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SEXUAL ABUSE IN CHILDHOOD AND ADULT DRUG ADDICTION

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This article reviews several studies on the relationship between having been sexually abused in childhood (CSA) and adult drug addiction. In this approach to the subject, seventeen studies and three books that relate the two variables are discussed. It is concluded that there is proof of higher incidence of sexual abuse during childhood among women with addiction problems, and the importance of approaching sexuality and affectiveness in the evaluation of treatment of drug addiction patients is stressed.
Key words: *Sexual abuse in childhood, sexuality, drug addiction.*

El presente trabajo revisa diversos estudios que abordan la relación entre haber sufrido abusos sexuales en la infancia (ASI) y padecer una drogodependencia en la edad adulta. En esta aproximación al tema se exponen diecisiete estudios y tres libros que relacionan ambas variables. Se concluye que existen probadas evidencias de una mayor incidencia de abusos sexuales durante la infancia entre las mujeres con problemas de adicción, y se destaca la importancia de abordar la sexualidad y afectividad en la evaluación y el tratamiento de los pacientes drogodependientes.
Palabras Clave: *Abusos sexuales en la infancia, Sexualidad, Drogadicción.*

Recent studies done under the Hombre Burgos Project (Pérez, Lara and González, 2010) have shown a significant positive correlation between drug use and having been sexually abused by an adult during childhood or adolescence in women who have been in treatment for psychoactive substance abuse in a Therapeutic Community, a significantly positive correlation between drug use and having been sexually abused by an adult in childhood or adolescence.

The same year and in the same Autonomous Region of Castile and Leon, Redondo and Santos (2010) published an extensive study in which they gave the following percentages: 30% of the women under outpatient or inpatient treatment for addiction problems had been physically abused, 44.9% psychologically abused and 18.4% sexually abused.

The relationship between having experienced childhood sexual abuse (CSA) and drug addiction as an adult is a subject which has hardly been approached in drug addiction. This article offers an approach to this question.

DEFINITION OF VARIABLES

Sexual abuse of minors may be defined as activity directed at providing sexual pleasure, stimulation or gratification in an adult who uses a child for it by taking advantage of his superiority. It is likewise considered sexual abuse when circumstances are asymmetric: a) age between victim and aggressor, b) power, when the abuser has some type of authority over the victim, c) knowledge or skill, when the abuser employs his astuteness and ability to manipulate, and d) gratification, when the child is subtly pressured (gifts, trips, etc.) to consent to the abuse (Sánchez-Meca, Alcázar and López, 2001).

In addition, drug addiction, or dependence, was defined in 1964 by the World Health Organization (WHO) as, "A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioral and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence."

PREVALENCE OF CSA

In 1977, the *Journal of Child Abuse and Neglect* was begun as the channel of expression of the *International Society for Prevention of Child Abuse and Neglect.* Rigorous studies on the subject may be found from that decade on, and furthermore, the percentages of persons who have been sexually abused is observed to increase from the 1970's to the 1990's, when there is a slight decline.

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In 1983, a study demonstrated that 30% of women reported having had a sexual aggression experience before they were 18 (Russell, 1983). Of epidemiological studies done in Spain, the study by López (1997), with a sample of 2000 people interviewed found a prevalence of sexual abuse in the general population of 19% (15% males and 23% females). The trend rose toward the nineties where it gradually began to fall, as confirmed in numerous publications (Jones and Fenkelhor, 2001, Almeida, Cohen, Subramanian and Molnar, 2008, McCarroll, Zizhong, Newby and Ursano, 2008, Miller and Rubin, 2009). This may have been due to a multitude of factors, such as the increase in social services, and although it cannot be clearly shown, several authors consider prevention another very important variable. Other factors could be the changes in social norms and practices, change in society's attitude, and finally, that the occurrence of sexual abuse has become a fact that is reported and has consequences (Jones and Finkelhor, 2003, Finkelhor and Jones, 2004, Finkelhor and Jones, 2006). This decline not only occurred in the US, but also in other western countries such as Australia and Israel (Dunne, Purdie, Cook, Boyle and Najman, 2003).

