Assessment and treatment of domestic violence in a substance abuse setting

Carlo DeFazio

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ABSTRACT

Assessment and Treatment of Domestic Violence in a Substance Abuse Setting

by

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Domestic violence and substance abuse have come to the forefront of the public’s awareness in the last decade. This document focuses on the simultaneous occurrence of these phenomena and proposes that providers reconcile any possible differences in treatment and collaborate, if not integrate services. Providers must move beyond their respective theoretical approaches and form a new transtheoretical delivery approach to treatment in order to provide the best possible outcomes for clients. Additionally, while the document assumes that substance abuse programs are offering appropriate assessment and treatment to their clients, it seeks to further heighten their awareness to issues concerning domestic violence, in particular the needs of the victim of domestic violence.
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CHAPTER 1

INTRODUCTION

The topic of domestic violence and substance abuse is a broad one, and usually refers to the relationship between psychotropic substances and the perpetration of violence by the abuser. This study will view any pattern of psychotropic substances in the course of domestic violence, by either the victim or the perpetrator, as problematic. In addition, it will view any act of aggression or violence as one that may lead to domestic violence.

This study will also focus on heterosexual men (perpetrators) who abuse or batter their domestic partners, and heterosexual women (victims) who are battered. There are many other patterns of domestic violence such as child abuse, elder abuse, women’s abuse of men, and abuse in same sex relationships. While important, these patterns of domestic violence are outside the scope of this study, in part because they are complex issues that would require a separate review.

In addition to reviewing the literature in these areas, this study will attempt to reconcile the distinctly different, and often opposed, methods of intervention and assessment in the fields of substance abuse and domestic violence. It will also suggest a collaborative, if not an integration, of the two fields. Additionally, it will use words and
phrases such as substance use, substance abuse, and chemical dependency, as well as
counselor and provider interchangeably.
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CHAPTER 2

LITERATURE REVIEW

Domestic Violence

Domestic violence is the use of intentional verbal, psychological, or physical force by one family member (including an intimate partner) to control another. Violent acts include verbal and physical intimidation; destruction of the victim's possessions; maiming or killing pets; threats; forced sex; and slapping, punching, kicking, choking, burning, stabbing, shooting, and killing victims. Parents, step-parents, children, siblings, elderly relatives, and intimates may all be targets of domestic violence (Peace at Home, 1995).

Women are the primary targets of domestic violence (Pagelow, 1984) and in the United States, where 94 percent of serious domestic assaults are male to female, a woman is beaten every 15 seconds (Dutton, 1992; Gelles & Straus, 1988). At least 30 percent of women seen in emergency rooms have been victims of domestic violence, and the medical costs associated with injuries done to women by their partners total more than $44 million annually (Langford, 1996). According to Straus and Gelles (1990), 5.25 million women are assaulted each year, and 1.8 million of these assaults are classified as severe with a high risk for causing serious injury. In a review of American and Canadian research on woman abuse, Dutton (1995) concluded that women are severely assaulted in 8.7 percent
to 12.1 percent of marriages, and that approximately two-thirds of the assaulters re-offend. Additionally, in 1992, an estimated 1,414 females were killed by intimates (Bureau of Justice Statistics, 1995).

Violence is a culturally transmitted disease of epidemic proportions in the contemporary United States, and domestic violence is one of its most insidious expressions (Carden, 1994). Clinical impressions and empirical data in the literature on domestic violence suggest that it is multigenerational. Within a given family, its occurrence in one form frequently predicts its occurrence in another; child, elder, and sibling violence tend to coexist (Gelles & Straus, 1979, 1988; Joureles & LeCompte, 1991; Straus & Gelles, 1986, 1990). A considerable body of evidence suggests that children who live in a household in which one parent is battered by another are at increased risk of being battered themselves. Stark and Flitcraft (1988) argued that wife abuse is the number one predictor of child abuse, and Pagelow (1992) cited statistics that indicate that at least half of all men who abuse their wives or partners also abuse their children.

In the United States, violent crimes occur more frequently within families than among strangers (Gelles & Straus, 1988; Langan & IIlnes, 1986; Straus & Gelles, 1990). Government surveys conducted between 1973 and 1981 identified 4.1 million reports of intrafamilial victimizations (Bureau of Justice Statistics, 1984). In 1990 alone, of 6,008,790 crimes of violence against persons age 12 and older reported in a national crime victimization survey (U.S. Department of Justice, 1992), 39 percent were perpetrated by a member of the victim's family or by a person in a relationship with the victim. Less than
half of these crimes were reported to the police. Fifty-eight percent of those reported involved the spouse or ex-spouse of the victim. The presence of intrafamilial violence has been documented in families of every race, religion, social class, and educational level (Bureau of Justice Statistics, 1984; Straus, 1980; Straus & Gelles, 1986; U.S. Department of Justice, 1992).

