
**Does childhood sexual abuse contribute to
alcohol, heroin and/or other
drug problems?**

Proceedings of a one-day workshop held at the
National Centre for Epidemiology and Population Health,
The Australian National University, Tuesday 22 June 1993.

Editor: Gabriele Bammer

Working Paper Number 5

**Feasibility Research into the Controlled
Availability of Opioids Stage 2**

National Centre for Epidemiology and Population Health
The Australian National University

Australian Institute of Criminology

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EXECUTIVE SUMMARY

This one-day workshop examined the evidence for a link between childhood sexual abuse and alcohol, heroin and/or other drug problems. ACT-based service providers and researchers were invited to attend and an overview of some of the available data and of current research is provided. There is also a summary of the workshop discussion. The topics covered were:

- interacting with the childhood sexual abuse survivor;
- training for service providers and researchers;
- collecting data about childhood sexual abuse;
- social structures which perpetuate abuse and alcohol and other drug dependence; and
- areas for action.

For each of these topics there are issues still under debate and others for which there is considerable agreement. This document aims to provide a summary of “where we are at” so that there is a clearer vision of how services can be improved and of what research needs to be conducted.

The priorities identified at the workshop were to:

- support on-going initiatives to improve training for service providers likely to encounter clients who have been sexually abused;
- establish a referral system for sexual abuse survivors;
- establish a men's network to deal with alcohol and other drug dependence and sexual abuse;
- improve collaboration between service providers and researchers;
- develop ethics guidelines for collecting data on and researching childhood sexual abuse;
- tackle structural issues underlying sexual abuse and alcohol and/or other drug dependence using a community development approach;
- establish a proactive lobby group.

INTRODUCTION

This workshop had its genesis in several places. A number of services that cater for women with alcohol, heroin and other drug problems have long been aware that many clients are survivors of childhood sexual abuse. The concerns of the services about inadequate resources to deal with these issues came to prominence in the discussions of the Alcohol and Other Drugs Working Party of the Women's Health Network. The service providers felt that those in charge of resource allocation were not convinced of a link between childhood sexual abuse and alcohol, heroin and other drug problems in later life; but, until resources were provided, evidence to either prove or disprove the link could not be gathered. So a vicious cycle was being set up.

The PhD research being conducted by Phyll Dance and Adele Stevens was also showing an association and highlighting the lack of resources for services. In addition, Phyll Dance's work indicated that childhood sexual abuse might also be an important issue for male illicit drug users.

The Feasibility Research into the Controlled Availability of Opioids had established a reference group to advise on the studies being conducted with illicit drug users. Phyll Dance, Margaret Shanahan and Timothy McGregor are members of that reference group and were influential in putting the issue of childhood sexual abuse on the agenda for the study. Clearly, if a 'heroin trial' was to proceed, it would need to take account of a potential link between heroin dependence and childhood sexual abuse.

It seemed that bringing together people with a concern about this issue might be a contribution to advancing understanding about whether or not a link exists and how services might best be provided for survivors of childhood sexual abuse who had problems with alcohol and other drug use. Not everyone who was invited was able to attend. At the beginning of the workshop, participants were asked to briefly give an account of their perspectives on this issue and particularly to provide any statistics they had. A number of the accounts are included here, but not all participants wished to have their contributions published. The rest of the workshop centred around discussions of various aspects of this issue and a summary is published here. Participants had the opportunity to comment on drafts of these proceedings.

While the workshop was held under the auspices of the Feasibility Research into the Controlled Availability of Opioids, it needs to be made clear that the workshop participants hold a range of views about the desirability of a 'heroin trial'. Participation in the workshop should also not be seen as endorsement of the Feasibility Research process.

SUMMARY OF PRESENTATIONS

Gabriele Bammer

Fellow and Feasibility Research Coordinator
National Centre for Epidemiology and Population Health
The Australian National University

The issue of childhood sexual abuse has come to the fore in three studies which form part of Feasibility Research into the Controlled Availability of Opioids.

The first study was conducted in collaboration with the Youth Affairs Network of the ACT and involved interviewing 155 people aged between 12 and 17. Because of family problems they were currently living away from home or had lived away from home in the last 12 months. Fifty-four percent reported that they had been physically abused and 28 percent that they had been sexually abused. Among the young men, 48 percent reported physical abuse and 10 percent sexual abuse. Among the young women, 61 percent reported physical abuse and 47 percent sexual abuse. Those with a family history of heavy alcohol or other drug use were more likely to have been abused than others. In addition, 54 percent of those who had been either physically or sexually abused reported attempting suicide. Suicide attempts were significantly more likely in those who had been abused than those who had not, although 30 percent of those who had not been abused had attempted suicide. Seventy-two percent of young women who had been abused had attempted suicide. This was significantly higher than for abused young men, although 27 percent of them had attempted suicide. There was no relationship between abuse and excessive drinking or use of illicit drugs. Excessive drinking was of concern in this population of young people however. Sixty-six percent usually had five or more drinks on a day when they drank. This binge drinking is above the safe limits for alcohol consumption. On the other hand, illicit drug use, with the exception of marijuana, reflected an experimental pattern typical of adolescents (see YANACT, 1992; Sibthorpe et al., 1993).

The second study where sexual abuse was reported was a documentation of the stories of people who had been dependent on heroin in the past. In this study we did not ask specifically about sexual abuse, but of the 18 people interviewed, three (one woman and two men) told us about such abuse. For two of them it had occurred in childhood. It had been something they had had to deal with to stop using heroin (Bammer and Weekes, 1993).

Finally, stories of sexual abuse have come up in our research with current heroin users. Again we did not specifically ask about it. We are still analysing the results of this study, so I am unable to report any figures.

There are real problems for researchers both in asking and not asking about these issues. How do we ask sensitively? How do we handle disclosures? How do we ensure adequate follow-up? It is important that the issue is not ignored because of these difficulties however.

References

- Bammer, G. and Weekes, S. (1993) *Becoming an ex-user: Would the controlled availability of heroin make a difference?* Feasibility Research into the Controlled Availability of Opioids Stage 2 Working Paper Number 4. National Centre for Epidemiology and Population Health, Australian National University and Australian Institute of Criminology.
- Sibthorpe, B; Sengoz, A. and Bammer, G. in collaboration with The Youth Affairs Network of the ACT (1993) *Drug use and HIV risk among homeless and potentially homeless youth in the Australian Capital Territory.* Feasibility Research into the Controlled Availability of Opioids Stage 2 Working Paper Number 3. National Centre for Epidemiology and Population Health, Australian National University and Australian Institute of Criminology.
- Youth Affairs Network of the ACT (YANACT) in association with the National Centre for Epidemiology and Population Health (NCEPH) (1992) *Goonies and Green: A survey of drug and alcohol use among homeless and potentially homeless young people in the ACT.* Canberra: YANACT.

Susan Bilton

Counsellor

In my counselling practice I work on a private consultation basis and generally see people who have a history of child abuse, particularly child sexual abuse in single perpetrator and group perpetrator forms. My client group represents a biased sample when compared to the population of abuse survivors across the full socio-economic spectrum, in that they are generally financially stable and those that are subsidised (that is, pensioners) possess a high enough level of self esteem to negotiate a cheaper rate with me.

I do not come into contact with people who are actively addicted to alcohol or illicit drugs, though some of my clients are addicted to marijuana, many are smokers, and some have ceased previous alcohol and hard drug use.

I believe that addiction is not about the substance or activity a person engages in, but rather it is a process which underlies the specific medium of the addiction. The addictive process is used to avoid what is hidden within ourselves. Jung states that the unconscious is always seeking the light of day, and the addictive process stops painful, humiliating and frightening contents of the unconscious from emerging. Our society views the expression of powerful emotions, loud noises (for example: screams, sobbing, wailing) and powerful body movements that occur during flashbacks as dangerous. The great western institutions— for example, the medical, legal and educational systems— are based on repressing such expression and misunderstand that powerful expression of emotion can really mean that a healing process is taking place.

When someone is sexually abused the degree of affront to the person *requires* loud protest, screaming, violent body movements in order to get away from the perpetrator, etcetera as a normal, healthy reaction to the abuse. Children are frightened into not reacting, but their bodies store the memory of what would have been a normal reaction. The release of this stored body reaction is a vital part of the healing process, allowing the full body/mind of the person to take back their power.

From observations of my clients (and myself) I have come to believe that we have layers of addictions and if one addiction is not successful in keeping our pain locked up inside, and we do not have the resources to face the pain, we will add another. In our culture, the ultimate addiction is seen as heroin.

