



Substance Abuse and Intimate Partner Violence

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Substance abuse (SA) and intimate partner violence (IPV) are closely associated in the public mind. Many people believe that men's abuse of drugs or alcohol is a primary reason for their battering. Others think that SA may increase the risk for IPV, but is not a direct cause of IPV. Still others believe SA and IPV are separate issues, which only appear to be related due to other factors. In fact, both SA and IPV have many causes and many effects, and their apparent correlation applies to only a sub-group of batterers and victims (Testa, 2004). For some men who batter, SA may increase the frequency or severity of their violence. For other men, SA and IPV are separate issues whose apparently high rate of co-occurrence may stem from shared pre-conditions such as antisocial personality (Fals-Stewart, Leonard & Birchler, 2005) or from a belief that when they get drunk or high, they are going to be violent (Field, Caetano, & Nelson, 2004). Finally, for some men, both substance abuse and IPV may be manifestations of an underlying need for power and control related to gender-based distortions and insecurities (Gondolf, 1995).

Regardless of the explanation for it, the co-occurrence of IPV and SA is substantial across a series of studies:

- Half of the men in batterer intervention programs appear to have SA issues (Gondolf, 1999) and are eight times as likely to batter on a day in which they have been drinking (Fals-Stewart, 2003).
- Approximately half of partnered men entering substance abuse treatment have battered in the past year (Chermack, Fuller & Blow, 2000; Fals-

Stewart & Kennedy, 2005) and are 11 times as likely to batter on a day in which they have been drinking (Fals-Stewart, 2003).

- Between a quarter and half of the women receiving victim services for IPV have SA problems (Bennett & Lawson, 1994; Downs, 2001; Ogle & Baer, 2003).
- Between 55 and 99 percent of women who have SA issues have been victimized at some point in their life (Moses, et al., 2003) and between 67 and 80 percent of women in SA treatment are IPV victims (Cohen, et al., 2003; Downs, 2001).

For all the reasons above, SA issues should always be considered when making decisions about the safety of IPV victims and the risk posed by IPV perpetrators. Likewise, past and current IPV, along with other trauma-related issues, should always be considered when assisting men and women recovering from the effects of SA. In the remainder of this paper, we will discuss the co-occurrence of SA and IPV, highlight the special role of men's drunkenness in IPV, examine substance abuse by victims, and briefly present issues related to coordination and integration of SA and IPV services.

In this paper, except when a special distinction is necessary, we will use the term SA (substance abuse) to refer to both the continued use of or dependency on alcohol or other drugs in the face of adverse consequences. We will use the term IPV (intimate partner violence) to refer to threatening or controlling behavior, both physical and non-physical, directed at women by men who are their partners or

ex-partners. While IPV also includes violence in gay and lesbian relationships, and violence to men by their women partners, very little information exists on the link between SA and these other forms of IPV. In this paper we will limit IPV to threatening or controlling behavior, both physical and non-physical, directed at women by men who are their partners or ex-partners.

Prevalence

Both SA and IPV are common, but the frequency of their co-occurrence is not entirely clear. The co-occurrence rates of substance use and IPV in most published studies have ranged between 25 and 50 percent. In a national study of man-to-woman IPV in 6,002 households, of the 12% of adults who reported IPV, 22% of the men and 10% of the women were using alcohol at the time of the violence, but in three out of four episodes of IPV, neither party had been drinking (Kantor & Straus, 1987). A study in Canada sets the co-occurrence rate closer to 50% (Pernanen, 1991). However, these figures demonstrate the number of batterers or victims who had been drinking at the time of the violence (alcohol use), and not their drinking patterns or the cumulative effects of drinking (alcohol abuse).

The proportion of men in the general population who use IPV increases with the frequency they get drunk (Johnson, 2001; Kantor & Straus, 1987). The relationship between drunkenness and IPV also varies by social class. In one study, lower income men who never got drunk rarely committed IPV (2%) compared to the rate of IPV among lower income men who got drunk often (40%). For men in the higher income group in this study, the annual IPV rate increased from 2% of men who never got drunk to 9% of men who got drunk often (Coleman & Straus, 1983). These data appear to support a public perception that men who batter are *drunken bums*, that is, men are more likely to commit IPV if they earn low income and abuse alcohol (Kantor & Straus, 1987).

