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Abstract

Correlates of alcohol-related help seeking were studied in women sexual assault survivors who were current problem drinkers (N = 526) in a large metropolitan area in 2002-2003. Volunteer participants completed several valid and reliable instruments, which assessed alcohol use and misuse and related help seeking (i.e., the TWEAK, GFM, and MAST). Data were analyzed using logistic regression models. Results suggest that correlates of women survivors' alcohol-related help seeking vary depending on the specific source. Limitations and implications are noted and recommendations for future research are made. This study was funded by the National Institutes on Alcohol Abuse and Alcoholism.

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Studies of women identified as substance abusers have revealed high rates of sexual victimization (Najavits, Weiss, & Shaw, 1997), and, conversely, women survivors of sexual assault have higher rates of problem drinking compared to others (Wilsnack, Plaud, Wilsnack, & Klassen, 1997). Rothman and colleagues (2008) recently found that medical inpatients with alcohol dependence who had recently experienced rape (but not other forms of interpersonal violence) were more likely than others to have sought alcohol treatment services, broadly defined as detoxification, counseling, or self-help. Further, rape victims were more likely to seek help, in part, because they experienced more PTSD symptoms and more severe alcohol problems than nonvictims. Although this study suggests that women survivors are more likely than others to seek alcohol-related treatment, it remains likely that a number of women survivors do not report or delay seeking help for alcohol-related problems because of the dual stigmas and negative reactions received in response to disclosures of sexual assault victimization and problem drinking (Gomberg, 1988; Ullman, 1999; see also Zemore, Mulia, Ye, Borges, & Greenfield, in press). Thus, it is critical to understand correlates of alcohol-related help seeking in women survivors to ensure they seek help for problem drinking and receive appropriate services.

Research has only recently begun to examine correlates of alcohol-related help seeking generally, however, and few studies have examined this issue in women survivors who are problem drinkers in particular. Although Rothman and colleagues (2008) did not examine whether treatment seeking for alcohol problems differed by gender, other research has shown that women are less likely than men to seek treatment, even though they appear to be equally likely to benefit from treatment as men (for review, see Greenfield et al., 2007). Measures of alcohol treatment seeking are often general, however, and do not distinguish among unique

sources of help. Thus, there is little knowledge regarding the specific sources from which women survivors' seek help for alcohol-related problems. There is some evidence, however, that men are more likely to seek specialty alcohol and drug treatment services whereas women are more likely to utilize self-help groups, such as Alcoholics Anonymous (AA) (Timko, Moos, Finney, & Connell, 2002). Informal support seeking may be more common for women than men, regardless of whether help is being sought for problems related to victimization or substance abuse, because women tend to have more extensive social networks and tend to rely on them to a greater extent compared to men (Taylor, 2007). Alternatively, women may face greater barriers to substance abuse treatment than men (e.g., child care; Ashley, Marsden, & Brady, 2003), which may lead them to rely on self-help groups instead of other forms of treatment. Women survivors are much more likely to disclose victimization to informal than to formal sources of support and few seek help from formal sources, especially soon after assault (Ullman, 1999). Thus, we explored correlates of women survivors' help seeking for problem drinking from professional support sources (e.g., doctors, social workers, clergymen) but also from alternate sources such as AA and informal support sources (e.g., family, friends, partners). Also, because treatment may result from alcohol-related arrests or hospitalizations, we examined correlates of these experiences.

Research suggests that social factors are important for understanding women's alcohol-related help seeking from informal sources. For example, Duffy, Cowell, Council, and Shi (2006) found that, among both men and women problem drinkers, low social support and severity of alcohol use disorders were related to more self-help group attendance. Research also suggests that demographics, trauma histories, sexual assault characteristics, coping strategies, and other post-assault experiences all influence mental health service seeking in women survivors (Starzynski, Ullman, Townsend, Long, & Long, 2007; Ullman & Brecklin, 2002b). For

example, Starzynski and colleagues found that women survivors were more likely to seek help from mental health professionals if they were lesbian or bisexual, White, older, experienced more severe PTSD, received more tangible aid from support sources, or had disclosed to more informal support sources. It is also possible that coping strategies and self-blame following an assault influence help-seeking, but studies have not examined these factors in relation to sexual assault survivors' seeking of alcohol-related help. Tucker (2001) suggested that mental health-related service seeking and alcohol/drug-related help seeking have similar correlates. Consistent with this, research suggests that problem drinkers are more likely to seek alcohol treatment if they have more comorbid mood or drug use disorders, but also if they are less educated or unmarried (Cohen, Feinn, Arias, & Kranzler, 2007; see also Duffy et al., 2006; Edlund, Belin, & Tang, 2006; Greenfield et al., 2007).