To my mind there are two reasons why an addiction is not effective: (1) our personal pain is erupting at a very fast rate— for example, in a crisis; and (2) there is a lot of unconscious material inside us, so we can't physically hold much more. In these cases we have a number of choices— we can commit suicide, dissociate from reality, find another addiction or decide to change direction and face the pain inside. The last option is the one least understood and supported in our society.

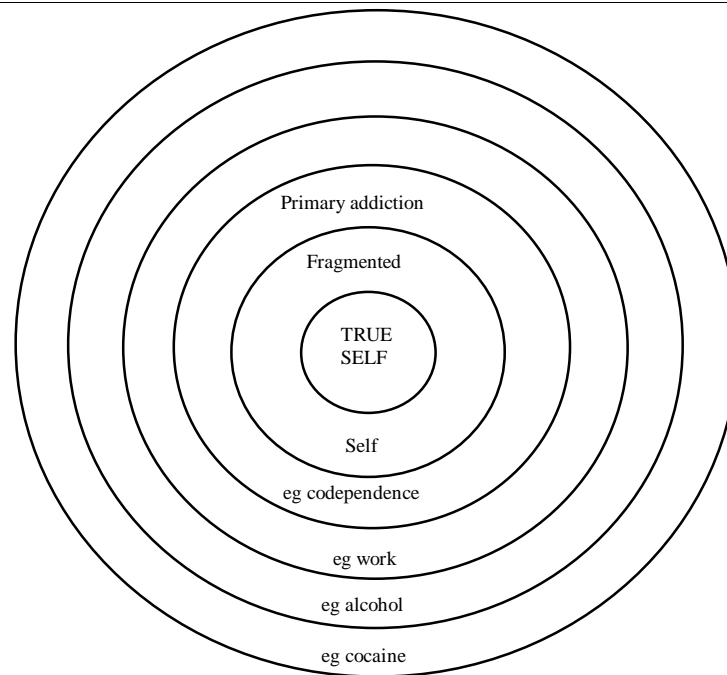


Figure 1: A model of layered addictions – (example only)

Table 1 shows the types of addictions I have observed in clients in my practice. I have 54 clients on my books, 36 of whom have been sexually abused or abused in a ritualised manner. Of these, 27 are women and 9 are men. Many clients use more than one addiction, but have a primary addiction which is the one they call on first in a crisis. Thirty-seven percent of females have a primary addiction to a substance and 33 percent of men do. I have included food in this category of substance abuse, as well as nicotine, alcohol, marijuana, heroin, etcetera, as I see this type of addiction as the use of an ingested substance as a mood alterer, and wish to avoid the value judgements society has placed upon drugs. Five of my clients have used heroin or other illicit drugs earlier in their lives, and replaced those addictions with quite strong addictions of other types. These clients seem to need to tightly control their healing process, possibly more so than others.

Table 1: Number of clients showing addictive behaviour (primary addiction in brackets)

Type of addiction	Sexual Abuse Survivors		
	Females (n=27) (ages 13–55)	Males (n=9) (ages 21–36)	Total (n=36)
Substance abuse			
Food	10 (3)	2 (1)	12 (4)
Nicotine	9 (5)	2 (2)	11 (7)
Alcohol	11 (1)	3	14 (1)
Marijuana	5 (1)		5 (1)
Heroin & others	5		5
Codependency	24 (9)	3 (1)	27 (10)
Activity addictions			
Sex	12 (1)	6 (3)	18 (4)
Religion	8 (1)	1 (1)	9 (2)
Sport	4 (1)	6 (1)	10 (2)
Work, being busy	21 (5)	5	26 (5)

There is a gender difference for other types of addictions: 33 percent of females are addicted to another person's behaviour as their primary addiction (that is, codependency) compared to 11 percent of men; and 30 percent of women are addicted to activity as their primary addiction (work, sex,

etcetera), while 55 percent of men are. Though the number of men in the sample is small, this does suggest that the choice of addiction is affected by the different gender socialisation processes for men and women.

Many of my clients use “softer” addictions to maintain their status quo. There are at least three reasons for this that I can see: (1) they have opened themselves for the healing process and released part of their “volcano” of stored energy and memories; (2) addiction such as workaholism, sport, etcetera are more easily sustained by those in the higher income brackets; and (3) for many, their early childhood abuse experiences were tempered (to some degree) by a comfortable material existence.

In my view we place value judgements on the range of addictions across society (for example, an addiction to sport is encouraged, while heroin use is not) and that the effect of this value judgement is to disempower hard drug users by forcing them into an expensive illegal lifestyle, which can only really be sustained by crime if they have no independent source of income, further eroding their self esteem. These people tend not to have enough money to feed themselves well, let alone be able to seek therapy. Also, for many their self esteem is so low they don't want help or good food anyway. And there is a catch 22 in legalising illicit drugs; if hard drug users' lives got easier, they would have room in their life for their unconscious pain to push its way to the surface. Most of us choose not to deal with our pain at the moment; it seems unfair that we should expect this from illicit drug users.

People need to make their own decision to reverse their addictive process and face the pain they store inside. I believe we need to respect people's need to do this in their own time, but to give them all the help they need for their healing process when the time comes.

Conclusion

All of my clients are healing from childhood abuse and they all use addictions of one sort or another to manage the emergence of their pain. This slows down their healing process, and suggests to me that a fundamental shift in attitude of society is needed to enable the people who have been hurt by its less caring members to have the full support of society to heal. As an ambit claim I suggest the provision of more “time-out shelters” where people can fall to pieces in safety and surrounded by trained support (at this stage I believe they would need to be single sex); paid leave for healing— not just illness; and the provision of adequate and free support systems be made a priority.

Maryanne Campbell*

Alcohol and Drug Service

ACT Health

It is extremely difficult, I feel, to find a causal link between alcohol and drug use and sexual abuse. Whilst there may be a high prevalence of drug use among sexually abused clients, there is also a high prevalence of sexual abuse in our society.

The sexual abuse figures are (if I recall correctly) 1 in 4 women, and 1 in 7 men. Not all of these persons are drug users.

Whilst working at the Crisis Detox Centre and at the Alcohol and Drug Service I observed that many clients (women especially) had suffered from sexual abuse.

However, instead of being evidence of a causal link between drug use and sexual abuse, it could simply demonstrate the prevalence of the objectification of women, considering that sexual abuse of males can be seen as a feminisation.

*Submitted on behalf of Alcohol and Drug Service. Maryanne Campbell did not attend the workshop.

I have also been told by clients that they don't want to talk about sexual abuse issues, that they don't want to go through traumatic memories again. They don't believe that it is a large factor in their drug use history. Do I tell them they're in denial? Do I know?

I'm also concerned about what happens if a causal link is found. What is the purpose of this research? Will it change treatment around drug and alcohol issues? In some ways I'm sure it would be beneficial. The longer I'm in counselling, the more value I see in focusing on explaining the broader perspective and attempting to pull away from the personal individual aspect.

Education about gender issues, the concept of being objectified, and issues of violence and sexuality within society seem far more beneficial than focusing too much on either personal sexuality or drug and alcohol issues.

If we find a causal link we also run the risk of relating drug and alcohol overuse to sexual abuse to the point where they become inseparable.

Also, how much do we know about the commonalities of the individual's experience of sexualities within the genders? How much do we understand of our own quirks around sexuality issues? What I may find pornographic or threatening, you may find erotic.

I think when it comes to issues of sexual abuse, we need to appreciate the differences in how individuals recover from trauma. For some individuals, internalised negative feelings from sexual assault in their youth may result in drug use, obsessive dietary behaviour or other destructive behaviour. Other victims of sexual assault may view the assault as a very bad incident, an unacceptable behaviour, but may well have come to terms with it.

My concern is also not to make sexuality any more important than it is now. To do so I feel would be to promote its importance and therefore in some ways promote anguish around it.

Perhaps what we need to begin with is a reliable methodology that measures indications of sexual assault and results in a scale to measure trauma.

We could then perhaps pitch treatment to suit the need.

Also, we may have to consider maintaining survivors of sexual assault, who present for treatment in a very traumatic state, on a drug which minimises the pain. For some people the nightmares and the flashbacks and the catatonic states may be too hard to handle and we as counsellors need to accept that.

Sometimes generalist concepts of addiction like co-dependency explain commonalities in issues, but do not allow for individual differences.

I think it is important to investigate whether there are causal links between drug use and sexual abuse, but it is equally important for researchers and counsellors to understand how to interpret this information.

