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Characteristics of Sexual Assault and Disclosure Among Women in Substance Abuse Recovery Homes

Bronwyn A. Hunter, MA[1], **Emily Robison**[1], and **Leonard A. Jason, PhD**[1]

[1]DePaul University, Chicago, IL, USA

Abstract

Research suggests that many women experience some form of sexual assault in their lifetime and that women who engage in substance abuse often have a higher incidence of past sexual assault than women in the general population. Given the documented rates of sexual assault among women in recovery from substance use, it is important to explore community interventions that promote positive recovery from substance use and sexual assault. One model that promotes successful substance use recovery is the Oxford House—a democratic, self-supported substance use recovery home. Research demonstrated that living in an Oxford House provides sober social support and that this increased social support may promote the use of positive coping strategies to strengthen recovery from substance use, however; the relationship between social support and sexual assault for women is unclear. Thus, the current study examines the Oxford House model for women in recovery from substance use who have experienced sexual assault. A cross-sectional sample of women living in Oxford Houses in the United States was obtained to examine the relationship among disclosure of sexual assault, social support, and self-esteem. Results suggested that many women used Oxford House as a setting in which to disclosure prior sexual assault. Results also indicated that women who disclosed their assault experience reported higher self-esteem and social support than women who had not disclosed. Possible implications include the value of substance abuse recovery homes as a safe, supportive environment for women to address issues related to sexual assault.

Keywords

sexual assault; substance use; disclosure; self-esteem; social support

Research suggests that almost 18% of all women have experienced some form of sexual assault in their lifetime (Tjaden & Thoennes, 2006) and that this experience may lead to many social, mental, and physical health-related consequences. Survivors of sexual assault often face immediate and later physical health problems and are at an increased risk for the development of posttraumatic stress disorder (PTSD), depression, anxiety, and substance use (Elliott, Mok, & Briere, 2004; Hedtke et al., 2008; Kaukinen & DeMaris, 2009; Kimerling & Calhoun, 1994; McCauley et al., 1997; Thompson et al., 2003). Although the negative consequences of sexual assault have been well documented, research has indicated that women do not always seek formal help or treatment to address the consequences of their

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Corresponding Author: Bronwyn A. Hunter, DePaul University, 990 West Fullerton Avenue, Suite 3100, Chicago, IL 60614, USA bhunter@depaul.edu.

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experience (Kaukinen & DeMaris, 2009; Kimerling & Calhoun, 1994; Monroe et al., 2005; Ullman & Filipas, 2001), and several studies have suggested that not all forms of formal assistance are beneficial to survivors (Ahrens, Cabral, & Abeling, 2009; Golding, Siegel, Sorenson, Burnam, & Stein, 1989; Littleton, 2010; Ullman, 2006).

Survivors often disclose their experience of sexual assault to informal and/or formal support systems (Ahrens et al., 2009; Borja, Callahan, & Long, 2006; Golding et al., 1989; Jaques-Tiura, Tkatch, Abbey, & Wegner, 2010; Littleton, 2010; Smith et al., 2000; Starzynski, Ullman, Townsend, Long & Long, 2007; Ullman, 1996; Ullman, 2006; Ullman & Filipas, 2001; Ullman, Starzynski, Long, Mason, & Long, 2008). For example, Ahrens and colleagues (2009) found that 81.36% of survivors had disclosed to at least one person, with similar rates across studies (65.2%; Golding et al., 1989; 80.0%; Starzynski et al., 2007). Even though these rates are high, disclosure is often difficult for survivors, as it may increase vulnerability to reactions of disbelief, blame, help refusal, possible reprisal from the perpetrator(s), and/or relationship challenges (Smith et al., 2000; Ullman, 1999; Ullman & Filipas, 2001). Factors associated with the likelihood of women's disclosure have included the age at which the assault occurred as well as the number of assaults experienced (McCauley et al., 1997; Smith et al., 2000; Ullman, 1999). For example, Smith and colleagues (2000) demonstrated that women who had experienced childhood sexual assault were less likely to disclose than women who had been victimized as an adult and that waiting to disclose after the assault was common. Research has also documented that many women who had experienced abuse as children were also abused as adults (McCauley et al., 1997) and that repeated victimization decreased the likelihood of disclosure (Smith et al., 2000). Furthermore, nondisclosure has been related to low self-esteem, depression, substance use, and an increased risk for subsequent victimization (Ullman & Filipas, 2001).

