., Cohen, L. R., & Koenen, K. C. (2006). *Treating the trauma of childhood abuse: Therapy for the interrupted life*. New York, NY: Guilford.

Cloitre, M., Garvert, D. W., Weiss, B., Carlson, E. B., & Bryant, R. A. (2014). Distinguishing PTSD, Complex PTSD, and Borderline Personality Disorder: A latent class analysis. *European Journal of Psychotraumatology, 5,* 10.

Cohen, K., & Collens, P. (2013). The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious post-traumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy, 5(6),* 570-577.

Cohen, L. R., & Hien, D. A. (2006). Treatment Outcomes for Women With Substance Abuse and PTSD Who Have Experienced Complex Trauma. *Psychiatric Services, 57(1),* 100–106.

Cohen, L. R., Tross, S., Pavlicova, M., Hu, M.-C., Campbell, A. N., & Nunes, E. V. (2009). Substance Use, Childhood Sexual Abuse, and Sexual Risk Behavior among Women in Methadone Treatment. *The American Journal of Drug and Alcohol Abuse, 35(5),* 305–310.

Coles, J., & Jones, K. (2009). "Universal Precautions": Perinatal Touch and Examination after Childhood Sexual Abuse. *Birth, 36(3),* 230–236.

Collins, P. H. (1990). *Black feminist thought: Knowledge, consciousness and the politics of empowerment*. Boston, MA: Unwin Hyman.

Collins, P. (2000). Gender, Black Feminism, and Black Political Economy. *The American Academy of Political and Social Science, 568(1),* 41-53.

Collinshaw, S., Pickles, A., Messer, J., Rutter, M., Shearer, C., & Maughan, B. (2007). Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample. *Child Abuse & Neglect, 31(3),* 211–229.

Collinson, B., & Hall, L. (2021). The role of social mechanisms of change in women's addiction recovery trajectories. *Drugs (Abingdon, England), 28(5),* 426–436.

Corrie, S., & Callahan, M. M. (2000). A review of the scientist--practitioner model: reflections

on its potential contribution to counselling psychology within the context of current health care trends. *The British Journal of Medical Psychology, 73 (3),* 413–427.

Covington, S. (2003). *Beyond Trauma: A Healing Journey for Women.* Center City, MN: Hazelden.

Covington S. (2008). Women and addiction: a trauma-informed approach. *Journal of Psychoactive Drugs, 5*, 377–385.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43(6),* 1241–1299.

Crotty, M., 1998. *The Foundations of Social Research: Meaning and Perspective in the Research Process*. London: Sage Publications.

Cunningham, T., Ford, E., Croft, J., Merrick, M., Rolle, I., & Giles, W. (2014). Sex-specific relationships between adverse childhood experiences and chronic obstructive pulmonary disease in five states. *International Journal of Chronic Obstructive Pulmonary Disease, 9,*1033-1042.

Cusick, L. (2006). Widening the harm reduction agenda: from drug use to sex work. *International Journal of Drug Policy, 17,* 3–11.

Daly, K. (1992). Women's pathways to felony court: Feminist theories of lawbreaking and problems of representation. *Southern California Review of Law and Women's Studies, 2,* 11–52.

Darlington, Y. (1997). Escape as a Response to Childhood Sexual Abuse. *Journal of Child Sexual Abuse, 5(3),* 77–93.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2005). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin, 32(3),* 443–450.

Davis, A. Y. (1974). *Angela Davis: An autobiography.*

Davis, J. L., Petretic-Jackson, P. A., & Ting, L. (2001). Intimacy dysfunction and trauma symptomatology: Long-term correlates of different types of child abuse. *Journal of Traumatic Stress, 14,* 63-71.

Davis, S. J., & Spillman, S. (2011). Reasons for drug abstention: a study of drug use and resilience. *Journal of Psychoactive Drugs, 43(1),* 14–19.

de Beauvoir, S. (1973). *The second sex*. New York: Vintage Books.

DeHart, D. (2008). Pathways to prison. Impact of victimization in the lives of incarcerated women. *Violence Against Women, 14*, 1362–1381.

DeHart, D., Lynch, S., Belknap, J., Dass-Brailsford, P., & Green, B. (2014). Life history models of female offending: The roles of serious mental illness and trauma in women's pathways to jail. *Psychology of Women Quarterly, 38,* 138–151.

Delker, B. C., & Freyd, J. J. (2014). From betrayal to the bottle: investigating possible

pathways from trauma to problematic substance use. *Journal of Traumatic Stress, 27(5),* 576–584.

Denzin, N. K. & Lincoln Y.S. (2005). Introduction: The discipline and practice of qualitative research. In: N. K. Denzin & Y. S. Lincoln, eds. (pp.1-33). *The SAGE handbook of qualitative research*, 3rd ed., London: Sage Publications.

Diego, M. A., Field, T. M., & Sanders, C. E. (2003). Academic performance, popularity, and depression predict adolescent substance use. *Adolescence*, *38*(149), 35–42.

Dingle, G. A., Stark, C., Cruwys, T., & Best, D. (2015). Breaking good: Breaking ties with social groups may be good for recovery from substance misuse. *British Journal of Social Psychology*, *54*(2), 236–254.

Dinwiddie, S., Heath, A. C., Dunne, M. P., Bucholz, K. K., Madden, P. A., Slutske, W. S., Bierut, L. J., Statham, D. B., & Martin, N. G. (2000). Early sexual abuse and lifetime psychopathology: a co-twin-control study. *Psychological Medicine, 30(1),* 41–52.

Dixon-Woods, M., Shaw, R. L., Agarwal, S., & Smith, J. A. (2004). The problem of appraising qualitative research. *BMJ Quality & Safety, 13(3),* 223-225.

Dodge, K. A., Malone, P. S., Lansford, J. E., Miller, S., Pettit, G. S., & Bates, J. E. (2009). A dynamic cascade model of the development of substance-use onset. *Monographs of the Society for Research in Child Development*, *74*(3), vii–119.

Domhardt, M., Münzer, A., Fegert, J. M., & Goldbeck, L. (2015). Resilience in survivors of child sexual abuse: A systematic review of the literature. *Trauma, Violence, & Abuse, 16*, 476–493.

Dong, M., Anda, R. F., Dube, S. R., Giles, W. H., & Felitti, V. J. (2003). The relationship of exposure to childhood sexual abuse to other forms of abuse, neglect, and household dysfunction during childhood. *Child Abuse & Neglect*, *27(6),* 625–639.

Dong M., Giles, W. H., Felitti, V. J., Dube, S. R., Williams, J. E., Chapman, D. P., & Anda, R. F. (2004). Insights into causal pathways for ischemic heart disease: The adverse childhood experiences study. *Circulation, 110*, 1761-1766.

Dorahy, M. J., Middleton, W., Seager, L., Williams, M., & Chambers, R. (2015). Child abuse and neglect in complex dissociative disorder, abuse-related chronic PTSD, and mixed psychiatric samples. *Journal of Trauma & Dissociation, 17(2),* 223–236.

Douglas, B., Woolfe, R., Strawbridge, S., Kasket, E., & Galbraith, V. (Eds.). (2016). *The handbook of counselling psychology.* Sage.

Douglas, K. R., Chan, G., Gelernter, J., Arias, A. J., Anton, R. F., Weiss, R. D., Brady, K., Poling, J., Farrer, L., & Kranzler, H. R. (2010). Adverse childhood events as risk factors for substance dependence: Partial mediation by mood and anxiety disorders. *Addictive Behaviors*, *35*(1), 7–13.

Downey, L., Rosengren, D.B., & Donovan, D.M. (2000). To thine own self be true: Self-

concept and motivation for abstinence among substance abusers. *Addictive Behaviors, 25*(5), 743-757.

Draucker, C. B., & Martsolf, D. S. (2008). Storying childhood sexual abuse. *Qualitative Health Research, 18*, 1034–1048.

Draucker, C. B., Martsolf, D. S., Roller, C., Knapik, G., Ross, R., & Stidham, A. W. (2011). Healing from childhood sexual abuse: A theoretical model. *Journal of Child Sexual Abuse, 20,* 435–466.

Driessen, M., Schulte, S., Luedecke, C., Schaefer, I., Sutmann, F., Ohlmeier, M., Kemper, U., Koesters, G., Chodzinski, C., Schneider, U., Broese, T., Dette, C., & Havemann-Reinicke, U. (2008). Trauma and PTSD in Patients With Alcohol, Drug, or Dual Dependence: A Multi-Center Study. *Alcoholism: Clinical and Experimental Research, 32(3)*, 481–488.

Dube, S. R., Fairweather, D., Pearson, W., Felitti, V. F., Anda, R. F., & Croft, J. (2009). Cumulative childhood stress and autoimmune diseases in adults. *Psychosomatic Medicine, 71(2),* 243-250.

Dube, S., Anda, R., Whitfield, C., Brown, D., Felitti, V., Dong, M., & Giles, W. (2005). Long-term consequences of child- hood sexual abuse by gender of victim. *American Journal of Preventive Medicine, 28,* 430–438.

Dube, S. R., Miller, J. W., Brown, D. W., Giles, W. H., Felitti, V. J., Dong, M., & Anda, R. F. (2006). Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence. *Journal of Adolescent Health, 38(4),* 1-10.

Dube, S. R., Felitti, V. F., Dong, M., Chapman, D., Giles, W., & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics, 111(3),* 564-572.

Ducrocq, F., Vaiva, G., Cottencin, O., Molenda, S., & Bailly, D. (2001). Etat de stress post-traumatique, dépression post-traumatique et épisode dépressif majeur: la littérature [Post-traumatic stress, post-traumatic depression and major depressive episode: literature]. *L'Encephale*, *27(2),* 159–168.

Duncan, T. E., Duncan, S. C., & Hops, H. (1994). The effects of family cohesiveness and peer encouragement on the development of adolescent alcohol use: A cohort-sequential approach to the analysis of longitudinal data. *Journal of Studies on Alcohol, 55*(5), 588–599.

Dunne, M., Zolotor, A., Runyan, D., Andreva-Miller, A., Choo, W. Y., Dunne, S., Youssef, R. (2009). ISPCAN child abuse screening tools retrospective version (ICAST-R): Delphi study and field testing in seven countries. *Child Abuse & Neglect, 33,* 815–825.

Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In C. Willig and

W. Stainton-Rogers (Eds.), *The Sage Handbook of Qualitative Research in Psychology* (pp.179-194). London: Sage.

Easton, S. D. (2013). Trauma processing reconsidered: Using account-making in quantitative research with male survivors of child sexual abuse. *Journal of Loss & Trauma, 18*, 342–361.

Edwards, V. J., Anda, R. F., Gu, D., Dube, S. R., & Felitti, V. F. (2007). Adverse childhood experiences and smoking persistence in adults with smoking-related symptoms and illness. *The Permanente Journal, 11(2),* 5-13.

Elhai, J. D., & Palmieri, P. A. (2011). The factor structure of posttraumatic stress disorder: A literature update, critique of methodology, and agenda for future research. *Journal of Anxiety Disorders*, *25*, 849–854.

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33(4),* 461–477.

EMCDDA. (2000a). Problems facing women drug users and their children. In EMCDDA. *2000 Annual report on the state of the drugs problem in the European Union* (pp. 32-35), European Monitoring Centre of Drugs and Drug Addiction.

EMCDDA. (2000b). *Understanding and responding to drug use: the role of qualitative research.* Scientific Monograph Series: No4, European Monitoring Centre for Drugs and Drug Addiction: Luxembourg.

EMCDDA (2005). *Differences in patterns of drug use between men and women*, Technical datasheet, European Monitoring Centre for Drugs and Drug Addiction: Lisbon.

EMCDDA (2006). *A gender perspective on drug use and responding to drug problems*,

EMCDDA 2006 selected issue, European Monitoring Centre for Drugs and Drug Addiction: Lisbon.

EMCDDA (2008a), *Statistical bulletin and Annual report 2008: the state of the drugs problem in Europe,* European Monitoring Centre for Drugs and Drug Addiction: Lisbon.

EMCDDA. (2008b). *Women's Voices: Experiences and perceptions of women who face drug-related problems in Europe*, European Monitoring Centre of Drugs and Drug Addiction.

EMCDDA (2021). *European drug report 2021: Trends and Developments*, European Monitoring Centre for Drugs and Drug Addiction, Publications Office of the European Union: Luxembourg.

Enoch M. A. (2011). The role of early life stress as a predictor for alcohol and drug dependence. *Psychopharmacology*, *214*(1), 17–31.

Ertl, V., Preusse, M., & Neuner, F. (2018). Are drinking motives universal? Characteristics of

motive types in alcohol- dependent men from two diverse populations. *Frontiers in Psychiatry*, *9*, 38.

Ettorre, E. (1992), *Women and Substance Use,* Basingstoke Macmillan.

Ettorre, E. (2004). Revisioning women and drug use: gender sensitivity, embodiment and reducing harm. *International Journal of Drug Policy, 15,* 327–335.

Fallot, R. & Harris, M. (2002). *Trauma-informed services: A Self-Assessment and Planning Protocol.* Washington DC: Community Corrections.

Fallot, R., & Harris, M. (2009). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol.* (Vol. 2.2). Washington, DC: Community Connections.

Farley, M., Golding, J. M., Young, G., Mulligan, M., & Minkoff, J. R. (2004). Trauma history and relapse probability among patients seeking substance abuse treatment. *Journal of Substance Abuse Treatment*, *27*(2), 161–167.

Fassinger, R.E. (2005). Paradigms, praxis, problems, and promise: grounded theory in counseling psychology research. *Journal of Counseling Psychology, 52*(2), 156-166.

Fassler, I. R., Amodeo, M., Griffin, M. L., Clay, C. M., & Ellis, M. A. (2005). Predicting long-term outcomes for women sexually abused in childhood: Contribution of abuse severity versus family environment. *Child Abuse and Neglect, 29,* 269-284.

Felitti, V. J., & Anda, R. F. (2009). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders and sexual behavior: Implications for healthcare. In R. Lanius and E. Vermetten (Eds.). *The Hidden Epidemic: The Impact of Early Life Trauma on Health and Disease.* Cambridge University Press.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P. & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14(4),* 245–58.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (2019). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 56(6),* 774-786.

Fergusson, D. M., Horwood, J. & Lynskey, M. (1996) Childhood sexual abuse and psychiatric disorder in young adulthood: II. Psychiatric outcomes of childhood sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*, 1365-1374.

Fergusson, D. M., McLeod, G. F., & Horwood, L. J. (2013). Childhood sexual abuse and

adult developmental outcomes: Findings from a 30-year longitudinal study in New Zealand. *Child Abuse & Neglect, 37*, 664–674.

Filipas, H. H., & Ullman, S. E. (2006). Child sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimization. *Journal of Interpersonal Violence, 21*, 652–672.

Fine, M. (1994) Working the hyphens: Reinventing self and other in qualitative research. In: Denzin, N., Lincoln, Y. S. (eds) *Handbook of qualitative research,* Thousand Oaks, CA: SAGE, pp. 70–82.

Fine, M., & Gordon, S. M. (1989). Feminist transformations of/despite psychology. In M. Crawford, & M. Gentry (Eds.), *Gender and thought: Psychological Perspectives* (pp. 146–174). New York, NY: Springer.

Finkelhor, D. (1987). The trauma of child sexual abuse. *Journal of Interpersonal Violence, 2,* 348-365.

Finkelhor, D., Ormrod, R., Turner, H., & Hamby, S. L. (2005). The victimization of children and youth: a comprehensive, national survey. *Child Maltreatment*, *10*(1), 5–25.

Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. (2014). The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *Journal of Adolescent Health, 55*, 329–333.

Finkelhor, D., Turner, H., Ormrod, R., & Hamby, S. L. (2009). Violence, abuse, and crime exposure in a national sample of children and youth. *Pediatrics*, *124*(5), 1411–1423.

Finkelstein, N. (1993). Treatment programming for alcohol and drug-dependent pregnant women. *The International Journal of the Addictions*, *28(13),* 1275–1309.