Phyll Dance

PhD Student

National Centre For Epidemiology And Population Health

The Australian National University

Last year I interviewed 139 Canberra-based illicit drug users for my PhD research. One hundred and seven people were Injecting Drug Users— most of these people were injecting heroin. Most people drank alcohol and the mean number of standard drinks a day was above daily recommended levels. Other drugs used by the respondents included marijuana, amphetamines and hallucinogens. My reading and discussions with other members of the Alcohol and Other Drugs Working Party of the ACT Women's Health Network informed me that there was a correlation between sexual abuse and drug use. For several reasons I did not, however, include questions on sexual abuse in my Interview Guide, but when people were relating their drug use histories to me, the issue came up on several occasions. Since I was largely interviewing people not in treatment, for some people this was the first time that they had disclosed. Both men and women told me in some detail their history of sexual abuse and though I spent some time talking to them and advising them to seek help from other agencies, I still had a strong sense that I had not been able to help them enough. I have maintained contact with many of the people I interviewed. One young woman who had a lot of problems with her drug use had been sexually abused by her father from the age of 8. Shortly after our interview, and due to this abuse, she needed an abortion. I have also been in contact with a couple of young men who were sexually abused and felt at a loss as to how to help them. These experiences fed into the idea of running today's workshop.

Patricia Easteal

Senior Criminologist

Australian Institute of Criminology

This talk could be subtitled "filling the vacuum within" (Easteal 1992a).

The close connection between female drug (alcohol) abuse and childhood sexual assault have been shown in two facets of my life. First, research on women in prison: there is evidence, including my own fieldwork, that 80 to 85 percent are drug addicts with a similar proportion estimated to have been victims of incest or other types of abuse (George 1988; Miner & Gorta 1987; Wilson 1987; Women and Girls in Custody Group 1991; Easteal 1992b, 1993). The second area is fifteen years' experience as a volunteer working with women who have drug and alcohol problems. I can state, without any reluctance, that at least three quarters and quite possibly more of the women who have identified as abusers of drugs (alcohol) also identified as survivors of childhood sexual assault.

If we accept that there is a strong connection between the two, what is the tie? 'Don't talk', 'Don't trust', and 'Don't feel', are the three rules that dominate households where addiction, abuse or other types of dysfunction are present (Beattie 1989; Bradshaw 1988; Wegscheider-Cruse 1985). It is theorised that, as a consequence of growing up in an environment with these rigid norms, there is an increased likelihood of the children developing certain personality traits and behavioural patterns of survival. Low self-esteem and deeply embedded feelings of shame may lead to alcoholism, drug abuse, other forms of dependency, and/or adult relationships marked by victimisation (Finkelhor 1979; Gelinas 1983; Whitfield 1979).

The incest victim or the child who is abused learns secrecy. Not only does she not talk to anyone outside of the home, but within the family the violence is also not discussed. The 'Don't talk' rule is mandatory and will usually be both explicit, 'We do not talk about this to anyone' and implicit through the on-going denial of the child's perception of reality. The 'Don't talk' rule is also a by-product of two other factors: her own sense of shame which assumes the responsibility for the abuse; and the idea

that such violence becomes so normative that it is no longer exceptional but just a part of her reality: the bizarre becomes normal.

A child learns to trust when she is nurtured and treated with love, consistency and caring. The abused child is not. She does not learn to trust in her parents or in their love. Within a continuum of degree, this lack of trust in others would take place for any child who is abused within or outside of the family. The childhood sexual assault survivor grows up with a deep void within; a lack of self or self-worth. In its place is a core of shame which continuously says to that child, 'You are the one responsible for this. You are bad.' She has probably been told either overtly or indirectly that this is the case. If grown-ups are a child's gods then the cause of such evil must emanate from her.

When he touches her, she learns not to feel the rage. She learns not to feel the pain because there is no one or no way to make it feel better. However, the hurt and the anger are within, buried beneath layer upon layer of denial, shame, and later perhaps drugs, food, relationships or other obsessive compulsive activities.

That is the process of surviving. Not talking, not trusting and not feeling do not help the child to heal, but they do enable her to live through it. She is left with a vacuum within as far as self-worth and she is left with feelings that must be pushed down: alcohol and other drugs serve to fill the hole within and numb the feelings, at least until they don't. By then it may be too late— as she is addicted.

References

- Beattie, M. (1989) *Beyond codependency*, Victoria: Collins Dove.
- Bradshaw, J. (1988) *Bradshaw on: The Family*, Florida: Health Communications.
- Easteal, P. (1992a) 'Don't talk, don't trust, don't feel: The dysfunctional environment of women's prisons', *Journal of Social Justice Issues*, accepted for publication.
- — (1992b) *The forgotten few: Overseas-born women in Australian prisons*, Canberra: Australian Institute of Criminology.
- — (1993) 'Overseas-born female inmates in Australia: A prison within a prison', *J.Criminal Justice*, 21(2), pp.173–184.
- Finkelhor, D. (1979) *Sexually victimized children*, New York: The Free Press.
- Gelinas, D.J. (1983) 'Persisting negative effects of incest', *Psychiatry* 46(4), pp.312–32.
- George, A. (1988) 'Women behind bars', *Chain Reaction* 54, Winter, pp.34–6.
- Miner, M. and Gorta, A. (1987) 'Heroin use in the lives of women prisoners in Australia', *ANZ J Criminology*, 20, pp.3–15.
- Wegscheider-Cruse, S. (1985) *Choice making*, Florida: Health Communication.
- Whitfield, C. (1979) 'Children of alcoholics: treatment issues', in *Services for children of alcoholics*, NIAAA Research Monograph 4.
- Wilson, S. (1987) 'Women and drugs in Mulawa', *Aust. Crime Prevention Council Journal*, August, pp.15–19.
- Women and Girls in Custody Group (1991) *Women in NSW Prisons: A discussion paper*, March.

Lyn Enright

for Toora Women's Addiction Recovery Service

It is widely recognised that a significant percentage of adult clients of alcohol and drug treatment services have experienced some form of childhood sexual abuse. Such abuse is frequently compounded by subsequent adult abuse and rape. There is further evidence to indicate that such abuse may go unrecognised and untreated in treatment and may therefore contribute to an inability to achieve treatment goals and an increased rate of relapse. Many workers in the alcohol and drug field have expressed concern at this phenomenon and some express a sense of inadequacy and inability in dealing

with the identification, intervention and counselling requirements of such clients. The bewilderment of workers is often exacerbated by the complexity of some of the issues surrounding these clients.

The range of issues includes: the possible causative role of childhood sexual abuse in adult dependency; the need to resolve abuse issues before commencing chemical dependency treatment; the relative importance of attaining and maintaining abstinence before commencing treatment for the resolution of abuse issues; and priority afforded each issue by particular services. In addition there are questions of the suitability of addiction professionals as sexual abuse therapists, the issues of the gender of treatment workers and the practical limitations faced by services in providing adequate support for clients. This is further complicated if one seeks to address questions of the relationship between childhood sexual abuse and dependent and abusive adult relationships (which are almost always present in the lives of chemically dependent women) and the strong possibilities of cycles of abuse involving children.

It is our view that, to some extent, there must be a thorough discussion of these issues before the formulation of an appropriate strategy to meet the needs of affected clients and those who work with them.

Some key issues

Whilst the importance of the effects and consequences of childhood abuse in the treatment and management of chemically dependent women must be acknowledged, great care must be taken before one concludes a causal relationship between these two experiences. This is particularly true in light of the incidence of abuse in the non drug using community, and the number of other abuse related variables likely to have been present in the sexually abusive background of a chemically dependent woman. Therefore, whilst it is critical to acknowledge the role that unaddressed abuse issues might play in contributing to and/or perpetuating dependency, or inhibiting the recovery process, it is as important that acknowledging the existence of childhood sexual abuse does not come to equal a lesser opportunity for positive change, but rather an important opportunity for understanding and growth. Specifically, it is important that evidence of prior abuse does not result in a lesser expectation of positive change, thus further damning the client.

In addition, there is considerable evidence to suggest that beyond the travesty of initial sexual abuse, a further travesty often occurs when the trauma of childhood sexual abuse is further exacerbated by the denial or poor handling by relatives, friends and helping professionals. This can result in disclosure meaning inappropriate intervention and subsequent institutionalisation. Thus, at this point it is difficult to distinguish the harm that arises from the abuse itself and that which arises as a result of the limited and often inadequate range of professional responses to abuse.

Heed must also be paid to the relationship between child sexual abuse, abusive adult relationships and the abuse/abuser cycle. Such a relationship presents an imperative to address the concerns many abused women have about the quality and process of their own relationships/parenting. Most importantly, this needs to be considered because it is the shame arising from these factors that frequently discourages women from seeking treatment for either dependency or abuse related issues.