*The Handbook of Family Violence* (Van Hasselt, Morrison, Bellack, & Hersen, 1988) identified five major types of family violence and presented the following incidence estimates on each: (1) child physical abuse - 1.4 to 1.9 million cases annually, (2) child sexual abuse - 80,000 to 250,000 cases annually, (3) parent/elder abuse - 500,000 cases annually, (4) marital rape - one in seven ever-married women, and (5) spouse abuse - 1.8 million annually. These figures probably underestimate the magnitude of the problem. True domestic violence incidence rates have been difficult to ascertain because cultural and sub-cultural norms in the United States have tolerated (and in some cases even condoned) violence within families, supported intrafamilial confidentially, and sanctioned gender roles based on power imbalance (Allen & Straus, 1980; Bogard, 1988, 1992; Dobash & Dobash, 1992; Gelles & Straus, 1988; Walker, 1979, 1984; Yllo & Straus, 1990). Only over the last two decades, in the wake of three powerful social movements -- the civil rights movement, the child advocacy movement, and the women's liberation movement -- has the prevalence of violence in our social institutions in general and in our nuclear families in particular become increasingly and alarmingly evident (Carden, 1994). In response, the American Medical Association (AMA) (1991) launched the National Campaign Against Family Violence, describing the problem as epidemic.
Wife abuse

In the United States, a woman is more likely to be physically assaulted, raped, or murdered by a current or former partner than by any other assailant (AMA, 1991; Langan & Ilnnes, 1986). Injuries to women from spousal assault surpass those sustained in motor vehicle accidents and muggings combined (McCleary & Anwar, 1989; Rosenberg, Stark, & Zahn, 1986). Just over 50 percent of all female murders (compared to 12 percent of all male murders) are spouse perpetrated (Frieze & Browne, 1989). In addition, four types of husband-to-wife violence -- physical, sexual, property, and psychological -- have been clinically observed and defined (Ganley, 1981; Sonkin, Martin, & Walker, 1985)

Documented sequale of wife abuse include miscarriage, abortion, drug and alcohol abuse, attempted suicide, physical disfigurement or disability, cognitive distortions, chronic depression, anxiety, and low self-esteem (Barnett & La Violette, 1993; Campbell, 1990; Casardi & O'Leary, 1992; Launius & Lindquist, 1988; Rosewater, 1988; Sato & Heiby, 1992; Stark & Flitcraft, 1988; Walker, 1979, 1984).

Rosewater (1988) noted that battered women have been mis-diagnosed as schizophrenic or borderline personality disordered on the basis of their profiles on the Minnesota Multiphasic Personality Inventory (MMPI) (Hathaway & McKinley, 1983). In addition, Rhodes (1992) reported elevations on the MMPI scale for battered women. Consistent with the findings of Rosewater (1988) and Rhodes (1992), researchers Nurius, Furrey, and Berliner (1992) reported significant impoverishment of a broad range of coping capacities for abused wives compared with two other groups of less directly threatened women and with a group of non-threatened women. Additionally, Walker
(1991) reports that Post-Traumatic Stress Disorder (PTSD) comes closer than any other Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) category to describing the psychological status of the battered woman. Other researchers have presented evidence supporting the proposition that cognitive, affective, and behavioral commonalities observed among battered women are consequences rather than antecedents of their abusive experiences (Follingstad, Brennan, Hause, Polek, & Rutlege, 1991; Gelles & Harrop, 1989; Houskamp & Foy, 1991; Wilson, Vercella, Brems, & Benning, 1992; Woods & Campbell, 1993).

Research that reports equal numbers of men and women as having been physically abused by their spouse (Straus, 1980) contrasts sharply with the Bureau of Justice Statistics (1984) report that in 91 percent of the spousal abuse cases reported between 1973 and 1981, the victim was a woman. Furthermore, domestic violence research has consistently found that men tend to under report their own acts of spousal aggression by denying that they ever happened, by minimizing their severity, frequency, and consequences, and by justifying them as appropriate responses to their spouses' behaviors (Arias & Beach, 1987; Dutton, 1986; Edleson & Gruszinski, 1988; Holtzworth-Monroe & Hutchingson, 1993; Riggs, Murphy, & O'Leary, 1989). In addition, due to males' greater size and physical strength, females suffer far more serious physical consequences from spousal assault than males (Cascardi, Langhinrichen, & Vivian, 1992; Schwartz, 1987; Stark & Flitcraft, 1988), and the spousal aggression reported by women is more likely than that reported by men to have been self-defensive (Saunders, 1986, 1988; Straus & Gelles, 1990). In conclusion, Gordon (1988), in her account of the social history of family
violence over the past 120 years, reported that the incidence of wife abuse in Western societies has remained relatively constant from the pre-Victorian era through the Industrial Revolution and into the modern age of technology.