Disclosure to formal systems, such as police and physicians, is less frequent and may provide less support than disclosure to informal systems, such as family members and friends (Ahrens et al., 2009; Golding et al., 1989; Ullman & Filipas, 2001). Women infrequently report their sexual assault experience to formal systems, which includes physicians (27.1%), police (26.4%), or rape crisis centers (14.1%; Ullman & Filipas, 2001). Although formal support systems have the ability to supply more tangible aid to survivors, women have reported feeling blamed or receiving little emotional support from these providers (Ahrens et al., 2009). Furthermore, negative responses to the disclosure of sexual assault may have adverse effects on a woman's mental and physical health (Jaques-Tiura et al., 2010; Littleton, 2010; Ullman, 2006). For example, Littleton (2010) found that negative disclosure experiences were related to posttraumatic stress symptoms and maladaptive coping strategies.

Although there are potential negative consequences of disclosure, most survivors do report disclosing their experience to at least one person, usually friends and family members (Ahrens et al., 2009; Starzynski et al., 2007). Rates of disclosure to family members and/or friends among assault survivors have ranged from 59.3% (Golding et al., 1989) to 94.2% (Ullman & Filipas, 2001). Positive social support from supportive family members and friends may benefit women who have experienced sexual assault (Borja et al., 2006; Golding et al., 1989; Starzynski et al., 2007). Specifically, the disclosure of an assault experience coupled with a positive response might facilitate recovery from the traumatic experience (Jaques-Tiura et al., 2010; Mason, Ullman, Long, Long, & Starzynski, 2009; Ullman, 2006). For example, Ullman (2006) found that women who had been believed and listened to by others were better adjusted than women who had experienced negative social reactions. Furthermore, disclosure has been related to women's self-esteem, as self-esteem is often negatively impacted by the trauma experience (Jordan, Campbell, & Follingstad, 2010; Neville, Heppner, Oh, Spanierman, & Clark, 2004; Ullman & Filipas, 2001). A negative

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response following disclosure may increase the survivor's self-blame for the assault, which may, in turn, lower self-esteem (Neville et al., 2004). Thus, it is important to examine the relationship between disclosure of an assault experience, social support, and self-esteem among women survivors.

Women in treatment for substance abuse report high rates of past sexual assault (e.g., Gutierres & Van Puymbroeck, 2006; Leserman, 2005; Liebschutz, Savetsky, Saitz, Horton, Lloyd-Travaglini, & Samet, 2002; Simpson & Miller, 2002). For example, 81% of women in detoxification treatment for substance use reported past physical or sexual assault compared with 69% of men (Liebschutz et al., 2002) and women with substance use disorders were two times more likely than women in the general population to have experienced childhood sexual abuse (Simpson & Miller, 2002). Substance use may be an avoidant coping strategy for those who have experienced sexual assault (Leserman, 2005). In addition, research on gender-responsive substance abuse treatment for women has highlighted the need for and current lack of gender-responsive treatment services for women to address their trauma histories during substance abuse treatment (Ashley, Marsden, & Brady, 2003; Greenfield et al., 2007; Greenfield & Pirard, 2009). Given the relationship between substance use and sexual assault, it is important to identify interventions that promote both recovery from substance use and provide a safe place to obtain support surrounding women's experience of sexual assault.