The present exploratory study examined the understudied issue of which of these various factors discriminate among different alcohol-specific sources to which women survivors may turn for help related to their drinking problems. We expected that less educated, older women with more extensive trauma histories and/or more severe sexual assault experiences would be more likely than other women to have had contacts with each alcohol-related help source. We also expected that women survivors who used more adaptive coping (e.g., problem-focused coping such as planning) and less maladaptive coping (e.g., avoidance coping) with greater self-blame, more severe PTSD, and greater alcohol consumption would be more likely than other women to engage in alcohol-related help seeking. Although overall we expected women to be more likely to seek help from informal sources (i.e., AA, other people) than formal sources (i.e., arrests, hospitalizations, professionals), given the exploratory nature of this study, we did not have hypotheses about different correlates of seeking help from different support sources.

Materials and Methods

Participants and Procedure

Advertisements in local newspapers and fliers distributed throughout the Chicago metropolitan area invited survivors of adult sexual assault who were at least 18 years old to participate in a confidential mail survey. Interested women were mailed the survey with a cover letter, information sheet describing the study, informed consent form, and a list of community resources for survivors of violence. The informed consent form and survey were returned by 1,084 women, who received $20 in exchange for their participation. The Sexual Experiences Survey (Koss & Gidycz, 1985) was used to ensure all women had experienced sexual assault (i.e., completed rape, attempted rape, sexual coercion, or unwanted sexual contact) at age 14 years or older. This criteria was met by 89% of respondents (n = 969). The TWEAK (T-Tolerance, W-Worry about drinking, E-Eye-opener, A-Amnesia/blackouts, K-Cut down; Russell, 1994) was used to identify women who exhibited problem drinking in the past year. A 7-point scale is used to score the instrument, with positive responses to tolerance and worry questions scored as 2 points, and to the last 3 items as 1 point, with total scores of 3 or more indicating problem drinking. The TWEAK is more sensitive and specific than other brief measures of problem drinking (e.g., the CAGE or B-MAST, Chan, Pristach, Welte, & Russell, 1993). The TWEAK identified 54% of survivors as problem drinkers. Thus, our final sample included 526 survivors who were also problem drinkers. The sample was quite diverse (48% Caucasian, 32% African American, 7% Hispanic/Latina, 4% Asian, and 8% other). Women were treated in accordance with the ethical guidelines of the institution through which this study was conducted.

Measures (for summary, see Table 1)

Demographics. We assessed participants' current age (*M* = 30 years old, *SD* = 10) and educational background (87% had at least a high school diploma).

Trauma history and assault characteristics. Traumatic life events were assessed with Goodman, Corcoran, Turner, Yuan, and Green's (1998) Stressful Life Events Screening Questionnaire, a brief self-report measure of 10 behaviorally specific items assessing a variety of traumatic events of an interpersonal nature (e.g., life-threatening illness or accident, physical abuse). This measure was scored as the summed number of events experienced by each respondent (*M* = 3.08, *SD* = 2.00). With regard to their assaults, women reported the number of perpetrators involved (*M* = 1.24, *SD* = .58) and whether they thought their lives were in danger (*yes*, *no*; 39% of survivors perceived life threat).

Coping strategies. Survivors' use of various strategies to cope with the assault in the past 30 days was assessed using the Brief COPE (Carver, Scheier, & Weintraub, 1989), with 28 Likert items ranging from 1 (*I didn't do this at all*) to 4 (*I did this a lot*). We computed the unweighted sum of responses to items composing subscales for planning (e.g., "I tried to come up with a strategy about what to do"; α =.78; *M* = 4.31, *SD* = 2.00) and avoidance coping (i.e., self-distraction, denial, behavioral engagement, e.g., "I refused to believe that it happened"; α =.75; *M* = 11.74, *SD* = 4.19). The COPE, widely used in studies of stressed populations, has adequate internal consistency reliability (all subscales alphas .60 or greater except for one) and test-retest reliability (correlations of .46 to .86; Carver et al., 1989).