Sociopolitical perspective

At one end of the perceptual continuum on the etiology of wife abuse, profeminist researchers, theorists, and service providers maintain that the patriarchal infrastructure of our political, cultural, and social relations sanctions woman abuse in general and wife abuse in particular (Bogard, 1988, 1992; Dobash & Dobash, 1992; Murphy & Meyer, 1991; Pagelow, 1992; Pence, 1989; Schechter, 1988; Walker, 1979, 1984; Yllo & Straus, 1990). They argue that many women have not achieved the political, economic, and social independence that would empower them to leave violent relationships. They also criticize mass media for romanticizing violence, male dominance, and female submissiveness (Dines, 1992; Jarvie, 1991; Kuhn, 1985).

Profeminists reject the notion that a wife shares responsibility for her husband’s violent behavior. They maintain that because the perpetrator commits the violent act, he alone bears responsibility for that particular act and its consequences (Adams, 1988, 1989; Avis, 1992; Bogard, 1988; Ganley, 1981, 1989; Kaufman, 1992; Pence, 1989). Additionally, Kantor and Straus (1987) reported that wife abuse was eight times more likely to occur among couples with husband-dominated versus egalitarian decision-making styles, and Stith and Farley (1993) reported data suggesting a direct link between wife abuse and nonegalitarian sex-role attitudes and approval of marital violence.
Other perspectives

At the other end of the perceptual continuum on the etiology of wife abuse, two psychological theories — attachment theory (Bowlby, 1973, 1980, 1984; Corvo, 1992; Delozier, 1982; Symonds, 1984; Young & Green, 1991; Zeanah & Zeanah, 1989) and social learning theory (Bandura, 1973; Dutton, 1988; Ganley, 1981; O'Leary, 1988; Stith & Farley, 1993)—locate the etiology of the phenomenon within the batter's developmental experience. An estimated 3 million children witness acts of violence against their mothers every year, and in the process, come to believe that the violent behavior is an acceptable way to express negative feelings (Bennett, 1995; Hamberger & Hastings, 1986; Kroll, 1985). The rate at which violence is transmitted across generations in the general population has been estimated at 30 percent (Kaufman & Zigler, 1993) and 40 percent (Egeland, 1988). Although these figures represent probabilities, not absolutes, they suggest that 3 or 4 of every 10 children who observe violence in their families are at increased risk for becoming involved in a violent relationship as an adult (Bennett, 1995).

According to Kantor and Straus (1987), Reed (1991), and Bennett (1995), many different factors are associated with domestic violence experiences of both survivors and perpetrators. These include witnessing/experiencing domestic violence during childhood, low income and educational status, social norms approving of violence against women, history of childhood aggression, and substance abuse. Much like the pattern of substance abuse, violence between intimate partners tends to escalate in frequency and severity over time (Bennett, 1995). In addition, according to Bennett (1995), certain psychological states are associated with both substance abuse and domestic violence, including negative
attitudes, poor interpersonal relationships, negative social values and rebelliousness (especially in youth), and low self-esteem.

Substance Abuse

According to the DSM-IV (American Psychiatric Association (APA) 1994, pp. 182-183), substance abuse is a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period. (1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household). (2) Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use). (3) Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct). (4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

The fabric of America is profoundly affected by problems of substance abuse. They are problems that directly affect those millions of Americans who suffer from substance abuse and indirectly touch the lives of millions more in the larger social and vocational networks around them (Beck, Wright, Newman, & Liese, 1993).

Approximately 10 percent of Americans in the United States have a serious drinking
problem, 60 percent are light to moderate drinkers, and the remaining 30 percent of adults in the United States do not consume alcohol. Alcohol abuse, however, accounts for approximately 81 percent of hospitalizations for substance abuse disorders (Institute of Medicine, 1987). The prevalence rate for alcoholism in the general population in the United States is 16 percent and for drug addiction, which includes prescription drugs and illicit drugs, it is 8 percent (Miller, Gold, & Smith, 1997). The National Household Survey on Drug Abuse (1996) estimated 13 million Americans were current illicit drug users, marijuana being the most commonly used illicit drug, and of the 13 million people 1.75 million of them were using cocaine. Additionally, 109 million Americans age 12 and older had used alcohol in the past month, about 32 million engaged in binge drinking, and about 11 million were heavy drinkers (drinking five or more drinks per occasion on five or more days in the past 30 days). The National Institute on Drug Use (1998) estimated that first time substance users for the year 1997 included alcohol (n=454,085), marijuana (n=245,824), hallucinogens (n=99,598), inhalants (n=72,733), cocaine (n=58,207), and heroin (n=13,323).