Finkelstein N. (1994). Treatment issues for alcohol- and drug-dependent pregnant and parenting women. *Health & Social Work*, *19(1),* 7–15.

Finkelstein, N., VandeMark, N., Fallot, R., Brown, V., Cadiz, S., & Heckman, J. (2004). *Enhancing substance abuse recovery through integrated trauma treatment*. Sarasota, FL: National Trauma Consortium, Center for Substance Abuse Treatment.

Finlay, L. (1998). Reflexivity: an essential component for all research? *Br J Occupational Therapy 61(10),* 453-6.

Finlay, L. (2011). *Phenomenology for clinicians: researching the lived world.* Chichester: Wiley-Blackwell.

Finlay, L., Ballinger, C. (2006). Qualit*ative Research for Allied Health Professionals: Changing Choices*. Joha Wiley & Sons, Chichester.

Fiske, S.T & Taylor, S.E. (1991). *Social Cognition* (2nd ed). New York: McGraw-Hill.

Fontes L. A. (2007). Sin vergüenza: addressing shame with Latino victims of child sexual abuse and their families. *Journal of Child Sexual Abuse*, *16*(1), 61–83.

Fontes, L. A., & Plummer, C. (2010). Cultural issues in disclosures of child sexual

abuse. *Journal of Child Sexual Abuse*, *19*(5), 491–518.

Ford, E. S., Anda, R. F., Edwards, V. J., Perry, G. S., Zhao, G., Tsai, J., & Croft, J. B. (2011). Adverse childhood experiences and smoking status in five states. *Preventative Medicine, 53*, 188-193.

Ford, J.D. (2013). *Treatment of complex trauma: A sequenced, relationship-based approach.* New York, NY, US: Guilford Press.

Ford, J. D., Fallot, R., & Harris, M. (2009). Group Therapy. In C. A. Courtois and J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp.415-440). New York, NY, US: Guilford Press

Forshaw, M. J. (2007). Free qualitative research from the shackles of method. *The Psychologist, 20,* 478 – 479.

Foster, J. M., & Hagedorn, B. B. (2014). Through the eyes of the wounded: A narrative analysis of children's sexual abuse experience and recovery process. *Journal of Child Sexual Abuse, 23*, 538–557.

Frauenglass, S., Routh, D. K., Pantin, H. M., & Mason, C. A. (1997). Family support decreases influence of deviant peers on Hispanic adolescents' substance use. *Journal of Clinical Child Psychology*, *26*(1), 15–23.

Freud, S. (1959). Inhibitions, symptoms, and anxiety. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud. (pp. 77–*175). London, UK: Hogarth.

Frisher, M., Crome, I., Macleod, J., Bloor, R., & Hickman, M. (2007). *Predictive Factors for Problematic Drug Use Among Young People: A Literature Review.* Home Office Online Report.

Frisman, L., Ford, J., Lin, H.-J., Mallon, S., & Chang, R. (2008). Outcomes of Trauma Treatment Using the TARGET Model. *Journal of Groups in Addiction & Recovery, 3(3–4),* 285–303.

Fuller, T. E., Baird, S. L., Dhrodia, R., & Brennenstuhl, S. (2016). The association between adverse childhood experiences (ACEs) and suicide attempts in a population based study. *Child: Care, Health & Development, 42(5),* 725–734.

Fuller-Thomson, E., Roane, J. L., & Brennenstuhl, S. (2016). Three Types of Adverse Childhood Experiences, and Alcohol and Drug Dependence Among Adults: An Investigation Using Population-Based Data. *Substance Use & Misuse, 51(11)*, 1451–1461.

Galaif, E. R., Stein, J. A., Newcomb, M. D., & Bernstein, D. P. (2001). Gender differences in the prediction of problem alcohol use in adulthood: Exploring the influence of family factors and childhood maltreatment. *Journal of Studies on Alcohol, 62,* 486-493.

Galbraith, V. (Ed.). (2017). *Counselling Psychology*. Routledge.

Galvani, S. & Humphreys, C. (2007). *The impact of violence and abuse on engagement and retention rates for women in substance use treatment*, National Treatment Agency, UK Department of Health: London.

Georgsdottir, M. T., Sigurdardottir, S., & Gunnthorsdottir, H. (2021). "This Is the Result of Something Else": Experiences of Men That Abused Drugs and Had Experienced Childhood Trauma. *American Journal of Men's Health, 15(2),* 15579883211009348.

Giano, Z., Wheeler, D. L., & Hubach, R. D. (2020). The frequencies and disparities of adverse childhood experiences in the U.S. *BMC Public Health, 20(1)*.

Gibson, L. E., & Leitenberg, H. (2001). The impact of child sexual abuse and stigma on methods of coping with sexual assault among undergraduate women. *Child Abuse and Neglect, 25*, 1343–1361.

Gil-Rivas, V., Prause, J., & Grella, C. E. (2009). Substance use after residential treatment among individuals with co-occurring dis- orders: The role of anxiety/depressive symptoms and trauma exposure. *Psychology of Addictive Behaviors, 23*, 303–314.

Gilbert, P. (2005). Compassion and cruelty: A biopsychosocial approach. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 9–74). London, UK: Routledge.

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment, 15,* 199–208.

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. London, UK: Routledge.

Gilbert, P., & Proctor, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. Clinical Psychology and Psychotherapy, 13, 353–379.

Gilchrist, G., Dennis, F., Radcliffe, P., Henderson, J., Howard, L. M., & Gadd, D. (2019). The interplay between substance use and intimate partner violence perpetration: A meta-ethnography. *The International Journal on Drug Policy, 65,* 8–23.

Gilchrist, G. & Taylor, A. (2009). Drug-using mothers: factors associated with retaining care of their children: Drug-using mothers. *Drug and Alcohol Review, 28(2),* 175–185.

Gilfus, M. E. (1992). From victims to survivors to offenders. Women's routes of entry and immersion into street crime. *Women & Criminal Justice, 4*, 63–90.

Gilgun, J.F. (2006). Commentary: Encouraging the use of reflexivity in the writing up of qualitative research. *International J Therapy Rehabilitation, 73,* 13, 5, 215.

Gilligan, C. (1977). *In a different voice: Women's conceptions of self and morality*, Harvard Educational Review.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Giorgi, A. (2010). Phenomenology and the practice of science. *Existential Analysis, 21*(1), 3–22.

Godbout, N., Sabourin, S., & Lussier, Y. (2009). Child sexual abuse and adult romantic adjustment: Comparison of single- and multiple-indicator measures. *Journal of Interpersonal Violence, 24*, 693–705.

Goldman, J. D. G. & Padayachi, U. K. (2000). Some methodological problems in estimating incidence and prevalence in child sexual abuse research, *The Journal of Sex Research, 37(4),* 305-314.

Golsworthy, R., & Coyle. A. (2001). Practitioners accounts of religious and spiritual dimensions in bereavement therapy. *Counselling Psychology Quarterly, 14,* 183-202.

Goode, E. (2007). Chapter 3: Theories of drug use. In *Drugs in American Society.* 7th edition. Boston, Mass, USA: McGraw Hill;

Goodman, R. (2017). Contemporary Trauma Theory and Trauma-Informed Care in Substance Use Disorders: A Conceptual Model for Integrating Coping and Resilience. *Advances in Social Work, 18(1),* 186–201.

Goodman-Brown, T. B., Edelstein, R. S., Goodman, G. S., Jones, D. P., & Gordon, D. S. (2003). Why children tell: a model of children's disclosure of sexual abuse. *Child Abuse & Neglect*, *27*(5), 525–540.

Gopiram, P., & Kishore, M. T. (2014). Psychosocial Attributes of Substance Abuse Among Adolescents and Young Adults: A Comparative Study of Users and Non-users. *Indian Journal of Psychological Medicine, 36(1),* 58–61.

Grant, B. F., Stinson, F. S., & Harford, T. C. (2001). Age at onset of alcohol use and DSM-IV alcohol abuse and dependence: a 12-year follow-up. *Journal of Substance Abuse*, *13*(4), 493–504.

Greger, H., Myhre, A., Lydersen, S., & Jozefiak, T. (2015). Previous maltreatment and present mental health in a high- risk adolescent population. *Child Abuse & Neglect*, *45*, 122–134.

Gregor, S. (2006). The nature of theory in information systems. *MIS Quarterly,* 611- 642.

Grella, C. (1999). Women in residential drug treatment: Differences by program type and pregnancy. *Journal of Health Care for the Poor and Underserved* 10 (2), 216-29.

Grella, C., Joshi, V., & Hser, Y. (2000). Program variation in treatment outcomes among women in residential drug treatment. *Evaluation Review* 24 *(4),* 364-83.

Grogan-Kaylor, A., Ruffolo, M. C., Ortega, R. M., & Clarke, J. (2008). Behaviors of youth involved in the child welfare system. *Child Abuse & Neglect*, *32*(1), 35–49.

Grossman, F. K., Sorsoli, L., & Kia-Keating, M. (2006). A gale force wind: Meaning making by male survivors of childhood sexual abuse. *American Journal of Orthopsychiatry, 76*, 434–443.

Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-Informed Organizational Toolkit*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network and the W.K. Kellogg Foundation

Guo, J., Hawkins, J. D., Hill, K. G., & Abbott, R. D. (2001). Childhood and adolescent predictors of alcohol abuse and dependence in young adulthood. *Journal of Studies on Alcohol*, *62*(6), 754–762.

Haahr-Pedersen, I., Perera, C., Hyland, P., Vallières, F., Murphy, D., Hansen, M., Spitz, P., Hansen, P., & Cloitre, M. (2020). Females have more complex patterns of childhood adversity: implications for mental, social, and emotional outcomes in adulthood. *European Journal of Psychotraumatology, 11(1),* 1708618.

Hales, T., Green, S., Bissonette, S., Warden, A., Diebold, J., Koury, S., & Nochajski, T. (2018). Trauma-informed care outcome study. *Research on Social Work Practice,* 1–11.

Hall-Flavin, D. K. & Hofmann, V. E. (2003). Stimulants, Sedatives, and Opiates. In J. H. Noseworthy (Ed.). *Neurological Therapeutics,* (vol. 2, pp. 1510-1518). London and New York: Martin Dunitz.

Ham, L. S., & Hope, D. A. (2003). College students and problematic drinking: A review of the literature. *Clinical Psychology Review, 23,* 719–759.

Hamburger, M. E., Leeb, R. T., & Swahn, M. H. (2008). Childhood maltreatment and early alcohol use among high-risk adolescents. *Journal of Studies on Alcohol and Drugs*, *69*(2), 291–295.

Hammersley, R., Dalgarno, P., McCollum, S., Reid, M., Strike, Y., Smith, A., Wallace, J., Smart, A., Jack, M., Thompson, A. & Liddell, D. (2016). Trauma in the childhood stories of people who have injected drugs. *Addiction Research & Theory, 24(2),* 135-151.

Hankins, C. (2008). Sex, drugs and gender? High time for lived experience to inform action. *International Journal of Drug Policy, 19(2),* Editorial.

Hankivsky, O., & Cormier, R. (2009). Intersectionality: *Moving Women's Health Research and Policy Forward.* Vancouver: Women's Health Research Network.

Haraway, D. (1988). Situated knowledges: The science question in feminism and the privilege of partial perspective. *Feminism Studies, 14(3),* 575–599.

Harding, S. (1991). *Whose science? Whose knowledge?,* Ithaca, N.Y.: Cornell University Press.

Harding, S. (1992). Rethinking standpoint epistemology: What is "strong objectivity"? *The Centennial Review, 36(3),* 437–470.

Harding, S. (1996). Gendered ways of knowing and the "epistemological crisis" of the West.

In N. R. Goldberger (Ed.), *Knowledge, difference, and power: Essays inspired by women's ways of knowing* (1st ed., pp. 431–454). New York, NY: Basic Books.

Harding, S. (2008). *Sciences from Below: Feminisms, Postcolonialities, and Modernities*, Durham: Duke University Press.

Harding, S. & Norberg, K. (2005). New Feminist Approaches to Social Science Methodologies: An Introduction. *Journal of Women in Culture and Society, 30(4).*

Hare-Mustin, R. T., & Marecek, J. (1988). The meaning of difference: Gender theory, postmodernism, and psychology. *American Psychologist, 43(6)*, 455–464.

Hare-Mustin, R. T., & Marecek, J. (Eds.). (1990). *Making a difference: Psychology and the construction of gender.* New Haven, CT: Yale University Press.

Harris, C. E., Carter, S., Powers, A., & Bradley, B. (2021). Impulsivity mediates the link between childhood sexual abuse and juvenile incarceration among low-income African American women. *Journal of Aggression, Maltreatment & Trauma, 30(3),* 389–409.

Harris, M., & Fallot, R. D. (Eds.). (2001). *Using trauma theory to design service systems. New directions for mental health services.* San Francisco, CA: Jossey-Bass.

Hartsock, N. (1983). *Money, Sex, and Power: Toward a Feminist Historical Materialism*, Boston: Northeastern University Press.

Hartsock, N. (1996). Community/Sexuality/Gender: Rethinking Power, In N. J. Hirschmann & C. Di Stefano (Eds.). *Revisioning the Political: Feminist Reconstructions of Traditional Concepts in Western Political Theory*, Boulder, CO: Westview Press.

Hassija, C. M., Garvert, D. W., & Cloitre, M. (2015). Brief report: Symptoms of PTSD, coping strategies, and social adjustment among survivors of early life interpersonal trauma. *Journal of Aggression, Maltreatment & Trauma, 24(5),* 520–531.

Hassija, C. M., Jakupcak, M., & Gray, M. J. (2012). Emotional numbing symp- toms of posttraumatic stress disorder among OEF/OIF veterans: A review of findings and implications for treatment. *Behavior Modification*, *36*, 832–854.

Hawkesworth, M. E. (2006). *Globalization and Feminist Activism*. (pp. 25–27). Rowman & Littlefield.

Hawkins, J. D., Catalano, R. F., & Arthur, M. W. (2002). Promoting science-based prevention in communities. *Addictive Behaviors*, *27*(6), 951–976.

Hays-Gilpin, K., & Whitley , D. (1998). *Reader in Gender Archaeology,* New York: Routledge.

Health and Care Professions Council (2015). *Standards of Proficiency-Practitioner Psychologists.* London: Health and Care Professions Council.

Health and Care Professions Council. (2016). *Guidance on conduct and ethics for students.* London: The Health & Care Professions Council.

Heffner, J. L., Blom, T. J., & Anthenelli, R. M. (2011). Gender differences in trauma history

and symptoms as predictors of relapse to alcohol and drug use. *The American Journal on Addictions, 20(4),* 307–311.

Heleniak, C., Jenness, J. L., Vander Stoep, A., McCauley, E., & McLaughlin, K. A. (2016). Childhood maltreatment exposure and disruptions in emotion regulation: A transdiagnostic pathway to adolescent internalizing and externalizing psychopathology. *Cognitive Therapy and Research, 40(3),* 394–415.

Henwood KL, Pidgeon NF. (1992) Qualitative research and psychological theorising. *British Journal of Psychology, 83(1),* 97-112.

Herman, J. L. (1992). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror.* New York: Basic Books

Herman, J. L. (1998). Recovery from psychological trauma: Recovery from psychological trauma. *Psychiatry and Clinical Neurosciences, 52(S1),* S105–S110.

Herting, J. & Guest, A., (1985). Components of Satisfaction with Local Areas in the Metropolis. *The Sociological Quarterly*, 26(1), pp.99-116.

Hesse-Biber, S. N. (2012). Feminist research: Exploring, interrogating, and transforming the interconnections of epistemology, methodology, and method. In S. N. Hesse-Biber (Ed.), H*andbook of feminist research: Theory and praxis* (pp. 1–26). Thousand Oaks, CA: SAGE.

Hetzel-Riggin, M., Brausch, A., & Montgomery, B. (2007). A meta-analytic investigation of therapy modality outcomes for sexually abused children and adolescents: An exploratory study. *Child Abuse and Neglect, 31(2),* 125–141.