Clearly, whilst there can be little doubt of the need for all health and helping professionals to gain a deeper appreciation of the issue, and that there are particular skills and sensitivities associated with the addressing and healing of abuse issues, WARS would caution against a possible danger associated with this; the danger that the so-called specialisation of some workers leads to an abdication of this basic health care responsibility in others. The reality is that childhood sexual abuse is far too widespread for any health care provider to allow the issue to become the province of only highly trained professionals. These issues must therefore, to some extent, become part of the repertoire of any well-rounded health worker, at least regarding quality assessment and referral.

Finally, a comment on the 'chicken/egg' type concerns many workers express regarding the treatment or acknowledgment of dependency issues and abuse issues. It is our view that such issues can and should be addressed concurrently. Experience indicates there is little value in attempting therapeutic resolution of childhood abuse whilst a woman is intoxicated. On the other hand, such a

woman is no less entitled to validation and basic respect for her suffering than any other. Likewise, a woman attempting some form of recovery from chemical dependency may need to either vigorously pursue issues of prior abuse or indeed retreat from these, whilst exploring and gaining an understanding of her drug use.

In short, there can be no prescription of the one right way to address childhood abuse issues present in chemically dependent women (or indeed people). Perhaps we might be guided by the principles of 'self pacing' in clients and the need for practitioners to be honest where we regard possible abuse issues to be impinging on the successful resolution of the presenting problem. Not least such honesty is necessary to be clear about our limitations as counsellors, therapists and advocates.

Jillian Fleming

PhD Student

National Centre for Epidemiology and Population Health
Australian National University

I am currently doing a PhD in the area of child sexual abuse and the development of alcohol dependency in women. Prior to this I worked as a counsellor in the alcohol and drug field in Canberra. It was during this time that I developed my interest in the effects of child sexual abuse on women. When I started working with clients I had little knowledge about the effects of sexual abuse, or even that there was a connection with alcohol and drug use. At first this was not a problem because I did not have any of these clients – or so I thought. It was not until a colleague was leaving and asked me to take over some of her clients, with whom she was working on a number of sexual abuse issues, that I became aware of this issue. I studied as much as I could and talked to many people working in the field. What amazed me then, was that once I opened myself to the possibility of sexual abuse – it seemed everywhere! Not surprisingly, I then had many women clients and some men clients with sexual abuse histories. In many instances this was the main problem in these women's lives, with alcohol being a way of coping until they felt able to deal with this issue. I believe it is a very real problem in the drug and alcohol area and yet it remains surprisingly hidden.

Research in this area has been steadily increasing over the last 20 years. The exact incidence of sexual abuse in the histories of chemically dependent women is not known. Various American studies have indicated that between 40–70 percent of women in treatment for alcohol or drug dependency have experienced incest in childhood. Anecdotal evidence in Australia given by some treatment centres has the figures as high as 98 percent. The reason for such differences in rates is due to problems with defining both childhood sexual assault and drug dependency, the use of specific populations and the lack of control groups. However, studies of non-clinical populations show rates of childhood sexual abuse between 15–30 percent, indicating that the incidence in chemically dependent women is at least 100 percent higher than in the general population.

Given the importance of the relationship between childhood sexual abuse and later chemical dependency in women, and a lack of research on this in an Australian context, my PhD aims to look at this relationship by way of a case control study.

Lynne Magor-Blatch

Program Director
Karralika

In a survey of 35 women admitted to Karralika over a 12 month period during 1991–1992 the following statistics were noted:

Non-parent	Custodial Parent	Non-custodial Parent	Evidence of sex abuse	Evidence of incest in addition to other sex abuse	No. seeking help prior to D&A treatment	Evidence of abuse of own children
8	24	3	28	17	10	12

In other words,

- 80 percent of those admitted were victims of sexual abuse and 60 percent of that number also admitted incest. Only 35 percent (10) had sought help prior to their arrival at Karralika— 32 percent (9) only receiving help at detox in the 2 months prior to Karralika admission (that is, only 1 person sought help outside a Drug and Alcohol agency).
- 42 percent of women who had been abused also admitted physical abuse of their own children.
- Of custodial parents:
 - One had lost custody of one of the children
 - One lost custody of children during course of treatment.

As D&A workers we are dealing with complex issues. Many of our clients are second and third generation abusers. The first generation may have managed their impulses by acting out— they often became the perpetrators. The second generation may have managed by internalising and medicating themselves. What of the third generation— those we presently have with their parents in treatment?

Poverty, isolation, low self esteem, guilt and shame are also issues shared by most of these women. Many are lone parents often facing legal and financial problems regarding their children. Many are homeless or living in inadequate housing or are residing in unsafe home environments due to violence.

Women also need to recognise that they have a lot to offer others, and that they have the right to relationships where they are cared for rather than abused.

To achieve this they firstly need to believe that someone cares enough to listen and help them to explore their feelings and experiences. By participating in groups they will learn that they have much in common with many other women.

Group therapy has the additional benefit of relieving some of the sense of isolation so many of these women express, and helps to shed some new light on the old belief that it is their own pathology that has created their problems. They can also clearly see many others who have also been damaged by past experiences.

Much of the literature supports 'women-only' programs, and cites low retention rates in mixed therapeutic communities and treatment services. In support, it would appear that women-only programs have a higher retention rate where perhaps the women find their issues surrounding abuse and prostitution, in particular, dealt with more sympathetically.

It is absolutely vital that we look not at the symptom— that is, the drug use— but at the problem— why the person is using drugs— and treat the underlying causes of drug addiction.

At Karralika we have two houses. Both have mixed populations, although the Family House tends to have a primarily female population. Single fathers with children and family groups are admitted and some of the 'back-up' parents are males— however the population tends to be 95–100 percent women. (This is based on the adult population and excludes the child population.)

Our own experience supports mixed programs, but also places emphasis on single sex groups.

(This has been adapted from the 1992 Annual Report of the Alcohol and Drug Foundation of the ACT.)

Tarquin McPartlan

Peer Education Worker
ACTIV League

The ACTIV League – service overview

The ACTIV League is an information, support and advocacy group for injecting drug users. Our clients have only one thing in common and that is that they all take drugs by injection. Some may use heroin; others steroids; some amphetamines. For us, what our clients inject is immaterial, as is how often they do it. Our primary concern is that they do it safely.

It is our aim to lessen the impact drug use has on the lives of our clients, in that they do not sustain any avoidable physical harm through their drug use. Some of the risks are uncontrollable due to the illegal status of most drugs: risk of overdosing; of impurities; of getting caught by the police; of jail— these are beyond the control of users.

However, by teaching people to inject safely there is much we can do to lessen the risks of contracting HIV or Hepatitis, of getting a 'dirty hit' or losing a limb. By offering support we may be able to assist them to stay healthy, to keep their electricity connected, to help them stay out of jail.

Service provision for people who inject drugs

Many of our clients have a history of childhood abuse. A primary difficulty with helping these clients is that many services either cannot or will not deal with people who are still using drugs. This is a problem across a wide variety of services and one we are all finding difficult to overcome.

Many people turn to drug use as a way of coping with childhood trauma. I believe that it is a great deal to ask of someone that they give up what has kept them insulated, kept them safe, before addressing how they got where they are in the first place. Many people have the experience of having to go to many counsellors before finding one who does not demand they give up drugs before they will be seen. It can be explained that their progress could well be inhibited by their drug use, but it is up to them to decide. Isn't that what it's all about— giving back control?

No one will deny the importance of talking about childhood abuse; of facing it. I firmly believe that if the only way a person can talk about it is when they're intoxicated, that has to be better than not talking about it at all— and with many people, initially, those are our only two choices.

Although it is difficult to enter into counselling with someone who has made drugs a major part of their lives, I do not believe that it's impossible— and given the number of people in need of such counselling it's a skill we must learn, for we can't just keep on ignoring the need of people who can't or won't give up their drug use simply to begin counselling.

Margaret Shanahan

I am a member of one of the reference groups for the 'Feasibility Research into the Controlled Availability of Opioids'. I have a broad range of friends and acquaintances who are IV drug users and ex-users— this includes my partner. I am also a volunteer worker in an information and referral agency. This access to information is often used on an informal basis by my friends and acquaintances. I have also had various interactions with alcohol and drug services and sexual abuse survivor services.