According to the National Parents’ Resource Institute for Drug Education (1996), nearly one in five 12th graders (18.3 percent) used an illicit drug weekly or more, almost one in ten (8.4 percent) used daily, and more than 25 percent admitted weekly alcohol use. In addition, 12.5 percent used hallucinogens, 11.6 percent used uppers, 7.1 percent used cocaine, and 3.5 percent used heroin within the past year.

Further, it is estimated that 2.3 percent of the United States population over 12 years old has an illicit drug problem sufficiently serious to warrant treatment. This statistic
is substantially higher, however, for individuals who are incarcerated (33 percent) or on parole (25 percent). When these people are included in the epidemiologic data, the estimate of illicit drug use problems in the overall population increases to 2.7 percent (Institute of Medicine, 1990). In addition, individuals abusing one psychoactive substance are likely to be simultaneously abusing another substance. In fact, between 20 percent and 30 percent of alcoholics in the general public and approximately 80 percent in treatment programs are dependent on at least one other drug. A prevalent combination is alcohol, marijuana, and cocaine (Miller, 1991).

Alcohol

Accord and Accord (1982) state that alcoholism is partly a behavioral disorder. The specific behavior that causes the problems is the consumption of large quantities of alcohol on repeated occasions. The motivation underlying this behavior is often obscure. When asked why they drink excessively, alcoholics occasionally attribute their drinking to a particular mood, such as depression or anxiety, or to stressful circumstances. Additionally, they sometimes describe an overpowering need to drink, variously described as a craving or an impulse (Goodwin, 1995).

Like other drug dependencies, alcoholism is marked by a preoccupation with ensuring the availability of the drug in quantities sufficient to produce intoxication. Early on, the patient may deny this preoccupation or rationalize the need by assertions that he or she drinks no more than his or her friends (Goodwin, 1995). As alcoholism progresses and problems from drinking become more serious, alcoholics may drink alone, sneak drinks, hide the bottle, and otherwise conceal the seriousness of their condition. This is
accompanied by guilt and remorse, which will produce more drinking, relieving the feelings. This results in a vicious cycle of drinking and when the cycle is stopped, a withdrawal symptom may follow (National Institute of Drugs, 1992).

Opiates

Opium and heroin are the usual opiates of choice and for more than a century, three major hypotheses have been put forth to account for their contentious use. The first is that after a period of years for whatever reason, people become physically dependent and then continue to use to avoid the stress of withdraw. A second hypothesis is that people continue to use opiates because they like the effect. The third major hypothesis is that, for some people, even on initial use, opiates continue to relieve some psychological distress that is not being caused by withdraw (Wilker, 1980). When heroin was readily available to U.S. Army personnel in Vietnam, 42 percent of enlisted men experimented with opiates and about half became physically dependent. Of those who tried it five times, 73 percent became physically dependent (Robins, 1979).

One of the most significant advances in understanding how opiate use can lead to sustained drug-using behavior and relapse after a period of withdrawal has been the recognition that drug effects and drug withdrawal phenomena can become linked through learning to both environmental cues and internal mood states. The concept of learned or conditioned craving tends to amplify and extend both the motivating effects of opiate withdraw and their positive reinforcing actions (Childress, McLellan, & O'Brien, 1986).
Cocaine

The National Household Survey on Drug Abuse (1993) estimated that 4.5 million Americans used cocaine in 1992, 1.3 million of whom used at least monthly. Cocaine abuse and dependence is a common problem that is part of the increasing population of poly-drug users, dependent on alcohol, nicotine, opiates, and/or cocaine (U.S. Department of Health and Human Services, 1993). Chronic cocaine users often experience persistent panic attacks or bouts of anxiety, which are reported to persist months after discontinuation of cocaine (Washington & Gold, 1984). In a study of 103 inpatient alcoholics and 51 outpatient alcoholics, 49 percent and 51 percent, respectively, were also cocaine dependent. Cocaine addiction is also common among heroin addicts; studies range between 20 and 50 percent for concomitant cocaine addiction (Kosten, Rounsaville, & Kleber, 1987).

Cocaine users describe intense craving for cocaine when cocaine is made available to them or merely when the word cocaine is uttered in conversation. Handling paper money or seeing a bill rolled may produce intense craving. Seeing places or people where cocaine was used, smelling cocaine, seeing a cocaine pipe, or seeing a friend who one used cocaine with can trigger an intense reaction in the user or the person who had used in the past but now abstinent (Gold, 1984). In addition, the presentation of cocaine paraphernalia after weeks or months of abstinence produces intense cravings and withdrawal-like symptoms (Dackis & Gold, 1990).
Amphetamines and other stimulants

Amphetamines and other stimulants produce feelings of euphoria and relief from fatigue, may improve performance on some simple tasks, increase activity levels, and produce anorexia. The abuse liability of these drugs is thought to be primarily related to their euphoric effects (Caldwell, 1980). Additionally, studies suggest behavioral disintegration and social isolation during chronic amphetamine administration (Ellinwood & Less, 1989; Ellinwood, Sudilovsky, & Nelson, 1974).