Hien, D., Cohen, L. R., Miele, G. M., Litt, L. C., & Capstick, C. (2004). Promising treatments for women with comorbid PTSD and substance use disorders. *The American Journal of Psychiatry, 161(8),* 1426–1432.

Hill, K. G., Hawkins, J. D., Catalano, R. F., Abbott, R. D., & Guo, J. (2005). Family influences on the risk of daily smoking initiation. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine*, *37*(3), 202–210.

Hillberg, T., Hamilton-Giachritsis, C., & Dixon, L. (2011). Review of meta-analyses on the association between child sexual abuse and adult mental health difficulties: a systematic approach. *Trauma, Violence & Abuse*, *12*(1), 38–49.

Hillis, S., Anda, R., Dube, S., Felitti, V., Marchbanks, P., & Marks, J. (2004). The association between adverse childhood experiences and adolescent pregnancy, long-term psychosocial consequences, and fetal death. *Pediatrics, 113(2),* 320-327.

Holmes, M. (2007). *What is Gender?: Sociological Approaches*. London: Sage Publications.

Horwitz, A. V., Widom, C. S., McLaughlin, J., & White, H. R. (2001). The impact of childhood abuse and neglect on adult mental health: A prospective study. *Journal of Health and Social Behavior, 42(2),* 184–201.

Huber-Lang, M., Lambris, J., & Ward, P. (2018). Innate immune responses to trauma. *Nature Immunology, 19,* 327–341.

Hughes, D. (2014, January 15). *Developing Reflexivity in Research*. Retrieved August 14, 2021, from http://www.neuro-memento-mori.com/teaching/doc/research/developing-reflexivity-in-research.pdf

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. The Lancet. *Public Health, 2(8),* e356–e366.

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology*. (D. Carr, Trans.). Evanston: Northwestern University Press.

Hutchison, P., Cox, S., & Frings, D. (2018). Helping you helps me: Giving and receiving social support in recovery groups for problem gamblers. *Group Dynamics: Theory, Research, and Practice, 22(4),* 187–199.

Hyland, P., Murphy, J., Shevlin, M., Vallières, F., McElroy, E., Elklit, A., Christoffersen, M., & Cloitre, M. (2017). Variation in post-traumatic response: the role of trauma type in predicting ICD-11 PTSD and CPTSD symptoms. *Social psychiatry and psychiatric epidemiology*, *52(6),* 727–736.

Hyland, P., Shevlin, M., Fyvie, C., & Karatzias, T. (2018). Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder in DSM-5 and ICD-11: Clinical and Behavioral Correlates. *Journal of traumatic stress*, *31(2),* 174–180.

Hyman, B. & Williams, L. (2001). Resilience among women survivors of child sexual abuse. *Affilia, 16(2),* 198–219.

Hyman, S. M., Gold, S. N., & Cott, M. A. (2003). Forms of social support that moderate PTSD in childhood sexual abuse survivors. *Journal of Family Violence, 18*, 295–300.

Hyman, S. M., Paliwal, P., Chaplin, T. M., Mazure, C. M., Rounsaville, B. J., & Sinha, R. (2008). Severity of childhood trauma is predictive of cocaine relapse outcomes in women but not men. *Drug and Alcohol Dependence*, *92(1-3),* 208–216.

Jadidi, N., & Nakhaee, N. (2014). Etiology of drug abuse: a narrative analysis. *Journal of Addiction, 2014*, 352835.

Jansen, K., Cardoso, T. A., Fries, G. R., Branco, J. C., Silva, R. A., Kauer-Sant'Anna, M., Kapczinski, F., & Magalhaes, P. V. S. (2016). Childhood trauma, family history, and their association with mood disorders in early adulthood. *Acta Psychiatrica Scandinavica*, *134*, 281–286.

Jarvis, T. J., Copeland, J., & Walton, L. (1998). Exploring the na- ture of the relationship between child sexual abuse and substance abuse in women. *Journal of Consulting and Clinical Psychology, 65*, 834–847.

Jennissen, S., Holl, J., Mai, H., Wolff, S., & Barnow, S. (2016). Emotion dysregulation mediates the relationship between child maltreatment and psychopathology: A structural equation model. *Child Abuse & Neglect, 62*, 51–62.

Jeong, S., & Cha, C. (2019). Healing from Childhood Sexual Abuse: A Meta-Synthesis of Qualitative Studies. *Journal of Child Sexual Abuse, 28(4),* 383–399.

Jha, D., & Singh, R. (2020). Analysis of associations between emotions and activities of drug users and their addiction recovery tendencies from social media posts using structural equation modeling. *BMC Bioinformatics, 21(Suppl 18),* 554.

Jonas, S., Bebbington, P., McManus, S., Meltzer, H., Jenkins, R., Kuipers, E. & Brugha, T. (2011). Sexual abuse and psychiatric disorder in England: Results from the 2007 Adult Psychiatric Morbidity Survey. *Psychological Medicine, 41(4),* 709-719.

Jones, M. S., Sharp, S. F., & Worthen, M. G. (2018a). Broken hearts and battered lives: Adverse and abusive life histories and externalized responses to anger as pathways to illicit drug use among incarcerated women. *Women & Criminal Justice, 28,* 167–188.

Jones, M. S., Worthen, M. G., Sharp, S. F., & McLeod, D. A. (2018b). Bruised inside out: The adverse and abusive life histories of incarcerated women as pathways to PTSD and illicit drug use. *Justice Quarterly, 35(6),* 1004–1029.

Jones, N. J., Brown, S. L., Wanamaker, K. A., & Greiner, L. E. (2014). A quantitative exploration of gendered pathways to crime in a sample of male and female juvenile offenders. *Feminist Criminology, 9*, 113–136.

Jordan, J. V., & Hartling, L. M. (2002). New developments in relational-cultural theory. In M. Ballou & L. S. Brown (Eds.), *Rethinking mental health and disorder: Feminist perspectives* (pp. 48–70). Guilford Press.

Kaltiala-Heino, R., Rimpelä, M., Rantanen, P., & Rimpelä, A. (2000). Bullying at school--an indicator of adolescents at risk for mental disorders. *Journal of Adolescence*, *23*(6), 661–674.

Kandel D. B. (1985). On processes of peer influences in adolescent drug use: a developmental perspective. *Advances in alcohol & substance abuse*, *4*(3-4), 139–163.

Kaplan, R. B., & Grabe, W. (2002). A modern history of written discourse analysis. *Journal of Second Language Writing, 11(3),* 191-223.

Karatekin, C. (2019). Adverse Childhood Experiences (ACEs) and Help-Seeking for Health-Related Interventions in Young Adults. *The Journal of Psychology, 153(1)*, 6–22.

Karatzias, T., Shevlin, M., Fyvie, C., Hyland, P., Efthymiadou, E., Wilson, D., Roberts, N., Bisson, J. I., Brewin, C. R., & Cloitre, M. (2017). Evidence of distinct profiles of Posttraumatic Stress Disorder (PTSD) and Complex Posttraumatic Stress Disorder

(CPTSD) based on the new ICD-11 Trauma Questionnaire (ICD-TQ). *Journal of affective disorders*, *207*, 181–187.

Kassel, J. D., Wardle, M., & Roberts, J. E. (2007). Adult attachment security and college student substance use. *Addictive Behaviors, 32,* 1164–1176.

Kaufman, G. (1989). *The psychology of shame: Theory and treatment of shame-based syndromes.* New York, NY: Springer.

Kaya Tezel, F., Tutarel Kişlak, Ş., & Boysan, M. (2015). Relationships between childhood traumatic experiences, early maladaptive schemas and interpersonal styles. *Noro Psikiyatri Arsivi, 52(3),* 226–232.

Khantzian E. J. (1985). The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. *The American Journal of Psychiatry, 142(11),* 1259–1264.

Keirns, N. G., Tsotsoros, C. E., Addante, S., Layman, H. M., Krems, J. A., Pearl, R. L., Tomiyama, A. J., & Hawkins, M. A. W. (2021). Adverse Childhood Experiences Associated with Greater Internalization of Weight Stigma in Women with Excess Weight. *Obesities, 1(1),* 49–57.

Kemp, R. (2019). Addiction and addiction recovery: a qualitative research viewpoint. *Journal of Psychological Therapies, 4(2),* 167–179.

Kendall-Tackett, K. A., Marshall, R., & Ness, K. E. (2000). Victimization, healthcare use, and health maintenance. *Family Violence and Sexual Assault Bulletin, 16*, 18–21.

Kendler, K. S., Bulik, C. M., Silberg, J., Hettema, J. M., Myers, J., & Prescott, C. A. (2000). Childhood sexual abuse and adult psychiatric and substance use disorders in women: an epidemiological and cotwin control analysis. *Archives of General Psychiatry, 57(10),* 953–959.

Kessler, R. C., Davis, C. G., & Kendler, K. S. (1997). Childhood adversity and adult psychiatric disorder in the US National Comorbidity Survey. *Psychological Medicine, 27(5),* 1101–1119.

Khalifeh, H., Hargreaves, J., Howard, L. & Birdthistle, I. (2013). Intimate Partner Violence and Socioeconomic Deprivation in England: Findings from a National Cross-sectional Survey. *American Journal of Public Health, 103(3),* 462-72.

Kilpatrick, D. G., Acierno, R., Saunders, B., Resnick, H. S., Best, C. L., & Schnurr, P. P. (2000). Risk factors for adolescent substance abuse and dependence: data from a national sample. *Journal of Consulting and Clinical Psychology*, *68*(1), 19–30.

Kilpatrick, D. G., Amick-McMullan, A,, Best, C. L., Burke, M. M. & Saunders, B. E. (1986). Impact of child sexual abuse: Recent research findings. *Fourth National Conference on Sexual Victimization of Children*, New Orleans, LA.

Kober, H., & Bolling, D. (2014). Emotion regulation in substance use disorders. *Handbook of*

Emotion Regulation, 2, 428–446.

Koposov, R. A., Ruchkin, V. V., Eisemann, M., & Sidorov, P. I. (2002). Alcohol use in adolescents from northern Russia: the role of the social context. *Alcohol and Alcoholism (Oxford, Oxfordshire), 37(3),* 297–303.

Korhonen, T., Huizink, A. C., Dick, D. M., Pulkkinen, L., Rose, R. J., & Kaprio, J. (2008). Role of individual, peer and family factors in the use of cannabis and other illicit drugs: a longitudinal analysis among Finnish adolescent twins. *Drug and Alcohol Dependence*, *97*(1-2), 33–43.

Kort-Butler L. A. (2009). Coping styles and sex differences in depressive symptoms and delinquent behavior. *Journal of Youth and Adolescence*, *38*(1), 122–136.

Kougiali, Z. G., Pytlik, A., & Soar, K. (2021). Mechanisms and processes involved in women's pathways into alcohol dependence and towards recovery: a qualitative meta-synthesis. *Drugs (Abingdon, England), 28(5),* 437–453.

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *Lancet (London, England)*, *360*(9339), 1083–1088. Retrieved August 18, 2021, from http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf

Kumpfer, K.L. & Bluth, B. (2004). Parent/child transactional processes predictive of resilience or vulnerability to "substance abuse disorders.". *Substance Use and Misuse 39,* 671-98.

Lancaster, K. E., Miller, W. C., & Go, V. F. (2020). "I was raised in addiction": Constructions of the self and the other in discourses of addiction and recovery. *Qualitative Health Research, 30(14),* 2278–2290.

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Pearson Education.

Langdridge, D. (2008). Phenomenology and critical social psychology: Directions and debates in theory and research. *Social and Personality Psychology Compass, 2(3),* 1126-1142.

Langdridge, D., & Hagger-Johnson, G. (2009). *Introduction to Research Methods and Data Analysis in Psychology,* 2nd Edition. Harlow: Pearson Education.

LaNoue, M. D., Cunningham, A. T., Kenny, L. C., Abatemarco, D., & Helitzer, D. (2020). What Do Adults Think About Their Adverse Childhood Experiences (ACEs), and Does It Matter? *Community Mental Health Journal, 56(7),* 1255–1261.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3,* 102-120.

Leahy, T., Pretty, G., & Tenenbaum, G. (2004). Perpetrator Methodology as a Predictor of Traumatic Symptomatology in Adult Survivors of Childhood Sexual Abuse. *Journal of Interpersonal Violence, 19(5),* 521–540.

Lebowitz, L., Harvey, M. R., & Herman, J. L. (1992). A stage-by-dimension model of recovery from sexual trauma. *Journal of Interpersonal Violence, 8*(3), 378-391.

Lederman, L. C., & Menegatos, L. M. (2011). Sustainable recovery: The self-transformative power of storytelling in alcoholics anonymous. *Journal of Groups in Addiction & Recovery*, *6*(3), 206–227.

Leeners, B., Stiller, R., Block, E., Görres, G., Imthurn, B., & Rath, W. (2007). Effect of Childhood Sexual Abuse on Gynecologic Care as an Adult. *Psychosomatics, 48(5),* 385–393.

Leenerts, M. H. (1999). The disconnected self: consequences of abuse in a cohort of low-income white women living with HIV/AIDS. *Health Care for Women International, 20(4),* 381–400.

Lengermann, P. & Niebrugge, G. (2010). Feminism. In G. Ritzer & J. M. Ryan, (Eds.). *The Concise Encyclopedia of Sociology*, (p. 223). John Wiley & Sons.

Lerman, H. (1990). *Feminist Ethics in Psychotherapy*, Springer Publishing Company.

Lesperance, T., Moore, K. A., Barrett, B., Young, M. S., Clark, C., & Ochshorn, E. (2011). Relationship between trauma and risky behavior in substance-abusing parents involved in a family dependency treatment court. *Journal of Aggression, Maltreatment & Trauma, 20(2),* 163–174.

Letourneau, N., & Allen, M. (2006). Post-positivistic critical multiplism: A beginning dialogue. In W. K. Cody (Ed.), *Philosophical and theoretical perspectives for advanced nursing practice* (pp. 221-231). Boston, MA: Jones and Bartlett Publishers.

Levers, M. D. (2013). Philosophical Paradigms, Grounded Theory, and Perspectives on Emergence. *SAGE Open, October-December,* 1-6.

Levine, P. (2010). *In an unspoken voice: How the body releases trauma and restores goodness.* Berkeley, CA: North Atlantic Books.

Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York, NY: International University Press.

Lewis, H. B. (Ed.). (1987). *The role of shame in symptom formation.* Hillsdale, NJ: Erlbaum.

Lezak, M. D. (1995). *Neuropsychological assessment* (3rd ed.). New York, NY: Oxford University Press.

Libby, A. M., Orton, H. D., Stover, S. K., & Riggs, P. D. (2005). What came first, major depression or substance use disorder? Clinical characteristics and substance use comparing teens in a treatment cohort. *Addictive Behaviors*, *30(9),* 1649–1662.

Ligiéro, D. P., Fassinger, R., McCauley, M., Moore, J., & Lyytinen, N. (2009). Childhood sexual abuse, culture, and coping: A qualitative study of Latinas. *Psychology of Women Quarterly, 33*, 67–80.

Lilly, M. M., London, M. J., & Bridgett, D. J. (2014). Using SEM to examine emotion

regulation and revictimization in predicting PTSD symptoms among childhood abuse survivors. *Psychological Trauma: Theory, Research, Practice, and Policy, 6,* 644–651.

Linden, I. A., Torchalla, I., & Krausz, M. (2013). Addiction in maternity: Prevalence of mental illness, substance use, and trauma. *Journal of Aggression, Maltreatment & Trauma, 22(10), 1*070–1084.

Lister, R. (1997). Citizenship: towards a feminist synthesis. *Feminist Review, 57(1),* 28-48.

Locher, B., & Prügl, E. (2001). Feminism and Constructivism: Worlds Apart or Sharing the Middle Ground? *International Studies Quarterly, 45(1),* 111-129.

