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Prevalence of family violence in clients entering substance abuse treatment

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Received 10 December 1998; accepted 22 January 1999

Abstract

The present study evaluated 105 clients who were assessed for substance-related problems and a history of domestic violence. A brief survey on family violence examined whether clients were adult victims, childhood victims, and/or perpetrators of physical violence. Results indicated that 37% of the sample reported that they experienced a family history of physical violence. A total of 22% reported being an adult victim of physical violence, 14% reported being a victim of childhood abuse, and 18% reported being a perpetrator of physical violence. There was a significant positive correlation between subtypes of family violence. Substance-using clients who were older reported more incidences of family violence. Results showed that substance-using clients with a history of family violence (SAFV+) tended to have more individual therapy sessions attended than substance-using clients without a history of family violence (SAFV-). The SAFV+ group was different from the SAFV- group in that they had significantly higher scores on the Michigan Alcoholism Screening Test and the Beck Depression Inventory (BDI) scores. The SAFV+ group also had significantly more self-reported and positive urine screens for cocaine use within the 2-month monitoring period. Additionally, substance-using clients with a history of childhood trauma had significantly more individual therapy sessions attended than clients without a history of childhood trauma. The group with a history of childhood trauma had significantly higher scores on the BDI. Findings indicate the importance of assessing family history of violence in substance abusers entering treatment, as this may have significant implications for treatment outcome. © 1999 Elsevier Science Inc. All rights reserved.

Keywords: Alcohol; Cocaine; Depression; Treatment; Family violence; Prevalence

1. Introduction

Co-occurring substance use and family violence-related problems constitute a major public health problem that is being encountered throughout various courts and mental health agencies. Within the last 5 years, reports in the literature found high rates of comorbid substance use and domestic violence-related problems. For example, a recent study by Brookoff et al. (1997) showed that 92% of assailants used alcohol or drugs on the day of the domestic violence assault, 44% had prior arrests for charges related to violence, and 72% had arrests related to substance use. Bennett and Lawson (1994) surveyed substance use and domestic violence providers and found that 46% of substance-abusing men were batterers, 60% of substance-abusing females were victims of domestic violence, and, 42% of women who were victims of violence and receiving domestic violence treatment were substance abusers. This illustrates the high rates of co-occurring substance use and domestic violence.

Alcohol and drug use are associated with more serious types of violence, which include risk of homicide. For example, Holtzworth-Munroe and Stuart (1994) assessed typology of batterers and found that alcohol and drug use was highest among the moderate to highly violent group of batterers. Recent findings suggest the need to further explore the relationship between substance use and risk of homicide within the home. Rivara et al. (1997) found alcohol and illicit drug abuse to be related to an increased risk of violent death in the home. Additionally, they found the risk of homicide was increased for non-substance abusing individuals living in households in which other members abused alcohol or drugs.

Other researchers have tried to assess the variables that are related to domestic-violence issues. The common risk factor for family violence is substance use. Bennett et al. (1994) found that one of the correlates of domestic abuse is early onset of drug and alcohol-related problems. In addition, Keller (1996) found that alcohol and drug abuse, antisocial personality disorder, and depression are associated with an increased risk of male violence in the home. Goldberg (1995) found that major risk factors of substance-abus-

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ing women include childhood sexual or physical abuse, adult victimization by domestic violence, and a spouse or partner who abuses substances.

When assessing the relationship between substance use and family violence, it is important to target both issues in an integrated way. From a family violence perspective, substance use can trigger or enhance violence. Some studies have shown that substance use symptoms raised rates of violence (Steadman et al., 1998) and recent use of cocaine and heroin use was associated with physical aggression (Tardiff et al., 1997). When evaluating this issue from a substance use perspective, anger, aggression, negative mood states, and psychological stress can trigger alcohol/drug craving and relapse in a substance-using population (Cooney et al., 1997; Emery, 1981; Marlatt and Gordon, 1980; Monti et al., 1988; Sinha et al., 1999). This underscores the need to address and treat both problems in an integrated way.

Within the past 5 years, some initial research suggests that by treating alcohol use, violence had reduced and, in return, drinking outcome status had changed as well (Murphy & O'Farrell, 1996; O'Farrell & Murphy, 1995). Although this particular treatment focus included behavioral marital therapy, it highlights the importance of assessing family violence and substance use as variables that may predict treatment engagement and outcome. Consequences of alcohol/drug use and family violence can include escalated substance use, violence, depression, legal difficulties, and other psychosocial and psychiatric sequelae. Given these vast negative consequences, which are often linked to poorer treatment outcomes, family violence-related issues within the substance-using population is a risk factor that needs to be assessed. With this in mind and given the evidence for high incidences of comorbid substance use and family violence-related problems, a preliminary study was undertaken to further assess the prevalence and engagement in treatment of clients entering substance use treatment with and without histories of domestic violence. An attempt to understand, assess, and treat this comorbid problem in an integrated way is needed to improve diagnosis, treatment, and prognosis.

