

# Substance Abuse, High-Risk Sex, and Sexual Violence: What's the Connection?

Article by Rowan Frost, Community Outreach Liaison, Southern Arizona Center Against Sexual Assault

When we care about someone who abuses substances, or puts themselves at risk for HIV repeatedly, we may have a difficult time understanding why they do things that are so obviously harmful. We may get angry and blame them, or accuse them of a lack of willpower. Unfortunately, they usually don't understand why they are hurting themselves either, and our anger and judgment doesn't help. There are clues, though, that may help professionals, family members, and the individuals we care about gain a better understanding of these behaviors. Research demonstrates that for both men and women, having experienced sexual violence is strongly associated with later substance abuse, high-risk sex, and other harmful behaviors. This article summarizes some of that research.

The term "sexual violence" includes a wide range of events that cause trauma to an individual, including: sexual abuse, child molestation, rape, hate crimes based on gender identity or perceived sexual orientation, and sexual harassment. Because sexual violence is so often unreported (the National Crime Victimization Survey found only 1 in 3 rapes, and 1 in 4 sexual assaults were reported to police), and because most victims do not seek support services, it often becomes an invisible precursor to further physical and emotional injury. (Rennison, 2002)

It is always appropriate to screen for sexual abuse/assault and mental health issues in any intake for behavioral health or medical services. The deep connections between body-mind-spirit mean that sexual trauma must be considered in all treatment planning with survivors, since it may be an underlying or predicating factor in the disease processes of addiction, depression, anti-social behavior, or a variety of physical problems.

The physical and mental health effects of sexual abuse and assault on a child or adolescent often extend well into adulthood. Forty-eight percent of child survivors meet the DSM-IV criteria for a diagnosis of Post-Traumatic Stress Disorder (PTSD), and their symptoms are often more intense and severe than those of non-sexual abuse victims with PTSD. (Briere & Elliott, 1994; Corbin, et al., 2001). Adult and child survivors are 4 times more likely to be diagnosed with major depression, and 5 times more likely to be diagnosed with an anxiety disorder. One out of six survivors of sexual violence reports at least one suicide attempt. (Briere & Elliott) It is essential that mental health professionals working with survivors have specialized training in sexual trauma in order to ensure that the issues are adequately addressed in treatment.

The relationship between sexual violence and substance abuse is commonly misunderstood. Popular perception is that being drunk or high makes one more susceptible to sexual abuse or assault; in fact, the first incidence of sexual abuse or assault usually precedes first alcohol or drug use. In other words, people don't get raped because they are drunk; they may get drunk because they have been raped. Female college students who had been abused as children were more likely to drink heavily than those who had not. (Corbin, et al., 2001) Perpetrators may get drunk in order to justify their actions, or may try to get their victims drunk or high to facilitate sexual assault. Again, the long-term consequences of sexual violence can be devastating: studies have found that survivors of sexual violence are more likely to develop drug addiction and alcoholism, and are less successful in completing substance abuse treatment. (Briere & Elliott, 1994; Corbin, et al.) This may be due in part to the structure of some substance abuse programs. Women, in particular, may feel unsafe in coed residential treatment programs, and there is some evidence that women do better in female-only treatment programs. (Gray & Nye, 2001; Kang, et al., 1999) Clients with symptoms of PTSD may need a longer period of time to establish trust with therapists; this should be taken into account in treatment planning. Confrontational styles of treatment are counterproductive in clients with trauma histories, increasing anxiety and decreasing engagement. When clients are encouraged to take responsibility for their own behavior it should also be reinforced that they are not responsible for the harm others have done to them in order to avoid blaming or shaming victims for any abuse they experienced. Whenever possible, client preferences for a therapist of a specific gender or cultural background should be respected. (Gray & Nye) Mental health professionals must consider the functions that alcohol and drug use provide. It is usually necessary to begin therapy to replace substance use with healthier coping strategies before clients can be expected to maintain sobriety for any length of time. (Glover, et al., 1995)

Both adolescent and adult survivors may "act out" sexually, engaging in high risk sexual activities with multiple partners. (Diaz, et al., 1999; Greenberg, 2001; Kang, et al., 1999) Studies consistently demonstrate strong links between adolescent and adult HIV risk behaviors, unintended pregnancy and partner pregnancy, and a history of sexual trauma (Greenberg). These findings are constant across gender, race, and region, although individuals from lower socio-

economic levels tend to experience greater long-term impacts. (Crowell & Burgess, 1996; Neville & Heppner, 1999) Among women living with HIV in New York City, 38% had experienced childhood sexual abuse; 46% had experienced sexual abuse in adulthood. The mean age at first incident for both groups was 15; the mean number of perpetrators was 3. (Simoni & Ng, 2000) One study of Hispanic men in San Francisco found that 50% had been sexually abused before the age of 16 by someone at least five years older. Among men in the study who had unprotected anal sex in the previous month, 73% had a history of sexual abuse. (Diaz, et al., 1999)

Knowledge of the consequences of high-risk sex (unintended pregnancy, transmission of HIV and other STDs) is not enough to change behavior. Counselors and medical professionals need to bring up the issue of sexual violence when discussing safer sex. Sexual abuse and assault may affect a person's ability to negotiate safer sex in several ways. Does the person have enough power within a sexual relationship to require, or to discuss, safer sex? Even to have consensual sex with a beloved and non-abusive partner, a survivor may have to dissociate (mentally remove themselves from a situation) or use substances in order to create distance between themselves and the memories of the violence. A person with a history of sexual trauma may not be able to think and have sex at the same time: intrusive memories may interfere. Non-cognitive sex is high risk sex. Interventions which stress risk-reduction and planning sexual activity are of limited use to someone who must take their mental processes out of gear in order to have sex. Again, addressing the underlying issue of sexual trauma is essential to providing appropriate services for survivors.

Other coping mechanisms for survivors of sexual trauma include self-mutilation, avoidance of relationships, and eating disorders (especially bulimia). (Briere & Elliott, 1994) After rape, 59% of female survivors experienced at least one form of sexual dysfunction, usually fear of sex or lack of interest and arousal. (Neville & Heppner, 1999) Behavioral health and medical professionals should be aware of the possibility of co-morbidity, and screen all clients.

Some service providers may hesitate to ask questions about sexual trauma when taking client histories for fear of invading privacy or retraumatizing victims, or perhaps out of discomfort with the subject. When asked whether or not they would like to be asked about sexual trauma, women responded that they felt it was both appropriate and relevant for medical personnel to include the topic in routine medical care. (Felitti, et. al., 1998) Providers who are uncomfortable bringing up the subject can receive continuing education to increase their ability to work with survivors.

This is only a brief summary of some of the research into the profound impact of sexual trauma on an individual's life. Sexual violence is fundamentally about power: the power someone else has to hurt the victim, and the loss of power (over body, identity, and environment) experienced by the victim. What we see as "high-risk behaviors" can be viewed as coping mechanisms, used by the individual in an attempt to get their power back. Survivors of sexual violence engaged in high-risk behaviors may be trying to empower themselves, to take back some control over how they feel and experience the world; the irony, of course, is that substance abuse and high-risk sexuality provide only temporary feelings of control, and ultimately put the individual at risk for revictimization. As empathic helping professionals and concerned family members and friends, we can support survivors by understanding how sexual trauma may be affecting their lives, and by helping them begin to replace dysfunctional coping mechanisms with skills that will truly serve them.

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