Logan, T., Walker, R., Cole, J., & Leukefeld, C. (2002). Victimization and Substance Abuse among Women: Contributing Factors, Interventions, and Implications. *Review of General Psychology, 6(4),* 325–397.

Luck, P. A., Elifson, K. W., & Sterk, C. E. (2004). Female drug users and the welfare system: a qualitative exploration. *Drugs (Abingdon, England), 11(2),* 113–128.

Lupien, S., McEwen, B., Gunnar, M., & Heim, C. (2009). Effects of stress throughout the lifespan on the brain, behaviour and cognition. *Nature Neuroscience, 10,* 434–445.

MacMillan, H. L., Fleming, J. E., Streiner, D. L., Lin, E., Boyle, M. H., Jamieson, E., Duku, E. K., Walsh, C. A., Wong, M. Y.-Y., & Beardslee, W. R. (2001). Childhood Abuse and Lifetime Psychopathology in a Community Sample. *American Journal of Psychiatry, 158(11),* 1878–1883.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology, 91(1),* 1-20.

Magnusson, E., Marecek, J. (2012) *Gender and culture in psychology: Theories and practices*, Cambridge, UK: Cambridge University Press.

Magnusson, E., & Marecek, J. (2017). Feminisms, psychologies, and the study of social life. In B. Gough (Ed.), *The Palgrave Handbook of Critical Social Psychology* (pp. 17–35). London, UK: Springer Nature.

Mandal, J., Acharya, S., & Parija, S. C. (2011). Ethics in human research. *Tropical Parasitology, 1(1),* 2–3.

Mandavia, A., Robinson, G. G., Bradley, B., Ressler, K. J., & Powers, A. (2016). Exposure to Childhood Abuse and Later Substance Use: Indirect Effects of Emotion Dysregulation and Exposure to Trauma. *Journal Of Traumatic Stress, 29(5),* 422–429.

Marich, J. (2009). EMDR in the addiction continuing care process: Case study of a cross-addicted female's treatment and recovery. Jo*urnal of EMDR Practice and Research, 3(2),* 98–106.

Marshall, G. N., Schell, T. L., & Miles, J. N. (2010). All PTSD symptoms are highly

associated with general distress: Ramifications for the dysphoria symptom cluster. *Journal of Abnormal Psychology, 119,* 126-135.

Martin, A., & Stenner, P. (2004). Talking about drug use: what are we (and our participants) doing in qualitative research? *International Journal of Drug Policy, 15(5–6),* 395–405.

Martin, J. L., Burrow-Sánchez, J. J., Iwamoto, D. K., Glidden-Tracey, C. E., & Vaughan, E. L. (2016). Counseling Psychology and Substance Use. *The Counseling Psychologist, 44(8),* 1106–1131.

Mason, M. (1991). Women and shame: Kin and culture. In C. Bepko (Ed.), *Feminism and addiction* (pp. 175-194). New York: Haworth Press.

Maté, G. (2008). In the realm of hungry ghosts: *Close encounters with addiction.* Toronto: Knopf Canada.

Maté, G. (2012). Addiction: Childhood Trauma, Stress and the Biology of Addiction. *Journal of Restorative Medicine, 1(1),* 56–63.

Matthews, B. & Collin-Vezina, D. (2019). Child Sexual Abuse: Toward a Conceptual Model and Definition. *Trauma, Violence, & Abuse, 20(2),* 131-148.

McClellan, D. S., Farabee, D., & Crouch, B. M. (1997). Early victimization, drug use, and criminality a comparison of male and female prisoners. *Criminal Justice and Behavior, 24,* 455–476.

McClure, F. H., Chavez, D. V., Agars, M. D., Peacock, M. J., & Matosian, A. (2008). Resilience in sexually abused women: Risk and protective factors. *Journal of Family Violence, 23,* 81–88.

McCrory, E., De Brito, S., & Viding, E. (2010). Research review: the neurobiology and genetics of maltreatment and adversity. *The Journal of Child Psychology and Psychiatry, 51(10),* 1079–1095.

McDaniels-Wilson, C., & Belknap, J. (2008). The extensive sexual violation and sexual abuse histories of incarcerated women. *Violence Against Women, 14,* 1090–1127.

McGee, H., Garavan, R., de Barra, M., Byrne, J., & Conroy, R. (2002). *The SAVI Report: Sexual abuse and violence in Ireland.* Dublin, Ireland: Liffey Press.

McGrath, J. E., & Johnson, B. A. (2003). Methodology makes meaning: How both qualitative and quantitative paradigms shape evidence and its interpretation. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 31–48). Washington, DC: American Psychological Association.

McHugo, G. J., Caspi, Y., Kammerer, N., Mazelis, R., Jackson, E. W., Russell, L., Clark, C., Liebschutz, J., & Kimerling, R. (2005). The assessment of trauma history in women with co-occurring substance abuse and mental disorders and a history of

interpersonal violence. *The Journal of Behavioral Health Services & Research*, *32*(2), 113–127.

McKeganey, N. (1995). Quantitative and qualitative research in the addictions: An unhelpful divide. *Addiction, 90*, 749–751.

McKeganey, N. (2006). Street prostitution in Scotland: the views of working women. *Drugs: Education Prevention and Policy, 13(2),* 151–166.

McKeganey, N., Neale, J. & Robertson, M. (2005). Physical and Sexual Abuse Among Drug users Contacting Drug Treatment Services in Scotland. Drugs: Education, Prevention and Policy, 12(3), 223-232.

McLean, C. P., Rosenbach, S. B., Capaldi, S., & Foa, E. B. (2013). Social and academic functioning in adolescents with child sexual abuse-related PTSD. *Child Abuse & Neglect, 37*, 675–678.

McNally, A. M., Palfai, T. P., Levine, R. V., & Moore, B. M. (2003). Attachment dimensions and drinking-related problems among young adults: The mediational role of coping motives. *Addictive Behaviors, 28,* 1115–1127.

McNaughton, C. C. (2008). Transitions through homelessness, substance use, and the effect of material marginalization and psychological trauma. *Drugs (Abingdon, England), 15(2),* 177–188

Mendus, S. (2005). Feminism. In T. Honderich, (Ed). *The Oxford Companion to Philosophy* (2nd ed., pp. 291–294). Oxford University Press.

Merleau-Ponty, M. (1945/1962). *Phenomenology of Perception*. London: Routledge.

Merriam-Webster. (n.d.). Epistemology. In *Merriam-Webster.com dictionary*. Retrieved August 3, 2021, from https://www.merriam-webster.com/dictionary/epistemology

Merriam-Webster. (n.d.). Ontology. In *Merriam-Webster.com dictionary*. Retrieved August 3, 2021, from https://www.merriam-webster.com/dictionary/ontology

Messina, N. & Grella, C. (2008). *Einal Report of the Gender Responsive Treatment for Women in Prison Prcject.* Submitted to the National Institute on Drug Abuse, Rockville, MD.

Messman-Moore, T. L., & Bhuptani, P. H. (2017). A review of the long-term impact of child maltreatment on posttraumatic stress disorder and its comorbidities: An emotion dysregulation perspective. *Clinical Psychology: Science and Practice, 24*(2), 154–169.

Miler, N. S. & Gold, M. S. (1993). A Hypothesis for a common neurochemical basis for alcohol and drug disorders. *Psychiatric Clinics of North America, 16(1),* 105-117.

Milton, M. (Ed.). (2010). *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues.* John Wiley & Sons, Ltd.

Minnes, S., Singer, L. T., Humphrey-Wall, R., & Satayathum, S. (2008). Psychosocial and

behavioral factors related to the post-partum placements of infants born to cocaine-using women. *Child Abuse & Neglect, 32(3),* 353–366.

Miranda, R., Meyerson, L. A., Long, P. J., Marx, B. P., & Simpson, S. M. (2002). Sexual assault and alcohol use: Exploring the self-medication hypothesis. *Violence and Victims, 17*, 205-217.

Miron, L. R., Orcutt, H. K., Hannan, S. M., & Thompson, K. L. (2014). Childhood abuse and problematic alcohol use in college females: The role of self-compassion. *Self and Identity, 13,* 364–379.

Miron, L. R., Seligowski, A. V., Boykin, D. M., & Orcutt, H. K. (2016). The potential indirect effect of childhood abuse on posttrauma pathology through self-compassion and fear of self-compassion. *Mindfulness, 7*, 596–605.

Molnar, B. E., Buka, S. L., & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: results from the National Comorbidity Survey. *American Journal of Public Health, 91(5*), 753–760.

Moretti, M. M., & Craig, S. G. (2013). Maternal versus paternal physical and emotional abuse, affect regulation and risk for depression from adolescence to early adulthood. *Child Abuse & Neglect, 37(1),* 4–13.

Morris, M., Compas, B., & Garber, J. (2012). Relations among posttraumatic stress disorder, comorbid major depression, and HPA function: a systematic review and meta-analysis. *Clinical Psychology Review, 32(4),* 301–315.

Morrissey, J., Jackson, E., Ellis, A., Amaro, H., Brown, V., & Najavits, L. (2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services*, *56*(10), 1213–1222.

Morrison, D. M., Golder, S., Keller, T. E., & Gillmore, M. R. (2002). The theory of reasoned action as a model of marijuana use: tests of implicit assumptions and applicability to high-risk young women. *Psychology of Addictive Behaviors : Journal of the Society of Psychologists in Addictive Behaviors*, *16(3),* 212–224.

Morrison, S. E., Bruce, C., & Wilson, S. (2018). Children's disclosure of sexual abuse: A systematic review of qualitative research exploring barriers and facilitators. *Journal of Child Sexual Abuse, 27*, 176–194.

Moylan, P. L., Jones, H. E., Haug, N. A., Kissin, W. B., & Svikis, D. S. (2001). Clinical and psychosocial characteristics of substance-dependent pregnant women with and without PTSD. *Addictive Behaviors, 26(3)*, 469–474.

Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1993). Childhood sexual abuse and mental health in adult life. *The British Journal of Psychiatry : The Journal of Mental Science, 163,* 721–732.

Murray, L. K., Nguyen, A., & Cohen, J. A. (2014). Child sexual abuse. *Child and Adolescent*

Psychiatric Clinics of North America, 23(2), 321–337.

Musher-Eizenman, D. R., Holub, S. C., & Arnett, M. (2003). Attitude and peer influences on adolescent substance use: the moderating effect of age, sex, and substance. *Journal of Drug Education*, *33*(*1),* 1–23.

Najavits, L. M. (2009). Psychotherapies for Trauma and Substance Abuse in Women. Trauma, *Violence & Abuse, 10(3),* 290-298.

Najavits, L. M., Harned, M. S., Gallop, R. J., Butler, S. F., Barber, J. P., Thase, M. E., & Crits-Christoph, P. (2007). Six-month treatment outcomes of cocaine-dependent patients with and without PTSD in a multisite national trial. *Journal of Studies on Alcohol and Drugs, 68,* 351–361.

Najavits, L. M., Weiss, R. D., & Shaw, S. R. (1997). The link between substance abuse and posttraumatic stress disorder in women. A research review. *American Journal on Addictions, 6*, 273-283.

Nakhaee, N., & Jadidi, N. (2009). Why do some teens turn to drugs? A focus group study of drug users' experiences. *Journal of Addictions Nursing, 20*(4), 203–208.

Nansel, T. R., Overpeck, M., Pilla, R. S., Ruan, W. J., Simons-Morton, B., & Scheidt, P. (2001). Bullying behaviors among US youth: prevalence and association with psychosocial adjustment. *JAMA*, *285(16),* 2094–2100.

Naples, N. A. (2017). Feminist Standpoint Theory. In *The Blackwell Encyclopedia of Sociology* (pp. 1–6). John Wiley & Sons, Ltd.

Naqavi, M. R., Mohammadi, M., Salari, V., & Nakhaee, N. (2011). The Relationship between Childhood Maltreatment and Opiate Dependency in Adolescence and Middle Age. *Addiction & Health*, *3(3-4),* 92–98.

Naranjo, C. A., Tremblay, L. K., & Busto, U. E. (2001). The role of the brain reward system in depression. *Progress in Neuro-psychopharmacology & Biological Psychiatry*, *25(4),* 781–823.

Narvaez, J. C., Magalhães, P. V., Trindade, E. K., Vieira, D. C., Kauer-Sant'anna, M., Gama, C. S., von Diemen, L., Kapczinski, N. S., & Kapczinski, F. (2012). Childhood trauma, impulsivity, and executive functioning in crack cocaine users. *Comprehensive Psychiatry*, *53*(3), 238–244.

Nathanson, D. L. (1992). *Shame and pride: Affect, sex, and the birth of the self*. New York, NY: Norton.

Neale, J. (2004). Gender and illicit drug use. *British Journal of Social Work, 34(6),* 851–870.

Neale, J., Nettleton, S., & Pickering, L. (2014). Gender sameness and difference in recovery from heroin dependence: a qualitative exploration. *The International Journal on Drug Policy, 25(1),* 3–12.

Neale, J., Tompkins, C.N.E., Marshall, A.D., Treloar, C., & Strang, J. (2018). Do women with

complex alcohol and other drug use histories want women-only residential treatment?. *Addiction, 113,* 989–997.

Nelson-Zlupko, L., Kauffman, E., & Dore, M. M. (1995). Gender differences in drug addiction and treatment: implications for social work intervention with substance-abusing women. *Social Work, 40(1),* 45–54

Neo, S. H. F., Norton, S., Kavallari, D., & Canfield, M. (2021). Integrated treatment programmes for mothers with substance use problems: A systematic review and meta-analysis of interventions to prevent out-of-home child placements. *Journal of Child and Family Studies.*

Newmann, J., & Sallmann, J. (2004). Women, trauma histories, and co-occurring disorders: Assessing the scope of the problem. *Social Service Review, 78(3),* 466.

NHS. (2018, September 27). Complex PTSD - Post-traumatic stress disorder, National Healthcare System (UK). Retrieved August 14, 2021, from https://www.nhs.uk/mental-health/conditions/post-traumatic-stress-disorder-ptsd/complex/

NHS. (2021a). How to Raise a Safeguarding Concern, National Healthcare System. Retrieved August 18, 2021, from https://www.england.nhs.uk/safeguarding/how-to-raise-a-safeguarding-concern/

NHS. (2021b). Where to Get Urgent Help for Mental Health. Retrieved August 18, 2021, from https://www.nhs.uk/mental-health/advice-for-life-situations-and-events/where-to-get-urgent-help-for-mental-health/

NICE (2014). Domestic Violence and Abuse: How Health Services, Social Care and the Organisations they work with can respond effectively. *Public Health Guidance, 50.*

NIDA. (1999, September 1). Drug Abuse and Addiction Research: 25 Years of Discovery to Advance the Health of the Public. Retrieved August 16, 2021, from https://archives.drugabuse.gov/publications/drug-abuse-addiction-research-25-years-discovery-to-advance-health-public

NIDA. (2004). *InfoFacts: Understanding Drug Abuse and Addiction Under- standing Drug Abuse and Addiction,* National Institute on Drug Abuse: USA.

NIDA. (2021, August 3). *Common Comorbidities with Substance Use Disorders Research Report,* National Institute on Drug Abuse. Retrieved August 16, 2021, from https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders

Noll, J. G., Trickett, P. K., Long, J. D., Negriff, S., Susman, E. J., Shalev, I., Putnam, F. W. (2017). Childhood sexual abuse and early timing of puberty. *Journal of Adolescent Health,* 60, 65–71.

Norman, S. B., Tate, S. R., Anderson, K. G., & Brown, S. A. (2007). Do trauma history and

PTSD symptoms influence addiction relapse context? *Drug and Alcohol Dependence, 90,* 89-96.

Oakley, A. (1998). Gender, methodology and people's ways of knowing: Some problems with feminism and the paradigm debate in social science. *Sociology, 32(4)*, 707–731.