In my interactions with IV users, a number of themes by way of need for referral have been recurring. One of these themes has been their experiences as survivors of sexual abuse. The interesting thing about this was the more it was talked about, the more people disclosed and often for the first time, particularly in the case of men. Most of the women were or had been in contact with services

addressing this issue. With the exception of one man, none of the men had and in fact, it would have been very difficult for men to use services in this area as very little is available.

Further reading and discussion revealed that substance abuse did seem to occur more frequently in survivors of sexual abuse in childhood, though there was limited research in this area and much of the evidence was anecdotal.

One article that I read indicated that substance abusers who were also survivors of abuse were more likely to relapse and require more health services in general than other users of substance abuse programs (Howard, 1993). Given the long-term effects of sexual abuse on survivors, I wondered if the abuse of substances was a survival strategy; an effective pain killer. This would allow the survivor a blanket for their feelings of hurt, confusion, helplessness and worthlessness— common traits of survivors.

If this was true, it may then be necessary to address the issue of the client's sexual abuse to facilitate a more successful withdrawal from the substance of their choice. Having said this I also felt, as did my partner, that this should be done by workers specifically trained to deal with these issues, whether that be in an Alcohol and Drug setting or abuse survivor services. Access to survivor services for women is a straightforward proposition though waiting lists are ever present. Access for men is not.

Men face a number of problems in disclosing their sexual abuse. Firstly, men in our current society are not supposed to be victims. In fact, the opposite is true. If a male was abused by another male he is open to being perceived as sexually deviant. If he was abused by a woman he should have enjoyed it. Secondly, there are very few people who are in a position to deal with male survivors. There is no referral system in place.

These problems are compounded for both men and women by their status in society as drug addicts and all that implies, including their alienation from mainstream services.

Alcohol and Drug workers are in a position where, during their work, disclosure may take place. I felt it was imperative that if this happened workers be in a position to deal sympathetically and effectively, by meeting their client's immediate needs as well as having an established referral system for both their male and female clients. It was also felt that the abuse may need to be taken into account during alcohol and/or drug treatment.

The result of my partner's and my concerns and our collaboration with the reference group was this workshop, to raise awareness of these issues, to discuss the need for research into possible connections and/or appropriate responses and referrals for clients.

Reference

Howard, J. (1993) 'Correlates of childhood physical and sexual abuse in adult male drug dependents', in Balzer, M (ed) *Drug and Alcohol Research and Evaluation. Concepts and Priorities. A report on AMPSAD's National Conference 1992, Thredbo, October 2-4*. Australian Medical and Professional Society on Alcohol and Other Drugs, Sydney, 50-59.

Adele Stevens

PhD Student

Women's Studies Program

The Australian National University

I am a graduate student researching in the area of women and illegal drugs. I first became aware of the importance of sexuality and shame issues for women in drug treatment agencies by attending a Women and Addiction workshop run by Toora in 1987. At that time, I was working at the Australian Institute of Criminology on a project examining the indicators of illegal drug use. Traditionally, in Australia, drug seizures and arrests have been used as an indicator of the level and nature of illegal drug use. There is a

significant connection between crime and illegal drug use for men, but not for women. A more important issue for women appears to be sexual assault. On examining the literature and talking to women, it became apparent that somewhere between 30 to 75 percent of the women in drug treatment agencies are survivors of incest and child sexual assault. However, except for the feminist services, most drug treatment agencies' staff were unaware of the problem and little had been done in drug treatment agencies to address the needs of incest survivors.

I am co-convenor of the Alcohol and Other Drugs working party of the ACT Women's Health Network, and last year the working party decided to make child sexual assault among alcohol and other drug services' clients the topic for discussion at the Women's Health Network meeting. Out of that meeting arose an agreement by the Alcohol and Drug Service of the ACT Department of Health to run a series of workshops for alcohol and other drug workers to assist staff in recognising clients with a problem in this area, with the aim of possible referral or treatment.

My research included interviewing women who used illegal drugs. Some of these women had been in drug treatment agencies and others not. Some women in both groups discussed their experiences of sexual assault and their concerns. This is not surprising given that about one in four women in the community are survivors of child sexual assault.

It has become clear to me that incest is a complex issue. Some of the women I interviewed were angry at service providers and welfare agencies for inappropriate intervention on their behalf. Clearly, incest is a sensitive issue that involves listening carefully to the client, whatever their age. I do not believe that the sensitivity of incest is an appropriate excuse for not giving clients the opportunity to deal with the issue as part of their treatment. There is some evidence that alcohol and other drug treatment clients who have not addressed these issues are more likely to relapse. Incest issues may not be dealt with in treatment because alcohol and other drug workers are not comfortable or equipped to deal with it. There is a taboo in the community in general and to a lesser extent among alcohol and other drug workers concerning *talking* about incest. Rather than incest being the taboo— given the relatively common occurrence of incest— it seems, as Diane Russell says, that talking about incest is the taboo. I see the workshop today as part of the process of breaking down that taboo.

Heather Strang

Executive Research Officer
Australian Institute of Criminology

Numerous studies have examined the initial and long-term consequences of child sexual abuse. Several have found that one effect on social functioning that frequently presents as a long-term consequence is the development of alcohol- and drug-related problems, especially in women. Examples of such studies are Hurley (1991), Duncan (1991), Brown and Anderson (1991), Singer (1989), Rohsenow et al (1988), and Herman (1981). However, research on the impact of childhood sexual abuse generally suggests that an increased risk for alcohol and other drug abuse may be only one of a range of consequences relating to overall significant identifiable mental health impairment (Finkelhor 1987).

The vagueness of the definitions of sexual abuse and substance abuse is problematic in interpreting research findings in this area. However, some research indicates that there may be a higher prevalence rate for diagnosis of alcohol and other drug dependence in survivors of childhood sexual abuse (Herman 1981) and child sexual abuse has been found to be a predictor of alcoholism (Miller et al 1987).

Although clearly, a history of sexual abuse is frequently found in those seeking assistance with their drug and alcohol dependencies, it is important to recognise that there is no inevitable connection between these two variables. Thus, even though any retrospective study is likely to confirm that a higher than expected proportion of those with alcohol and other drug problems have experienced childhood sexual abuse, a prospective study of those who have experienced such abuse would find that

not all go on to develop such problems. (Of course, it is highly likely that they develop other problems, but that is beyond the scope of this workshop.)

Turning to the question of the causal mechanism between these two variables: one possibility is that survivors of childhood sexual abuse may have more negative internal feelings about themselves (Sgroi 1982); some studies indicate that women alcoholics often initiate drinking to deal with feelings of discomfort or inadequacy (Beckman 1980). Thus early negative feelings towards oneself that follow childhood sexual abuse may result in the development of unhealthy coping mechanisms for dealing with these painful feelings.

In addition, it may be that the antecedents of alcoholism may be similar to the consequences of childhood sexual abuse (Miller et al 1987): for example, social isolation and emotional disturbances appear to be more characteristic of adolescents who later develop alcohol problems (Jones 1971), as compared with those who do not. Likewise, there are indications that emotional disturbances and social isolation are consequences of childhood sexual abuse (Browne and Finkelhor 1986). In addition, low self-esteem and distorted self-image are found among women alcoholics (Kinsey 1968), whilst similar negative self-perceptions and emotional reactions have been documented in survivors of childhood sexual abuse (Browne and Finkelhor 1986). There may also be similar consequences for children flowing from both parental alcoholism and childhood sexual abuse: for example, children of alcoholics frequently experience role reversal with their parents, suffer from loss of self-esteem and are often socially isolated because of the coping mechanism and denial processes typically surrounding both parental alcoholism (Barnes 1977) and childhood sexual abuse (Finkelhor 1979).

It must be noted, however, that parental alcoholism may provide a confounding effect: studies indicate that a high proportion of identified incestuous fathers are alcoholics (Gebhard et al 1965). There is also evidence that children of alcoholics may be at greater risk for developing alcoholism (Cloninger et al 1981). In addition, parental alcoholism or drug dependency may contribute indirectly to vulnerability of their children to sexual abuse either through environmental factors (such as family separation resulting from the dependency and consequent lack of family protection and exposure to sexual exploitation) or because of psychological factors (for example, lack of affection and communication between family members).

These research findings have important implications for service delivery: for example, unresolved issues arising from childhood sexual abuse may be a hidden factor underlying much substance abuse, and if not addressed may lead to rapid relapse. At the same time, it is important to realise that alcohol and drug dependence may play an important role in allowing individuals to function at all by relieving them of the pain of surviving sexual abuse, and the interconnection of the abuse and the dependence needs to be recognised.

