Partner Violence Experiences and Women's Drug Use: Exploring the Connections

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INTRODUCTION

This chapter focuses on women's drug use and their experiences with partner violence. First, the chapter presents rates of partner violence in the United States and evidence from previous research connecting partner violence and women's substance abuse. Second, data from an ongoing study in western New York demonstrate evidence for the connection between women's drug use and their experiences of partner violence. Finally, the chapter discusses possible explanations for these connections and the implications for policy and practice.

RATES OF PARTNER VIOLENCE AND PRIOR RESEARCH

Partner violence can be identified by specific acts and behaviors that are directed from one partner to another. One of the more commonly used instruments to assess partner violence is the Conflict Tactics Scale (CTS) developed by Straus and colleagues (Straus and Gelles 1990, pp. 113-132). Specific acts are used to define minor and severe violence and can be measured for the past year or other specified time periods. Severe violence is indexed by the following behaviors: kicked, bit, or hit with a fist; hit or tried to hit with something; beat up; choked; threatened with a knife or gun; or used a knife or fired a gun.

Based on a random national survey conducted in 1985 in which the CTS was used, baseline rates of husband-to-wife violence were estimated at 11 percent for overall violence and 3 percent for severe violence (Straus and Gelles 1990, p. 118). These rates were for the 12 months preceding the survey and represent a yearly estimate of violence. When compared with a similar national survey conducted in 1975 (Straus and Gelles 1990, p. 118), these rates of husband-to-wife violence did not show a statistically significant difference. Applying

this rate of husband-to-wife violence to the general population, Straus and Gelles estimated that more than 2 million wives are severely assaulted each year by their husbands.

From these same nationwide data, Kantor and Straus (1990, pp. 203-224) report finding a connection between spousal violence and women's and men's drinking. They report one in four incidents of wife abuse involved drinking by either the husband alone or the husband and wife immediately preceding the event. However, because three-fourths of all incidents involved violent situations in which neither the husband nor the wife was drinking, alcohol or other drug (AOD) use can best be described as connected to partner violence only for some events and/or some people.

In addition to studies by Eberle (1982) and Gorney (1989) that identified relationships between women's AOD use and their experiences of partner violence, work by the author and colleagues has demonstrated evidence for these connections. Based on interview data from 472 women drawn from 5 sources (outpatient alcoholism clinics, drinking/driving classes, shelters for partner violence, outpatient mental health clinics, and a general population sample), significantly higher levels of severe partner-to-woman violence were reported by women in alcoholism treatment relative to the general population (Downs et al. 1993; Miller et al. 1993). Another study also showed higher rates of partner violence for a sample of women in alcoholism treatment than for women in the community (Miller et al. 1989).

RECENT EVIDENCE FOR CONNECTIONS

In a study funded by NIDA, the author and coworkers have continued to investigate the relationships between women's AOD use and their experiences of violent victimization, focusing specifically on samples of women identified because of their involvement with illicit drugs. Two directions for these relationships were investigated: Does drug use increase the risk of partner violence? Does partner violence increase the risk of drug use?

This NIDA study includes 609 women drawn from three different sources: outpatient drug treatment (n=157), shelters for partner violence (n=144), and the community (n=308). Two different samples were drawn from the community to match the drug treatment and

shelter samples on age and on geographic proximity of residence. This geographic match is important when focusing on violent victimization to control for the context and social settings in which people live. Figure 1 shows the distribution of the sample across the shelter, drug treatment, and two matched community sources.

Data for this study were obtained from indepth interviews. Four waves of data were collected at 6-month intervals. Results presented here are limited to the data collected in the first wave.

Women's drug use focused on illegally obtained drugs or prescription drugs used intentionally in a nonprescribed manner. Women were asked whether they had ever used, used regularly (defined as at least once a week for at least a month), or used daily (defined as daily use for 2 weeks or more) any of the following substances: sedatives or tranquilizers, stimulants (e.g., methamphetamine), analgesics (e.g., Dilaudid), inhalants, marijuana, hallucinogens, cocaine in any form, and heroin and methadone. Specifically, lifetime drug use and drug use in the 6 months preceding the first interview were used in these analyses. Drug-related problems also were assessed, as well as measures of tolerance and withdrawal. Although the primary focus was on women's use of drugs other than alcohol, measures of women's alcohol use and alcohol problems also were obtained. Quantity and frequency measures of alcohol use allowed for assessment of heavy drinking periods across the lifespan and within the past 6 months. Alcohol-related problems were assessed according to the criteria for alcohol abuse and alcohol dependence of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition,*