But, the *drunken bum* perspective on IPV is limited in several ways. First, the relationship between SA and IPV is strongest for those men who already think IPV is appropriate in certain situations (Field, et al., 2004; Kantor & Straus, 1987). One study found that when the endorsement of men's dominance was considered, the correlation between SA and IPV disappeared (Johnson, 2001). Second, even though the per capita rate of IPV is higher among lower socio-economic groups (Gelles, 1993); the occurrence of IPV is well established across all income groups. Third, the amount of alcohol used prior to most episodes of intimate violence is often far less than imagined. In Pernanen's (1991) classic study of alcohol-related violence, the average amount of alcohol consumed prior to a violent episode was only about an ounce, equal to a beer or glass of wine.

A common misunderstanding is that men who batter are extremely intoxicated and *out of control* when they batter. Despite the impairment in men's behavior caused by alcohol and drugs, IPV remains a matter of choice, a *guided doing* (Pernanen, 1991). IPV usually occurs in a safe setting (for the batterer), selected for the protection it affords him, at a time of his choosing, with a predictable victim. The fact that violence rarely occurs outside men's comfort zone suggests that men who batter are very much in control, not out of control. Drug use may be even more strongly correlated to IPV than use of alcohol (Murphy, O'Farrell, Fals-Stewart, & Feehan, 2001; Kantor & Straus, 1989; Testa, 2004), but in most cases, this difference does not reflect the biochemical properties of the substance but rather exposure to criminals and antisocial lifestyles. Although drunkenness is a strong predictor of IPV, SA is far less a factor in IPV than in violence between strangers (Felson, Burchfield, & Teasdale, 2005). One reason for this is that the choice to batter often precedes the drinking or drugging. In most cases, there is a pre-existing pattern of dominant and controlling behavior by the perpetrator toward his traditional victim. This pattern reflects a different relationship between perpetrator and victim in IPV than in stranger violence, where substance-related violence is often opportunistic.

Overall, research has established links between SA and IPV, but this link is not always simple and direct. SA may increase the risk that men will batter their partners, but the chemical properties of the substance are not the determining factor, or even the most important factor. A majority of heavy drinkers never batter (Kantor & Straus, 1987), which suggests that IPV is linked to other factors in addition to any direct effects of substances.

Perspectives on the Relationship between Substance Abuse and Woman Abuse

We acknowledge the concern of victims' advocates that connections between SA and IPV could shift the responsibility for IPV from the man who batters to the substance abused, making prevention or treatment of SA the issue while ignoring the key dynamics of gender and power. This is a legitimate concern, but it is both possible and desirable to maintain a gender-informed perspective on IPV while simultaneously identifying co-occurring issues and targeted interventions. None of the perspectives below interfere with our understanding of IPV as a choice men make in a society covertly supporting men's power and control of women.

In order to conclude that SA *causes* IPV, at least three conditions need to be met. First, the substance use behaviors must precede the IPV in time. Second, the relationship between the SA behaviors and IPV must be strong enough to state that the co-occurrence is not due to chance. Finally, there must not be any other explanation for both SA and IPV. While the first two conditions have been established by research (Fals-Stewart & Kennedy, 2005), the third condition—no other explanation—is the fatal flaw in an argument that SA causes IPV. Several of these complicating factors are described below.

The ways that substance use or abuse impact IPV, or vice versa, are complex and research aimed at understanding the relationship continues. Here, we distinguish between the acute effects of alcohol or drugs (e.g. intoxication) and the chronic effects (e.g.

substance abuse or dependency). Evidence suggests that both acute and chronic effects impact men's use of IPV, but operate differently. Among men who are in programs for either substance abuse or battering, 80% of all battering episodes occur within four hours of alcohol use (Fals-Stewart, 2003), supporting the view that understanding the acute effects of drinking is important. On the other hand, a study of factory workers showed that a diagnosis of alcohol abuse is a better predictor of IPV in men than the quantity or frequency of alcohol use (Leonard, Brommet, Parkinson, Day, & Ryan, 1985). This study supports the importance of understanding the chronic effects of alcohol abuse, in addition to any immediate effects of intoxication. Chronic SA increases the risk for IPV in several ways. For instance, it can gradually erode cognitive functioning, such as problem solving and memory. It can also impair social relationships, including relationship with one's intimate partner. Specific effects of acute and chronic SA are described below. SA also increases the risk for income loss through various mechanisms, which in turn increases the risk for IPV.