A recent international meta-analysis done in 2009 shows that the victimization rate (percentage of people who report having been victims) varies from 7.4% in males to 19% in women (Pereda, Guilera, Forns and Gómez-Benito, 2009).

CONSEQUENCES OF CSA

The review by Trickett and McBride-Chang (1995) on the consequences of sexual abuse showed the existence of a multitude of results, such as disruptive behavior, delinquency and stronger dissociative symptomology. It should also be mentioned that such consequences may be mid-to-long-term (López, 1994; Jumper, 1995; Paolucci, Genuis and Violato, 2001; Pereda, 2010).

The bibliography has related it to depression episodes (Wiss, Longhurst and Mazure, 1999). Other authors have found relationships between CSA and adult Posttraumatic Stress Syndrome (PSS) (Ozer, Best, Lipsey and Weiss, 2003; Marty and Carvajal, 2005), and borderline personality disorder (Jerez, 1997), and it has also been related to eating disorders, and more specifically, with bulimia (Behar, 2000). More recent studies have confirmed the presence of sexual affective problems, for example, living unsatisfactory and dysfunctional sexuality, sexual risk behaviors (e.g.., having sex without protection, a larger number of mates and higher presence of sexually transmitted diseases and risk of HIV (Pereda, 2010).

Connections have also been found between childhood sexual abuse and multiple personality disorder, or dissociative identity disorder, the term used by the DSM-IV. This disorder has even been understood as a defense mechanism for overcoming the pain or fear caused by repeated sexual abuse during childhood (Huertas, 2011). In the eighties, many scientific references established a relationship between childhood sexual abuse and multiple personality, but it is well known that correlation does not imply causality. That is, we cannot establish a causal relationship, and on the other hand, not take into account many other variables. It is not required for one thing to occur because the other has occurred (Wittgenstein, 1999).

Finally, Ibaceta (2007) showed that it is impossible to determine whether sexual aggression is a unique and specific etiological factor in the development of those pathologies in adults. Neither may it be established that the effects of sexual aggression lead to a single, homogeneous syndrome.

Bearing in mind these logical precautions, it may be said today that studies can be found showing a correlation between CSA and some type of substance dependence as an adult.

RELATIONSHIP BETWEEN CSA AND DRUG ADDICTION

In this approach to the subject we found 17 studies in scientific journals published in the last 30 years that relate CSA to drug addiction as an adult. Most of the studies were taken from the journal *Child Abuse & Neglect*. Furthermore, three books were found in which the relationship between CSA and psychoactive substance dependence is discussed.

To begin with, it should be stressed that given the importance of the problem, they are not just isolated or marginal studies with no scientific status. We find some articles that clearly relate both variables (López, Carpintero, Hernández, Martín and Fuertes, 1995; Jarvis and Copeland 1997; Molnar, Buka and Kessler, 2001; Dunlap, Golub and Johnson, 2003; Owens and Chard, 2003; Swanston, Plunkett, O'Toole, Shrimpton, Parkinson and Oates, 2003; Sartor, Lynskey, Bucholz, McCutcheon, Nelson, Waldron, et al., 2007; Bentley and Widom, 2009).

In chronological order, in 1979, Finkelhor found that "19% of women and 9% of men revealed sexual aggression experiences which seem to have had prolonged harmful effects on their self-image and ability to maintain sexual relations." In 1988, Briere and Runtz showed that people who had been sexually abused in childhood later had more problems with drugs compared to the population that had not been sexually abused (20.9% vs. 2.3%), and the relationship between alcohol and sexual abuse was somewhat similar (26.9% vs. 10.5).

We come across studies that maintain that the incidence of alcoholic women who have undergone incest is higher than in the general population (Hurley, 1991).

And according to Moreno, Prior and Monge (1998), studies with broad samples show that substance abuse and dependence rates, percentages of attempted suicide, and drug use rates are higher among women who were sexually abused in childhood. And as is usual, the more severe and frequent the abuse is, the more severe psychopathology is found.