ONS. (2020a). *Drug misuse in England and Wales: year ending March 2020.* Office for National Statistics, Retrieved August 12, 2021, from https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2020#glossary

ONS. (2020b). *Personal wellbeing in the UK: April 2019 to March 2020.* Office for National Statistics, Retrieved August 12, 2021, from https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/april2019tomarch2020

Orwin, R., Francisco, L., & Bemichon, T. (2001). *Effectiveness of Women's Substance Abuse Treatment Programs: A Meta-Analysis.* Rockville, MD: National Evaluation Data Services, Center for Substance Abuse Treatment.

Paine, M. L., & Hansen, D. J. (2002). Factors influencing children to self-disclose sexual abuse. *Clinical Psychology Review*, *22*(2), 271–295.

Pagano, M. E., Post, S. G., & Johnson, S. M. (2010). Alcoholics anonymous-related helping and the helper therapy principle. *Alcoholism Treatment Quarterly, 29(1),* 23–34.

Palic, S., Zerach, G., Shevlin, M., Zeligman, Z., Elklit, A., & Solomon, Z. (2016). Evidence of complex posttraumatic stress disorder (CPTSD) across populations with prolonged trauma of varying interpersonal intensity and ages of exposure. *Psychiatry Research*, *246*, 692–699.

Paolucci, E., Genuis, M., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *The Journal of Psychology, 135,* 17–36.

Papalia, N. L., Luebbers, S., Ogloff, J. R., Cutajar, M., & Mullen, P. E. (2017). The long-term co-occurrence of psychiatric illness and behavioral problems following child sexual abuse. *Australian and New Zealand Journal of Psychiatry, 51,* 604–613.

Paras, M. L., Murad, M. H., Chen, L. P., Goranson, E. N., Sattler, A. L., Colbenson, K. M., Zirakzadeh, A. (2009). Sexual abuse and lifetime diagnosis of somatic disorders: A systematic review and meta-analysis. *Journal of the American Medical Association, 302*, 550–561.

Parritt, S. (2016). Working with difference and diversity. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.), *The Handbook of Counselling Psychology.* (4th ed., pp. 198-212). London: Sage.

Payne, B. K., Gainey, R. R., & Carey, C. S. (2007). All in the family: Gender, family crimes, and later criminality. *Women & Criminal Justice, 16*, 73–89.

Pearlman, L. A., & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150–177). Brunner/Mazel.

Pereda, N., Guilera, G., Forns, M., & Gómez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: a meta-analysis. *Clinical Psychology Review*, *29*(4), 328–338.

Pérez-Fuentes, G., Olfson, M., Villegas, L., Morcillo, C., Wang, S., & Blanco, C. (2013). Prevalence and correlates of child sexual abuse: a national study. *Comprehensive Psychiatry*, *54*(1), 16–27.

Perry, B. (2009). Examining child maltreatment through a neurodevelopmental lens: clinical applications of the neurosequential model of therapeutics. *Journal of Loss & Trauma, 14(4),* 240–255.

Phanichrat, T., & Townshend, J. M. (2010). Coping strategies used by survivors of childhood sexual abuse on the journey to recovery. *Journal of Child Sexual Abuse, 19,* 62–78.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Psychological Journal, 20(1)*, 7-14.

Piko, B. F., & Balázs, M. Á. (2012). Authoritative parenting style and adolescent smoking and drinking. *Addictive Behaviors*, *37*(3), 353–356.

Piotrowski, C. C. (2020). Chapter 15: ACEs and trauma-informed care. In G. J. G. Asmundson & T. O. Afifi, (Eds). *Adverse Childhood Experiences: Using Evidence to Advance Research, Practice, Policy, and Prevention* (pp. 307-328). Academic Press.

Platt, M. G., & Freyd, J. J. (2012). Trauma and negative underlying assumptions in feelings of shame: An exploratory study. *Psychological Trauma: Theory, Research, Practice, and Policy, 4,* 370–378.

Platt, M. G., Luoma, J. B., & Freyd, J. J. (2017). Shame and dissociation in survivors of high and low betrayal trauma. *Journal of Aggression, Maltreatment & Trauma, 26(1),* 34–49.

Ponterotto, J. G. (2005). Qualitative Research in Counseling Psychology: A Primer on Research Paradigms and Philosophy of Science. *Journal of Counseling Psychology*, *52*(2), 126-136.

Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry, 42(3),* 269–278.

Puurunen, K., & Vis, J.A. (2019). Pregnancy as an opportunity for trauma-intervention among women who are addicted to substances. *Journal of Aggression, Maltreatment & Trauma, 28(3),* 281–296.

Radford, L., Corral, S., Bradley, C. & Fisher, H.L. (2013). The prevalence and impact of child maltreatment and other types of victimisation in the UK: Findings from a population survey of caregivers, children and young people and young adults. *Child Abuse & Neglect, 37(10),* 801-813.

Ramazanoglu, C. (2012). *Feminism and the contradictions of oppression*. Routledge.

Rao, U., Ryan, N. D., Dahl, R. E., Birmaher, B., Rao, R., Williamson, D. E., & Perel, J. M. (1999). Factors associated with the development of substance use disorder in depressed adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *38(9),* 1109–1117.

Reeves, E. (2015). A Synthesis of the Literature on Trauma-Informed Care. *Issues in Mental Health Nursing, 36(9),* 698–709.

Reffi, A. N., Boykin, D. M., & Orcutt, H. K. (2019). Examining pathways of childhood maltreatment and emotional dysregulation using self-compassion. *Journal of Aggression, Maltreatment & Trauma, 28(10),* 1269–1285.

Rhodes, T., Lilly, R., Fernández, C., Giorgino, E., Kemmesis, U. E., Ossebaard, H. C., Lalam, N., Faasen, I., & Spannow, K. E. (2003). Risk Factors Associated With Drug Use: The importance of 'risk environment'. *Drugs: Education, Prevention & Policy, 10(4),* 303–329.

Rhodes, T., & Moore, D. (2001). On the qualitative in drugs research. *Addiction Research and Theory*, *9*(4), 1–19.

Rich, S. L., Wilson, J. K., & Robertson, A. A. (2016). The Impact of Abuse Trauma on Alcohol and Drug Use: A Study of High-Risk Incarcerated Girls. *Journal of Child & Adolescent Substance Abuse, 25(3),* 194–205.

Riessman, F. (1990). Restructuring help: A human services paradigm for the 1990s. *Community Psychology, 18(2),* 221–230.

Riessman, F. (1997). Ten self-help principles. *Social Policy, (3),* 6–12.

Riger, S. (1992). Epistemological debates, feminist voices: Science, social values, and the study of women. *American Psychologist, 47(6),* 730–740.

Robohm, J. S., & Buttenheim, M. (1997). The Gynecological Care Experience of Adult Survivors of Childhood Sexual Abuse: A Preliminary Investigation. *Women & Health, 24(3),* 59–75.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95 -103.

Rolin, K. (2006). The Bias Paradox in Feminist Standpoint Epistemology, *Episteme, 3(1–2),* 125–37.

Romans, S. E., Martin, J. L., Anderson, J. C., O'Shea, M. L., & Mullen, P. E. (1995). Factors

that mediate between child sexual abuse and adult psychological outcome. *Psychological Medicine, 25(1),* 127–142.

Romans, S. E., Martin, J. L. & Mullen, P. (1994). Child sexual abuse (CSA) and later eating disorders: a New Zealand epidemiological study. *Neuropsychopharmacology, 10*, 92.

Ross, C. A., Engle, M. C., & Baker, B. (2019). Reductions in symptomatology at a residential treatment center for substance use disorders. *Journal of Aggression, Maltreatment & Trauma, 28(10),* 1173–1180.

Ross, N. (1948) War Stress and Neurotic Illness: By Abram Kardiner, M.D. with the collaboration of Herbert Spiegel, M.D. Second Edition of The Traumatic Neuroses of War. New York: Paul B. Hoeber, Inc., *Psychoanalytic Quarterly 17,* 102-103

Roy, R. (2018). Psychosocial Factors Contributing Towards Substance Abuse among Adolescents – A Qualitative Study. *Journal of Psychosocial Research, 13(2)*, 425-433.

Saathoff-Wells, T., Culp, R., & Yancey, C. (2005). Expectancies of sexually abused children: Evidence of perceiver bias. *Journal of Child and Family Studies, 14(4),* 487–503.

Sacks, J. Y., McKendrick, K., & Banks, S. (2008). The impact of early trauma and abuse on residential substance abuse treatment outcomes for women. *Journal of Substance Abuse Treatment, 34(1),* 90–100.

Salisbury, E. J., & Van Voorhis, P. (2009). Gendered pathways: A quantitative investigation of women probationers' paths to incarceration. *Criminal Justice and Behavior, 36,* 541–566.

SAMHSA. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-informed Approach.* Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved August 12, 2021, from https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

SAMHSA. (2015a). *A guide to GPRA data collection using trauma-informed interviewing skills.* Washington, DC: Substance Abuse and Mental Health Services Administration.

SAMHSA. (2015b). *Core competencies for peer workers in behavioral health services*. Substance Abuse and Mental Health Services Administration. Retrieved August 12, 2021, from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies.pdf

SAMHSA. (2019). *National Survey on Drug Use and Health: Detailed Tables*, United States, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality.

SAMHSA. (2021). *National Survey Of Substance Abuse Treatment Services (N-Ssats):*

2020, Data On Substance Abuse Treatment Facilities, Substance Abuse and Mental Health Service Administration.

Sanders, J., Hershberger, A. R., Kolp, H. M., Um, M., Aalsma, M., & Cyders, M. A. (2018). PTSD symptoms mediate the relationship between sexual abuse and substance use risk in juvenile justice–involved youth. *Child Maltreatment*, *23*(3), 226–233.

Sarangi, L., Acharya, H. P., & Panigrahi, O. P. (2008). Substance abuse among adolescents in urban slums of sambalpur. *Indian Journal of Community Medicine: Official Publication of Indian Association of Preventive & Social Medicine*, *33*(4), 265–267.

Sartor, C. E., Waldron, M., Duncan, A. E., Grant, J. D., McCutcheon, V. V., Nelson, E. C., Madden, P. A. F., Bucholz, K. K., & Heath, A. C. (2013). Childhood sexual abuse and early substance use in adolescent girls: the role of familial influences. *Addiction, 108(5)*, 993–1000.

Sartre, J. P. (1956/1943). *Being and nothingness*. New York: Washington Square Press.

Scannell, C. (2021). By helping others we help ourselves: insights from peer support workers in substance use recovery. *Advances in Mental Health,* 1–10.

Scherrer, J. F., Xian, H., Pan, H., Pergadia, M. L., Madden, P. A., Grant, J. D., Sartor, C. E., Haber, J. R., Jacob, T., & Bucholz, K. K. (2012). Parent, sibling and peer influences on smoking initiation, regular smoking and nicotine dependence. Results from a genetically informative design. *Addictive Behaviors*, *37*(3), 240–247.

Schimmenti, A., & Caretti, V. (2016). Linking the overwhelming with the unbearable: Developmental trauma, dissociation, and the disconnected self. *Psychoanalytic Psychology, 33(1),* 106–128.

Schönbucher, V., Maier, T., Mohler-Kuo, M., Schnyder, U., & Landolt, M. A. (2012). Disclosure of child sexual abuse by adolescents: a qualitative in-depth study. *Journal of Interpersonal Violence*, *27*(17), 3486–3513.

Schönbucher, V., Maier, T., Mohler-Kuo, M., Schnyder, U., & Landolt, M. A. (2014). Adolescent Perspectives on Social Support Received in the Aftermath of Sexual Abuse: A Qualitative Study. *Archives of Sexual Behavior, 43(3),* 571–586.

Schultz, K., Teyra, C., Breiler, G., Evans-Campbell, T., & Pearson, C. (2018). "they gave me life": Motherhood and recovery in a tribal community. *Substance Use & Misuse, 53(12),* 1965–1973.

Schulz, K. F., & Grimes, D. A. (2005). Sample size calculations in randomised trials: Mandatory and mystical. *The Lancet, 365*(9467), 1348-1353.

Scotland J. (2012). Exploring the philosophical underpinnings of research: relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching, 5(9),* 9–16.

Scott, C. K., Dennis, M. L., & Lurigio, A. J. (2015). Comorbidity among female detainees in

drug treatment: An exploration of internalizing and externalizing disorders. *Psychiatric Rehabilitation Journal, 38,* 35–44.

Scott, C. K., Grella, C. E., Dennis, M. L., & Funk, R. R. (2014). Predictors of recidivism over three years among substance-using women released from jail. *Criminal Justice and Behavior, 41*, 1257–1289.

Shaaf, K. K., & McCanne, T. R. (1998). Relationship of childhood sexual, physical, and combined sexual and physical abuse to adult victimization and posttraumatic stress disorder. *Child Abuse and Neglect, 22,* 1119-1133.

Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology, 7,* 233-243.

Shields, A., & Cicchetti, D. (1998). Reactive aggression among maltreated children: The contributions of attention and emotion dysregulation. *Journal of Clinical Child Psychology, 27(4),* 381–395.

Shin, S. H., Hong, H. G., & Hazen, A. L. (2010). Childhood sexual abuse and adolescent substance use: A latent class analysis. *Drug and Alcohol Dependence, 109(1–3),* 226–235.

Shinebourne, P. (2011). The theoretical underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis, 22(1)*, 16–31.

Shipman, K., Zeman, J., Penza, S., & Champion, K. (2000). Emotion management skills in sexually maltreated and nonmaltreated girls: A developmental psychopathology perspective. *Development and Psychopathology, 12(1),* 47–62.

Shonkoff, J. P., Garner, A. S., Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, & Section on Developmental and Behavioral Pediatrics (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, *129(1),* e232–e246.

Simantov, E., Schoen, C., & Klein, J. D. (2000). Health-compromising behaviors: why do adolescents smoke or drink?: identifying underlying risk and protective factors. *Archives of Pediatrics & Adolescent Medicine*, *154*(10), 1025–1033.

Simons-Morton, B., Haynie, D. L., Crump, A. D., Eitel, S. P., & Saylor, K. E. (2001). Peer and parent influences on smoking and drinking among early adolescents. *Health Education & Behavior : The Official Publication of the Society for Public Health Education*, *28*(1), 95–107.

Simpson, S., Yahner, J., & Dugan, L. (2008). Understanding women's pathways to jail: Analysing the lives of incarcerated women. *Australian and New Zealand Journal of Criminology, 41,* 84–108.

Singh, A. A., Garnett, A., & Williams, D. (2013). Resilience strategies of African American

women survivors of child sexual abuse: A qualitative inquiry. *Counseling Psychologist,* 41, 1093–1124.

Singh, A. A., Hays, D. G., Chung, Y. B., & Watson, L. (2010). South Asian immigrant women who have survived child sexual abuse: Resilience and healing. *Violence Against Women, 16*, 444–458.

Siqveland, J., Ruud, T., & Hauff, E. (2017). Post-traumatic stress disorder moderates the relationship between trauma exposure and chronic pain. *European Journal of Psychotraumatology, 8(1),* 1–9.

Skeer, M. R., McCormick, M. C., Normand, S. L., Mimiaga, M. J., Buka, S. L., & Gilman, S. E. (2011). Gender differences in the association between family conflict and adolescent substance use disorders. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, *49*(2), 187–192.

Smith, D. E. (1987). *The everyday world as problematic: A feminist sociology*. Toronto, Canada: University of Toronto Press.

Smith, D. E. (1991). Writing women's experiences into social science. *Feminism & Psychology, 1(1)*, 155–169

Smith, D. W., Letourneau, E. J., Saunders, B. E., Kilpatrick, D. G., Resnick, H. S., & Best, C. L. (2000). Delay in disclosure of childhood rape: Results from a national survey. *Child Abuse & Neglect, 24,* 273–287.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11,* 261-271.

Smith, J. A. (2008). Introduction. In J. A.Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed.) (pp. 1-7). London: Sage.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*(1), 9-27.

Smith, J. A., & Eatough, V. (2007). Interpretative Phenomenological Analysis. In E. Lyons & A. Coyle (Eds.), *Analysing Qualitative Data in Psychology* (pp. 35-51). London: SAGE Publications.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Smith, J. A., Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & Chamberiain (Eds.), *Qualitative Health Psychology: Theories and Methods* (pp. 218–240). London: Sage Publications.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53-80). London, UK: Sage.