Although popular, it is too simple to say that the chemical properties of a substance act on the part of the brain that inhibits violence. Since no such inhibition center has been located in the brain, the *direct disinhibition* model has been challenged by most experts. If direct disinhibition explained the relationship between substance use and IPV, we would expect batterers who were substance abusers to become non-violent when they were treated and achieved abstinence. In some cases this does happen (Klostermann & Fals-Stewart, 2006), but abstinent and recovering substance abusers are well-represented in domestic violence courts and batterers programs, some with many years of stable sobriety. The effect of substances on IPV, if one exists, is much more complicated than direct disinhibition would allow. Other explanations for the high co-occurrence of SA and IPV are briefly described below. Regarding IPV, substances/SA may be:

- A cognitive disrupter. The most prominent explanation of how alcohol increases the risk for violence is the proximal model. The proximal model proposes that, in a sub-set of men, alcohol use causes IPV by compromising a man's ability to judge social cues, react appropriately, and maintain attention (Klosterman & Fals-Stewart, 2006; Field, et al., 2004). Batterers are more likely than non-batterers to misperceive the motives of their partners as abandoning, aggressive, or unjust, and alcohol enhances those misperceptions. For example, without alcohol consumption, a man may interpret his partner's coming home later than expected as inconsiderate. If he drank a six-pack of beer, he may view the same behavior as evidence of infidelity. A similar cognitive distortion may also occur with no alcohol consumption. For instance, watching a TV program about a woman having an affair or talking to a friend about a partner's infidelity are also cognitive disrupters for some men who choose to abuse their partners. Different men have different thresholds for aggression. Alcohol will have little effect on a man with a high threshold of aggression. Likewise, a man with a low threshold for aggression does not need alcohol to reduce his threshold, which has already been crossed.
- A co-occurring situation. The apparent relationship between SA and IPV may be linked to personality characteristics such as hostility (Leonard & Blane, 1992), to co-occurring disorders such as antisocial personality disorder (Fals-Stewart, et al., 2005), or to other co-occurring situations such as poverty (Kantor & Straus, 1987). Conduct disorder and antisocial personality, for example, increase the risk for both IPV and SA in adult men. We would speculate that, on average, more co-occurring conditions are associated with greater likelihood of men's aggression against their partners. It is important to remember, however, that most poor men, most men with antisocial personality disorder, most men with high levels of hostility, and most men with SA disorder do not batter.
- A power motive. McClelland (1975) suggested that the alcohol-aggression relationship is conditional upon individual power needs. Small quantities of alcohol tend to increase a social user's sense of *altruistic power*, or the power to help others. A large quantity of alcohol for social drinkers—or any quantity of alcohol for addicted persons—tends to increase the user's sense of *personal power* and domination over others rather than their altruistic power. Several researchers (Gondolf, 1995; Kantor & Straus, 1987) have suggested power theory may explain, in part, the co-occurrence of SA and IPV. The eminent alcoholism researcher Robin Room (1980) referred to alcohol as an *instrument of intimate domination*. From this view, both IPV and SA would be, in part, outcomes of a man's need for power, particularly power over other people. A man's need for power may have origins both in early experiences and in social interactions, so power theory is not inconsistent with traditional gendered perspectives on men's violence. The power motive may be viewed as a psychological condition that predisposes men to abuse substances and people, but the relationship between power and abuse is usually gendered and reinforced in culture.
- Situational. Violence may occur during the process of obtaining and using substances, rather than from the substances per se (Goldstein, 1985). The situational relationship between SA and IPV is particularly relevant when illegal drugs are involved (Roberts, 1988). In general, IPV by men using illegal drugs is more severe than IPV by men using alcohol alone (Willson, et al., 2000), but the reasons have less to do with the drug itself than the situation in which the drug is used and the lifestyle of the user (Testa, 2004). Procuring and trafficking drugs increases the opportunity for exposure to criminals, weapons, and violent sub-cultures. Conflict between intimate partners over whether, where, and when to use substances, including alcohol, is not uncommon. In one study of alcoholic patients using a violence recollection procedure, conflict over drinking alcohol was cited as the topic of conflict in over half of the episodes recalled by both perpetrator and victim (Murphy, Winters, O'Farrell, Fals-Stewart, & Murphy, 2005). A battered woman may also use substances with her abuser in an attempt to manage his violence and increase her own safety, or she may be forced by her batterer to use substances with him (Center for Substance Abuse Treatment, 1997).