There are benefits of rape crisis centers for individuals who are survivors of sexual assault (Decker & Naugle, 2009). Yet given the low rates of survivors who receive this type of formal service (14.1%; Ullman & Filipas, 2001), it is important to identify additional settings that might provide support to survivors. Furthermore, as many women who use substances are survivors of sexual assault, it is important to highlight community-based settings that provide support surrounding both substance use recovery and sexual assault. One example of a community intervention that may provide informal support for trauma recovery is Oxford House. Oxford House is a network of safe and sober living environments for individuals in recovery from substance use. The structure of Oxford House is unique, as there are no paid staff members or employees, houses are self-supported, and house members democratically run the house themselves. House members contribute to the house by paying rent and completing house chores (Oxford House, 2011). Houses are frequently located in middle-class neighborhoods, are single-sex dwellings, and many allow children (Ferrari, Jason, Sasser, Davis, & Olson, 2006). Oxford Houses do not provide formal substance abuse or trauma treatment, rather; they are an aftercare setting that provides peer-based support for substance abuse recovery (Oxford House, 2011). Research has documented that this environment provides social support and decreases high-risk behaviors such as criminal activity and substance abuse relapse among its members (Jason, Olson, Ferrari, & Lo Sasso, 2006). As a setting, Oxford House promotes a communal living environment that is empowering for its' residents (Maton, 2008), provides abstinence-specific social support (Groh, Jason, Davis, Olson, & Ferrari, 2007) and promotes a high sense of community (Olson et al., 2003). Prior research has established that 84.5% of women Oxford House members reported a history of sexual trauma (Curtis, Jason, Olson, & Ferrari, 2005; Olson et al., 2003) and has proposed this model as an alternative setting for women in domestic violence shelters (Olson et al., 2003). However, research has yet to investigate specific characteristics of survivors of sexual assault and the use of disclosure as a supportive mechanism for women who lived in Oxford House.

The purpose of the present study was to explore the relationships among sexual assault characteristics, disclosure, social support, and self-esteem for women who lived in Oxford Houses and reported an experience of sexual assault. First, we believed that a childhood assault experience or multiple assault experiences would be associated with less disclosure

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of the assault to other house members. We also believed that prior service utilization or disclosure by another house member would be associated with more disclosure to other house members. In addition, we were interested in the relationship between disclosure to Oxford House members and women's self-esteem and perceived social support. We believed that the disclosure of sexual assault would positively influence self-esteem and social support from friends, family, and significant others. It is important to identify characteristics of the women living in Oxford House who have experienced sexual assault and to evaluate how the characteristics of this setting provide social support, contributes to self-esteem, and promotes safe disclosure among this population.

Method

Participants

Women who lived in Oxford Houses located throughout the United States were invited to participate in a larger study exploring factors of empowerment among women in recovery from substance use (Hunter, Jason, & Keys, 2011). The original sample size included 296 women from data collected between September 2009 and June 2010. The present study analyzed data from a subset of 129 women to examine sexual assault variables among women who had completed a revised version of the survey (the survey was revised in January 2010, 2 months after the start of the study, to include additional questions on sexual assault) and who had reported an experience of sexual assault. Within the larger sample of 294 women (2 participants did not answer the sexual assault question), 68.70% (N = 202) reported an experience of sexual assault.

On average, participants were 37.56 years old (SD = 10.76), and most were White (75.6%; N = 93) and African American (14.6%; N = 18). Most participants had completed some college or had a college degree (64.4%; N = 83). Many participants had never been married (47.3%; N = 61) or were divorced (41.9%; N = 54). Although most participants had children (69.0%; N = 89), few had their children living with them at the time of the survey (18.0%; N = 16). The demographic characteristics of women who lived in Oxford House are similar to those of women in other Oxford House studies (Jason et al., 2006).

Most women reported an experience of sexual assault below age 16 (48.8%; N = 63) and had been assaulted more than two times (62.5%; N = 80). Although more than three-fourths of participants knew about services to help them (78.7%; N = 100), slightly more than half of these women reported using services (63.0%; N = 63), and the length of time between the assault occurrence and service utilization ranged from 1 to 300 months (M = 69.79; SD = 87.78; Mdn = 24.00). Almost half of the women (46.8%; N = 59) disclosed to another Oxford House member. On average, women disclosed to four house members (SD = 3.69; Mdn = 3.00). The frequencies of additional sexual assault-specific variables are presented below in Table 1.

