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Integrating a brief substance abuse awareness intervention
into a couples treatment program for intimate partner violence.

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Abstract

Substance abuse (SA) and intimate partner violence (IPV) frequently co-occur providing challenges to researchers and treatment professionals alike. Researchers have struggled to understand the nature of the relationship between these two difficult issues. Are they wholly unrelated, indirectly related, or is there a causal relationship between the two? Treatment professionals face the dilemma of how to provide treatment to clients who abuse substances and who are violent with their intimate others. Most treatment for these two disorders is provided separately with varying degrees of effort to coordinate them. Models of combined treatment are few, and none address couples in which both partners are violent and/or abuse substances. In this paper, we briefly review the literature on SA and IPV and then describe a brief substance abuse awareness intervention, based on Motivational Interviewing, that we have integrated into our conjoint couples treatment model for IPV.

Integrating a brief substance abuse awareness intervention into a couples treatment program for intimate partner violence.

Substance abuse (SA) and intimate partner violence (IPV) exact tremendous tolls at both the societal and personal levels. The fact that they so frequently co-occur has posed a dilemma to the treatment community wherein services to treat each problem are typically provided separately and in isolation from each other. In addition, there is disagreement about the nature of the relationship between SA and IPV, a disagreement that raises questions about the primacy of treatment. In this paper, we will review the evidence for the co-occurrence of SA and IPV, briefly examine competing theories explaining the relationship between SA and IPV, describe various ways in which efforts have been made to integrate SA and IPV treatment for individuals, and describe our attempt to integrate a motivational interviewing-style intervention into a treatment program for couples in which physical or psychological aggression has occurred. Finally, we will provide thoughts about next steps in both the research and practice arenas.

The Co-Occurrence of SA and IPV

There is ample evidence for the co-occurrence of SA and IPV. Studies have demonstrated a relationship between alcohol use and IPV in both clinical and non-clinical samples. In a non-clinical sample, White and Chen (2002) conducted a longitudinal study of 725 men and women and found that problem drinking significantly predicted IPV perpetration and victimization for both men and women. Using 2002 National Survey on Drug Use and Health data, Lipsky & Caetano (2008) found that those who experienced any IPV (perpetration, victimization, or mutual assault) are significantly more likely to seek alcohol treatment than those in non-violent relationships. In addition, the United States Department of Justice (1998) suggests that two-thirds of incidents of IPV involve alcohol.

Foran and O’Leary (2008) are the first to look at the effect of alcohol on female violence from a meta-analytic perspective. They conclude that there is an association between alcohol use and both male-to-female IPV and female-to-male IPV. There is a small to moderate effect size for the association of alcohol and male-to-female IPV and a small effect size for the association of alcohol and female-to-male IPV.

The co-occurrence of substance abuse and IPV is also common in those seeking treatment and has been studied in two ways – the occurrence of IPV in substance abuse treatment populations and the occurrence of substance in IPV treatment seeking groups. Studies of patients entering substance abuse treatment find that 40 – 60% of those who are married or co-habiting report at least one episode of IPV in the prior year (Fals-Stewart, Golden & Schumacher, 2003; O’Farrell & Murphy, 1995). However, the study of only those living together may underestimate intimate partner assaults by leaving out dating or separated couples. Chermack, Fuller, and Blow (2000) gathered self-report data from 126 men and 126 women in a substance abuse program and discovered that 57% of the participants reported partner violence within the 12 months prior to substance abuse treatment.

Substance abuse problems are also found in significant numbers of men participating in batterer treatment programs. Substance abuse among IPV perpetrators ranges from 40-92%, depending on the study examined (Smith Stover, Meadows, & Kaufman, 2009). Brown, Werk, Caplan, and Seraganian, (1999) found that 63% of the men in their batterer treatment study were diagnosed with a current substance abuse disorder while 95.5% had a lifetime diagnosis. The more severe the substance abuse, the more severe or frequent the IPV. While not a treatment study *per se*, Brookoff, O’Brien, Cook, Thompson and Williams (1997) surveyed participants (perpetrators and victims) and examined police reports for 62 domestic violence incidents

reported to the police. They found that 92% of the perpetrators were reported to have used alcohol or other drugs on the day of the assault. Fals-Stewart (2003) provided insight into how alcohol was contributing to domestic violence on a day- to-day basis by collecting diaries from 272 men entering either a domestic violence or alcoholism treatment. Male participants and their partners documented alcohol consumption and relationship violence for 15 months. Men in the batterer program were 8 times more likely to be physically aggressive toward their partner on days where they consumed alcohol and men in alcohol treatment program were 11 times more likely to be physically aggressive toward their partners on days when they consumed alcohol.