Those involved in research and service delivery in the area of child sexual abuse should be aware of the establishment of the National Clearing House for Information and Research on the Prevention of Child Abuse and Neglect. This body is under the auspices of the National Child Protection Council and located within the Australian Institute of Criminology. Its objective is to collect and disseminate Australian and overseas material relating to the prevention of child abuse and neglect. It has conducted an audit of all existing prevention programs and research in Australia and established links with a large number of relevant agencies. It welcomes requests for information from any individual or organisation involved in any aspect of child abuse and neglect.

References

- Barnes, G.M. (1977), 'The development of adolescent drinking behavior: an evaluative review of the impact of the socialization process within the family', *Adolescence*, vol.12, no.48, pp571-591.
- Beckman, L.J. (1980), 'Perceived antecedents and effects of alcohol consumption in women', *Journal of Studies on Alcohol*, vol.41 no.5, pp.518-530.
- Brown, G.R. & Anderson, B. (1991), 'Psychiatric morbidity in adult inpatients with childhood histories of sexual and physical abuse', *American Journal of Psychiatry*, vol.148, no.1, pp.55-61.

-
- Browne, A. & Finkelhor, D. (1986), 'Impact of child sexual abuse: A review of the research', *Psychological Bulletin*, vol.99, no.1, pp.66–77.
- Cloninger, R; Bohman, M. & Sigvardsson, S. (1981), 'Inheritance of alcohol abuse', *Archives of General Psychiatry*, vol.38, pp.861–868.
- Duncan, D.F. (1991), 'Physical and sexual abuse in the life histories of adolescents in drug abuse treatment', *Family Violence Bulletin*, vol.7, no.3, pp.17–19.
- Finkelhor, D. (1979), *Sexually Victimized Children*, The Free Press, New York.
- Finkelhor, D. (1987), 'The sexual abuse of children: current research reviewed', *Psychiatric Annals*, vol.17, no.4, pp.233–237, 241.
- Gebhard, P.H; Gagnon, J; Pomeroy, W. & Christenson, C. (1965), *Sex Offenders: An Analysis of Types*, Harper & Row, New York.
- Herman, J. (1981), *Father–Daughter Incest*, Harvard University Press, Cambridge, Mass.
- Hurley, D.L. (1991), 'Women, alcohol and incest: An analytical review', *Journal of Studies on Alcohol*, vol.52, no.3, pp.253–268.
- Jones, M.C. (1971), 'Personality correlates and antecedents of drinking patterns in women', *Journal of Consulting and Clinical Psychiatry*, vol.36, pp.61–69.
- Kinsey, B.A. (1968), 'Psychological factors in alcoholic women from a state hospital sample', *American Journal of Psychiatry*, vol.124, pp.1463–1466.
- Miller, B.A; Downs, W.R; Gondoli, D.M. & Keil, A. (1987), 'The role of childhood sexual abuse in the development of alcoholism in women', *Violence and Victims*, vol.2, no.3, pp.157–172.
- Rohsenow, D.J; Corbett, R. & Devine, D. (1988), 'Molested as children: A hidden contribution to substance abuse?', *Journal of Substance Abuse*, vol.5, pp.13–18.
- Sgroi, S.M. (1982), *Handbook of Clinical Intervention in Child Sexual Abuse*, D C Heath, Lexington MA.
- Singer, M.I; Petchers, M.K. & Hussey, D. (1989), 'The relationship between sexual abuse and substance abuse among psychiatrically hospitalized adolescents', *Child Abuse and Neglect*, vol.13, no.3, pp.319–325.
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WORKSHOP DISCUSSION

At the workshop, issues were discussed under the following headings: issues for all of us, issues for service providers, issues for researchers, and needs for action. Points for discussion were extracted from the morning's presentations and written on a white-board as starters for the afternoon's work.

A different way of grouping the issues has been used for this proceedings: interacting with the childhood sexual abuse survivor; training for service providers and researchers; collecting data about childhood sexual abuse; social structures that perpetuate abuse and alcohol and other drug dependence and areas for action.

Interacting with the childhood sexual abuse survivor

These issues are relevant for both service providers and researchers.

There are difficulties in how to raise the issue of childhood sexual abuse and there is no consensus on how this can best be done. How can people be adequately prepared if they are going to be asked about this issue? How should questions be worded? Is it more appropriate to ask using a self-completion form or in a face-to-face interaction? When should questions be asked? Should the person asking questions be the same sex as the survivor? It is also important to consider if questions about childhood sexual abuse should be asked at all and to work through who benefits if questions are asked. It was agreed that there needs to be a policy for obtaining informed consent if the issue is to be raised by service providers or researchers and that this should also cover the way the information could be used. Further, it was agreed that there needs to be a policy about the protection of confidentiality which is binding on those to whom disclosures about childhood sexual abuse may be made. This was seen to include not only alcohol and other drug workers and researchers, but also professionals like school counsellors.

In addition, it was agreed that:

- there must be respect for the individual's needs;
- value judgements must be avoided;
- the vulnerability of the survivor must be sensitively recognised;
- there must be recognition that the survivor may be disclosing for the first time;
- if the issue is raised, people must not be pushed too far too soon;
- situations in which there is a legal obligation for a professional to report child abuse require particular sensitivity;
- the issue must be dealt with in a culturally appropriate manner. Where there are language difficulties, every effort should be made to find same language counsellors or, if not available, interpreters;
- apart from cultural issues, which are relevant to Aboriginal people and people from non-English speaking backgrounds, other groups may also have special needs. These include people who are injecting drug users and people who have been in prison;
- there is some disagreement about whether or not people who are dependent on alcohol and/or other drugs must deal with the dependence before they can deal with the childhood sexual abuse;
- trust must be established. This is likely to involve long-term interaction and follow-through. For service providers this suggests that brief intervention approaches are unlikely to be successful. The implications for researchers have still to be worked through;
- a person who has disclosed must be offered appropriate back-up. For example, they can be asked if they would like to talk about the issues with the person to whom they have disclosed or if they would like to be referred to an appropriate agency;

- it must be recognised that there is a shortage of adequate agencies to which survivors can be referred. There is a particular shortage of agencies for men who are survivors. It was agreed that funding for services for either sex is a particular problem;
- there must be understanding that many survivors respond to their abuse with denial, secrecy and shame;
- there must be an holistic approach to individuals. Sexual abuse and alcohol and/or other drug use and/or dependency must be seen in a total life context. The whole person must be recognised and their other life experiences taken into consideration. The person may also have other issues which need to be dealt with, including other dependencies;
- it must be recognised that society's response to abuse is often institutionalisation and that this often has harmful effects. Similarly, other aspects of the welfare system to which survivors may be exposed may also have harmful effects;
- people may have been misdiagnosed as having a psychiatric disorder;
- it must be recognised that survivors of childhood sexual abuse may have been subjected to cycles of abuse by different perpetrators in childhood and adulthood. This is often referred to as 're-victimisation';
- the risks of contracting HIV or other sexually transmitted diseases as a result of sexual abuse need to be sensitively raised with the survivor;
- although for many people there seems to be a causal link between childhood sexual abuse and drug use or dependence, the existence of both in any one individual should not lead to an immediate assumption that the childhood sexual abuse has caused the alcohol and/or drug dependence. In other words, people must be allowed to tell their stories fully and without preconceptions on the part of the listening service providers or researchers;
- both women and men can be sexual abuse survivors, and service providers and researchers who have contact with both sexes need to be prepared to handle disclosures from either women or men;
- childhood sexual abuse may occur in "spiritual" settings. This can occur in ritual abuse or when abuse is perpetrated by people who are involved in organised religion, as in recent examples of abuse of children at Catholic institutions. This can complicate the ability to deal with spiritual issues that may be part of coming to terms with abuse and alcohol and/or other drug use and/or dependence;
- the possibility that reported physical abuse may be a euphemism for actual sexual abuse must be considered;
- it is possible that people who seem to be lying about abuse may be 'testing the water' to determine if it is safe to disclose actual abuse. In any case, there is an over-emphasis on people who are thought to be falsely reporting abuse. The factors mitigating against disclosure far outweigh those which would encourage false reporting;
- in addition, the sorts of behaviours that often lead to someone being seen as untrustworthy are often the sorts of behaviours which are a product of abuse.

Training for service providers and researchers

It was agreed that training was important for service providers and researchers who might be faced with disclosures about childhood sexual abuse. There was some discussion about the relative merits of specialist versus generalist training. It was agreed that service providers, in particular, needed to be better trained to recognise childhood sexual abuse.