Procedure

Women's Oxford Houses in the United States listed in the Oxford House directory (N = 312) were contacted by phone to introduce the study, and residents were asked if house members were (a) interested in participating in the present study and, if yes, (b) preferred an online or paper-based survey. The survey was easily accessed online through SurveyMonkey (2009), a secured web-based data collection tool. Subsequently, each house/individual respondent who indicated they had Internet access in their house, wanted to participate in the online version of the survey, and provided an email address (individual or house) was emailed a link to the SurveyMonkey website to participate in the study.

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Members of Oxford Houses who were not interested in completing the survey online were asked if they would be interested in completing the survey by mail. Each interested house was subsequently mailed a packet that contained copies of the instructions and the surveys with prepaid postage return envelopes for the current number of women residents. Follow-up phone calls were made 4 to 6 weeks after survey distribution to remind house members to complete and return the surveys in the mail. Reminder emails were also sent 4 to 6 weeks after email distribution. Additional data were collected by an Oxford House recruiter from DePaul University, who distributed paper versions of the survey to women residents in the greater Chicago area. All participants were offered the opportunity to be entered into a raffle for a US$25.00 Visa gift card as an incentive for their participation. Of the total sample (N = 296), most respondents completed the survey by mail (N = 173), online (N = 54), and through the Oxford House recruiter (N = 36). Also, 33 women completed the survey at the Oxford House World Convention in September 2009. In total, we mailed 1,086 surveys to 158 Oxford Houses, and 173 surveys were returned for a 15.93% individual response rate, from 29.11% (N = 46) Oxford Houses. For the subset of women who had experienced sexual assault and completed a revised version of the survey, women completed the mail (N = 119) and online (N = 10) surveys.

Measures

Sexual assault—Previous experience of sexual assault was assessed by one question, "Have you ever experienced sexual assault (yes/no)," with the following definition provided: Sexual assault is any nonconsensual sexual conduct, including, penetration by body part or object, touching, fondling, being forced or coerced to participate in pornography, and/or being forced or coerced to watch others conduct sex acts. Participants who had experienced sexual assault completed additional questions related to their experience of sexual assault (see Table 1).

Self-esteem—The Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965) is a 10-item, 4-point Likert-type scale (*strongly disagree* to *strongly agree*) that assesses an individual's global self-esteem. Previous research on the RSE indicated excellent internal reliability, test-retest reliability, and demonstrated convergent, and discriminant validity (Blascovich & Tomaka, 1991). After reverse coding five items, a sum score was created. Overall, participants reported high levels of self-esteem, M = 30.01, SD = 6.18. In the present study, the RSE demonstrated excellent reliability, α = .91.

Social support—The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) is a 12-item, 7-point Likert-type scale (*strongly disagree* to *strongly agree*) which evaluates an individuals' social support from friends, family and significant others. Scores were averaged for each subscale. Prior research on the MSPSS established adequate internal reliability for each of the three subscales, ranging from 0.81 to 0.90 for the Family subscale; 0.90 to 0.94 for the Friends subscale, and 0.83 to 0.98 for the Significant Other subscale as well as factorial and sub-scale validity (Zimet, Powell, Farley, Werkman & Berkoff, 1990). The present study demonstrated excellent reliability, Friends α = .94; Family α = .94, and Significant Other α = .94. See Table 2 for overall means and standard deviations for Self-Esteem and Social Support, as well as Social Support sub-scales and Self-Esteem means and standard deviations for women who had disclosed and not disclosed.

Results

Chi-square analyses were conducted to examine if age of sexual assault, service utilization, number of times a woman experienced assault, and disclosure by other house members

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influenced the likelihood of disclosure. Receiving services following the assault, $\chi^2(1, N = 123) = 7.87$, $p < .01$, Cramer's V = 0.25, and having another woman disclose her assault experience, $\chi^2(1, N = 121) = 15.12$, $p < .01$, Cramer's V = 0.35, were both associated with disclosure. In the present study, more women who had received services (30.1%) disclosed their experience to other house members than women who had not received services (17.1%). Likewise, more women who had another house member disclose their experience to them disclosed their own sexual assault experience (37.2%) than women who had not had another house member disclose their experience (10.7%). Age of sexual assault, $\chi^2(2, N = 126) = 0.82$, *ns*, (below 16, above 16, both) and the number of times a woman was assaulted, $\chi^2(2, N = 126) = 2.30$, *ns*, (once, twice, more than two times) were not associated with disclosure.