Characterological self-blame (e.g., "I am unlucky," "I am a careless person") was assessed with a subscale of the Rape Attribution Questionnaire (Frazier, 1998), a valid and reliable self-report measure of sexual assault victims' attributions about why the assault occurred. Five items were answered with respect to the past 30 days on a scale ranging from 1

(*strongly disagree*) to 5 (*strongly agree*). Frazier (1998) reported subscale reliability of .81 and test-retest reliability ranging from .68-.80 in samples of women sexual assault victims. The measure was also reliable in this sample ($\alpha = .76$). Responses were summed to calculate characterological self-blame ($M = 13.26$, $SD = 4.55$).

Current symptoms. We assessed past-year alcohol consumption with an item from the Graduated Frequency Measure (Rehm et al., 1999). Specifically, we asked participants, "Think of all kinds of alcoholic beverages combined, that is, any combination of cans, bottles, or glasses of beer; glasses of wine; or drinks containing liquor of any kind. During the last 12 months, what is the largest number of drinks you had on any single day?" Women reported consuming an average of 3.41 drinks in a single day ($SD = 1.17$).

PTSD symptoms were assessed with the Posttraumatic Stress Diagnostic Scale (Foa, 1995), a standardized 17-item instrument based on DSM-IV criteria. On a scale ranging from 0 (*not at all*) to 3 (*almost always*), women rated how often each symptom (i.e., re-experiencing/intrusion, avoidance/numbing, hyperarousal) had bothered them in relation to the assault during the past 30 days. The PDS has acceptable test-retest reliability for a PTSD diagnosis in assault survivors over two weeks ($\kappa = .74$; Foa, Cashman, Jaycox, & Perry, 1997) and was reliable in our sample ($\alpha = .91$; $M = 18.71$, $SD = 12.05$).

Alcohol-related help seeking. Alcohol-related help seeking was assessed using 5 items from the Michigan Alcoholism Screening Test (MAST; Selzer, 1971), a standardized 25-item screening instrument for alcohol abuse and dependence. Specifically, survivors reported whether they had any of the following 5 experiences in the past year: an alcohol-related arrest (8%, or $n = 43$), an alcohol-related hospitalization (9%, or $n = 49$), an AA meeting (16%, or $n = 83$), sought

help from a professional for an alcohol-related problem (13%, or $n = 66$), or sought help from anyone for an alcohol-related problem (12%, or $n = 63$).[1]

<<<<<TABLE 1>>>>>

Results

Overall, 37 women sought help only from formal sources (i.e., arrests, hospitalizations, or professionals) and 42 sought help only from informal sources. An additional 58 women sought help from both formal and informal sources of help. Contrary to our expectation, women were no more likely to seek help from informal sources than formal sources, $\chi^2(1, 79) = .32$, *ns*.

We conducted separate logistic regression analyses predicting each of our 5 dependent measures. Each logistic regression model included 10 predictor variables. Missing data randomly distributed across variables in the regression models reduced the sample, but by using pairwise deletion we preserved between 409 and 412 valid cases in each of the models. This sample size yielded over 40 cases per predictor variable, exceeding Hosmer and Lemeshow's (1989) recommendation of 10 cases per predictor variable. Each model was statistically significant, all χ^2s(10, *n*s = 409–412) $\geq$ 47.12, *p*s < .001. The models explained approximately 26% of the variance in alcohol-related arrests, 37% of the variance in alcohol-related hospitalizations, 26% of the variance in attendance at AA meetings, 33% of the variance in seeking help from professionals, and 28% of the variance in seeking help from other people. Table 2 presents the regression coefficients (*B*), Wald, and odds ratio (*OR*) statistics for each variable in each model. Next, we discuss significant effects (i.e., $p \leq .05$), marginal effects (i.e., $p > .05$ and $\leq .10$), and nonsignificant effects (i.e., $p > .10$) of demographics, trauma history and assault characteristics, coping strategies, and current symptoms on each measure of alcohol-related help seeking.

<<<<<TABLE 2>>>>>

Demographics

Survivors' current age was significantly associated with alcohol-related hospitalizations, AA meeting attendance, and help seeking from professionals and other people. Specifically, older women were 5–7% more likely to engage in these forms of help seeking compared to younger women. Age was not significantly related to alcohol-related arrests, however.

Education was marginally related to alcohol-related hospitalizations and significantly related to alcohol-related arrests and AA meeting attendance. Survivors who did not complete high school were more likely to engage in these types of help-seeking behaviors than survivors who did complete high school. Education was unrelated, however, to seeking help from professionals or other people.