2. Methods

The present study evaluated 130 clients who were referred to an outpatient substance abuse treatment facility. A random 2-month time period was used to assess this population for prevalence of family violence in clients with substance-related problems. A brief survey was submitted to each of the 130 incoming clients.

Clients were further assessed when they were admitted to the clinic for substance abuse treatment. A total of 105 clients was admitted for outpatient treatment and 25 were referred to a higher level of care. There was no significant difference in prevalence of family violence between clients who were admitted into treatment and those referred to other agencies ($\chi^2 = 3.7, p < .15$).

Clients who were admitted into treatment and completed the family violence survey, participated in a Clinical Diagnostic Interview. All patients also completed the Michigan Alcoholism Screening Test (MAST; Selzer, 1971), the Beck Depression Inventory (BDI; Beck et al., 1971), submitted a sample for urine toxicology, and gave a breathalyzer to assess recent alcohol use. Urine samples were also obtained at frequent and irregular time intervals to randomly monitor psychoactive substance use throughout the 2-month time period.

One hundred and five subjects, aged 18 to 64 years, participated in the study. The sample was 80% male and consisted of the following racial composition: 37% African American, 43% Caucasian, and 20% Hispanic. Clients completed an average of 12.26 ± 2.34 years of education. The clients were referred to the clinic via the following referral sources: 62% adult probation, 7% detox clinics, 14% self-referred, and 17% other agencies (State and General Assistance, and other outpatient facilities).

2.1. Procedures

2.1.1. Family violence survey

All clients were administered a brief self-report survey that assessed lifetime prevalence of family violence. The questions were based on physical violence items from the Conflict Tactic Scale (Straus et al., 1996). The brief survey consisted of the following questions:

1. Have you been in a fight with a spouse or partner in which *you were physically hurt*? (example: slapped, pushed, punched, beat up, or sexually assaulted).
2. Have you been in a fight with a spouse or partner in which *you physically hurt* a spouse or partner? (example: slapped, pushed, punched, beat up, or sexually assaulted).
3. As a child, were you ever physically or sexually hurt by a parent, family member, friend of the family, or some other adult? (example: slapped, pushed, punched, beat up, or sexually abused).

Prevalence of family violence was calculated via a frequency of tally counts. Those that reported a history of family violence became the substance use/family violence positive group (SAFV+) and those that reported the absence of a history of family violence became the substance use/family violence negative group (SAFV-).

After the initial clinical evaluation, patients were assigned to both individual and/or group psychotherapy treatment and assessed over a 3-month period.

2.2. Statistical analyses

Group differences in demographic, substance use, and violence-related variables were analyzed using a one-way analysis of variance (ANOVA) for continuous variables and the χ^2 test for nominal/categorical variables. Significant differences in demographic and substance use characteristics

were analyzed using separate one-way analyses of covariance with age, BDI, and MAST as covariates. Significance was assumed at $p < .05$.

3. Results

Demographics and substance use characteristics are summarized in Table 1 and Table 2, respectively. It should be noted that the two groups (SAFV+ and SAFV–) were statistically equivalent in education level, gender, racial composition, marital status, and referral source. Results indicated that 37% of the sample reported that they experienced a family history of physical violence. A total of 22% reported being an adult victim of physical violence, 14% reported being a victim of childhood abuse, and 18% reported being a perpetrator of physical violence. There was a significant positive correlation between types of reported family violence. For example, perpetrators of physical violence had a significant positive correlation with a history of reported adult victimization ($r = 0.41, p < .000$).

An ANOVA was performed and the findings showed that the SAFV+ group had significantly more individual therapy sessions attended than the SAFV– group, $F(1, 40) = 6.3, p < .02$ (refer to Table 2). There was no significant difference between SAFV+ and SAFV– in number of groups attended. However, significant differences between SAFV+ and SAFV– were observed across age, MAST, and BDI

scores. The SAFV+ group was older, had higher MAST and BDI scores than the SAFV– group.

Additionally, clients with a history of childhood trauma had significantly more individual therapy sessions attended than those without a history of childhood trauma ($M = 5.8$ vs. $M = 2.8$, respectively), $F(1, 40) = 6.1, p < .02$. There was no significant difference between clients with or without histories of childhood trauma in the number of group therapy sessions attended. However, clients with histories of childhood trauma had significantly higher BDI scores than those without histories of childhood trauma, $F(1, 97) = 8.7, p < .004$.