- Effective across generations. The SA-IPV link may transcend generations. Adverse childhood experiences (ACEs), such as witnessing IPV or being physically or sexually abused, greatly increases the likelihood of a SA problem as an adult (Dubea, Anda, Felitti, Edwards, & Crofta, 2002). In general, men and women with more ACEs have a greater likelihood of having SA and IPV issues as adults. A substantial proportion of adult women observed their mother being battered (13.9%), or were themselves physically abused (25.1%) or sexually abused (22.2%) and the rate of ACEs for men is similar (Whitfield, Anda, Dube, & Felitti, 2003). Each violent ACE doubles the odds of a woman being an IPV victim or a man being an IPV perpetrator. Likewise, parental SA increases the chances that a child will grow up to be an abuser, a victim of abuse, and/or a substance abuser. Surprisingly, experiencing violence in the family of origin is a more important predictor of adult SA by men than is being the child of alcoholic parents (Kantor & Asdigian, 1993).
- An excuse. In many societies, including ours, substance use has a role as a *time out* from responsibility during which the user can engage in exceptional behavior and later disavow the behavior as caused by the substance rather than the self (MacAndrew & Edgerton, 1969). A variation of *it wasn't me; it was the alcohol* is a theme heard in courts, in batterer programs, and in pleas to a battered partner. While many people believe that men use their being drunk or stoned as an excuse for violence, research indicates that the criminal justice system no longer accepts this excuse. The reverse is true for victims, however; her use of alcohol and drugs increases the degree criminal justice professionals attribute responsibility to her for her own victimization (Klostermann & Fals-Stewart, 2006).

Which of the above models is the best explanation for the high rates of co-occurring SA and IPV? Our perspective is that it is more useful to apply all these models as standpoints or filters through which to view IPV and SA. We believe our understanding of IPV and SA will be enhanced if we

learn to ask: (1) When did the perpetrator or victim use drugs or alcohol relative to an episode of IPV, what did they use, and how much? (2) What aspects of personality or living conditions might be influencing SA and IPV? (3) What power and control issues are in play in this case? (4) What was the specific situation and setting in which the SA and IPV occurred? (5) What is the family and social history of violence, trauma, and SA in the life of victim and perpetrator that is background to the current situation? (6) To what do the victim and perpetrator attribute the IPV and the SA? and (7) How do they believe SA and IPV are linked? We believe answers to these questions gives research legs, and better accomplishes the transition of knowledge to applicability.

The Role of Drunkenness

Drunkenness occupies a central and usually unexamined role in our understanding of SA and IPV. Drunkenness, more so than quantity or frequency of substance use or even a diagnosis of SA, is the single best predictor of re-offense by men ordered to batterer intervention programs (Gondolf, 2002). The more frequently a man drinks heavily, the more likely he is to batter (Johnson, 2001). Drunkenness includes both proximal and chronic features of SA, but it also contains a feature that links it more closely with IPV: fear, which leads to domination.

Bystanders, especially intimate partners, alter their behavior to compensate for their inability to predict the other person's responses while drunk. Alternately, for some batterers, drunkenness is a signal that battering will follow, and victims know when to take protective actions. Whether abuse following drunkenness is a sure thing or only a possibility, drunkenness controls behavior in intimate relationships through instigation of fear and concern for one's safety. A study of drunkenness and fear found that the frequency of drunkenness almost quadrupled the likelihood that a victim feared her batterer, even after researchers controlled for the amount of alcohol the man used, class, race, marital

status, and his levels of prior abuse (Hutchinson, 1999).

The Victim's Substance Abuse

The role that SA plays in men's IPV is much more prominent than the role SA plays in women's victimization. There is little evidence to support the belief that a woman's SA causes her victimization. SA plays a more substantial role in maintaining women in IPV relationships, as SA may impair women's ability to adequately protect themselves. The lifestyle associated with abuse of illegal drugs may put women even closer to harm's way (Testa, 2004).

Many studies have found a significant relationship between the amount of childhood trauma and adult SA (see Gutierrez & Van Puymbroeck, 2006, for a review). In addition to childhood trauma, IPV suffered by adult women also increases the risk for SA. Women are more likely than men to report that they initiated substance use to alleviate the trauma associated with abuse (Gutierrez & Van Puymbroeck, 2006). Moreover, women's SA and IPV have a reciprocal relationship. A longitudinal study of 3,006 women found that drug use increased the risk of IPV and IPV increased the risk of substance use (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997). A woman's SA may increase her risk of IPV through numerous paths, such as impairing judgment, increasing financial dependency, or exposing her to violent men who also abuse substances (El-Bassel, Gilbert, Schilling, & Wada, 2000). IPV may lead a woman to both abuse substances and to partner with men who abuse them (Gutierrez & Van Puymbroeck, 2006; Najavits, Sonn, Walsh, & Weiss, 2004).

Advocates working with battered women with co-occurring SA identify many reasons women may be at increased risk for harm, including:

- Acute and chronic effects of SA may prevent women from accurately assessing the level of danger posed by their perpetrators. Under the influence, women may feel a sense of increased power, and may erroneously believe that they can defend

themselves against physical assaults. SA may make safety planning more difficult.