Trauma History and Assault Characteristics

Traumatic life events marginally predicted alcohol-related arrests and significantly predicted attendance at AA meetings. The more traumatic life events survivors had experienced, the more likely they were to seek help in these ways. In contrast, traumatic life events did not significantly relate to alcohol-related hospitalizations or help seeking from professionals or other people.

The number of perpetrators involved in the assault did not significantly predict survivors' alcohol-related help seeking. Although perceived life threat was not significantly related to alcohol-related arrests, AA meeting attendance, or help seeking from professionals or other people, it was a marginal predictor of alcohol-related hospitalizations. Specifically, women who perceived that their lives were in danger during their assault experiences were more than twice as likely as other women to experience an alcohol-related hospitalization.

Coping Strategies

Planning as a coping strategy was significantly associated with alcohol-related hospitalizations and help seeking from professionals and other people. Specifically, survivors who engaged in this type of coping strategy were 27% more likely than other women to experience an alcohol-related hospitalization and 21–24% more likely to seek help from other people or professionals. Planning did not significantly predict AA meeting attendance or alcohol-related arrests, however. Avoidance coping also did not predict alcohol-related arrests, nor was it significantly associated with alcohol-related hospitalizations or help seeking from professionals or other people. But it was a marginal predictor of AA meeting attendance. Somewhat counterintuitively, women who engaged in greater avoidance coping were significantly more likely to attend an AA meeting.

Characterological self-blame was significantly associated with alcohol-related arrests and hospitalizations and seeking help from professionals, but not other people or through AA meeting attendance. Specifically, engaging in more characterological self-blame was associated with 14% greater likelihood of reporting an alcohol-related arrest or hospitalization and 13% greater likelihood of seeking help from professionals.

Current Symptoms

PTSD symptoms did not significantly relate to any measure of alcohol-related help seeking. In contrast, alcohol consumption marginally predicted AA meeting attendance and significantly predicted the other 4 measures of alcohol-related help seeking. Specifically, greater alcohol consumption was *negatively* related to help seeking from each of the sources studied here.

Discussion

Research suggests that there are some overlapping, yet other distinct correlates of alcohol-related treatment seeking from sources such as AA compared to hospitalizations, counseling, or other alcohol-focused treatment from a professional source. For example, Tucker, Vuchinich, and Rippens (2004) found that all problem drinkers who sought help did so because of drinking-related social and functional impairments, encouragement from social support sources to seek help, and being unable to solve the problem on their own. However, AA participants cited positive perceptions of AA features and practical considerations (e.g., convenience, no expense) whereas those who utilized other sources were likely to refer to job-related, religious, or legal motivations. Our research builds on such findings by showing that correlates of alcohol-related help seeking specifically among women sexual assault survivors vary depending on the source of support.

As expected, older women and less educated women were more likely to seek help, consistent with past research on seeking alcohol treatment in adults generally (Greenfield et al., 2007) and in Latinos (Zemore et al., in press). There are various possible explanations for these findings. Older women may have a longer history of problem drinking and related negative consequences, but may also have more resources and knowledge to access support groups such as AA or professional help, as well as greater willingness to recognize their problem drinking and reach out for help. Less educated women may have more formal system contacts for other reasons that lead them to alcohol treatment such as higher rates of trauma exposure and PTSD (Hein, Cohen, & Campbell, 2005; Ullman & Filipas, 2001). Some support for this hypothesis comes from the finding that greater AA meeting attendance and more alcohol-related arrests were associated with more extensive trauma histories.

It is somewhat reassuring that women survivors with more extensive trauma histories are more likely to have certain alcohol-related treatment contacts, given the robust association of trauma history with alcohol problems found in this sample reported elsewhere (Ullman, Filipas, Townsend, & Starzynski, 2005) and in adults generally (Stewart, 1996). This finding is consistent with some research on patient populations showing that trauma history is positively related to alcohol treatment (Rothman et al., 2008). Even so, trauma histories did not relate to other forms of alcohol-related help seeking, and number of assault perpetrators did not relate to any of the forms of alcohol-related help seeking studied here. Perceived life threat during the assault, however, was related to greater odds of an alcohol-related hospitalization. This suggests that, although women survivors with more *subjectively* severe assaults may receive help, those with more *objectively* severe assaults may not seek or receive help specifically for alcohol problems. It may be that such victims do not perceive their assaults to be associated with problem drinking and/or that they avoid seeking help because they have received negative social reactions in response to past disclosures, consistent with research showing that survivors of more severe assaults tend to receive more negative reactions from others (Ullman & Filipas, 2001).