When age, MAST, and BDI scores were used as covariates, there was decrease in the level of significant differences between the SAFV+ and SAFV– groups, $F(1, 37) = 4.64, p < .04$. When the BDI scores were used as a covariate for the childhood trauma subgroup, there was not a significant difference between substance users with or without histories of childhood trauma in the number of individual therapy sessions attended, $F(1, 37) = 2.98, p < .10$.

There was a significant difference between SAFV+ and SAFV– groups in substance use characteristics. For example, the SAFV+ group had significantly higher reported cocaine use and significantly higher urine screen results that were positive for cocaine use than SAFV– group ($\chi^2(4,77) = 12.1, p < .02$ and $\chi^2(4,76) = 11.8, p < .04$, respectively) while the SAFV– group showed significantly higher self-reported and positive urine results for cannabis use.

Table 1
Demographic characteristics

Variable	Total	SAFV+ (1)	SAFV– (2)	Test statistic	<i>p</i>
<i>n</i>	105	38	67		
Age					
<i>M</i> (<i>SD</i>)	34.5 (10.1)	37.3 (12.1)	33.0 (8.4)	ANOVA	<.04
Education					
<i>M</i> (<i>SD</i>)	12.3 (2.3)	12.2 (2.4)	12.3 (2.3)	ANOVA	<.74
Male (%)	80	82	79	χ^2	<.76
Race (%)				χ^2	<.87
African American	36	34	37		
Caucasian	43	45	42		
Hispanic	21	21	21		
Marital status (%)				χ^2	<.77
Never married	41	50	56		
Married/cohabiting	11	16	13		
Separated	11	19	10		
Divorced	12	13	19		
Unknown	25	2	2		
Referral source (%)				χ^2	<.14
Probation	62	49	71		
Detox	7	8	6		
Self	14	22	11		
Other	17	22	12		

SAFV+ = substance-abusing clients with a history of family violence; SAFV– = substance-abusing clients without a history of family violence; ANOVA = analysis of variance.

Table 2
Substance use characteristics

Variable	Total	SAFV+ (1)	SAFV– (2)	Test statistic	<i>p</i>
<i>n</i>	105	38	67		
MAST scores					
<i>M (SD)</i>	3.7 (3.7)	4.8 (3.6)	3.0 (3.5)	ANOVA	<.02
BDI scores					
<i>M (SD)</i>	8.0 (9.1)	10.7 (11.2)	6.4 (7.2)	ANOVA	<.02
Self-report drug use (%)				χ^2	<.02
Alcohol	38	41	36		
Cocaine	21	25	11		
Cannabis	17	6	31		
Opioids	4	9	0		
No drug	21	19	22		
Urine results (%)				χ^2	<.04
Negative	54	55	53		
Cocaine	15	28	6		
Cannabis	16	4	23		
Illy (cann. + phen.)	2	0	2		
Opioids	8	10	6		
Amphetamines	7	4	9		
No. of psychotherapy sessions attended					
<i>M (SD)</i>	3.3 (2.9)	4.6 (3.6)	2.4 (1.9)	ANOVA	<.02

SAFV+ = substance-abusing clients with a history of family violence; SAFV– = substance-abusing clients without a history of family violence; MAST = Michigan Alcoholism Screening Test; BDI = Beck Depression Inventory; ANOVA = analysis of variance.

4. Discussion

In this study, we examined the rate of family violence in a clinical sample of patients entering outpatient substance abuse treatment. We found an overall prevalence rate of 37% of clients that entered substance abuse outpatient treatment admitted to having a history of physical violence with a family member or significant other.

The rate of co-occurring family violence in substance-abusing clients was moderately consistent with Bennett and Lawson's (1994) finding, in which 46% of substance-abusing men were batterers of domestic violence and 42% of women receiving domestic violence treatment were substance abusers. With respect to the finding in which perpetrators of violence also reported being a victim of family violence, there are studies that report a link between early childhood family experiences (e.g., witnessing parental violence, experiencing child abuse, and methods of childhood discipline) and the use of aggression in their adult interpersonal relationships (Cadsky & Crawford, 1988; Hotaling & Sugarman, 1986). This may help explain why perpetrators of violence also reported being a victim of violence. That is, it is likely that offenders of violence also experienced childhood abuse or witnessed violence within their home.