Most of what we know about the relationship between substance abuse and IPV is related to the impact alcohol and drugs have on the perpetrator. Less research is available on the role substance abuse has on IPV victimization. Some studies find that women's substance abuse does not incite physical abuse from their partner (Kantor & Asdigian, 1997; Leonard & Quigley, 1999). In fact, one study suggests that women victimized by IPV may use heavy drinking as a way of coping rather than heavy drinking being a catalyst for IPV (Testa & Leonard, 2001). However, other studies have suggested that substance abuse may increase women's risk of victimization through a variety of paths, such as impairing their judgments, increasing financial dependency, and exposing women to violent men who also abuse substances (El-Bassel, Gilbert, Schilling, & Wada, 2000). More recently, Wupperman, Amble, Devine, Zonana, Fals-Stewart, and Easton (2009) discovered that the majority of female partners of men in IPV treatment in their study reported not only being violent with their partners, but also reported that they were as likely as their male counterparts to use substances the week prior to the men's participation in IPV treatment. Based on these findings, the authors suggest that substance abusing women in relationships experiencing IPV should also seek treatment. Regardless of whether IPV leads to

drinking by female victims or whether female victims increase their risk of being victimized by IPV when they drink, it seems clear that there is a link between drinking and IPV for both victims and offenders (White & Chen, 2002; Testa & Leonard, 2001; Testa, 2004).

Although the majority of research linking IPV and substance use focuses on alcohol, a substantial amount of research has suggested that a relationship between illicit substances and IPV does indeed exist (Kantor & Straus, 1989; Moore & Stuart, 2004; Chermack & Blow, 2002; Chermack, Fuller, & Blow, 2000) and should be addressed in treatment settings (Moore & Stuart, 2004).

The Nature of the Association between SA and IPV

The nature of the association between alcohol use and IPV remains controversial. Leonard and Quigley (1999) proposed 3 possible models – the relationship is spurious, the relationship is indirect, or the relationship is proximal. Fals-Stewart and Clinton-Sherrod (2009) note that the spurious effect model is the most commonly endorsed view among victim advocates, policy makers, and many therapists. This model posits no causal relationship between SA and IPV. Some proponents of the spurious model suggest that intoxication and IPV may co-occur as part of a larger pattern of deviant behavior (Osgood, Johnson, O'Malley & Backman, 1988). Other proponents of the spurious relationship suggest that drinking or drug use is simply an excuse used by perpetrators to avoid responsibility for their aggressive behavior (CSAT, 1997). The indirect effects model suggests that substance abuse's causal link with IPV operates through mediating variables. Substance use may increase marital discord, for instance, which in turns leads to IPV. The proximal effects model suggests that the effects of alcohol use and intoxication are directly related to IPV. Perhaps the most common empirically supported proximal model is the psychopharmacological model (Bushman & Cooper, 1990; Pihl &

Peterson, 1993). The psychopharmacological model suggests that the effects of intoxication cause aggressive behavior. A number of effects of intoxication are proposed as links to IPV including removal of restraints against violence through disinhibition and impairment in cognitive processing (Leonard, 2001).

While there are advocates for each of these three models, recent reviews of available research have begun to provide support for a causal relationship between substance abuse and IPV. Fals-Stewart and Kennedy (2005) review the evidence in support of a causal relationship between substance abuse and IPV and conclude that there is significant evidence in favor of such a relationship although ethical and practical limitations make it impossible to prove such a relationship beyond doubt.