Problem-focused coping, assessed here as using planning as a coping strategy, was related to more seeking of alcohol-related help from hospitals, professionals, and other people, whereas avoidance coping was marginally related to greater AA meeting attendance only. Thus, survivors who use more approach-oriented, problem-focused coping are more likely to seek treatment for their drinking. In contrast, those relying on avoidant forms of coping may be seeking help from AA for drinking, but may be simultaneously avoiding dealing explicitly with their assaults. It is unclear why these patterns were observed but future research is needed to understand the role of coping in support seeking for alcohol problems in women survivors.

Women who blamed themselves for assault, which is generally an indicator of worse psychological functioning (Frazier, Mortenson, & Steward, 2005), had more alcohol-related arrests and hospitalizations and formal help seeking, but self-blame was unrelated to more informal help seeking from other people or AA. This may indicate that those who feel more blameworthy for their assaults or who feel stigmatized because of their assaults and/or their problem drinking experiences are unwilling to initiate help seeking from informal contacts. If so, this is unfortunate because these support sources are likely to be helpful in de-stigmatizing survivors and validating their experiences (Golding, Siegel, Sorenson, & Burnam, 1989; Ullman, 1999).

Of interest, PTSD was unrelated to alcohol-related help seeking, in contrast to our hypotheses. PTSD has been shown to relate to mental health service seeking in this sample (Starzynski et al., 2007), so perhaps women survivors only seek help for psychological distress from mental health sources and not alcohol-related sources. Alternatively, given that 68% of women in this sample met the criteria for a diagnosis of PTSD, this variable may have been less able to discriminate alcohol-related help seeking specifically. Also in contrast to our hypotheses, we found that alcohol consumption was negatively related to alcohol-related help seeking. Unfortunately, this suggests that the survivors who are most in need of help related to their problem drinking are least likely to seek it. Women who are heavy drinkers may be less willing or able to seek help.

Although past research shows that social support plays a key role in relapse and help-seeking in women alcoholics (Duffy et al., 2006; McCrady & Epstein, 2005), relations between social support and disclosure variables in bivariate analyses did not reach the statistical significance threshold we set and were not included in the multivariate analyses (see Footnote 1).

Associations between support and alcohol-related help seeking may not have been significant in this study because our measures assessed current support at the time of the survey and in relation to the assault, not problem drinking. Future research should more thoroughly explore whether support influences help seeking.

Limitations of this study are its cross-sectional, restrospective design and reliance on a convenience sample of women who volunteered to participate in a study of unwanted sexual experiences. Although victims did vary in trauma histories, alcohol use, and various other factors that could relate to alcohol-related help seeking, all women were functioning well enough to come forward and complete the survey and the large sample was diverse in terms of ethnicity and socioeconomic status and included victims who can be difficult to reach with traditional random sampling methods (e.g., women without telephones, in shelters). It is not known if correlates of seeking help for drinking in women survivors would differ in a representative community sample, but such research would be informative. Lack of a diagnostic measure of alcohol use disorders is another limitation of this study. Also, our help seeking items were limited single-item measures that may be inadequate for comprehensively capturing actual help seeking. Memory biases and/or stigma associated with acknowledging problematic drinking and contacts with help sources for their drinking may have led to under-disclosure of these issues in this sample, but, unfortunately, there is no way to know whether such biases influenced our results. In addition, we ran several analyses, which might have increased the likelihood that some of the findings are spurious. Even so, the sample was large and we were very conservative in selecting which predictor variables to enter into these models.

Despite these limitations, this study does improve upon past research by providing initial information about correlates of seeking help from specific sources in a subgroup (women sexual

assault survivors) known to be at high risk for problem drinking and in need of support and treatment. Given that women are known to participate in formal substance abuse treatment at a much lower rate than men, it is important to learn about where they turn for help, particularly for victimized women with alcohol problems, as these women are more vulnerable to mental health problems including suicidal behavior (Ullman & Brecklin, 2002a). Although the results of this study suggest that attempts to understand survivors' help-seeking experiences should consider the type of help sought, future research should also seek to understand the timing of and motivations (i.e., internal versus external) for survivors' help seeking. Much more information is needed from representative samples of women on their victimization histories and the various forms of treatment they seek help from for alcohol problems as well as for other substance use, psychological, and physical health problems.