Snedker, K., Herting, J., & Walton, E. (2009). Contextual Effects and Adolescent Substance Use: Exploring the Role of Neighborhoods. *Social Science Quarterly, 90*(5), 1272-1297.

Solis, J. M., Shadur, J. M., Burns, A. R., & Hussong, A. M. (2012). Understanding the diverse needs of children whose parents abuse substances. *Current Drug Abuse Reviews*, *5*(2), 135–147.

Spaccarelli, S. (1994). Stress, appraisal, and coping in child sexual abuse: a theoretical and empirical review. *Psychological Bulletin, 116*, 340-362.

Spaccarelli, S. & Kim, S. (1995). Resilience criteria and factors associated with resilience in sexually abused girls. *Child Abuse and Neglect, 19*, 1171-1182.

Speck, V., Schlereth, T., Birklein, F., & Maihofner, C. (2017). Increased prevalence of post-traumatic stress disorder in CRPS. *European Journal of Pain, 21(3),* 466–473.

Stacey, J., & Thorne, B. (1985). The missing feminist revolution in sociology. Social Problems, 32(4), 301–316

Staiger, P. K., Melville, F., Hides, L., Kambouropoulos, N., & Lubman, D. I. (2009). Can emotion-focused coping help explain the link be- tween posttraumatic stress disorder severity and triggers for substance use in young adults? *Journal of Substance Abuse Treatment*, *36*, 220–226.

Stanley, L., & Wise, S. (1983). *Breaking Out: Feminist Consciousness and Feminist Research,* London: Routledge and Kegan Paul.

Steine, I. M., Winje, D., Skogen, J. C., Krystal, J. H., Milde, A. M., Bjorvatn, B., Pallesen, S. (2017). Posttraumatic symptom profiles among adult survivors of childhood sexual abuse: A longitudinal study. *Child Abuse & Neglect, 67,* 280–293.

Stevens, A. (2011). *Drugs, Crime and Public Health: The Political Economy of Drug Policy,* London: Routledge.

Stoiber, K. C., & Good, B. (1998). Risk and resilience factors linked to problem behavior among urban, culturally diverse adolescents. *School Psychology Review, 27*(3), 380-397.

Stoltenborgh, M., van Ijzendoorn, M., Euser, E., & Bakermans-Kranenburg, M. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment, 16(2),* 79–101.

Strawbridge, S. & Woolfe, R. (2010). Counselling Psychology: Origins, Developments and Challenges. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of Counselling Psychology* (3rd ed., pp.3-20). London: Sage.

Strine, T. W., Dube, S. R., Edwards, V. J., Prehn, A., Rasmussen, S., Wagenfeld, M.,

Dhingra, S., & Croft, J. B. (2012). Associations between adverse childhood experiences, psychological distress, and adult alcohol problems. *American Journal of Health Behaviors, 36(3),* 408-423.

Sumner, S., Mercy, J., Saul, J., Motsa-Nzuza, N., Kwesigabo, G., Buluma, R., Hillis, S. (2015). Prevalence of sexual violence against children and use of social services–seven countries, 2007–13. *Morbidity and Mortality Weekly Report, 64,* 565–569.

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: What is it and how can we further its development? *Mental Health Review Journal, 21(3),* 174–192.

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. *BJPsych Advances, 24(5),* 319–333.

Sweeney, A., Perôt, C., Callard, F., Adenden, V., Mantovani, N., & Goldsmith, L. (2019). Out of the silence: Towards grassroots and trauma-informed support for people who have experienced sexual violence and abuse. *Epidemiology and Psychiatric Sciences, 1–5.*

Szymanski, D. M. (2005). A feminist approach to working with internalized heterosexism in lesbians. *Journal of College Counseling, 8,* 74-85.

Szymanski, D. M., Kashubeck-West, S., & Meyer, J. (2008). Internalized heterosexism: A historical and theoretical overview. *The Counseling Psychologist, 36(4),* 510-524.

Taşören, A. B. (2017). Drug use and self-harming behavior among incarcerated men: Does childhood abuse, anger, and executive function make a difference? *Journal of Aggression, Maltreatment & Trauma, 26(9),* 1006–1023.

Tanaka, M., Wekerle, C., Schmuck, M. L., & Paglia-Boak, A. MAP Research Team. (2011). The linkages among childhood maltreatment, adolescent mental health, and self-compassion in child welfare adolescents. *Child Abuse & Neglect, 35*, 887–898.

Tavris, C. (1993). The mismeasure of woman. *Feminism & Psychology, 3(2),* 149–168.

Taylor, A. (1993). Women Drug Users: An Ethnography of a Female Injecting Community. *Choice (Chicago, Ill.), 31(05),* 31-2762-31–2762.

Taylor, O. D. (2011). Adolescent depression as a contributing factor to the development of substance use disorders. *Journal of Human Behavior in the Social Environment, 21*(6), 696–710.

Temple, S. D. (2003). Schema therapy: A practitioner's guide. *The American Journal of Psychiatry*, *160*(11), 2074-a-2075.

Testa, M., Kubiak, A., Quigley, B. M., Houston, R. J., Derrick, J. L., Levitt, A., Homish, G. G.,

& Leonard, K. E. (2012). Husband and wife alcohol use as independent or interactive predictors of intimate partner violence. *Journal of Studies on Alcohol and Drugs, 73(2),* 268–276.

Teusch, R. (2001). Substance abuse as a symptom of childhood sexual abuse. *Psychiatric Services*, *52*, 1530-1532.

Tharp-Taylor, S., Haviland, A., & D'Amico, E. J. (2009). Victimization from mental and physical bullying and substance use in early adolescence. *Addictive Behaviors*, *34*(6-7), 561–567.

Thom B. (2010) Women in Recovery, chapter 4 in: Yates R. and Malloch M.(eds) *Tackling Addiction Pathways to Recovery,* London: Jessica Kingsley Publishers.

Thomas, M. S., Crosby, S., & Vanderhaar, J. (2019). Trauma-informed practices in schools across two decades: An interdisciplinary review of research. *Review of Research in Education, 43(1),* 422–452.

Thornberry, T. P., Krohn, M. D., Lizotte, A. J., & Chard-Wierschem, D. (1993). The role of juvenile gangs in facilitating delinquent behavior. *Journal of Research in Crime and Delinquency, 30*(1), 55–87.

Titus, J. C., Godley, S. H., & White, M. K. (2007). A post-treatment examination of adolescents' reasons for starting, quitting, and continuing the use of drugs and alcohol. *Journal of Child & Adolescent Substance Abuse, 16(2),* 31–49.

Tompkins, C. N. E., & Neale, J. (2018). Delivering trauma-informed treatment in a women-only residential rehabilitation service: Qualitative study. *Drugs (Abingdon, England), 25(1),* 47–55.

Tonmyr, L., & Shields, M. (2017). Childhood sexual abuse and substance abuse: A gender paradox? *Child Abuse & Neglect, 63,* 284–294

Tonmyr, L., Thornton, T., Draca, J., & Wekerle, C. (2010). A review of childhood maltreatment and adolescent substance use relationship. *Current Psychiatry Reviews, 6*(3), 223–234.

Toporek, R. L., Gerstein, L., Fouad, N., & Israel, T. (2006). *Handbook for social justice in counseling psychology: Leadership, vision, and action.* Sage.

Treloar, C., Champness, S., Simpson, P. L., & Higginbotham, N. (2000). Critical appraisal checklist for qualitative research studies. T*he Indian Journal of Paediatrics, 67(5),* 347-351.

Tripodi, S. J., & Pettus-Davis, C. (2013). Histories of childhood victimization and subsequent mental health problems, substance use, and sexual victimization for a sample of incarcerated women in the US. *International Journal of Law and Psychiatry*, *36*(1), 30–40.

Trucco, E. M., Colder, C. R., Bowker, J. C., & Wieczorek, W. F. (2011). Interpersonal Goals

and Susceptibility to Peer Influence: Risk Factors for Intentions to Initiate Substance Use during Early Adolescence. *The Journal of Early Adolescence*, *31*(4), 526–547.

Tucker, J. S., Green, H. D., Jr, Zhou, A. J., Miles, J. N., Shih, R. A., & D'Amico, E. J. (2011). Substance use among middle school students: associations with self-rated and peer-nominated popularity. *Journal of Adolescence*, *34*(3), 513–519.

Tummala-Narra, P., Liang, B., & Harvey, M. R. (2007). Aspects of safe attachment in the recovery from trauma. *Journal of Aggression, Maltreatment & Trauma, 14(3),* 1–18.

UK Home Office. (2003). *Vulnerability and involvement in drug use and sex work,* Home Office Research Study 268, London.

Ullman, S. E., Starzynski, L. L., Long, S. M., Mason, G. E., & Long, L. M. (2008). Exploring the relationships of women's sexual assault disclosure, social reactions, and problem drinking. *Journal of Interpersonal Violence*, *23*(9), 1235–1257.

UNODC. (2004), *Substance abuse treatment and care for women: case studies and lessons learned*, United Nations: New York.

UNODC. (2015). *World Drug Report 2015*. United Nations Publication.

UNODC. (2016). *World Drug Report 2016*. United Nations Publication.

UNODC. (2020a). *World Drug Report 2020*. United Nations Publication.

UNODC. (2020b). *World Drug Report 2020- booklet 5: Socioeconomic Characteristics and Drug Use Disorders,* United Nations Publication.

UNODC. (2021). *World Drug Report 2021 - booklet 2: Drug Use and Health Consequences,* United Nations Publication. Retrieved August 12, 2021, from https://www.unodc.org/res/wdr2021/field/WDR21_Booklet_2.pdf

Ussher, J. M. (1995). The nature and long-term effects of childhood sexual abuse: A survey of adult women survivors in Britain. *British Journal of Clinical Psychology, 34,* 177-192.

van der Kolk, B. (2014). *The body keeps score: Brain, mind, and body in the healing of trauma.* New York: Penguin Books.

van Loon, A. M., Koch, T., & Kralik, D. (2004). Care for female survivors of child sexual abuse in emergency departments. *Accident and Emergency Nursing, 12(4),* 208–214.

Velleman, R. D., Templeton, L. J., & Copello, A. G. (2005). The role of the family in preventing and intervening with substance use and misuse: a comprehensive review of family interventions, with a focus on young people. *Drug and Alcohol Review*, *24*(2), 93–109.

Verona, E., Murphy, B., & Javdani, S. (2015). Gendered pathways: Violent childhood maltreatment, sex exchange, and drug use. *Psychology of Violence, 6,* 124–134.

Verona, E., Murphy, B., & Javdani, S. (2016). Gendered pathways: Violent childhood

maltreatment, sex exchange, and drug use. *Psychology of Violence, 6(1),* 124.

Vettese, L. C., Dyer, C. E., Li, W. L., & Wekerle, C. (2011). Does self-compassion mitigate the association between childhood maltreatment and later emotion regulation difficulties? A preliminary investigation. *International Journal of Mental Health and Addiction, 9,* 480– 491.

Vilenica, S., Shakespeare-Finch, J., & Obst, P. (2013). Exploring the process of meaning making in healing and growth after childhood sexual assault: A case study approach. *Counselling Psychology Quarterly, 26*, 39–54.

Violato, C., & Genuis, M. (1993). Problems of research in male child sexual abuse. *Journal of Child Sexual Abuse, 2*, 33–54.

Wagenmans, A., Van Minnen, A., Sleijpen, M., & De Jongh, A. (2018). The impact of childhood sexual abuse on the outcome of intensive trauma-focused treatment for PTSD. *European Journal of Psychotraumatology*, *9(1),* 1430962.

Waldrop, A. E., Back, S. E., Verduin, M. L., & Brady, K. T. (2007). Triggers for cocaine and alcohol use in the presence and absence of posttraumatic stress disorder. *Addictive Behaviors*, *32*, 634–639.

Walker-Barnes, C. J., & Mason, C. A. (2004). Delinquency and substance use among gang-involved youth: the moderating role of parenting practices. *American Journal of Community Psychology*, *34(3-4),* 235–250.

Wallace, J., Smart, A., Jack, M., Thompson, A., & Liddell, D. (2016). Trauma in the childhood stories of people who have injected drugs. *Addiction Research & Theory, 24(2),* 135–151.

Walsh, K., Fortier, M. A., & DiLillo, D. (2009). Adult coping with childhood sexual abuse: A theoretical and empirical review. *Aggression and Violent Behavior, 15,* 1-13.

Whitesell, M., Bachand, A., Peel, J., & Brown, M. (2013). Familial, social, and individual factors contributing to risk for adolescent substance use. *Journal of Addiction, 2013*, 579310.

WHO. (1993). *The ICD-10 Classification of mental and behavioural disorders-diagnostic criteria for research.* World Health Organization, Geneva.

WHO. (2004). *ICD-10: International statistical classification of diseases and related health problems :* tenth revision, 2nd ed. World Health Organization. Retrieved August 10, 2021, from https://apps.who.int/iris/handle/10665/42980

WHO. (2006). *Preventing child maltreatment: A guide to taking action and generating evidence.* Geneva, Switzerland: World Health Organization. Retrieved August 10, 2021, from https://apps.who.int/iris/handle/10665/43499

WHO (2017). Child maltreatment infographic in English: The health sector responds. World

Health Organization. Retrieved August 24, 2021, from http://www.who.int/violence_injury_prevention/violence/child/en/

WHO. (2018). International classification of diseases for mortality and morbidity statistics (11th Revision). Retrieved August 24, 2021, from https://icd.who.int/browse11/l-m/en

Widom, C. S. (2014). The 2013 Sutherland address: Varieties of violent behavior. *Criminology*, *52*(3), 313–344.

Wigginton, B., & Lafrance, M. N. (2019a). Doing critical feminist research: A Feminism & Psychology reader. *Feminism & Psychology, 29(4),* 534-552.

Wigginton, B., & Lafrance, M. N. (2019b). Learning critical feminist research: A brief introduction to feminist epistemologies and methodologies. *Feminism & Psychology,* 1-17.

Willig, C. (2008) *Introducing qualitative research in psychology* (2nd ed.), Maidenhead: Open University Press.

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper (Ed.), *The handbook of research methods in psychology* (pp.5-21). Washington, DC: American Psychological Association.

Willig, C. (2013). *Introducing Qualitative Research in Psychology*. Maidenhead: Open University Press.

Willig, C. (2017). Interpretation in qualitative research. In C. Willig & W. Rogers *The SAGE Handbook of qualitative research in psychology* (pp. 274-288). London: SAGE Publications.

Wills, T. A., Sandy, J. M., Yaeger, A. M., Cleary, S. D., & Shinar, O. (2001). Coping dimensions, life stress, and adolescent substance use: a latent growth analysis. *Journal of Abnormal Psychology, 110(2),* 309–323.

Wilsnack, S. C., Vogeltanz, N. D., Klassen, A. D., & Harris, T. R. (1997). Childhood sexual abuse and women's substance abuse: National survey findings. *Journal of Studies on Alcohol, 58,* 264-271.

Wilson, J., Fauci, J., & Goodman, L. (2015). Bringing trauma-informed practice to domes- tic violence programs: a qualitative analysis of current approaches. *American Journal of Orthopsychiatry, 85(6),* 586–599.

Wincup, E. (2001). Surviving through substance use: the role of substances in the lives of women who appear before the courts. *Sociological Research Online, 4(4).*

Wincup, E. (2016), Gender, recovery and contemporary UK drug policy. *Drugs and Alcohol Today, 16(1),* 39-48.

Wonderlich, S. A., Brewerton, T. D., Jocic, Z., Dansky, B. S., & Abbott, D. W. (1997). Relationship of childhood sexual abuse and eating disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 36(8),* 1107–1115.