The debate about the nature of the relationship between SA and IPV is far from academic. Understanding this relationship has implications for the type of treatment provided to individuals and couples in which IPV and alcohol misuse co-occurs. The spurious effects model suggests that IPV and SA are separate problems needing separate, and specific, treatments. Further, treatment of one problem would not be expected to affect the other problem. The experience gained from the study of Behavioral Couples therapy (BCT; Fals-Stewart, O'Farrell, & Birchler, 2004) is instructive in this regard. Despite not directly addressing relationship aggression, BCT produced reductions in male-to-female IPV among alcoholic men to the same level as a comparison group of non-alcoholic men. This finding has held up consistently across a number of studies by this group suggesting that successful substance abuse treatment can reduce levels of IPV. We do not have studies, however, that examine the effect of IPV intervention on substance use.

Treatment of Co-occurring IPV and Substance Abuse

Despite the frequent co-occurrence of SA and IPV, SA treatment and IPV intervention typically constitute separate tracks often delivered at separate agencies. Treatment personnel in each setting must assess for both problems and decide which treatment will take precedence.

Bennett (2008), writing from the perspective of male batterer intervention programs, suggests three strategies for providing both services: 1) serial treatment which generally begins with treatment for substance abuse followed by IPV treatment; 2) coordination of concurrent separate treatment for both issues; and 3) integrated IPV/Substance abuse treatment.

Serial service approaches involve suspending IPV intervention when a client is found to have a substance abuse problem and referring the client to a substance abuse treatment program for treatment of the substance abuse problem. IPV intervention resumes when SA treatment is finished or has proceeded far enough that the offender is thought capable of making use of the IPV intervention. One problem with this approach is that most clients do not move to the next type of treatment unless mandated.

Given that the standard treatment for someone with co-occurring substance abuse and IPV is offender-only group treatment for battering in addition to group treatment for substance abuse, the next logical suggested step in improving services has been for service providers to coordinate these two types of treatment. The logic for coordinated treatment stems from the acknowledgment that people who experience coexisting SA and IPV need services for both problems. In the coordination model, both types of programs are encouraged to assess for both problems and refer individuals to the other service.

While researchers agree that both problems need to be addressed, the coordination of treatment between two different providers usually presents challenges. First, since it is often

difficult for people to attend one treatment program, they are unlikely to attend two separate treatments during the week (Fals-Stewart & Kennedy, 2005; Dalton, 2001). Part of the problem is that often one of these treatments is mandated but the other is not. In fact, mandated participation in both treatments is rare. Fals-Stewart and Kennedy (2005) found that only 2% of people mandated to substance abuse treatment were also mandated to IPV treatment. Particularly with IPV, it is atypical for clients to attend treatment voluntarily making participation in two difficult and non-mandated treatments much less likely.

Even if individuals attended both programs, coordination between these programs is generally poor (Bennett & Lawson, 1994; Fals-Stewart & Kennedy, 2005). For example, when Bennett and Lawson (1994) surveyed 338 staff from 74 agencies about coordinating substance abuse and DV treatment, they found that although there was a desire to collaborate, agencies did not cross-refer clients often. This was due to low awareness of coexisting conditions, poor links between agencies, professional prejudice, and beliefs that the problem they worked with was primary and that the other problem was secondary. Gondolf (2009) studied male batterers who had coexisting mental health problems and substance abuse and were mandated to both batterer and mental health treatment programs in an effort to coordinate services. However, the additional coordination, efforts, procedures, and costs to implement the dual mandatory treatments did not improve batterer program outcomes overall (Gondolf, 2009, p. 586).

Furthermore, even when programs attempt to coordinate treatment, the services offered are still designed only for substance abuse or IPV, and there is little acknowledgement of the role that substance abuse plays in IPV or that IPV plays in substance abuse (Fals-Stewart & Kennedy, 2005). Thus, the cyclical relationship between the two problems is ignored with separate treatments occurring at the same time. The logical next step to improve on the coordinated

treatment model, is to integrate SA and IPV treatment in the same program (Fals-Stewart & Kennedy, 2005; Dalton, 2001).

Integrated Treatment of Substance Abuse and IPV

Integrated models of treatment do exist. Two of the main concurrent treatment options for substance abuse and IPV are Behavioral Couples Therapy (BCT) and Substance Abuse Domestic Violence (SADV). SADV is a cognitive-behavioral coping skills group for men with coexisting substance abuse and IPV (Easton, Mandel, Babuscio, Rounsaville, & Carroll, 2007). Easton and colleagues' preliminary study of SADV recruited 75 men from an outpatient alcohol abuse program who had been arrested for perpetrating violence against their female partners. Compared to a 12-step substance abuse group condition, SADV participation resulted in significantly less substance abuse and a trend toward reduction in frequency of IPV. SADV is the first program to demonstrate potential efficacy for an integrated approach which involves only male offenders beyond collaborated services.