- SA may be encouraged or forced by an abusive partner as a mechanism of control. Women's abstinence and recovery efforts may be sabotaged. For example, a domestic violence/sexual assault victim receiving methadone on a daily basis could easily be stalked.
- There may be reluctance on the part of the victims to seek assistance or contact police for fear of arrest, deportation or referral to a child protection agency.
- The compulsion to use and withdrawal symptoms may make it difficult for SA victims of IPV to access services such as shelter, advocacy, or other forms of help. Recovering women may find that the stress of securing safety leads to relapse.
- Women who are using substances or who have used substances in the past may not be believed.

An inability to be safe or heal from IPV makes it harder for women to address their co-occurring issues. For women in substance abuse treatment, failure to address current or past victimization can interfere with treatment effectiveness and can lead to relapse. Behaviors stemming from trauma, self-harming actions, such as cutting or suicidal threats, may make group living challenging. Alcohol or other drug overdose or suicide threats/attempts, etc., are indicators that immediate intervention is required (Bland & Edmund, 2008; IDHS, 2000; CSAT, 1997).

Serial, Coordinated, and Integrated Services

Historically, SA and IPV have been regarded as independent problems requiring independent interventions (CSAT, 1997; IDHS, 2005). Our current understanding about the relationship between SA and IPV is that they are, for most people, independent of one another, but for a substantial subgroup of men and women, the status of one problem influences the other problem (Testa, 2004). This recognition makes practice with some people experiencing co-occurring SA and IPV more complicated. Beliefs about the independence of SA

and IPV underlie serial, parallel, coordinated, and integrated approaches to services.

Batterer intervention programs usually screen for SA, recognizing that active SA is potentially a threat to a victim's safety, but there is no consensus on what to do when a man screens positive for SA. In some cases, a program refers the man for SA treatment, and when he is stable, he is permitted to begin the IPV program. This is a *serial* approach and is similar to the outdated approach historically employed when SA and mental illness co-occur (Mueser, Noordsy, Drake, & Fox, 2004). Alternately, the batterer program could admit the man and refer him to simultaneous SA treatment, expecting him to be responsible for entering treatment, but not actively enabling him to do so. This *parallel* approach has little or no contact between SA and IPV providers. If there were active contact between IPV and SA providers, including sharing information on progress, discharge, and other issues, we move from a parallel to a *coordinated* service configuration. Finally, when IPV and SA services are provided under the same roof, or at least by the same agency, we can identify an *integrated* program. These terms are also used to describe service configurations for IPV victims with co-occurring SA problems, and programs for men and women in SA treatment.

In the past decade, there has been a trend away from serial and parallel service approaches and toward coordinated and integrated service approaches, but there is little research to indicate which approach to service is more effective. What we mean by *effective* is important. If a person enters service through a SA door, effective will mean, above all else, reduction or abstinence from psychoactive substances, as well as adoption of behavioral changes to maintain recovery. Violence, if assessed at all, will be seen as lowering the prospects for recovery (Chermack, et al., 2000). If a person enters service through an IPV door, effective will mean, above all else, reduction or elimination of aggressive behavior (if entering a batterer program) or implementation and maintenance of a safety plan (if entering a victim

program). SA, if assessed at all, will be seen as lowering the prospects for a batterer's non-violence and lowering the prospects of a victim getting and staying safe (IDHS, 2005).

There are concerns about the effectiveness of IPV and SA programs even when the problems of SA and IPV don't co-occur (Babcock, et al., 2004; Gondolf, 2002). Regardless of how effective a program may be, the presence of unexamined co-occurring problems makes it less effective.

Unattended, the co-occurring problem can become an issue that is impossible to ignore. In the sections that follow, we discuss services for women victims and services for men who batter.

Services for Victims

Serial approaches for women who abuse alcohol or drugs and are the victims of IPV are generally contra-indicated. IPV services should, at a minimum, be provided along with SA treatment if needed. A consensus practice principle is that all women should be screened for SA and IPV—as well as other trauma and co-occurring issues such as depression and PTSD—regardless of where they seek help (shelter, walk-in program, substance abuse treatment, or mental health treatment). The aim of the Women's Co-Occurring Disorders and Violence Study (WCDVS), which began in 1998 as a five year study at 14 sites across the U.S., is to increase knowledge for developing comprehensive and integrated services for women with co-occurring mental health and substance abuse disorders and who have experienced trauma, including IPV (Jahn Moses, Reed, Mazelis, & Ambrosio, 2003). The centers participating in the WCDVS featured integrated trauma-focused programs, peer-led services, advocacy, and resource coordination into existing services in a variety of traditional settings. The following includes the key findings from the study (Jahn Moses, et al., 2003):

- Women are consumers, survivors, or recovering (C/S/R), and it is important to integrate C/S/R women into every level of the process.