The underground production of amphetamines in the United States is controlled by small clandestine laboratories. Amphetamine production is estimated to be a $3 billion a year industry, with every indication of expansion (Cho, 1990). In addition, Cho (1990) concludes increase in the use of amphetamines may be motivated by the fact that the duration of amphetamine's effects is approximately 10-12 hours versus 45 minutes for cocaine.

Sedative and hypnotics

Sedative-hypnotics are drugs and medications that have, as prominent pharmacological effects, the ability to reduce anxiety or induce sleep. Sedative-hypnotic abuse is often attributed to physician's over prescribing (Wesson & Smith, 1990). What constitutes over prescribing, however, is a complex judgement that is molded by beliefs about the cause and appropriate treatment of anxiety and insomnia (Roy-Byrne & Crowley, 1990). At the very minimum, physicians are faulted for giving in to their patients' request or demand for sedative-hypnotics (Wesson & Smith, 1990).
Intoxication with sedative-hypnotics is qualitatively similar to alcohol intoxication. The desired effect is a state of disinhibition in which the mood is elevated. A person intoxicated on sedative-hypnotics commonly has an unsteady gaze, slurred speech, sustained horizontal nystagmus (rapid eye movement), poor judgement, and may produce amnesia similar to alcoholic blackouts (Lader, 1991). Signs of withdrawal include anxiety, insomnia, nausea, vomiting, postural hypotension, seizures, delirium, and excessive excitation (Ries, Cullison, Horn, & Ward, 1991).

Phencyclidine (PCP)

PCP (angel dust) was developed by Parke-Davis under the trade name Sernyl during the 1950s in a research program targeting general anesthetics. Patients anesthetized with PCP appeared catatonic with rigid posturing and sometimes waxy flexibility. It was inferred that without overt loss of consciousness, patients were sharply dissociated from the environment. In addition, up to half of patients subjected to PCP anesthesia developed severe intraoperative reactions including agitation and hallucinations. As a result of these findings, PCP was removed from the market in 1965 and officially limited thereafter to veterinary applications (Lowinson, Ruiz, Millman, & Langrod, 1997).

The percent of persons reporting lifetime use of PCP has been increasing since 1985, when the estimate was 2.9 percent. More current reports range as high as 8.2 percent. About twice as many males report use as females. Whites are more likely to use PCP than the other groups, with Hispanics reporting higher rates than African Americans (Substance Abuse and Mental Health Services, 1995).
The majority of PCP intoxicated patients manifest nystagmus (rapid eye movement), which may be horizontal, vertical, or rotatory. Coma can occur at any point in intoxication, and a psychotic state can be observed after extremely low doses. In fact, such cognitive and emotional alterations are the threshold effect of this drug (McCarron & Schulze, 1981). PCP stands as the prototype of a unique category of drugs that have high abuse potential and severe medical effects in the abuse situation (Baldridge & Bessen, 1990).

Theoretical models

Disease models suggest that addictions are caused by some combination of pre-existing physiological deficiency, heritable genetic traits, and/or metabolic changes resulting from drug use (Collinger, 1987). The inability to control use is not due to lack of willpower or psychological inadequacies. Rather, it results from physiological characteristics that cause addicts to react differently than nonaddicts to both drug ingestion and drug withdrawal (Dole & Nyswanger, 1967).

Drawing on psychoanalytic theories of personality, symptom models suggest that drug use is a manifestation of unconscious emotional conflict (Accord & Accord, 1982). Some psychodynamic theorists have asserted that addicts experience narcissistic defects of self (Kohut, 1977) or that they have poor self-esteem because of tense depression (Rado, 1933). Others have argued that addictions result from unconscious power motivation (McClelland, 1972).
Definitions of addictions based on learning theory assert that addictions are learned behaviors maintained by antecedent and consequent events (Miller & Mastria, 1977). Early learning theorists argued that addictive behaviors persist because of the tension reduction qualities of drugs (Cappell & Greeley, 1987). Other theorists have emphasized the role of social learning and modeling in the development of drug use (Bandura, 1969). Still others have stressed the role of conditions and expectancies (Marlatt & Gordon, 1985).