BCT is primarily considered a treatment method for substance abuse, but has an IPV component. A recent study (Fals-Stewart & Clinton-Sherrod, 2009) compared the effect of BCT versus individual substance abuse treatment for cohabitating or married substance-abusing men on the day-to-day level of IPV. In BCT treatment, the non-substance abusing female victims were taught skills to avoid IPV when their partners were using substances. At a one year follow-up, the participants assigned to BCT reported less IPV and substance use overall and the male partners were less likely to engage in IPV on the days that substance use occurred. However, on the days that substances were not used, there was no difference in IPV perpetration between the men who received BCT and those who received individual substance abuse treatment.

Both BCT and SADV only address coexisting substance abuse and IPV for men who are the substance abusers and IPV perpetrators. BCT involves female partners who are non-substance abusers and are victims of IPV only. In the SADV treatment study, the female partners were not involved in treatment, but 59% of the women self-reported engaging in mild and 55% self-reported engaging in severe violence against their partners (Wupperman et al., 2009). These rates of violence were much higher than what the male partners were reporting for themselves or their partners. Furthermore, at the beginning of the husbands' treatment, the female partners were as likely to use substances as the male partners, and their use increased over the course of treatment to be higher than their husband's use. Findings such as these, in addition to the previous literature that shows that women also use substances and participate in violence in relationships, suggest that both partners are frequently in need of treatment options for coexisting substance abuse and IPV. It is also important that couples are offered treatment in which they have the choice to stay together or to separate with the cessation of violence as the goal for treatment (Wupperman et al. 2003; Easton et al., 2007). Therefore, programs that safely treat both partners in a relationship who experience IPV and substance abuse concurrently are needed. In our model of couples treatment for IPV – Domestic Violence Focused Couples Treatment (DVFCT) – we have introduced a substance abuse module that we will describe below. Based on Motivational Interviewing concepts, it is designed to help clients privately assess the level of difficulty they are having with substances and decide what, if any, action they would like to take. We present this as one beginning strategy to provide concurrent SA and IPV treatment. Much more work is needed in this area.

Domestic Violence Focused Couples Therapy

DVFCT is an 18-week program delivered in either individual couple or multi-couple group format that is designed to be used with couples who have experienced IPV. As we have reported elsewhere (e.g. Stith & McCollum, 2009) DVFCT includes a number of strategies to enhance the safety of the couples participating in the program. We begin with careful selection of couples, monitor risk and recurrence of aggression throughout the course of treatment; modify the session structure to include individual check-ins before and after each conjoint session; teach a negotiated time out procedure, and so forth. The program includes weekly sessions beginning with 6 weeks of sessions during which the couples are seen almost entirely separately. These sessions are psychoeducational in nature with the therapist presenting information to the clients and then helping them apply that information to their specific situations. Thus, for instance, in Session four we discuss IPV in detail – types of aggression, the relationship between aggression and anger, and the importance of self responsibility. Each partner is encouraged to look at his or her own behavior and identify times and acts that fit the definition of IPV. One weekly session in the initial 6 week period focuses on substance abuse and IPV. We have described the model in more detail elsewhere (for instance, Stith, McCollum, Rosen, Locke & Goldberg, 2005) and have also provided outcome data on the model (Stith, Rosen, McCollum & Thomsen, 2004).

DVFCT is designed for couples in which neither partner has an active, untreated substance abuse disorder. During the initial assessment both self report instruments and self and partner reports are used to try to determine the extent of past and current substance use. We use the Alcohol Use Disorders Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders & Monteiro, 2001) and the Drug Abuse Screening Test (DAST-10; McCabe, Boyd, Cranford,

Morales & Slayden, 2006) to obtain written self report data. In order to determine eligibility for our program, we specifically ask about drug and alcohol use in the past 30 days. We will consider admitting couples in which one or both partners are currently in primary substance abuse treatment if they appear to be stable enough to participate in the treatment and report no substance use in the past month. Substance abuse relapses during the course of DVFACT may lead to the discontinuation of DVFACT in favor of more intensive substance abuse treatment. DVFACT may resume when the client is more stable in their substance abuse treatment.