- Individual and team-based case management with relatively small caseloads (30-50) was the staple of the clinical integration approach. The basic service package available for consumers include: outreach, screening and assessment, treatment, parental support, advocacy, trauma-specific services, crisis intervention, and peer-run services.
- Outcomes for the WCDVS are positive but modest. A 6-month follow-up study that compared 1,023 women receiving WCDVS intervention with treatment-as-usual, found significant improvement in substance abuse behavior and mental health symptoms of WCDVS participants compared to treatment-as-usual (Morrissey, et al., 2005). In general, all the data from the WCDVS project support the value of integrated services over the way interventions are customarily delivered.

The WCDVS study recommended that services for women, where IPV and SA co-occur, must be integrated. The first step toward an integrated approach is screening and referral, coupled with ongoing contact and coordination with staff at the agencies where the woman is being referred. The screening process itself can be helpful if conducted properly. For example, Ogle and Baer (2003) conducted a pilot experiment in an IPV victim service agency using the Drinkers Check Up (DCU) screening tool. The DCU draws from the motivational interviewing FRAMES process (feedback, responsibility, advice, menu, empathy, and self-efficacy) to create supportive referrals of women who screen positive for heavy alcohol use. In this study, the researchers identified 33 of 147 (22%) shelter residents as either “heavy drinking” or using illegal drugs (Ogle & Baer, 2003). SA treatment agencies should: include screening all women for childhood and adult abuse; shift the treatment focus from confrontational to empowerment approaches; focus on increased self efficacy to counter feelings of helplessness, hopelessness, and low self esteem; include resilience building programs; trauma recovery programs; and woman-specific treatment facilities (Gutierrez & Van Puymbroeck, 2006). Hands-on, practitioner-friendly

manuals are increasingly available to assist agencies in developing trauma-informed services for women with co-occurring SA and IPV (e.g. Bland & Edmund, 2005).

Programs for Batterers

Interventions for men’s co-occurring SA and IPV can occur regardless of whether the man comes through the IPV door, the SA door, or another door. The fact that half of all the men referred to batterer intervention programs do not complete them (Daly & Pelowski, 2000), even when court ordered, indicates a need to develop approaches to increase men’s participation in these programs. Approaches that emphasize engagement, such as motivational enhancement therapy (MET: Miller, Zweban DiClementi, & Ryctarik, 1995) and readiness to change have proven useful in SA treatment. Two studies of MET found preliminary evidence for its effectiveness in terms of change, compliance, alcohol use, and anger in a single motivational session (Easton & Sinha, 2002). Easton and Sinha’s study also suggested that motivational techniques integrated throughout the program, rather than condensed into a discrete session toward the end of the program, may lead to better results. Researchers have also used MET principles and a variant of the DCU to develop the Men’s Domestic Abuse Check-Up (MDACU) to reach untreated and unadjudicated men who may be abusing substances and battering (Roffman, Edleson, Neighbors, Mbilinyi, & Walker, 2008).

Research on coordinating and integrating SA and IPV for men has been slow to develop. In addition to MET described above, Behavioral Couples Therapy (O’Ferrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004), cognitive-behavioral group therapy (Easton, et al., 2007), and the Dade County experiment on integrated SA and batterer intervention (Goldkamp, Weiland, Collins & White, 1996) have all shown positive effects on both SA and IPV. There are a number of other coordination and integration efforts without published evaluations that are nevertheless well

established (e.g. Alternatives to Domestic Aggression and Dawn Farm, 2005; AMEND in Colorado, described by Pettit & Smith, 2002).

Although Behavioral Couples Therapy (BCT) has been shown to reduce the annual prevalence of IPV from 64% to the United States average of 12% (O’Ferrell, et al., 2004), BCT is problematic because: (1) the restrictions on the batterer’s behavior would eliminate most men referred by the court; (2) BCT effects have been found only for those men who maintain their sobriety after treatment; and (3) conjoint counseling may increase risk for women partners. This is a longstanding concern of the IPV community and the use of couples counseling is either cautioned or prohibited by most state standards for batterer programs (Austin & Dankwort, 1999). Advocates are concerned that in couple counseling, IPV may be relabeled as a couple behavior rather than the responsibility of the batterer. Couple counseling may require victims to choose between lying about abuse to remain safe, thus undermining therapy, or telling the truth about abuse and risking their safety. There is also concern that professionals providing couples counseling are not required to have any training in IPV.