Substance-using clients with a history of family violence (SAFV+) had more individual therapy sessions attended than substance-using clients without a history of family violence (SAFV–). The SAFV+ group was different from the SAFV– group in that they had significantly higher MAST and BDI scores. This group was significantly older than the SAFV– group. The SAFV+ group also had significantly

more self-reported and positive urine screens for cocaine use within the 2-month screening period. The SAFV– group showed significantly higher reported and positive urine results for cannabis use.

The SAFV+ group had more psychopathology than the SAFV– group as defined by increased use of alcohol and cocaine and higher levels of depressive symptoms. The literature supports the finding that individuals who experienced interpersonal stress have greater psychological symptoms and treatment needs (Kessler & Magee, 1994). This likely explains why the SAFV+ group attended more therapy sessions than the SAFV– group. Although, this treatment focus was substance-use specific and not an integrated substance use-family violence program, other researchers found positive treatment outcomes within the substance use-family violence patient population. For example, a recent study by Goldkamp et al. (1996) examined treatment outcomes and same-victim reoffending in clients who attended an integrated substance use-domestic violence treatment program versus clients who did not participate in this hybrid approach. The findings showed that the integrated treatment approach was more successful at getting offenders and probationers to attend treatment (43% of the control group were no shows as compared to 13% of the integrated treatment group). The integrated treatment approach had greater success in keeping participants in treatment as well as having lower rates of same-victim reoffending. It is possible that the integrated group had patients with greater psychopathology and hence, greater treatment needs that the patients utilized. Our findings also suggest that patients may

be more likely to engage in treatment if family violence and substance use were focused on in an integrated way.

Substance-using clients with a history of childhood trauma had significantly more individual therapy sessions attended than clients without a history of childhood trauma. The group with a history of childhood trauma had significantly higher BDI scores. Again, this coincides with Kessler and Magee's (1994) findings in which they link childhood family violence to adult recurrent depression. However, the results from the present study should be viewed cautiously because the sample size was small and recalling past childhood events has limitations.

The present study should be considered preliminary for several reasons. Although the literature reports higher rates of family violence in substance-using clients (42–92%), this study found that 37% had a history of violence. A possible explanation for this lower rate of reported family violence is that our family violence survey specifically focused on *physical violence* as opposed to a composite of subtypes of violence. The composites often include verbal, psychological, sexual, and property violence. The current literature often includes this composite as the construct for violence. The use of this overall construct would likely increase the prevalence rates by including other types of violence. However, the advantage of focusing on specific subtypes of violence that are clearly defined with examples is that it can be more specifically related to severity of substance use and violence and engagement in treatment. Another possible explanation for the current findings is that the use of a self-report survey of violence rather than the use of a clinical interview could contribute to underreporting. This lower rate of family violence could be due to the survey that was administered. A semi-structured interview by a clinician that includes rapport building, confidentiality, and trust may yield higher rates of self-disclosure about family violence.

Other possible explanations for the findings include the demographic characteristics of this population. For example, 62% of this population was probation referred. It is possible that clients with legal cases pending could fail to report family violence. Although this survey was explained as being confidential and that the information would be used for research purposes, clients may have decided not to disclose based on their current court case. Additionally, this population was primarily composed of male clients (80%) and, therefore, may not accurately reflect female client's histories of family violence.

The finding in which there were significant differences between the SAFV+ and SAFV– groups in number of individual psychotherapy sessions attended and no significant differences in group therapy sessions attended suggests that a confidential and personal atmosphere may be a necessary ingredient for change within this population of substance users with a history of family violence. A possible explanation for the finding in which there were no significant differences between SAFV+ and SAFV– in number of group therapy sessions attended is that the standard group therapy

within the substance use clinic focused on coping skills and relapse prevention for substance use. Negative mood states and maladaptive behaviors are discussed in treatment in relevance to substance use triggers. Again, this underscores the need to include group therapy that specifically targets aggression and substance use symptoms in an integrated way.

Additionally, the SAFV+ group had significantly more reported depressive symptoms than the SAFV– group. This finding suggests the need to explore and further assess a pharmacotherapy adjunct to individual therapy as a way to improve treatment outcome among substance users with co-occurring family violence issues. Furthermore, it is necessary to treat substance use and family violence issues in an integrated way to decrease substance use and aggression as their co-occurrence serves to increase the risk of attrition and relapse.

In conclusion, findings indicate the importance of assessing family history of violence in substance abusers entering treatment, as this may have implications for treatment outcomes.

Acknowledgments

Support for this research was provided, in part, by grant no. P50-DA09241. We would like to especially thank Dolores Jackson and Ellen Davis for their technical assistance as well as the Substance Abuse Treatment Unit (SATU) staff for their time and effort in this project.

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