It was agreed that the issues outlined above must be covered as part of training. Other issues seen to be important were that

- use of and/or dependence on alcohol and/or other drugs was a coping strategy preferable to suicide;

- both men and women can perpetrate abuse. (It was also noted that there are no services for perpetrators, nor are workers trained to deal with perpetrators. While it is important to establish such services and training, this should not be at the expense of services for survivors or training of workers to deal with survivors.)

There was some discussion about the dangers associated with inappropriate people setting up and running services for childhood sexual abuse survivors. The question of who goes into the helping professions was raised. There was recognition of the need to appropriately supervise both service providers and researchers dealing with these issues. The possibility that service providers and researchers might have their own issues to deal with was also recognised.

There was some discussion, but no consensus, about the appropriate role of women in services for male survivors of childhood sexual abuse. It was agreed that much of the experience accumulated in women's services could be of benefit to those establishing men's services; however, there was no discussion on how this experience might be made available.

It was agreed that both service providers and researchers must be given appropriate opportunities to debrief.

It was agreed that it is important for both service providers and researchers to be aware of their own limitations and to attempt to compensate for them through appropriate networking and referrals. The lack of services and hence adequate referral possibilities is a problem here though.

Collecting data about childhood sexual abuse

There was some discussion about the necessity of conducting research to determine whether or not there is a causal link between childhood sexual abuse and alcohol, heroin and/or other drug dependence. On the one hand, it is important for service providers in the alcohol and other drugs field to be able to recognise and work with sexual abuse survivors regardless of whether or not there is a proven link. On the other hand, if a clear causal link was found, it could lead to more resources, so that better services could be provided for survivors.

There was agreement that good working definitions of childhood sexual abuse are important.

There was extensive discussion about the difficulties of collecting statistics about childhood sexual abuse. It was recognised that in principle a useful source of information would be the records kept by service providers. In practice, however, this is less straightforward. Many service providers have concerns that the collection of statistics may breach confidentiality. For example, if a high proportion of clients at an agency are known to be abuse survivors, the chances are high that any particular client is a survivor and this breaches confidentiality. Clients would need to be fully informed about the data collection and the implications of this and to give permission for the collection. Client records held by agencies are not immune from access through Freedom of Information requests or from subpoena. Service providers therefore currently take great care in how much and what information they record. If records were to form the basis of more extensive data collection, there would need to be appropriate legal protections. The Commonwealth and ACT *Epidemiological Studies (Confidentiality) Acts* provide models for how protection could be provided. Service providers also had real concerns about how data would be interpreted and the uses to which it would be put. There was a strong feeling that information must not 'damn' the client. Most agencies do not have adequate resources to allow data collection and it was agreed that funding would need to be made available. It was also agreed that more funding for research should be made available to agencies. Further, it was agreed that researchers had to be aware of the demands that they made on already-stretched services when requesting information and that they should take care not to exploit agencies.

In light of these difficulties, it was recognised that there are problems with currently available data, particularly that it may not be accurate. The available data needs to be scrutinised for the way in which it was collected and for whether or not it is meaningful.

There was some discussion about what form data collection should take. There are real difficulties in obtaining so-called objective measures. It was agreed that the value of personal experience

must be recognised by those collecting data and by those who have an interest in the data. There may be some value in collecting information about indicators of sexual abuse, such as nightmares. It was agreed that better indicators of social harm associated with abuse are needed. There was support for action research approaches to this problem; in other words, conducting the research in collaboration with survivors on issues that they see to be important, and in such a way that the research strengthens any action that they may wish to take. It was also agreed that research should not just focus on the negative and on problems, but that it should also allow the positive and the healthy aspects to be documented. There was agreement that research should not rediscover the obvious.

It was agreed that there would be substantial value in cooperation between researchers, service providers and policy makers and that the three groups should work together in designing data collections. It was agreed that an important potential use of statistics would be to support funding applications to enhance services for abuse survivors with alcohol and other drug problems.

It was agreed that there needed to be clear ethical guidelines for people researching this area and that the National Health and Medical Research Council Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research would be a good model. These guidelines go much further than other ethics guidelines in addressing issues such as the use to which the research will be put, consultation with affected parties and ownership of the results.

Social structures which perpetuate abuse and alcohol and other drug dependence.

The workshop recognised that a focus on the individual alone is not adequate for dealing with this issue. Both alcohol and other drug use and sexual abuse are deeply rooted in and perpetrated by social structures. It was agreed that this is not well recognised.

It was agreed that alcohol use, in particular, is socially condoned. In general, the expression of emotion is not seen to be acceptable, except when this is under the influence of alcohol. It is particularly important that survivors are able to express the rage, grief and other emotions arising from the abuse. It was agreed that new socially acceptable coping strategies are needed. The appropriateness of “Western” ways of operating was questioned.

It was agreed that there must be social change and community development was seen as a starting point. There was recognition of the importance of prevention and education.

In particular, it was agreed that those who control resources need to be educated and influenced about this issue. It was recognised that some of these people may also be survivors of abuse, which they may or may not have come to terms with.

Areas for action

The priorities identified at the workshop were to:

- improve training for service providers who were likely to encounter clients who had been sexually abused. It was recognised that significant initiatives to provide training were under way with multi-agency participation under the coordination of the ACT Drug and Alcohol Service;
- establish a referral system for sexual abuse survivors. This would involve establishing a register of existing agencies. In addition, it was agreed that networking between agencies must be facilitated and that existing agencies need to be seen and to see each other as a valid continuum which gives clients increased choices whether they want assistance with alcohol and/or other drug problems, sexual abuse or both. It was also agreed that agencies need to find ways of working together in light of shrinking funding. This process would also allow gaps to be identified and documented;
- establish a men's network to deal with alcohol and other drug dependence and sexual abuse. The Alcohol and Other Drug Working Party of the Women's Health Network was seen to be a possible model;
- improve collaboration between service providers and researchers, in particular to allow data on prevalence of sexual abuse among people with alcohol and other drug problems to be gathered. It was also agreed that collaborative research was needed on models of practice and to undertake needs analysis. In addition, there was agreement that training in research should be available for interested service providers and that training in dealing with alcohol and other drug issues and in sexual abuse should be encouraged for researchers in these areas;
- develop ethics guidelines for collecting data on and researching childhood sexual abuse;
- tackle structural issues underlying sexual abuse and alcohol and/or other drug dependence. This should be done using a community development approach with priority areas being the school curriculum, training of school counsellors and the social and economic status of women and children;
- establish a proactive lobby group. One function could be to have input into existing enquiries and committees and to interact with existing services. It should aim to influence policy in both government and non-government areas to allow appropriate recognition of this issue.

BIBLIOGRAPHY

- Burnie, R. with Sattler, K; Bynon, J. and Arachne, J. (n.d.) *Males Who Have Been Sexually Assaulted. A Needs Analysis among 26 ACT Welfare Agencies*. Unpublished (copies of this report were circulated to workshop participants).
- Causton, S. (1993) 'Child Sexual Assault', *Connexions*, May/June, pp16–21.
- Heins, T; Gray, A. and Tennant, M. (1990) 'Persisting Hallucinations Following Childhood Sexual Abuse', *Australian and New Zealand Journal of Psychiatry*, Vol.24, pp561–565.
- Howard, J. (1993) 'Correlates of Childhood Physical and Sexual Abuse in Adult Male Drug Dependents', in M. Balzer (ed) *Drug and Alcohol Research and Evaluation, Concepts and Priorities. A Report on AMPSAD's National Conference 1992*, Australian Medical and Professional Society on Alcohol and other Drugs: Sydney, pp50–58.
- Hurley, D.L. (1991) 'Women , Alcohol and Incest: An Analytical Review', *Journal of Studies on Alcohol*, Vol.52 No.3, pp253–268.
- Rohsenow, D.J; Corbett, R. and Devine, D. (1988), 'Molested as Children: A Hidden Contribution to Substance Abuse?', *Journal of Substance Abuse*, Vol.5, pp13–18.
- Russel, S.A. and Wilsnack, S. (1991) 'Adult Survivors of Childhood Sexual: Substance Abuse and Other Consequences', in P. Roth (Ed) *Alcohol and Drugs Are Women's Issues, Vol.1: A Review of the Issues*, Women's Action Alliance and The Scarecrow Press, Inc: Metuchen NJ and London, pp61–71.
- Stephens, T. (1991) 'Substance Use and Sexual Assault', *Substance*, Vol.2 No.2, pp12–13.
- Wallen, J.A. (1992), 'Comparison of Male and Female Clients in Substance Treatment', *Journal of Substance Abuse Treatment*, Vol.9, pp243–248.
- Young, E.B. (1990) 'The Role of Incest Issues in Relapse', *Journal of Psychoactive Drugs*, Vol.22, April–June, pp249–258.
- Zierler, S; Feingold, L; Laufer, D; Velentgas, P; Kantrowitz–Gordon, I. and Mayer, K. (1991), 'Adult Survivors of Childhood Sexual Abuse and Subsequent Risk of HIV Infection', *American Journal of Public Health*, Vol.81, No.5, pp572–575.