Some theorists have explained addictions as functions of social arrangements and have argued that they are caused by conditions producing alienation, frustration, and despair (Biernacki, 1986), or by the existence of subcultures that support deviant lifestyles such as drug use (Godde, 1972). Some social theorists have argued that addictions may be the result of a disengagement from conventional values and norms (Lukoff, 1980). Others have asserted that social and cultural arrangements legitimize and influence the behavioral patterns associated with alcohol and drug use (Fine, Akabas, & Bellinger, 1982). Still others have declared that addicts are double failures who have been unable to reach culturally approved goals by either legitimate or illegitimate means (Cloward & Ohlin, 1960). Taken together, the definitions illustrate that alcoholism and other drug addictions are biopsychosocial conditions (Galizio & Maisto, 1985).

Family history

Alcoholism (Cotton 1979; Goodwin, 1988; Hartford, Haack, & Spiegler, 1988) and other drug addictions (Fawzy, Coombs, & Gerber, 1983; Meller, 1988) have been described as family diseases that are transmitted intergenerationally. Persons whose
parents were alcoholic have an increased risk for alcoholism (Goodwin, 1995), other drug addictions (Cadoret, 1986), and other social-emotional difficulties (Woodside, 1988). Parental alcoholism also is associated with higher rates of alcoholism among opiate addicts, those addicted to both heroin and alcohol (Kosten, Rounsaville, & Kleber, 1985). Finally, parents’ abuse of other drugs (marijuana and prescription drugs) is predictive of the abuse of the same drugs by their children (Fawzy, Coombs, & Gerber, 1983).

A Comparison Among the Two Fields

Relational factors

Researchers have found that one-fourth to one-half of men who commit acts of domestic violence also have substance abuse problems (Bennet, 1995), and a Bureau of Justice Statistics (1991) survey of convicted abusers revealed that 31 percent of batterers were raised by parents who abused drugs or alcohol. Studies also show that women who abuse alcohol and other drugs are more likely to be victims of domestic violence (Miller, 1989).

Although prevalence rates vary among reports examining the relationship between domestic violence and substance abuse, the relationship has been clearly demonstrated in a number of studies (Kantor & Straus, 1987; Leonard & Jacob, 1987). Both substance abuse and domestic violence cut across socioeconomic, cultural, racial, and ethnic lines. Anyone can become a substance abuser, and anyone can find themselves a victim of domestic violence (Bennett & Lawson, 1994). While a connection between the abuse of alcohol and other drugs and the likelihood that a woman will experience domestic violence
appears clear, which comes first is not as easily identified (Miller, 1990).

In a representative sample, alcoholic women reported both moderate and severe violence by a partner more often than nonalcoholic women (Miller, 1990). Alcohol use has been implicated in more than 50 percent of cases involving violent behavior (Roy, 1982), and a recent study by the Bureau of Justice Statistics (1994) found that more than half of defendants accused of murdering their spouses had been drinking at the time. Although current research has found that substance abuse is only one of many factors that influence violent behavior, higher incidences of substance abuse clearly correlate with higher incidences of domestic violence (Collins & Messesschmidt, 1993).

Research resulting in the power theory (Gondolf, 1995) has found that the typical batterer uses violence or the threat of violence to achieve a sense of control over his victim. Furthermore, Gondolf (1995), building on McClelland's (1975) widely accepted theory of alcohol and power, suggested that the need for personal power may be the factor that accounts for the high correlation between substance abuse and domestic violence. According to this theory, men who have a high need for power over others are more likely to abuse alcohol and to use violence.

Cohen (1985) describes some of the major interactions and mechanisms for drug-violence interactions as the following. (1) Specific actions of particular drugs may induce belligerence and hostility. (2) Drug-induced aggression varies by dosage, often following a curvilinear path as maximum dosage incapacitates the user. (3) Aggression is more likely to occur on the ascending limb of the blood drug concentration than on the descending limb. (4) The set and setting of the drug modifies and can even overwhelm the
pharmacologic effect of the substance. (5) There are a number of pathways that drug-induced violence might take, including: (a) the drug might diminish ego controls and release submerged anger; (b) it might impair judgement; (c) it might induce restlessness, irritability, and impulsiveness; (d) it could produce a paranoid thought disorder; (e) an intoxicated or delirious state might result in combativeness, hyperactivity, and violence; (f) a user’s drug-induced feelings of omnipotence and bravado may promote dangerous behavior; and (g) unpredictable and uncharacteristic behavior may be associated with amnestic and fugue states.

Although violent behavior may be associated with the use of any drug (Niven, 1986), certain substances appear to be more commonly aggression-stimulating than others. These are alcohol, cocaine (Efron & Efron, 1990), amphetamines, sedative-hypnotics, and phencyclidine (PCP) (Levenson, 1985).