Linear regression analyses were conducted to determine the relationship between disclosure, self-esteem and social support. Disclosure was significantly related to self-esteem, $R^2 = .09$, $F(1, 123) = 11.59$, $p < .01$, such that women who disclosed to other Oxford House members scored 3.64 points higher on self-esteem than women who had not disclosed ($B = 3.64$; $SE = 1.07$; $\beta = .30$; CI [1.52, 5.76]), $t(123) = 3.40$, $p < .01$. Disclosure was also significantly related to social support from friends, $R^2 = .06$, $F(1, 123) = 7.94$, $p < .05$ and significant others, $R^2 = .06$, $F(1, 122) = 7.51$, $p < .05$. Specifically, women who disclosed scored 0.63 points higher on social support from friends ($B = 0.63$; $SE = 0.22$; $\beta = .25$; CI [0.19, 1.07]), $t(123) = 2.82$, $p < .05$, and a 0.64 points higher on social support from significant others ($B = 0.64$; $SE = 0.23$; $\beta = .24$; CI [0.18, 1.10]), $t(122) = 2.74$, $p < .05$, than women who had not disclosed. Disclosure was not a significant predictor of social support from family members.

Discussion

The present study explored past sexual assault experiences among women who lived in Oxford House, with specific attention to disclosure of the assault experience to other house members. Most women reported knowledge of formal services, yet only slightly more than half used those services, and of those who did use services, not all women found them helpful. This finding is supported by research which suggested that not all formal services benefit survivors (Ahrens et al., 2009; Golding et al., 1989; Littleton, 2010; Ullman, 2006). In addition, almost half of the women who lived in Oxford House had disclosed their sexual assault experience to other house members, which is consistent with literature which indicated that women frequently disclose to informal support systems (Ahrens et al., 2009; Starzynski et al., 2007). Furthermore, many women in the present study had had another house member disclose an assault experience to them, which may indicate that the Oxford House setting is an environment that has the ability to promote both substance abuse and trauma recovery.

Assault characteristics that were related to disclosure included formal service utilization and disclosure of an assault experience by another house member. More women who had received formal services disclosed their experience to other house members than women who had not received services. This finding lends support to the importance of formal service receipt, although the types (police, medical, mental health) of services received by women in the present study are unclear. Therefore, it may be important for women to disclose their assault experiences to both formal and informal support systems to help facilitate recovery. In addition, more women who had an Oxford House member disclose an assault experience to them disclosed their own assault experience. Thus, Oxford House may provide an opportunity for reciprocal disclosure among house members, such that women who identify as survivors might relay their own experience and gain support from disclosure in a peer-based setting. Use of peers to disclose and garner support from similar peers surrounding an assault experience may be an important phenomenon that may help to

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strengthen relationships among survivors. Peer support in Oxford House is integral to substance abuse recovery, as research has demonstrated the importance of abstinent social support on substance use outcomes (Groh et al., 2007). In this context, the democratic environment of Oxford House may promote a sense of equality and increased rapport among house members which may be conducive to disclosure. Certain setting-level characteristics of Oxford House, such as the democratic environment, sense of community (Olson et al., 2003) and empowerment (Maton, 2008), may also greatly influence women's use of Oxford House as a setting in which disclosure is possible. Future research should examine the characteristics of the relationships among house members who disclosed their experience, as the strength of women's relationships with other house members may provide additional support to facilitate trauma and substance abuse recovery. Furthermore, research should examine the impact of the types of reactions received on disclosure from other house members, and how the reactions of other house members impact substance abuse and trauma recovery outcomes.