WORKSHOP PARTICIPANTS

Gabriele Bammer
NCEPH
The Australian National
University
CANBERRA ACT 0200

Sue Bilton
76 Morgan Cres
CURTIN ACT 2605

John Bynon
Woden Youth Centre
PO Box 35
WODEN ACT 2606

Susi Chamberlain
Lifeline Canberra
PO Box 583
CANBERRA ACT 2601

Cinmayii
Toora Single Wimmins Shelter
PO Box 75
WATSON ACT 2602

Jenny Daly
ACT Alcohol and Drug
Service
GPO Box 825
CANBERRA ACT 2601

Phyll Dance
NCEPH
The Australian National
University
CANBERRA ACT 0200

Patricia Easta
Australian Institute of
Criminology
GPO Box 2944
CANBERRA ACT 2601

Lyn Enright
Women's Addiction Recovery
Service
PO Box 75
WATSON ACT 2602

Erutan
Canberra Rape Crisis Centre

PO Box 31
LYNEHAM ACT 2602

Deborah Felton
ACT Alcohol & Drug Service
GPO Box 825
CANBERRA ACT 2601

Jillian Fleming
NCEPH
The Australian National
University
CANBERRA ACT 0200

Christine Hall-Pascoe
Drug Referral & Information
Centre
GPO Box 2421
CANBERRA ACT 2601

Nerida Knight
ACT Alcohol & Drug Service
Woden Valley Hospital
Garran ACT 2605

Lynne Magor-Blatch
Karralika
PO Box 75
ERINDALE ACT 2903

Timothy McGregor
3 Tate St
O'Connor ACT 2601

Tarquin McPartlan
ACT IV League
GPO Box 2421
CANBERRA ACT 2601

Rex Murray
Winnunga Nimmityjah
Aboriginal Health Service
GPO Box 2636
CANBERRA ACT 2601

Elizabeth Price
Lifeline Canberra
PO Box 583
CANBERRA ACT 2601

Kim Sattler
Woden Youth Centre
PO Box 35
WODEN ACT 2606

Margaret Shanahan
3 Tate St
O'Connor ACT 2601

Kairo Steiner
The Incest Centre
PO Box 158
DICKSON ACT 2601

Adele Stevens
Women's Studies
The Australian National
University
CANBERRA ACT 0200

Heather Strang
Australian Institute of
Criminology
GPO Box 2944
CANBERRA ACT 2601

Gaby Thomson
Karralika
PO Box 75
ERINDALE ACT 2903

Rosemary White
Red Cross Youth Health
GPO Box 897
CANBERRA ACT 2601

Kery Wright
ACT Red Cross
GPO Box 897
CANBERRA ACT 2601

FEASIBILITY RESEARCH INTO THE CONTROLLED AVAILABILITY OF OPIOIDS

The Feasibility Research into the Controlled Availability of Opioids arose from a request to the National Centre for Epidemiology and Population Health (NCEPH) from the Select Committee on HIV, Illegal Drugs and Prostitution established by the Australian Capital Territory (ACT) Legislative Assembly.

A first stage of research, conducted in collaboration with the Australian Institute of Criminology (AIC), found that a trial to provide opioids, including heroin, to dependent users was feasible in principle. It was recommended that a second stage of feasibility investigations to examine logistic issues be conducted.

The first stage investigations examined illegal drug use in the ACT, the arguments for and against the controlled availability of opioids as reviewed in the literature, the current Australian political context for a trial, the role of interest groups in social controversies, legal issues, possible options for a trial, ethical issues, attitudes to a trial in the general community and among key interest groups (police, service providers, and illegal drug users and ex-users), and evaluation by a randomised controlled trial.

In addition, a proposal for a trial was developed as the starting point for the Stage 2 investigations.

The research which needs to be conducted to determine Stage 2 logistic feasibility can be divided into five areas:

- core information (for example, estimating numbers of users, determining relevant characteristics of ACT-based users, documenting the known information about the psychopharmacological and toxicological effects of opioids);
- information relevant to trial design and evaluation;
- information relevant to service provision;
- information about relevant legal, law enforcement and criminological matters;
- community and key stakeholder acceptability of a specific trial proposal.

The Stage 2 research is also governed by the following principles:

- the research should have intrinsic value so that, regardless of whether or not a trial goes ahead, the research should be of value to treatment services or to drug policy generally;
- research should be conducted in all relevant disciplines and the disciplinary findings should be integrated to address the central problem;
- the process should involve to the greatest extent possible the key interest groups— illicit drug users, ex-users, service providers, police, policy makers and the community.

Stage 2 of the feasibility research into the controlled availability of opioids has many components. As significant advances are made in each particular substudy, we publish the results as a working paper, so that the information is available for discussion in the public arena.

PUBLICATIONS

Reports

- * National Centre for Epidemiology and Population Health (1991), *Feasibility Research into the Controlled Availability of Opioids. Volumes 1 and 2*. NCEPH, The Australian National University, Canberra.
- * Bammer, G. and Gerrard, G. (eds) (1992), *Heroin Treatment – New Alternatives*, Proceedings of a one-day seminar, Becker House, Canberra, November 1991.

Working papers

- * Larson, A (1992), *Estimating the numbers of heroin users in the ACT*, Feasibility Research into the Controlled Availability of Opioids Stage 2, Working Paper Number 1.
- * Bammer, G. (ed) (1993), *Australian drug markets research: What are we doing? Where are we going? What are the gaps? Proceedings of a one-day workshop held at the Scarth Room, University House, The Australian National University, Monday 22 February 1993*, Feasibility Research into the Controlled Availability of Opioids Stage 2, Working Paper Number 2.
- * Sibthorpe, B., Sengoz, A. and G. Bammer in collaboration with The Youth Affairs Network of the ACT (1993), *Drug use and HIV risk among homeless and potentially homeless youth in the Australian Capital Territory*, Feasibility Research into the Controlled Availability of Opioids Stage 2, Working Paper Number 3.
- * Bammer, G. and S. Weekes (1993), *Becoming an ex-user: Would the controlled availability of heroin make a difference?* Feasibility Research into the Controlled Availability of Opioids Stage 2, Working Paper Number 4.
- * Bammer, G. (ed) (1993), *Does childhood sexual abuse contribute to alcohol, heroin and/or other drug problems? Proceedings of a one-day workshop held at the National Centre for Epidemiology and Population Health, The Australian National University, Tuesday 22 June 1993*, Feasibility Research into the Controlled Availability of Opioids Stage 2, Working Paper Number 5.

Published papers

- # Hartland, N; McDonald, D; Dance, P. and Bammer, G. (1992), 'Australian reports into drug use and the possibility of heroin maintenance', *Drug and Alcohol Review*, 11, pp.175–182.
- # Bammer, G. (1992) 'A trial of controlled availability of heroin for the ACT?', in White, J. (ed) *Drug problems in our society: dimensions and perspectives* (Selected papers from the Window of Opportunity, First National Congress. An Intersectoral Approach to Drug Related Problems in Our Society, December 2–5, Adelaide), pp.57–62.
- # Bammer, G. (1993), 'Should the controlled provision of heroin be a treatment option? Australian feasibility considerations', *Addiction*, 88, pp.467–475.
- # McDonald, D; Stevens, A; Dance, P. and Bammer, G. (1993), 'Illicit drug use in the Australian Capital Territory: Implications for the feasibility of a heroin trial', *Australian and New Zealand Journal of Criminology*, 26, pp.127–145.
- # Bammer, G; Douglas, B; Moore, M. and Chappell, D. (1993) 'A heroin trial for the Australian Capital Territory? An overview of feasibility research', in Heather, N; Wodak, A; Nadelman, E.A. and O'Hare, P. (eds) *Psychoactive drugs and harm reduction: from faith to science* (Selected papers from the Third International Conference on the Reduction of Drug-related Harm), Whurr, London, pp.137–150.

Newsletters

Newsletters reporting project results are also published from time to time.

These publications are available free from:
Dr Gabriele Bammer
Feasibility Study Co-ordinator
National Centre for Epidemiology &
Population Health
The Australian National University
ACT 0200
Phone: (06) 2490716
Fax: (06) 2490740

* These publications are for sale through:
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