Cognitive Behavioral Group Therapy (CBGT) is 12-session structured intervention designed to remedy some of the problems in BCT mentioned above. An evaluation showed that CBGT intervention resulted not only in reduced IPV, but also in reduced alcohol consumption (Easton, et al., 2007). Unfortunately, the CBGT program would not meet the standards for batterer intervention programs in most states and provinces. Nevertheless, these programs have demonstrated that SA and IPV can be addressed in an integrated way.

In an approach more consistent with IPV practice, a Florida experiment compared parallel and integrated domestic violence and SA interventions in the Dade County Domestic Violence Court. Batterers were randomly assigned to either parallel treatment or integrated treatment and were followed for seven months (Goldkamp, et al.,

1996). The integrated treatment condition was more successful than the parallel condition at engaging offenders in treatment (87% v. 57%), maintaining offenders in treatment (160 days v. 99 days), and reducing re-arrest at 7-month follow-up (6% v. 14%). These findings suggest that domestic violence courts could be an important catalyst for incubating coordinated and integrated SA and partner violence services.

Substance Abuse and IPV in Gay and Lesbian Relationships

SA and IPV are just as likely to permeate same-sex couples (Burke & Follingstad, 1999; Waldner-Haugrud, Vaden Gratch, & Magruder, 1997). Although limited by the difficulty of obtaining a random sample, most studies find the rate of IPV is approximately the same among gay and lesbian couples as heterosexuals (Burke & Follingstad, 1999; Waldner-Haugrud, Vaden Gratch, & Magruder, 1997). In a recent survey of 817 gay men in Chicago, 157 (19.2%) report a lifetime history of physical IPV (Houston & McKirren, 2007) and the National Lesbian Health Care Survey found an annual IPV prevalence of 8% in a diverse, nonclinical sample of nearly 2,000 women (Bradford, Ryan, & Rothman, 1994). Both of these figures are in line with surveys of heterosexuals. The prevalence of SA among gays and lesbians is a matter of debate, due to the absence of control groups, dependency on data gathered from bar samples, lack of a clear definition of “gay” and “lesbian,” and the fact that many gay men and lesbian women may remain in-the-closet (hidden from study) (Bux, 1996). Despite these limitations, the consensus is that prevalence of SA in the gay and lesbian community, however defined, is higher than the prevalence among heterosexuals (SAMHSA, 2001).

The few studies that examine co-occurring same-sex IPV and SA (Cruz & Peralta, 2001; Schilit, Lie, & Montagne, 1990) suggest that the prevalence of co-occurrence is not different from that among heterosexuals (Island & Letellier, 1991;

Rose, 2008). In the Chicago study, gay men reporting IPV were almost twice as likely (26.4% v. 15.6%) to report substance abuse issues than were gay men not reporting IPV (Houston & McKirren, 2007) and in a study of 228 gay men IPV perpetrators, 40% reported substance abuse by parents and 40% were themselves substance abusers (Farley, 1996). Despite limited data to support practice, counselors and advocates working with victims and perpetrators of IPV can proceed with the same engagement, support, and safety approaches as with heterosexuals, although with caution (SAMHSA, 2001). At the community level, however, the lack of civil protections for a gay or lesbian relationship coupled with a paucity of services for them make referral, coordination, and integration a challenge.

Conclusion and Recommendations

Both research and experience suggests that SA is one of several important factors that increase the risk of IPV. IPV also increases the risk for SA. SA may be affected by other risk factors (e.g., violence in the family of origin, belief in the aggression-increasing power of substances) and SA may affect risk factors (e.g., power motivation, cognitive and behavior skills, and the belief that violence against women is appropriate under certain circumstances). These risk factors are not only personal, but they also bear the imprint of society. Various perspectives have been offered to explain these complex relationships, but no single perspective can explain the relationship between SA and IPV in all cases. Conversations between advocates and SA professionals, cross-training, and careful research will help us choose which perspectives are best for the development of practice and programs in specific settings. We are in the early stages of developing interventions and programs that target both SA and IPV, but a few tentative recommendations follow from our current level of knowledge.

When either SA or IPV are encountered in practice, the chance of encountering the other is substantial. This suggests that assessment for both

problems is needed if either of the problems is detected, regardless of the setting. Second, since SA and IPV have a reciprocal relationship, viewing one problem as a cause of the other is not useful. Both SA and IPV should be regarded as primary problems, and reduction of one problem to the familiar language and interventions of the other problem is ill-advised. Since the relationship between SA and IPV is complex, and since both are primary problems and have personal and social causes and manifestations, social agencies and institutions that address these co-existing problems need to be capable of addressing and managing the complexities involved. Since this is usually beyond the scope of a single agency, service networks and coordinated community responses to both problems are essential. Serial interventions (e.g. completion of SA treatment first, followed by IPV intervention) are usually contra-indicated. Coordinated programs (IPV and SA intervention at the same time, with information flowing between programs) and integrated programs (the same program providing both interventions) are likely to be superior to serial services. In order to effectively implement coordinated services, it is important that IPV and SA programs work collaboratively.