Wright, M. O. D., Fopma-Loy, J., & Fischer, S. (2005). Multidimensional assessment of resilience in mothers who are child sexual abuse survivors. *Child Abuse & Neglect, 29*, 1173–1193.

Wu, N. S., Schairer, L. C., Dellor, E., & Grella, C. (2010). Childhood trauma and health outcomes in adults with comorbid substance abuse and mental health disorders. *Addictive Behaviors, 35,* 68–71.

Wu, P., Bird, H. R., Liu, X., Fan, B., Fuller, C., Shen, S., Duarte, C. S., & Canino, G. J. (2006). Childhood depressive symptoms and early onset of alcohol use. *Pediatrics*, *118*(5), 1907–1915.

Wylie, A. (2009). Social Constructionist Arguments in Harding's Science and Social Inequality. *Hypatia, 23(4),* 201–11.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15,* 215-228.

Yardley, L. (2008). Demonstrating validity in qualitative psychology, in J. A. Smith (Ed.) *Qualitative psychology: A practical guide to methods* (2nded.). London: Sage.

Yeatmann, A. (1997). Feminism and Power, In M. L. Shanley & U. Narayan (Eds.). *Reconstructing Political Theory: Feminist Perspectives*, University Park, Pennsylvania: The Pennsylvania State University Press.

Young, I. M. (1992). Five Faces of Oppression, In T. Wartenberg (Ed.). *Rethinking Power*, Albany, NY: SUNY Press.

Young, J. E. (1999). *Cognitive therapy for personality disorders: A schema-focused approach* (3rd ed.). Professional Resource Press/Professional Resource Exchange.

Yufik, T., & Simms, L. J. (2010). A meta-analytic investigation of the structure of posttraumatic stress disorder symptoms. *Journal of Abnormal Psychology*, *119*, 764–776.

Zolotor, A., Runyan, D., Dunne, M., Jain, D., Peturs, H., Ramirez, C., Isaeva, O. (2009). ISPCAN Child Abuse Screening Tools Children's Version (ICAST-C): Instrument development and multi-national pilot testing. *Child Abuse & Neglect, 33,* 833–841.

Appendices

Appendix A: Recruitment Flyer

Printed Version

Department of Psychology
City, University of London

PARTICIPANTS NEEDED
FOR RESEARCH
ON SUBSTANCE MISUSE
& CHILDHOOD SEXUAL TRAUMA
IN WOMEN

We are looking for volunteers to take part in a study of **women with a history of frequent illicit drug use** and **experiences of childhood sexual trauma**.

As a participant in this study, your participation would involve 1 digitally recorded interview session, which is approximately 60 minutes.

In order to participate you must be a woman over 18 years old, with a history of frequent illicit drug use (but not current use), have had a history of childhood sexual abuse, not currently self-harming or having suicidal ideation, and currently attending (or in the past) personal therapy for more than 3 months at the time of your participation.

For more information about this study, or to volunteer for this study, please contact the researcher, Styliani Kyrimi from the Department of Psychology at the email: [redacted]

This study has been reviewed by, and received ethics clearance through the City, University of London Psychology Department Research Ethics Committee.

If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on [redacted] or via email: [redacted] City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at [redacted]

Online Version

PARTICIPANTS NEEDED FOR RESEARCH ON SUBSTANCE MISUSE & CHILDHOOD SEXUAL TRAUMA IN WOMEN

We are looking for volunteers to take part in a study of women with a history of frequent illicit drug use and experiences of childhood sexual trauma.

research email: [redacted]

I want to participate

Supervised by Dr. Jacqui Farrants.

This study has been reviewed by, and received ethics clearance through the City, University of London Psychology Department Research Ethics Committee.

If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on [redacted] or via email: [redacted] City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at [redacted]

WHAT IS INVOLVED IN MY PARTICIPATION?

As a participant in this study, your participation will only involve 1 audio recorded interview session (phone call or video call), which will last approximately 60 minutes.

WHO CAN PARTICIPATE IN THIS STUDY?

In order to participate you must be:

- a woman over 18 years old
- with a history of past frequent illicit drug use, but not current use
- have had a history of childhood sexual abuse
- not currently self-harming or having suicidal ideation
- have participated or are currently participating in therapy for more than 3 months at the time of your participation.

UNTIL WHEN CAN I SHOW INTEREST?

You can request to participate in the study until 30th May 2020.

VOLUNTEER FOR THE STUDY

Send an email or fill in the form to volunteer or request more information about the study.

Research email: [redacted]

Name

Email

Type your message here...

Submit

Appendix B: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Title of study
The Experience of Problematic Drug Use of Women Survivors of Childhood Sexual Abuse: An Interpretive Phenomenological Analysis

Name of principal investigator: Styliani Kyrimi
We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
The purpose of the study is to investigate how women survivors of childhood sexual abuse, who have a history of self-reported problematic drug use, perceive and understand their drug use. The study's duration is from Spring 2019 until September 2020. This study is part of a doctoral thesis for the Professional Doctorate in Counselling Psychology at City University of London.

Why have I been invited?
You have been invited to participate in this study based on the inclusion criteria for participants, which are your age (over 18 years old), your gender (female), your history of problematic drug use, your history of childhood sexual trauma, the absence of current risk (no current self-harm or suicidal ideation), and your participation in personal counselling/therapy. Six women who meet the same criteria will participate in this study.

Do I have to take part?
Your participation in this study is completely voluntary. You may withdraw your participation at any stage, and/or you may avoid answering questions which are felt to be too personal or intrusive. Withdrawing your participation or not wanting to answer any questions will not affect your ability to access the services you currently have access to, or any future services, and you will not be penalized or disadvantaged in any way. It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. Your therapist or anyone else involved in your mental health care will not be informed of your participation. Your participation, or lack of, will have no effect to any services you might be accessing. Once the data you have provided us with has been de-identified or published, you will no longer be able to withdraw them.

What will happen if I take part?

- You will be involved in participating in a one-to-one digitally recorded interview with one of the researchers
- The study will take up to 18 months but your participation will be needed only for one interview meeting
- First you will have a brief phone conversation with the researcher and the information sheet will be sent to you via email. Then you will be asked to respond whether you wish to participate in the study. If you agree to participate, a face-to-face interview meeting will be arranged.
- Your meeting with the researcher for the interview will last for approximately 50-60 minutes
- Personal and in-depth information about your experience will be collected through a semi-structured interview
- The research method used is Interpretative Phenomenological Analysis of interview transcripts. This analysis is used to extract your subjective and unique way of giving meaning to your experiences.
- The interviews will take place at City, University of London.

What do I have to do?

You will participate in a semi-structured interview where you will be invited to share your experience of problematic drug use and any significant life events and experiences, both in childhood and adolescence, that you have found particularly difficult and you feel may be related to your drug use.

What are the possible disadvantages and risks of taking part?

Some of the interview questions may seem too personal or intrusive, or might cause you distress. The severity of this distress may vary according to how comfortable you feel answering questions that relate to your history of sexual trauma you experienced during your childhood and your problematic drug use.

What are the possible benefits of taking part?

By taking part in this study you may benefit through enriching your current understanding regarding your experience of childhood trauma and your experience of problematic drug use, and the possible connection between the two phenomena. This newfound understanding could assist you in processing your past experiences. Potential benefits for others include the promotion of further research regarding this specific group of issues and this particular population.

What will happen when the research study stops?

Your data will be stored in a secure password-protected file that only the researchers will have access to. Your data will not be used in any way if the research study stops, and they will be deleted appropriately. Any hard copies of written material you have provided us with will be securely destroyed.

Will my taking part in the study be kept confidential?

- Before de-identifying the data, only the researcher will have access to them. After de-identifying them they will be used in the written and verbal presentation of the thesis.
- The interviews will be digitally recorded and the audio-documents will be kept in a secure password-protected computer file which only the researcher will have access to.
- Your data will not be used for any future research purposes.
- Your data will not be shared with third parties.
- We will have to break confidentiality by contacting the appropriate authorities only if you report any potential risk to yourself or others, in order to protect your own and others' wellbeing.

- The records will be stored in a secure password-protected computer file for the statutory requirement time (10 years) and will be deleted after that time has passed.

What should I do if I want to take part?
If you want to take part in the study you can contact the researcher on the phone number provided. The researcher will then have a brief conversation with you highlighting potential risks to your participation, and your rights as a participant. During that time you will be able to ask questions in order to reassure your understanding of the process. If you still wish to continue, an interview time and date will be arranged.

What will happen to results of the research study?
The results of this study will be used in the written and oral presentation of a doctoral thesis, and will be used in any possible future publication of said thesis in academic journals. If you wish to receive a copy of the thesis publication or a summary of the results you can let the researcher know, and they will send you one via email.

What will happen if I do not want to carry on with the study?
You may withdraw your participation at any point before the data analysis stage. Because of the nature of the analysis, during the data analysis stage all data from all interviews are collectively analysed, and therefore removing your set of data would be near to impossible. Withdrawing your participation will not affect your ability to access the services you currently have access to, or any future services, and you will not be penalized or disadvantaged in any way.

Who has reviewed the study?
This study has been approved by City, University of London Psychology Research Ethics Committee

Further information and contact details
If you have any questions about the study you can contact the researcher: Styliani Kyrimi at [redacted] or the research supervisor: Dr. Jacqui Farrants at [redacted]

Data Protection Privacy Notice: What are my rights under the data protection legislation?
City, University of London is the data controller for the personal data collected for this research project. Your personal data will be processed for the purposes outlined in this notice. The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.

The rights you have under the data protection legislation, and apply to the personal data collected in this research project, are listed below:
- right to be informed
- right of access
- right to rectification
- right to erasure

For more information, please visit [redacted]

What if I have concerns about how my personal data will be used after I have participated in the research?
In the first instance you should raise any concerns with the research team, but if you are dissatisfied with the response, you may contact the Information Compliance Team at [redacted] or phone [redacted], who will liaise with City's Data Protection Officer [redacted] to answer your query. If you are dissatisfied with City's response you may also complain to the Information Commissioner's Office at [redacted]

What if there is a problem?
The research is undertaken in the UK if you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone [redacted] You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: **The Experience of Problematic drug use of Women Survivors of Childhood Sexual Abuse: An Interpretive Phenomenological Analysis**

You could also write to the Secretary at:
[redacted]
Research Integrity Manager
Research & Enterprise
City, University of London
Northampton Square
London, EC1V 0HB
Email:[redacted]
City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Thank you for taking the time to read this information sheet.

Appendix C: Screening Phone Call Guidance

Introductions, thanking for interest in participation, explain relevance and safeguarding rationale for the phone call, describe that some questions might seem difficult to answer or not necessarily relevant, let participants know that they can opt-out from answering any questions if uncomfortable, prompt participants to ask any questions regarding the process, ask permission to ask questions.

The question below correspond to the inclusion criteria:

- **Do you identify as a woman?**
- **Is English your native language? If not, do you feel confident expressing yourself in English?**
- **Do you have a history of CSA?**
- **Do you have a history of PDU? - brief explanation around frequency and duration of behaviour**
- **How long have you been abstinent from PDU? (Min of 12 months without lapses/relapses)**
- **Have you ever been to therapy? Min of 3 months at time of participation**
- **Have you disclosed your CSA and PDU in therapy?**

If the individual does not respond positively to the above questions, then the researcher will explain how this research would not be suitable for her and thank her again for taking the time to consider participation. Introduce that the next set of questions has to do with mental health and wellbeing.

The questions below correspond to the exclusion criteria:

- **Do you currently use any medication that is impacting negatively your memory, or concentration? (Give examples of reading, watching tv, engaging in a long conversation with a friend)**

The topic we will be discussing during the interview might be distressing at times, therefore it would be important for me to have a general understanding of your current emotional and mental health, would that be ok? If yes, proceed:

- **Do you have any mental health diagnoses? If yes, do you take any medication for it or receive therapy? Are these diagnoses severely impacting on your emotional wellbeing currently to the extent that you felt in crisis?**
- **Have you self-harmed in the past year?**
- **Have you had thoughts/intentions/made plans to end your life in the past year?**

The researcher's clinical skills and experience with relevant populations will be used to assess participants on the above questions. If the researcher deem that risk is moderate/high she will tentatively communicate to the participant that her wellbeing needs to be cared for and prioritised and participation might affect her wellbeing. Therefore maybe participation might not be the soundest decision at this time. If it appears relevant and appropriate based on participant's disclosure, the researcher will let the participants know that they can access A&E if in crisis and will share with her the relevant mental health resources that are mentioned in the debrief forms.

Thank individual again, set date/time/medium for interview.

Appendix D: Interview Schedule

Welcome & Admin	• Nice meeting you
	• Questions regarding participant information sheet
	• Risk assessment
	  ○ Change of circumstances
	  ○ Reasons to not undertake interview
	• Sign consent form
	• Thank you again for coming today
	• Confidentiality
	• It may be the first time you are asked some of these questions. There is no right or wrong answers, so take as much time as you need to think about them and feel free to tell me if they are not clear. If you feel uncomfortable with any of the questions you can choose not to answer them.
	• And finally remind you that information that could identify you will not be published in my study.

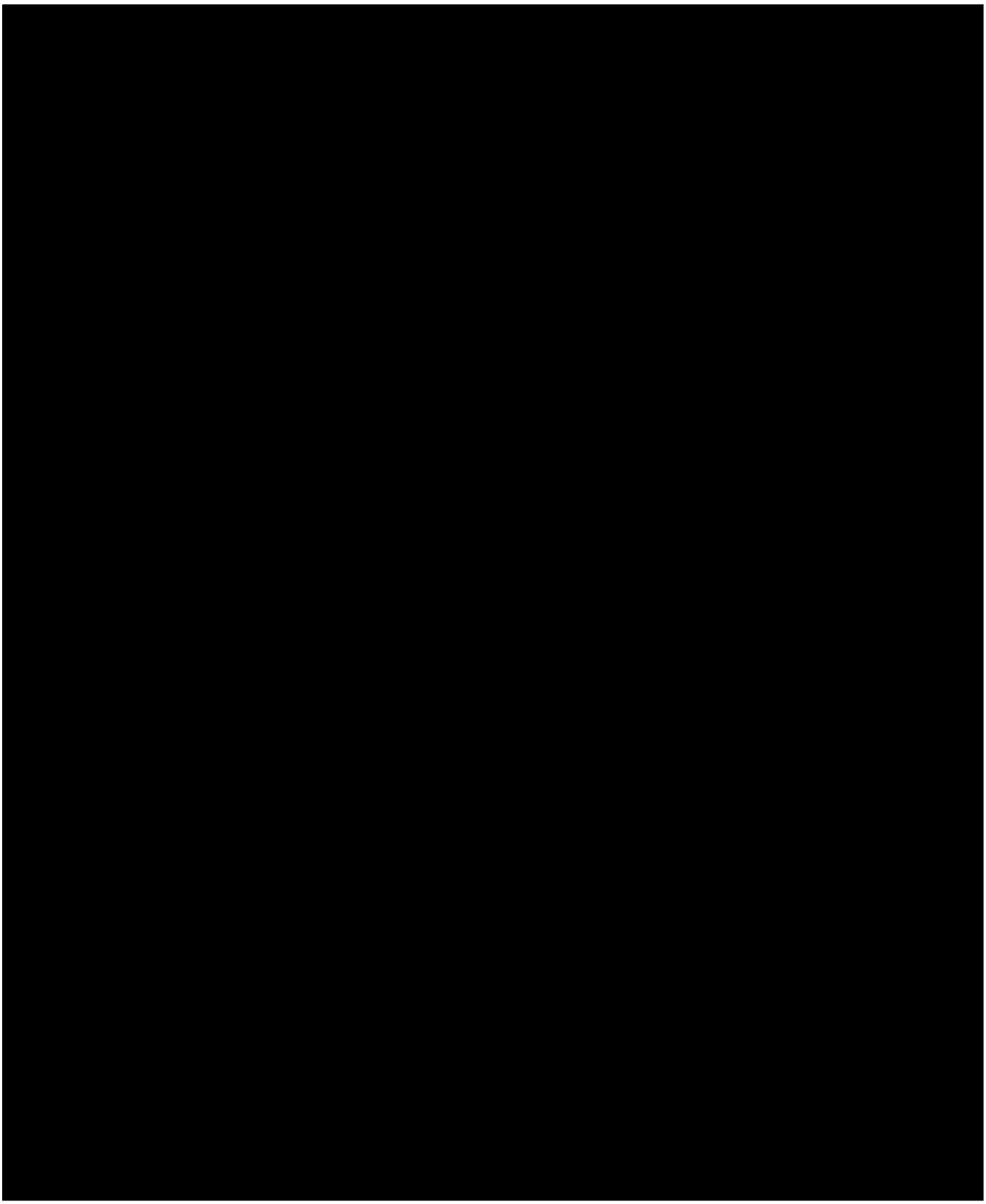
Q1 (Intro)	• I am curious to know how you felt about coming today? • What made you decide to take part in this study?