López and del Campo (1999), like most of the authors, suggest that the effects of sexual abuse may be very different, depending on the type of aggression, age of the aggressor and of the victim, their relationship, duration of the aggression, frequency of aggression, personality of the child abused, reaction in the setting, etc. And, although these authors recognize that the long-term effects of sexual abuse are hard to study due to interference of other factors, they point out drug addiction as one of the best demonstrated consequences.

More recently, due to the optimization achieved in indicators measuring variables properly, several studies show that these percentages continue rising and reach considerably high figures. Thus we find that the review by the European Group IREFREA (2001) concludes that from 50% to 80% of women with addiction problems have been sexually abused in their childhood. Another meta-study states that the percentage of women diagnosed with substance dependence and who have been sexually abused varies on a curve from 23% to 74% (Meneses, 2002). Three years later, Rathus, Nevid and Fichner-Rathus (2005) in the sixth edition of their Manual of Human Sexuality, citing a study on adverse experiences in childhood by Edwards, Holden, Felitti and Anda (2003), wrote that children who are the subject of sexual abuse may suffer from a variety of short or long-term psychological problems, including drug abuse. The same year, Llopis (2005) stated that the incidence of sexual abuse and molestation among European addicts studied was 69%.

Finally, in Pérez and Martín (2007), although in this case, the book concentrated on nontoxic addictions (shopping, sex, gambling, etc.), they showed a clear relationship between addiction and sexual abuse, and emphasized the importance of approaching sexuality from the beginning of the treatment. More recently in Spain, as already mentioned at the beginning, we found studies such as the one by Pérez, Lara and González (2010), and Redondo and Santos (2010).

DISCUSSION AND CONCLUSIONS

The studies presented show the existence of a higher incidence of childhood sexual abuse among women with addiction problems than among women who do not have a problem. The conclusions these researchers arrive at and books reviewed confirm our hypothesis, which came out of the daily therapeutic practice and accumulation of evidence.

We know that psychoactive substances can fulfil a function: one of not feeling, not feeling despicable, not thinking, avoiding the problem, avoiding feared situations (Pérez, Martín, 2007), and definitely creating a "fictitious" situation through the relation with an object.

Given the correlation found between the two variables, we recommend that:

1. Therapists and educators in drug addiction attention programs should receive proper formation in sexuality in general, and in particular, on approaching sexual abuse and aggression.
2. The first evaluation of any new case must include sexuality and take it into account. We also know that although a person may have been sexually abused and this may be related to his history of substance abuse, the person may not initially reveal what occurred. Thus the program must habilitate spaces free of prejudice and favoring expression, where they can freely express traumas or emotional wounds.
3. Programs must have resources and professionals close who have been trained in sexology and can refer a case when they deem it necessary.
4. The studies presented found higher incidence of CSA among women than men. This fact must be kept in mind by programs. (Yes, it is true that psychological treatment in drug addiction has greatly improved since the eighties, but it was at the end of the nineties when gender-

differentiated therapeutic-educational intervention developed).

5. As in other studies, (López, Carpintero, Hernández, Martín and Fuertes, 1995; Putnam, 2003), we share the idea that education and prevention is fundamental for persons who have been abused.

Concerning therapy for CSA, and keeping in mind the fact that the aggressor is usually known to the victim, one of the tasks of the therapist who receives a person who has been sexually abused in childhood is to help construct a reliable pattern of relations, with him/her and with the world that surrounds him. This is an essential element of treatment.

The therapeutic alliance is a basic component in this case. Let us not forget that the quality of this alliance represents the majority of the variance in treatment results, and is up to seven times more influential in the change than the treatment model being applied (Wampold, 2001; Duncan, Miller and Sparks, 2004).

In conclusion, we would like to note that, in addition to taking into account what happened and individual characteristics, the social and family context surrounding the person must not be forgotten. The treatment must take on both the social reality and the closest setting in which the person lives (customs, beliefs, values, etc.), or else we run the risk of losing objectivity.

Along general lines, there are no therapeutic packages that can be successfully applied the same way, and treatment must be adapted to the person's own reality.

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