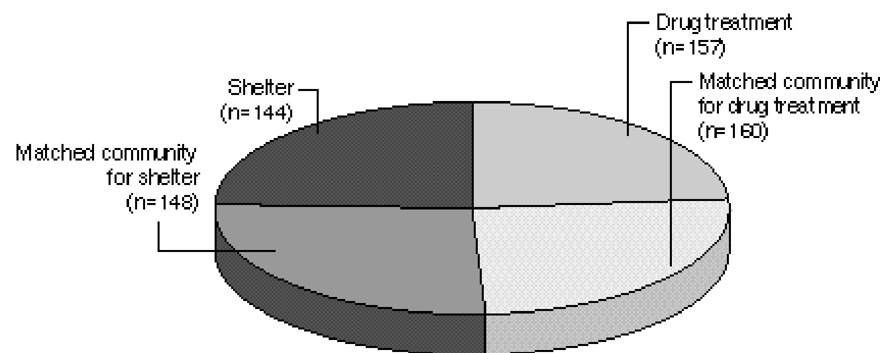

FIGURE 1. *Distribution of the sample across the shelter, drug treatment, and two matched community sources (n=609)*

Revised (American Psychiatric Association 1987). Women were defined as having an AOD problem if they met one of the following three criteria: any daily drug use, any regular drug use and symptoms of tolerance or withdrawal, or a diagnosis of alcohol dependence. For these comparisons, the community and shelter groups were divided into women with AOD problems and those without.

Violence from intimate partners was assessed by the CTS (Straus 1979; Straus et al. 1980; Straus and Gelles 1990, pp. 113-132) supplemented by additional items (Miller et al. 1989). In the first interview in wave one, women were asked about violence occurring in their lifetime and in the past 6 months.

Figure 2 compares the rates of severe partner violence for women in the drug treatment group with that of their matched sample from the community. The community sample is separated into two groups according the presence or absence of lifetime AOD problems. Rates

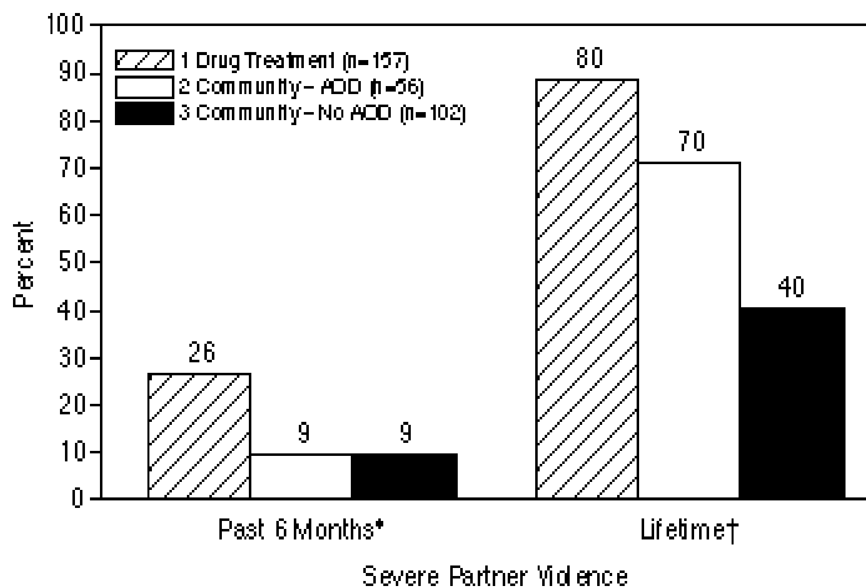

FIGURE 2. *Rates of severe partner violence: Comparisons of women in drug treatment and women in the community with and without lifetime AOD problems*

*Significant posthoc tests (1 v. 2; 1 v. 3)

†Significant posthoc tests (1 v. 2; 1 v. 3; 2 v. 3)

KEY: AOD=alcohol or other drug

of partner violence are presented for the past 6 months and lifetime. Significantly more women in the drug treatment group (26 percent) experienced severe partner violence during the 6 months prior to the first interview than did women in the two community comparison groups (9 percent each). The second comparison in this figure presents the percentage of women who had experienced any severe violence from a partner during their lifetimes. A significantly higher percentage of women in the drug treatment group experienced severe partner violence than did women from either community group (88 percent, 70 percent, and 40 percent, respectively). Furthermore, women in the community who had AOD problems reported significantly higher rates of lifetime severe partner violence than did community women without AOD problems.