Contrary to our hypotheses, neither age of first assault nor times assaulted were associated with women's disclosure. Previous literature demonstrated that women who had experienced childhood sexual assault were, in fact, less likely to disclose their assault experience than women who had experienced trauma as an adult (McCauley et al., 1997). In addition, although the number of prior assaults was not related to disclosure to other house members, it should be noted that most women had experienced multiple assaults. This finding is consistent with research that has articulated that women who experience sexual assault are at increased risk for subsequent victimization (Smith et al., 2000). However, this finding should be interpreted with caution, as data on the details surrounding assault experiences in this study are limited. Research should continue to closely examine details surrounding each occurrence of assault, and how the specific characteristics of the assault influence disclosure.

Women who disclosed their assault experience reported higher self-esteem scores than women who had not disclosed. This finding is supported by previous research which documented that a trauma experience and/or nondisclosure is related to low self-esteem (Jordan et al., 2010; Ullman & Filipas, 2001). High self-esteem may help to facilitate recovery from an assault experience, as it may positively impact a woman's sense of self-worth and confidence. Furthermore, disclosure coupled with a positive reaction might reduce feelings of self-blame (Neville et al., 2004). Although women who disclosed their assault experience had higher self-esteem scores than women who had not disclosed, the present study was cross sectional and does not imply causality. Thus, it is equally plausible that women who had high self-esteem were more likely to disclose their assault experience. Regardless of the direction of the relationship between disclosure and self-esteem, the present study indicates that self-esteem is important to disclosure and may help women to feel more confident and valued. Thus, substance abuse and trauma treatment settings should focus on building self-esteem while providing a safe setting for disclosure.

Women who had disclosed their experience reported more social support from friends and significant others than women who had not disclosed. This finding provides additional support for the ability of disclosure to increase social support among survivors living in Oxford Houses. The benefits of disclosure for women in recovery from substance use also add to the literature on the importance of gender-responsive services for women in recovery, as women who disclosed were in a setting that promoted not only abstinence from substances but also support surrounding issues related to sexual assault (Greenfield et al., 2007; Greenfield & Pirard, 2009). As mentioned previously, given the cross-sectional nature of the present study, the direction of the relationship is not causal. However, there is a relationship between disclosure and social support that is significant, and it is possible that

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disclosure to an informal support system strengthens interpersonal relationships among women which may aid in both substance abuse and trauma recovery. Future research should continue to examine how relationship bonds are strengthened or hindered by disclosure and should also explore domain-specific (disclosure-specific) social support.

Although these findings provide support for Oxford House as a safe place for sexual assault survivors to disclose, there were several limitations that should be addressed. First, the external validity of the present study is limited, as it is a cross-sectional sample of women who lived in Oxford Houses; however, we believe that our sample is representative of women in long-term recovery programs. Second, the cross-sectional design did not allow for an investigation of longitudinal outcomes among survivors. Subsequent research should examine if disclosure in a setting such as Oxford House influences women's likelihood of substance use relapse. Third, our analyses do not reflect causal relationships between disclosure, self-esteem, and social support. It is equally plausible that women with high self-esteem and social support were more likely to disclose their assault experience to other house members, and future longitudinal studies are needed to address this issue. In addition, it is likely that women who were willing to disclose their assault experience on a survey might have had higher self-esteem and more social support than those who were not willing to disclose on the survey. It should also be noted that there were limitations in the type and depth of questions asked, as most questions related to sexual assault were dichotomous and categorical, as the study qualified for exempt status under the Internal Review Board. Future research should examine disclosure among Oxford House members with more detailed questions, and identify the relationship between disclosure of sexual assault and substance use outcomes.

Taken together, our findings demonstrate the utility of the Oxford House model as an informal support system for women who are in recovery from substance use and who have experienced sexual assault. Women who disclosed in this setting and used other women Oxford House members as a support network reported higher self-esteem and social support from friends and significant others than women who did not disclose. Furthermore, most women who disclosed believed their disclosure was helpful and provided them with additional support. An interesting finding revealed that more women who used services disclosed their sexual assault experience. Furthermore, there was a reciprocal relationship between disclosure and having a peer disclose their experience. Our findings have implications for substance abuse and trauma recovery settings. Treatment providers should ensure that the setting promotes women's empowerment and sense of community. Furthermore, the utility of peer support and disclosure of a similar experience suggests that peers are integral to substance abuse and trauma recovery, and should be used in the treatment process. Finally, research should continue to examine interpersonal relationship and setting-level characteristics that are important to safe disclosure. This research has implications for providing gender-responsive services for women in recovery from substance use, and for exploring the use of substance abuse aftercare settings as alternative avenues for disclosure of sexual assault.