The trauma-informed approach to services promises to transform the way programs view men and women who have co-occurring situations. Integrating services, changing from a “what’s your problem?” approach to a “what has happened to you?” approach, and attending to how our services may compromise or re-traumatize those we seek our help may improve service engagement and retention. On the other hand, viewing IPV as simply another trauma and SA as simply another trauma-managing behavior are reductionist and ignore the gender and power elements in both SA and IPV.

Screening for both SA and IPV should be routine in all settings that specialize in either SA or IPV, as well as in settings where we can expect a high prevalence of both SA and IPV, such as health care (both physical and mental), child welfare, and public aid agencies. Screening will be useful only if systems are modified to engage and refer those who

screen positive and if agencies are in place to assess, educate, or treat the problems referred to them. Ultimately, the success of interventions for co-occurring SA and IPV depend on the investment a society is willing to make. Although rates of IPV and SA are roughly equivalent in the population, our society has viewed SA as the greater problem, while placing less emphasis (in terms of funding) on IPV. A greater awareness of IPV and a more balanced approach to co-occurring IPV and SA will benefit perpetrators, victims, and our society as a whole.

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In Brief: Substance Abuse and Intimate Partner Violence

Half of the men in batterer intervention programs appear to abuse alcohol or drugs, approximately half of the men in treatment for substance abuse batter, between a quarter and half of the women in treatment for substance abuse have been battered, and a substantial portion of the women in IPV programs are substance abusers (Gondolf, 1999, Chermack, Fuller & Blow, 2000; Fals-Stewart & Kennedy, 2005, Fals-Stewart, 2003, Lawson, 1994; Downs, 2001; Ogle & Baer, 2003). Despite these high numbers, the relationship between substance abuse (SA) and intimate partner violence (IPV) is complex and should not be reduced to ideas about one causing the other. Many theoretical perspectives explain the co-occurrence of SA and IPV including: substance use disruption of thinking processes; adverse childhood experiences; power motivation; during the process of obtaining and using substances; and co-occurring situations like hostile personalities, antisocial personality disorder, or poverty; however none of these theories account for all the co-occurrence of SA and IPV to indicate that SA causes IPV. Therefore, we recommend practitioners learn to ask a series of questions rather than adhere to a single theory. The questions are: (1) When did the perpetrator or victim use drugs or alcohol relative to an episode of IPV, what did they use, and how much? (2) What aspects of personality or living conditions might be influencing SA and IPV? (3) What power and control issues are in play in this case? (4) What was the specific situation and setting in which the SA and IPV occurred? (5) What is the family and social history of violence, trauma, and SA in the life of victim and perpetrator that is background to the current situation? And, (6) to what do the victim and perpetrator attribute the IPV and the SA, and how do they believe SA and IPV are linked?

The role that SA plays in men's IPV is much more prominent than the role SA plays in women's victimization. There is little evidence to support the belief that a woman's SA causes her victimization. SA plays a more substantial role in maintaining women in IPV relationships, as SA may impair women's ability to adequately protect themselves. Thus, the lifestyle associated with abuse of illegal drugs may put women even closer to harm's way.

Services provided for co-occurring SA and IPV may be serial, where SA treatment precedes IPV services, parallel or coordinated, where services are provided at the same time by different agencies, or integrated, where services are provided at the same time by the same agency. In the past decade, there was been a trend away from serial and parallel approaches and toward coordinated and integrated services.

Screening for both SA and IPV should be routine in all settings that specialize in either SA or IPV, as well as in settings where we can expect a high prevalence of both SA and IPV, such as health (both physical and mental), child welfare, and public aid agencies. Screening will be useful only if systems are modified to engage and refer those who screen positive and if agencies are in place to assess, educate, or treat the problems referred to them. Ultimately, the success of interventions for co-occurring SA and IPV depend on the investment a society is willing to make. Although rates of IPV and SA are roughly equivalent in the population, our society has viewed SA as the greater problem, while placing less emphasis (in terms of funding) on IPV. A greater awareness of IPV and a more balanced approach to co-occurring IPV and SA will benefit perpetrators, victims, and our society as a whole.