DVFACT Substance Abuse Module

Given our screening criteria, we designed the substance abuse module of DVFACT to provide an appropriate intervention for clients scoring within Zone 1 (Alcohol Education) and 2 (Simple Advice) on the AUDIT and within the limits for “Monitoring and re-assessment” on the DAST-10. Clients with more severe levels of substance abuse will either be concurrently involved in substance abuse treatment or excluded from DVFACT. Using the framework of Motivational Interviewing (MI; Miller & Rollnick, 2002), we provide information about substance abuse and its relationship to IPV as well as guide clients through a series of self-assessment exercises designed to help them evaluate their own substance use and make whatever plans for change they wish to make. The substance abuse module takes the entire 6th session and is delivered to male and female partners separately (either in a group format with other men or women or in an individual format with one client and one therapist in one room and the partner and a co-therapist in another room). We will briefly describe the educational content and self assessment exercises here. Readers wishing more information about the specific content of the module may contact the authors.

We set the stage for the session by discussing the ways in which people typically deal with conversations about alcohol use. Some conversations center around bragging about how much one has drunk and one's ability to "handle my liquor" or complaints about the after effects of drinking ("I was so hung over after last night . . ."). Other conversations are more defensive in nature and tend to minimize the amount or effects of drinking. Some conversations are centered on blaming others for our level of drug and alcohol use. We invite clients to participate in a different kind of conversation – a conversation that looks at both the pros and cons of alcohol use and what, if anything, each person wants to do about it.

Before we present information about alcohol use and IPV, we reiterate our recommendation – made during the intake process– that all DVFACT participants refrain from any drug or alcohol use at least during the course of treatment. We now ground this recommendation in portions of the data presented earlier in this paper about the common co-occurrence of SA and IPV. We do our best to be factual and acknowledge that some people who drink do not abuse their partners and some people who abuse their partners do not drink. However, we believe that when couples experiencing IPV use alcohol and drugs it raises their risk of aggression.

We next talk about what constitutes problem drinking and drug use. We present information about what we mean when we say "a drink." Many charts and other visual aids are available to describe standard amounts of alcoholic beverages (e.g. see National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2005). In order not to misinterpret the information to be provided, we then present NIAAA daily and weekly maximum drinking limits as well as talk about how drinking in certain situations can be risky even when it doesn't exceed the maximum limits (e.g. while driving, when pregnant, when taking certain medications and so forth). During

this discussion, we do our best to be as dispassionate as possible and not enter into a debate about the amount of drinking considered excessive. Since there are no officially recommended levels for illicit drug use, and in order to capture the effects of SA above and beyond mere quantity, we also ask our clients to consider where their life energy is directed. We use a drawing illustrating many areas of life – family, job, spiritual life, and so forth – and include alcohol and drugs as one area of life. Clients are invited to examine how much of their energy is going to each area with the assumption that as more and more life energy goes into drugs and alcohol (time spent using, feeling guilty about using, arguing with family members, recovering from using, etc.), there is more likely to be a problem. We then ask the participants to consider the pros and cons of their drug and alcohol use. We have adapted an exercise called the Awareness Window from Ingersoll, Wagner and Gharib (2002). This exercise asks participants to discuss both the good things and the “not-so-good” things about substance use in several life areas in both the short term and the long term. Thus, what are the pros and cons of alcohol use for Relationships, Happiness, Health and so on. We have modified the Ingersoll version to ask participants to specifically examine issues of self control and violence vis-à-vis their substance use since this is the focus of our work and of this particular session.

We prefer to use the Awareness Window in a group setting since we have found that the group discussion can be synergistic with clients learning from one another through the discussion. However, if working with an individual, or if we feel that the group is either too reticent to have a good discussion or that the group discussion will not be productive, we use an individually-administered inventory of drinking consequence – the Short Inventory of Problems (SIP-2L; Center on Alcoholism, Substance Abuse and Addictions, 1994). This instrument asks

clients to respond to questions about a variety risk and consequences of alcohol use. Although the instrument is focused specifically on drinking, we also ask clients to consider any illicit drug use (including misuse of prescription drugs) as they complete it. Because the SIP-2L does not address positive aspects of drug and alcohol use, therapists have to lead this discussion.