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Biographies

Bronwyn A. Hunter, MA, is a graduate student in the clinical community psychology PhD program at DePaul University. She graduated with a BS in psychology from Southern Connecticut State University and was awarded her MA in 2010 from DePaul University. Currently, Bronwyn works as a graduate assistant with Dr. Leonard Jason on a project evaluating the Oxford House model as an effective aftercare program for women exiting the criminal justice system in Chicago. In the future, she hopes to work in the community developing, implementing, and evaluating programs that facilitate reentry for women offenders.

Emily Robison is a feminist and activist living in Chicago. She holds bachelor's degrees in psychology and English from DePaul University and has been fighting sexual violence for several years. She began as volunteer medical advocate with Rape Victim Advocates (RVA), where she provided support and crisis counseling to survivors of sexual violence. Her stead with RVA shifted toward prevention education when she began as volunteer educator and was later named senior education intern. As an educator, Emily created curriculum and facilitated workshops with youth and adults on issues surrounding sexual violence and created and organized Art Restores, a benefit art show for RVA. It was through this vein that she began combining her passions for both sexual violence prevention with sexual health and came to SHEER (Sexuality Health Education to End Rape). She is a founding, steering committee, funding workgroup and event planning workgroup member of SHEER, a sex-positive, proconsent collective dedicate to clarifying consent and promoting pleasure. Furthermore, Emily's passion for women's issues extends to substance use behavior, which led her to the DePaul University Center for Community Research. In this setting she studies women's experiences with substance use recovery and healing from sexual violence. She also currently works as contractual prevention educator for RVA and as statistics and client-support staff at a Domestic Violence shelter, where she provides support for women and children survivors of domestic violence.

Leonard A. Jason, PhD, is a professor of psychology at DePaul University and the director of the Center for Community Research. He is a former president of the Division of Community Psychology of the American Psychological Association. He received the 1997 Distinguished Contributions to Theory and Research Award and the 2007 Special Contribution to Public Policy Award by the Society for Community Research and Action. He has edited or written 23 books, and he has published more than 540 articles and 77 book chapters on ME/CFS; recovery homes; the prevention of alcohol, tobacco, and other drug abuse; media interventions; and program evaluation.

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Table 1

Frequencies of Sexual Assault Specific Variables

Variable	*N*	%
Age of sexual assault		
Under age 16	63	48.8
16 or older	40	31.0
Both	26	20.2
Times assaulted		
Once	27	21.1
Twice	21	16.4
More than 2 times	80	62.5
Knowledge of available services		
Yes	100	78.7
No	27	21.3
Service utilization		
Yes	63	63.0
Services helpful		
Yes	47	83.9
No	10	17.5
Disclosed to Oxford House members		
Yes	59	46.8
No	67	53.2
Used services and disclosed to Oxford House members	37	28.7
Helpful to disclose to Oxford House members		
Not at all	3	2.3
Somewhat	16	27.1
Helpful	30	50.8
Extremely helpful	10	16.9
Other Oxford House members disclosed to you		
Yes	72	58.5
No	51	41.5
Telling other Oxford House members provides me with support		
Strongly disagree	2	3.4
Disagree	4	6.9
Not sure	9	15.5
Agree	24	41.4
Strongly agree	19	32.8

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Table 2

Overall and Disclosure Specific Means and Standard Deviations for Self-Esteem and Social Support

Scale	Overall Mean (*SD*)	Disclosure	
		Yes (*SD*)	No (*SD*)
Self-Esteem	30.01 (6.18)	31.94 (5.39)	28.31 (6.41)
Social Support			
Friends	5.97 (1.27)	6.28 (1.25)	5.65 (1.24)
Family	5.17 (1.72)	5.36 (1.69)	4.97 (1.77)
Significant Other	6.08 (1.31)	6.40 (1.21)	5.76 (1.36)