Q2	• Would you like to tell me a bit about your drug use?
	  ○ *How have you experienced your drug use?*
	  ○ Prompt: type of drugs? when did it start? under what circumstances? What feelings/thoughts do you associate with it?; How has it affected your life?; What does your drug use mean to you? How do you understand your drug use? How has it affected the way you see yourself?

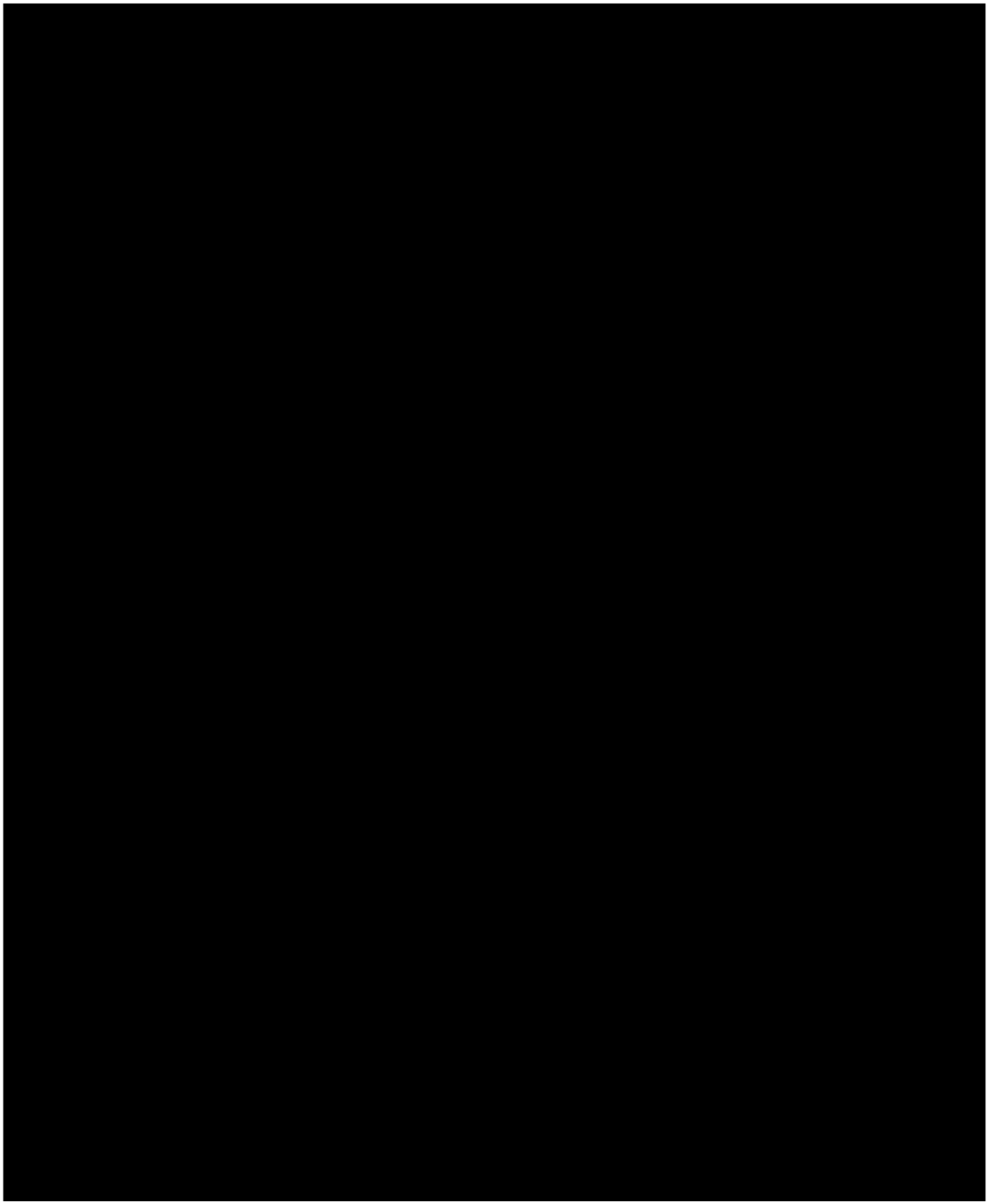
Q3	• Would you like to tell me a bit about the sexual abuse you experienced as a child?
	  ○ *How have you experienced the fact that you were abused sexually as a child?*
	  ○ Prompt: When did it happen? By whom? For how long? What did you do at the time? Tell anyone? Where you the only one? What feelings/thoughts do you associate with it?; How has it affected your life?; How has it affected your relationships?; How has it affected the way you see yourself? How do you understand your abusive childhood?

Q4	• How does this experience of sexual abuse has impacted on your drug use? ○ Prompt: How do you think these two experiences are connected? Would your drug use be different if you weren't abused in childhood?
Q5 (Outro)	• Is there anything you want to add? Any comments/thoughts/ideas? • How did you feel having taken part in this study? • How did it feel to talk about these issues? • Do you feel it raised any difficult feelings or issues for you? ○ Offer debriefing resources • Do you have any further questions about the interview, the purpose, and process of the research?

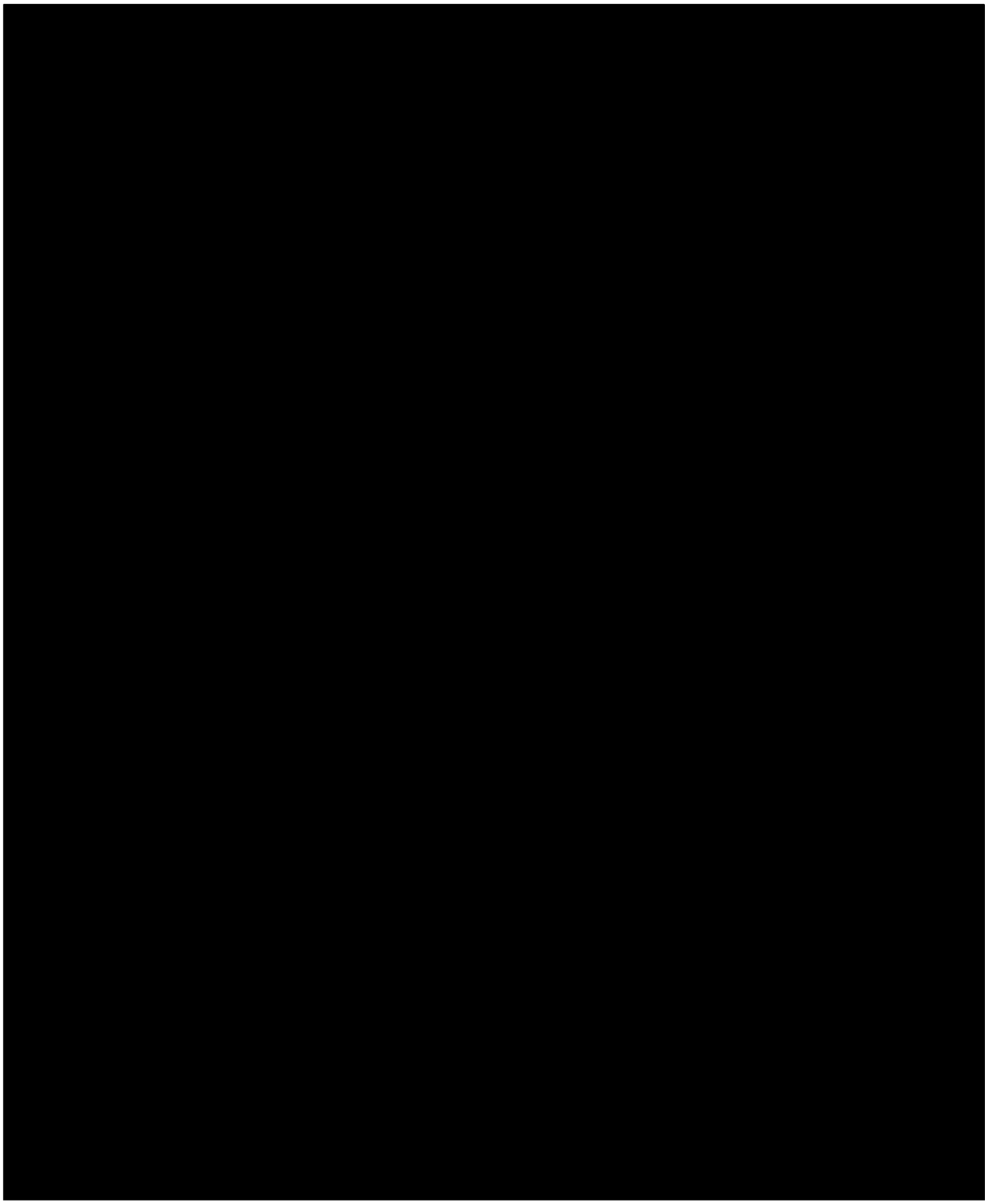
Appendix E: Transcript Extract - Initial Coding



Appendix F: Table of Emergent Themes



Appendix G: Final Themes Table



Appendix H: Ethical Approval

City, University of London

Dear Styliani

Reference: [redacted]

Project title: The Experience of Substance Misuse of Women Survivors of Childhood Sexual Abuse: An Interpretive Phenomenological Analysis

Start date: 3 Jun 2019

End date: 30 Sep 2020

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology committee: medium risk. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

Kind regards

[redacted]

Psychology committee: medium risk

City, University of London

Ethics [redacted]: Styliani Kyrimi (Medium risk)

Appendix I: Informed Consent Form

CONSENT FORM

Title of Study: The Experience of Problematic Drug Use of Women Survivors of Childhood Sexual Abuse: An Interpretive Phenomenological Analysis

		Please initial box
1	I confirm that the project was explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve:	
	• be interviewed by the researcher (once)	
	• allow the interview to be audiotaped	
2	This information will be held by City as data controller and processed for the following purpose: Doctoral research project. Public Task: The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.	
3	I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
4	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any	

	stage of the project without being penalised or disadvantaged in any way.	
5	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose set out in this statement and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
6	I agree to the arrangements for data storage, archiving, sharing.	
7	I agree to the use of anonymised quotes in publication.	
8	I agree to take part in the above study.	

Name of Participant	Name of Researcher
Signature	Signature
Date	Date

Appendix J: Participant Debriefing Sheet

DEBRIEFING INFORMATION

Title of study: The Experience of Problematic Drug Use of Women Survivors of Childhood Sexual Abuse: An Interpretive Phenomenological Analysis

Problematic drug use is a serious problem amongst all genders, both for the individual and the society as a whole. Research shows that the proportion of women who have accessed support services for their problematic drug use and are survivors of childhood sexual abuse (CSA) is particularly high. Improving insight into the experience of problematic drug use by women survivors of CSA, as well as gaining understanding on how women understand and give meaning to these experiences, can have a positive impact on both drug abuse prevention and intervention strategies for this particular population and, consequently, is of vital importance for researchers, clinicians, and society. The purpose of this study is to gain an insight into your own unique way of giving meaning to your experiences in order for researchers to investigate further, and for clinicians to inform their practice to improve the its efficiency.

It is difficult to answer these types of questions, and your generosity and willingness to participate in this study are greatly appreciated. Your input will help contribute to the advancement of the psychological research field, as well as the advancement of clinical and therapeutic practices for women survivors of CSA with problematic drug use. If participating in the interview led you to feel distressed and you would like to speak to someone about your thoughts, please contact one of the following:

Name	**Phone Number**
• SupportLine (mental health helpline)	01708 765200
• Samaritans (mental health helpline)	116 123
• Sane Line (mental health helpline)	0300 304 7000
• NAPAC (helpline for survivors)	0808 801 0331
• The Survivor's Trust (helpline for survivors)	08088 010 818
• DAN 24/7 (drug and alcohol helpline)	0808 808 2234
• Talk to Frank (drug and alcohol helpline)	0300 123 6600
• UK Narcotics Anonymous (drug helpline)	0300 999 1212

Alternatively, if you feel suicidal or feel like harming yourself or other people you can call 999, or go to your nearest Accident and Emergency department (A&E). For non-emergency situations you can visit your GP or your therapist, if you currently have one.

We would ask you to maintain confidentiality about the purpose of the study since any pre-knowledge of the purpose will bias the answers for that person and thus cannot be used in the study.

This study has been approved by City, University of London Psychology Research Ethics Committee. If you have any complaints, concerns, or questions about this research, please feel free to contact, the researcher Styliani Kyrimi at [redacted] or [redacted]. The research is undertaken in the UK if you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone [redacted]. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: **The Experience of Problematic Drug Use of Women Survivors of Childhood Sexual Abuse: An Interpretive Phenomenological Analysis**

You could also write to the Secretary at:
[redacted]
Research Integrity Manager
Research & Enterprise
City, University of London
Northampton Square
London, EC1V 0HB
Email: [redacted]

City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

If you are interested in this area of research, you may wish to read the following references:

- https://oneinfour.org.uk/survivors-resources/
- Burkinshaw, P., knight, J., Anders, P., Eastwood, B., Musto, V., White, M., & Marsden, J. (2017), *An evidence review of the outcomes that can be expected of drug misuse treatment in England.* Public Health England: UK.
- Einci, S., & Kandemir, H. (2015). Childhood trauma in the lives of substance-dependent patients: The relationship between depression, anxiety and self-esteem. *Nordic Journal of Psychiatry, 69, 249-253.*
- EMCDDA (2005), Differences in patterns of drug use between men and women. *Technical Datasheet,* European Monitoring Centre for Drugs and Drug Addiction: Lisbon.
- EMCDDA (2006), A gender perspective on drug use and responding to drug problems. *EMCDDA 2006 Selected Issue,* European Monitoring Centre for Drugs and Drug Addiction: Lisbon.
- EMCDDA (2008), *Statistical Bulletin and Annual report 2008: The State of the Drugs Problem in Europe.* European Monitoring Centre for Drugs and Drug Addiction: Lisbon.
- Hall, M., & Hall, J. (2011). *The long-term effects of childhood sexual abuse: Counseling implications.* Retrieved from http://counselingoutfitters.com/vistas/vistas11/Article_19.pdf
- Medrano, M., Hatch, J., Zule, W., & Desmond, D. (2002). Psychological distress in childhood trauma survivors who abuse drugs. *American Journal of Drug and Alcohol Abuse, 28(1), 1-13.*

- Naqavi, M., Mohammadi, M., Salari, V., & Nakhaee, V. (2011). The relationship between childhood maltreatment and opiate dependency in adolescence and middle age. *Addict & Health, 3(3-4), 92-98.*
- Tonmyr, L., & Shields, M. (2016). Childhood sexual abuse and substance abuse: A gender paradox? *Child Abuse and Neglect, 11(4).*

Thank you very much for participating!

Part B: Case Study/Process Report

A combined Case Study/Process Report using a Cognitive Analytic framework

"Beggars can't be choosers": The struggle to relate to the self and others and the therapeutic relationship as a vehicle for change

Styliani Kyrimi

Word count: 6,596

Part C: Journal Article

“It Was Absolutely Unavoidable”: The Impact of Trauma on Problematic Drug Use for Women Survivors of Childhood Sexual Abuse