There is a general consensus that alcohol is the drug most commonly associated with violence (Cohen, 1985). Males with a history of physical abuse score higher on the Michigan Alcoholism Screening Test than do other males in discordant marriages, without incidences of physical abuse (Van Hassalt, 1985). Additionally, alcoholics who are not anti-social, but have a history of violence, drink more per day than other alcoholics, have a higher percentage of alcohol related problems, and have a poorer ability to maintain sobriety after treatment (Stuckit & Russell, 1984).

The aggression associated with alcohol cannot be fully explained through models that rely entirely upon either physiological or sociocultural explanations of that behavior (Efron & Efron, 1990). Laboratory studies indicate that individuals generally become
more aggressive when they drink alcohol and that high alcohol use predicts more aggression than lower use. Also, when a placebo is substituted for the alcohol, individuals do not become more aggressive, thus indicating that the effect is not entirely environmental or cognitive. However, not all alcohol users become aggressive as noted in a study where 32 percent of high dose users did not become aggressive (Taylor & Leonard, 1983). Cloninger (1987) views the links between violence and alcohol use as occurring predominantly in “Type II” alcoholics - those with a kind of alcoholism manifested by an early onset with an ability to periodically abstain, an almost exclusively male membership, and in which arrests and fights are frequent. Additionally, Taylor and Leonard (1983) conclude that aggression is a function of the interaction of the pharmacological state induced by alcohol and the cues in the social setting.

Cocaine is an extremely volatile substance in that the intoxication state is both intense and short lived (Efron & Efron, 1990). Crowley (1987) found such minor psychological problems as irritability, guardedness, and suspiciousness among 99 percent of his subjects, while 43 percent reported more serious symptoms including hallucinations, delusions, and serious suicidal ideation or attempts. Gawin (1987) added that withdrawal from the cocaine high may be associated with dysphoria, restlessness, and irritability, and that these mood states may certainly increase the potential for domestic aggression. Additionally, Horner (1987) notes that smoking crack, a more recently appearing method of self-administrating cocaine, seems more likely to trigger significant psychotic symptoms, thoughts, or acts of domestic violence than previous modes of intoxication,
and that cocaine can definitely not be considered a safe drug with regard to domestic aggression and violence.

The adverse effects of amphetamines include irritability, hostility, and psychosis (Grinspoon & Bakalar, 1985). Cohen (1983) links large doses of amphetamines with hyperactivity, paranoid suspiciousness, and impulsivity. Moyer (1976) notes that the tendency toward aggression tends to be cumulative with continuing amphetamine usage and that intravenous use increases the risk for domestic violence. Withdrawal from amphetamines, especially after a use of over two weeks, is also associated with assaultiveness and destructiveness. Additionally, ice (smokeable amphetamines) has recently gained popularity and must be considered very likely to trigger episodes of domestic violence (Efron & Efron, 1990).

Withdrawal from sedative-hypnotics, in particular the barbiturates, is strongly associated with both interpersonal violence (Levenson, 1985) and with suicidal intent (Grinspoon & Bakalar, 1985). Cohen (1985) rates these drugs second only to alcohol as contributors to assaultive behavior. Although these chemicals are supposedly sedating, they tend to produce argumentative and irritable behavior, perhaps because the affected individual is released from normal inhibitions as part of the intoxicant effect.

Spotts and Shantz (1984) conducted an in-depth interview of heavy barbiturate users, seeking to discover how the drug interacts with the ego state of the user. They found the user experiences a welling up of anger, rage and hostility, and intense impulses to violence, a need to strike out, hit or attack things or people, and to wreck and destroy. In addition, users suffered paroxysmal outbursts of rage, becoming bellicose, belligerent,
quarrelsome, and abusive, and they tended to provoke senseless fights with family and others.

PCP is regularly associated with the appearance of aggression, and is most common among those heavy, chronic users who develop a psychosis that in many ways mimics a schizophrenic episode (Allen, 1980; Peterson & Stillman, 1978). PCP psychosis is characterized by insomnia, tension, hyperactivity, and intermittent unexpected aggressive behavior (Luisada & Brown, 1976). Chronic PCP usage is associated with gradual personality changes, with about one-third of the users at a residential treatment facility reporting that they become more angry, irritable, and violent when regularly using PCP (Fauman & Fauman, 1980). Further, PCP remains one of the most dangerous drugs of abuse currently available with regard to the appearance of aggression and violence (Efron & Efron, 1990).