Figure 3 compares the rates of partner violence for women in the shelter with and without AOD problems with rates in the matched

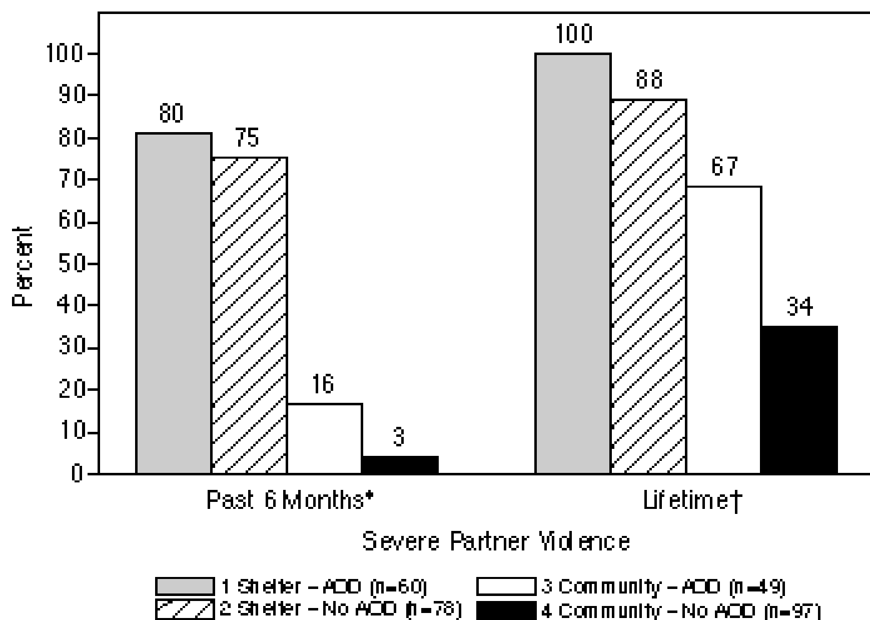

FIGURE 3. *Rates of severe partner violence: Comparisons of women in shelters with and without AOD problems and women in the community with and without AOD problems*

*Significant posthoc tests (1 v. 3; 1 v. 4; 2 v. 3; 2 v. 4)

†Significant posthoc tests (1 v. 3; 1 v. 4; 2 v. 3; 2 v. 4; 3 v. 4)

KEY: AOD=alcohol or other drug

(to shelter) community sample with and without AOD problems. As expected, women in the shelter, regardless of whether or not they had AOD problems, had extremely high rates of severe partner violence during the past 6 months (with AOD problems, 80 percent; without AOD problems, 75 percent). These rates were significantly higher than the rates for women in both community samples (with AOD problems, 16 percent; without AOD problems, 3 percent). Figure 3 also presents the prevalence of severe partner violence across the lifetime for women in the shelter and community samples. There were no significant differences in rates of severe partner violence among women in the shelter, with and without AOD problems (100 percent and 88 percent, respectively). In contrast, within the community, women with AOD problems had rates of partner violence almost twofold higher than the rates of women without AOD problems, and these differences were significant.

The measure of severe violence is based on specific violent behaviors women have experienced from their partners. Table 1 presents these behaviors for four groups of women: women from drug treatment, women from shelters, women from the community with AOD problems, and women from the community without AOD problems. For these analyses, women from both community samples (community matched to the drug treatment and community matched to the shelter samples) are

TABLE 1. *Prevalence of different types of severe partner violence: Comparisons for drug treatment, shelter, and community samples (percent)*