Up to this point in the session, we have promoted discussion, asked clients to share what they feel comfortable sharing, and otherwise promoted openness about personal experiences with substance abuse. From this point on, however, we use written materials that the clients complete privately (that is, they do the work in the session, but do not share their answers). The final part of the session involves a planning for the future exercise. In it, we ask the clients to indicate on a worksheet we provide how they currently assess the costs and benefits of their own drug and alcohol use, from “The costs far outweigh the benefits” to “The benefits far outweigh the costs.” The participants are then asked to consider what change, if any, they would like to make in their substance use and what consequences of that change they would expect to see in 6 months. They are also asked to indicate on the worksheet any potential obstacles to change as well as their level of motivation to make the change. At the end of this exercise, clients are given an envelope in which he or she seals their worksheet and signs their name across the seal. The therapists collect the envelopes and lets the clients know that they will return their worksheets – unread – at the end of the 18-week program. Participants are reminded that whatever change they wish to make in their substance use is up to them.

Throughout this session, the therapists do their best to stay true to the principles of Motivational Interviewing (Miller & Rollnick, 2002). Above all, MI is designed to reduce resistance to promote the client’s readiness to change to the extent possible. Paradoxically,

acceptance of the client's current state and acknowledgement of the normal ambivalence about change as well as the possible benefits of the problematic *status quo* is a better path to promoting change than is confrontation. Ingersoll, Wagner and Gharib (2002) lay out principles of this approach that we find helpful. First, ambivalence about change is normal. Any change has both a set of benefits and a set of costs. Our approach is designed to help clients assess the particular play of costs and benefits in their own lives rather than in a universal sense. Second, resistance to change is not necessarily a stable characteristic of the client but can fluctuate based on the quality of the relationship between therapist and client. Thus, the therapist should be respectful and appropriately friendly to the client. The therapist should also make room for the client's view of things and for the natural ambivalence about change. Clients are clearly in charge of their own progress and the ultimate decision about what, if any, action to take is left with them. Some information or mild advice can be useful – therefore we provide clients with information about recommended level of alcohol use and ways to evaluate their overall substance use and the place it holds in their lives. Finally, we leave it up to clients to set their own goals and hopefully display our trust in their ability to do so by not demanding that they share the goal with us nor report to us about progress along the way. Our hope is that by providing an intervention geared to the relatively mild levels of substance abuse that we screen for, we can help clients move toward change in this area.

Discussion

We concur with Wupperman et al. (2009) in their call for more study of violence occurring in couples in which one or both are abusing substances. Both research and practice in this area have often been framed in terms of a sole perpetrator – sole victim paradigm despite the

fact that the literature in IPV suggests a significant proportion of relational aggression is bi-directional – that is, both partners physically or psychologically assault one another (e.g. Johnson & Leone, 2005; Jose & O’Leary, 2009). In our own work, we found that even when we were receiving referrals for couples in which the male was identified as the aggressor, careful assessment revealed that the majority of women had also physically assaulted their male partners. The single-perpetrator – single victim paradigm may now be impeding progress in both understanding and treating this complex issue by imposing a too simplistic framework on it. In addition, what we can gain from examining couples in which only one partner is abusing substances may also be limited. There is a consistent, and complex, relationship between partners’ patterns of substance use and abuse. One study, at least, has linked discrepant drinking patterns, level of marital dissatisfaction, and the occurrence of IPV (Leadley, Clark & Caetano, 2000). Thus studies need to examine the influence of both partners’ substance abuse as well as both partners’ aggression.

Similar complexity needs to be taken into account in the treatment arena. As we learn more about the various typologies of IPV, it seems clear that one approach will not serve all clients equally well. In fact, Smith-Stover, Meadows and Kaufman (2009) make clear in their review that no intervention for IPV can be judged better than another and that we need more complex models of triage to decide which approaches will best benefit which clients. There is some evidence for the utility of couples-focused treatment for substance abuse in reducing IPV even when IPV is not directed targeted by the treatment program. In our work, we have begun to experiment with introducing a substance abuse intervention into what is primarily a couples focused treatment for IPV. We feel that further work in finding ways to integrate these two

modalities of treatment is needed.

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