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Footnote

1. We also used bivariate correlational analyses to examine relations between alcohol-related help seeking and several other demographics (sexual orientation, marital status, ethnicity, income, medical insurance history, employment status), trauma history (CSA history), assault characteristics (age at time of assault, perpetrator identity, victim substance use, perpetrator substance use, level of force involved, use of weapon, level of victim resistance, level of injury, assault severity, level of post-assault upset), coping strategies (venting, positive reframing, humor, acceptance, religion, behavioral self-blame), social support (number of confidants, frequency of contact with social network members), current symptoms (perceived control over recovery, depressive symptoms), and other assault outcomes (suicidal ideation, suicidal attempts, number of formal support sources told, number of informal support sources told). Although some of the relations were significant, they did not meet the strict criteria we set to control for the number of analyses conducted. Specifically, to be included as a predictor in our analyses, we required independent variables to relate to at least 3 of the 5 alcohol-related help seeking measures using an alpha of .005. Results from these analyses and the full correlation matrix are available upon request.

Table 1

Summary of Measures

Variable	Measure
Demographics	
Current age	"How old are you today?"
Educational background	"What is the highest level of education you have completed?"
Trauma history and assault characteristics	
Traumatic life events	Stressful Life Events Screening Questionnaire (Goodman et al., 1998)
Number of perpetrators involved in assault	"How many men were involved in the incident?"
Perceived life threat	"Did you think your life was in danger?"
Coping strategies	
Planning coping	Planning subscale of the Brief COPE (Carver et al., 1989)
Avoidance coping	Self-distraction, denial, and behavioral engagement subscales of the Brief COPE
Characterological self-blame	Characterological self-blame subscale of the Rape Attribution Questionnaire (Frazier, 1998)
Current symptoms	
Past-year alcohol consumption	Item from the Graduated Frequency Measure (Rehm et al., 1999)
PTSD symptoms	Posttraumatic Stress Diagnostic Scale (Foa, 1995)
Alcohol-related help seeking	5 items from the Michigan Alcoholism Screening Test (Selzer, 1971)

Table 2

Logistic Regression Models Predicting Alcohol-Related Help Seeking

	Arrest (*N* = 410)			Hospitalization (*N* = 409)			AA Meetings (*N* = 412)			Sought Help from Other People (*N* = 409)			Sought Help from Professionals (*N* = 409)		
Predictors	*B*	Wald	*OR*	*B*	Wald	*OR*	*B*	Wald	*OR*	*B*	Wald	*OR*	*B*	Wald	*OR*
Demographics															
Age	.03	1.78	1.03	.07**	9.04	1.07	.06***	13.95	1.06	.07***	13.96	1.07	.05**	7.60	1.05
Education	-1.31**	6.41	.27	-.94†	2.79	.39	-.92*	4.42	.40	.16	.08	1.18	-.42	.65	.66
Trauma history & Assault characteristics															
Traumatic life events	.18†	2.96	1.20	.11	1.14	1.12	.17*	4.27	1.18	.11	1.42	1.11	.09	1.17	1.10
Number of perpetrators	.24	.66	1.27	.06	.04	1.06	.16	.41	1.17	.18	.39	1.19	-.22	.56	.81
Perceived life threat	.72	2.34	2.06	.85†	2.68	2.33	.11	.09	1.12	-.27	.39	.77	-.12	.08	.89
Coping strategies															
Planning	.12	1.17	1.13	.24*	4.11	1.27	.05	.32	1.05	.21*	4.98	1.24	.19*	4.00	1.21
Avoidance	-.08	1.59	.92	-.01	.01	.99	.08†	2.70	1.08	.04	.67	1.04	.03	.41	1.03
Characterological self-blame	.14**	7.63	1.14	.13**	6.01	1.14	.05	1.78	1.05	.07	2.62	1.07	.12**	8.25	1.13
Current symptoms															
PTSD symptoms	-.02	.50	.99	-.00	.03	1.00	.01	.74	1.01	.01	.17	1.01	.01	.47	1.01
Alcohol consumption	-.56**	8.10	.57	-.95***	16.92	.39	-.26†	3.59	.77	-.67***	14.39	.51	-.95***	27.37	.39

Note: $^{\dagger}p \leq .10$, $*p \leq .05$, $**p \leq .01$, $***p \leq .001$.