Type of Severe Violence	Drug Treatment (1)	Shelter (2)	Community With AOD (3)	Community Without AOD (4)	Significant Posthoc Comparisons
Hit with fist	80	86	54	22	1,4; 2,4; 3,4; 1,3; 2,3
Hit with object	69	67	40	13	1,4; 2,4; 3,4; 1,3; 2,3
Beat up	79	82	50	21	1,4; 2,4; 3,4; 1,3; 2,3
Burned or scalded	10	6	5	2	1,4
Choked	66	64	38	18	1,4; 2,4; 3,4; 1,3; 2,3
Threatened with gun or knife	45	47	23	11	1,4; 2,4; 1,3; 2,3
Other threat	58	68	38	11	1,4; 2,4; 3,4; 1,3; 2,3
Used gun or knife	23	20	13	5	1,4; 2,4
Forced sex	44	51	37	12	1,4; 2,4; 3,4

KEY: AOD=alcohol or other drug

combined. Women in the drug treatment group and women from the shelters show similar rates of each specific form of violence; there were no statistically significant differences. Although high rates of severe violence were expected among women from the shelter sample, the similarity in rates for women in drug treatment was surprising. For example, 80 percent of the women in drug treatment had been hit with a fist, 66 percent had been choked, and 45 percent had been threatened with a knife or gun, whereas the corresponding figures for the shelter sample were 86 percent, 64 percent, and 47 percent.

Comparisons of women in the community with and without AOD problems reveal that for virtually all types of severe violence, women with AOD problems have much higher levels of violence—often two, three, or almost four times higher. For example, 54 percent of the women in the community with AOD problems have been hit with a fist compared with 22 percent of the women in the community without AOD problems. Also, 38 percent of the women with AOD problems and 11 percent of the women without AOD problems report other threats against their lives.

IMPLICATIONS FOR POLICY AND PRACTICE

Do victimization experiences, such as partner violence, make women more vulnerable to AOD problems? The author and associates' work on childhood victimization suggests that they do (Miller et al. 1993). One mechanism that may link victimization experiences to AOD problems is posttraumatic stress disorder (Miller et al. 1997, pp. 357-385). AOD use may also be a more general coping mechanism for victimization experiences (Miller et al. 1997, pp. 357-385).

Do AOD problems make women more vulnerable to victimization, such as partner violence? There is some indication that a relationship exists in this direction as well (Miller 1996, pp. 239-260). Both the acute condition of being intoxicated or high and the chronic condition of being addicted to alcohol or other drugs may make women more vulnerable to victimization. This view is not a case of blaming women for their victimization but rather one of understanding vulnerabilities and empowering women to make changes in their lives.

These data and other studies suggest that drug problems and partner violence co-occur for women. Although the data are insufficient

to determine the causal pathways, the relationships discussed here provide important information for policy and practice. For treatment providers, it is critical to understand the importance of victimization and victimization histories to the experiences of women and their willingness and ability to respond to specific treatment protocols. Not only are experiences of partner violence common in the lives of most women who are in drug treatment, but also the experiences of severe partner violence are recent. Many women were in treatment during the 6 months prior to the interviews. Thus, experiences of violent victimization are occurring while women are *in treatment* for their addictive disorders. This should be expected to affect their treatment experience and their vulnerabilities to relapse.

From a policy standpoint, designing systems that are responsive to women's needs and to their experiences is important. For women drug users, consolidated support services for both addiction and victimization issues are needed. Many AOD treatment facilities fail to screen for family violence or to provide services for identified problems (e.g., Bennett and Lawson 1994). Likewise, AOD problems are not addressed in shelters, and in some cases women are removed from shelters if they have an AOD problem.

Addressing partner violence through the criminal justice system is often insufficient for solving the problems of today's families (Fagan 1996). Identifying someone to blame does not constitute a solution to the problem. Of particular concern is that focusing resources on the offender fails to address the intergenerational issues of AOD problems and family violence. More recent work by the author and colleagues has begun to examine the impact of mothers' AOD problems on their children (Smyth and Miller 1997; Miller et al. 1995), specifically, children's vulnerability to violent victimization by their mothers or by other adults that surround the families. Understanding how the experiences in childhood set the stage for adult experiences and actions can promote more effective intervention efforts and specifically promote prevention strategies that can address problems early in the process.

Much of the research to date has focused on the individual and dyad level of analyses. Yet, families are affected by their communities also. Restructuring norms and values in communities to reduce the acceptance of violence is needed. Recognition that individuals who try to change must face environments and social settings that promote drug

use and violence is important. We need to consider contextual and structural changes that can be promoted to support individuals in looking for a way out of cycles of violence and substance abuse.

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