

Many problem drug users have a history of child sexual abuse. **Ronno Griffiths, Brian Pearson** and **Zetta Bear** unravel the complex relationship between childhood sexual trauma and substance misuse

Drugs of abuse

THE case of 18-year-old Sarah Campbell, who died after being jailed despite a history of problems around mental health, drugs and childhood trauma (see *Druglink* November/December 2003) highlighted the undeniable link between childhood sexual abuse and later drug use.

There is an increasing body of research and clinical data on this relationship. The incidence of sexual abuse in the general population is, according to NSPCC research, in the region of 12–24 per cent for women and nine per cent for men. A number of studies have found significantly higher rates among drug misusers. Practitioners in community, residential and prison settings are increasingly dealing with clients who have been abused. Yet the problem remains largely unacknowledged at national policy level, while workers often report that they feel unsupported when attempting to address this area of work.

Psychologist David Finkelhor developed an influential model describing the effects of the four trauma-causing dynamics of childhood sexual abuse, which in combination cause long term trauma reactions at psychological and behavioural levels. We have adopted this model to understand the ways in which substances can mediate the effects. Drugs can be used in various ways to manage this distress. While any drug can have a general self-medicating effect in suppressing, avoiding, or dulling memories and feelings for events in the past, it can help both the user and worker to explore the precise function of the particular substances taken.

TRAUMATIC SEXUALISATION

The experience of abuse and the actions and manipulations of the perpetrator shape the developing

sexuality of the child. Consequences can include a confusion about sexual identity and sexual norms; sex as the only means of giving and receiving attention and affection; involvement in prostitution; sexual dysfunction, including problems with arousal and orgasm; adverse or phobic reactions to sexual intimacy and compulsive sexual behaviour.

To deal with this, women may use amphetamines to control body size, producing an immature, desexualised body, even suppressing menstruation, and helping those fearful of sexual maturity to feel protected against sexual interest or further assault. For some women with a deep attachment to their abuser, amphetamine use enables them to retain a childlike figure in the hope of regaining or retaining the perpetrator's attention.

For people who wish to avoid sex, heroin is useful in repressing libido. The rush after injecting and the feeling of being 'held', which is characteristic of the drug, can replace some aspects of sexual relating. Injecting drug use may replicate the experience of penetration during sexual abuse and therefore represent a re-enactment of the trauma. People who are otherwise too fearful or inhibited may use ecstasy to facilitate intimacy.

POWERLESSNESS

Sexual abuse entails the violation of a child's body space, the abuser using force or manipulation to control the child. This causes anxiety, fear and the loss of a sense of personal efficacy. Some victims feel a need for disproportionate levels of control and may identify with the aggressor. Sleep disorders, including nightmares, phobias, depression, vulnerability to further abuse or reactive aggressive or abusive behaviour may follow.

Feeling powerless can leave people unable to take appropriate action on the distress resulting from child

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sexual abuse. Heroin can then be used as self-medication, an emotional painkiller for people who would otherwise be at the mercy of their distress. Crack, cocaine and amphetamines, which engender feelings of power and omnipotence, can be employed as an antidote to feelings of powerlessness. They can also aid alertness to danger. This is particularly useful to women involved in prostitution who are at risk of assault, and to anyone who experiences anxiety and mistrust resulting from sexual abuse. Lastly, for those wishing to conceal their history of abuse, any substance may be used to convey feelings of powerlessness to others and to conceal the original dynamic underlying it.

STIGMATISATION

This can arise as a direct result of the abuser blaming and humiliating the child. Alternatively, the child may be affected by the furtiveness or shame of the abuser. The child may be pressured into keeping the abuse secret by the abuser or others. Stigmatisation can be exacerbated by disbelief, shock or negative reactions to disclosure. It

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is associated with powerful feelings of guilt and shame, lowered self-esteem and a sense of being different and alone. These feelings can result in self-harm or suicide.

Substance use can be a powerful way to express feelings of stigmatisation. Heroin, as the most ‘unacceptable’ substance, can both symbolise feelings of contamination and attract responses which reinforce this. So-called ‘chaotic’ use may express and reinforce stigmatisation. Injecting, especially if accompanied by poor self-care, may be a form of self-injury related to feelings of stigma.

Illicit drug use offers users the opportunity to express feelings of belonging and connection with others. Joining a group that is already stigmatised in the eyes of the dominant culture allows people who feel unable to enter mainstream society to meet vital psychological needs.

BETRAYAL

This occurs when a child is betrayed through assault by someone they love or are taught to respect. It can be more intense if people they trusted have failed to protect them. Psychological effects include grief, depression, extreme dependency, an inability to trust others and the use of hostility as a form of self-protection. Yearning for a redeeming relationship, a tendency to be clinging and over-dependent and a vulnerability to subsequent abuse may result. Conversely, isolation, discomfort in intimate relationships and aggressive behaviour can also occur.

All substances can provide users with an experience of a ‘redeeming relationship’, while avoiding the risk of an intimate relationship with another person. The substance of choice represents rescue, nurture, protection and soothing – all desired elements of a relationship which cannot otherwise be met because of an aversion to intimacy and the fear of further rejection and betrayal. Heroin may be particularly significant in this respect, providing a powerful experience of being safely cocooned. A user’s relationship with a substance may also replicate the ambivalence which some who have been abused experience in relation to the perpetrator, where feelings of loyalty and attachment conflict with the experience of being harmed.

UNDERSTANDING

We are not suggesting that drug workers should focus solely on the abuse, or embark upon intensive, therapeutic work. However, it is important that both worker and client understand the possible connections between past child sexual abuse and subsequent substance use. Understanding these can make assessment, interventions, casework and onward referral more effective. When drugs are being used to manage the effects of abuse, changes in substance use – withdrawal, reduction, stabilisation or abstinence – will probably have a significant impact. If workers are able to gain information on a drug’s relationship with past child sexual abuse, they will be in a position to facilitate changes in its use.

Discussing a history of sexual abuse will help drugs workers and clients to explore the function of the substance. If child sexual abuse is not integrated into the work at each stage, it is likely that, at best, victims of abuse will be unable to achieve lasting change. At worst, deprived of a vital coping strategy (substance use), they may be exposed to memories or feelings which they fear are intolerable, and therefore be at significantly higher risk of suicide. ■