Other substances such as opiates are often associated with criminal behavior in order to procure money to purchase drugs (Cohen, 1983; Jaffe, 1985). Since all drives are diminished with heroin intoxication, Cohen (1983) suggests that early withdrawal is a more likely time to expect domestic aggression. Hallucinogens are occasionally linked with violent behavior (Siegel, 1980), and frequent cannabis use is sometimes associated with criminal behavior (Dembo, 1987) and aggressive impulses (Nicholi, 1983). Finally, it should be noted that most studies on the effect of cannabis have been done with relatively minor dosage levels. The increasingly potent quality of marijuana and related drugs now available in the American market might be significantly more aggression stimulating as well as addiction promoting (Efron & Efron, 1990).
Treatment discrepancies

Chiswick Women's Aid, the first refuge for battered women and their children, was founded in Britain in 1972. Americans followed suit with the openings of Women's Advocates in Minnesota during 1973, Transition House in Boston during 1974, and Women Together in Cleveland during 1976. By 1985, an estimated 780 battered women's shelters were operating nationwide (Carden, 1994). In contrast, as of 1987 there were only eighty-nine programs for batterers nationally (Gondolf, 1995). Batterers programs have been subject to more controversy, have had more difficulty maintaining adequate funding, and have been researched less intensively (Carden, 1994).

Domestic violence is viewed by some theorists, not all, as a learned behavior which is not caused by genetics, illness, or substance abuse (Dutton, 1988). Therefore, cognitive-behavioral therapy is the intervention most used in the field of domestic violence for victims and perpetrators alike. This intervention includes various combinations of anger management, communication skills development, cognitive restructuring, systematic relaxation, modeling of new behaviors, and accepting responsibility and ownership of the problem (Faulkner, Stoltenberg, Cogen, Nolder, & Shooter, 1992). In addition, these programs attempt to advocate for and empower the victim of domestic violence (Carden 1994). Advocacy supports the victim and works as a link between the victim and other services such as a temporary shelter and the court system. Empowering victims helps them take responsibility for attitudes and claim responsibility for choices. To be empowered means to be responsible for every decision one makes, and to know that you are not a victim of circumstances but that you most often participate in creating the circumstances.
of your experiences. To be empowered does not release persons from the consequences of their actions. It places them in direct relatedness to the results of their choices. A person's actions are seen as expressions of freedom of choice (Brinegar, 1992).

Although there are over 100 separate definitions for substance abuse, the modern disease concept dominates the field (Gitterman, 1991). An extensive professional service-delivery system, based on the disease model, exists for people with addiction problems. These include detoxification units, inpatient rehabilitation facilities, and outpatient settings. Core interventions are designed to address the basic addiction problems that all clients face including: (1) altering addictive life-styles, (2) developing more effective coping skills, and (3) establishing social networks that are supportive of abstinent behavior (Miller & Hester, 1986). According to Gitterman (1991), behavioral therapy is most often used in these settings. Some other programs providing services in the field of substance abuse are Women for Sobriety formed in 1976, Rational Recovery formed in 1985, Moderation Management formed in 1993, and Men for Sobriety formed in 1994 (Lowinson, Ruiz, Millman, & Langrod, 1997).

Alcoholics Anonymous (AA), which has influenced the treatment of alcoholism for more than five decades, and other self-help groups like Narcotics Anonymous (NA), while not part of the formal service-delivery system, have reached the largest number of substance abusers and are more often than not recommended by professionals and non-professionals alike (Gitterman, 1991). These groups adhere to the disease model and are based upon a program of Twelve Steps to recovery that act as a personal guide to sobriety. The most important step in the recovery process is Step One: We admitted we
were powerless over alcohol—that our lives had become unmanageable. In the First Step, you admit that you cannot control your drinking and because of that powerlessness, your life is out of control. In order to do this, you have to understand clearly that drinking and drugging are the causes of many of your problems (Gorski, 1989).
CHAPTER 3

RESEARCH OBJECTIVE

Although substance use/abuse has been implicated in 20 percent to 80 percent of reported episodes of wife abuse (Brisson, 1981; Stith & Farley, 1993), the relationship between the two is still unclear. Workers in the field of domestic violence do not acknowledge substance abuse as a causal factor in domestic violence. While substance abuse workers do not directly implicate a causal relationship between the two, they do imply that substance abuse is the cause of many problems. Additionally, the key concepts of each program, empowerment and powerlessness, further exacerbate the incompatibility between the two fields and may encourage approaching substance abuse and domestic violence as two distinct phenomena.

The research objective proposes a collaboration of the two fields and an integration of treatment services in order to provide the best possible outcome for their respective clients. Although the means of treatment may differ, a sensitivity and understanding of the co-existing problems would greatly benefit client outcomes. A clear definition of responsibility, powerlessness, empowerment, higher power, denial, enabling, and the Twelve Steps of AA would be of significant importance to both clients and workers. Without a collaborative and integrative effort, clients may find it impossible to come to terms with the existing philosophical differences in treatment and continue to be
hopelessly entangled in the web of both problems. In addition, this document attempts to
heighten the awareness of substance abuse counselors to the occurrence of domestic
violence in a substance abuse setting and to bring particular attention to the safety needs
of the victim of the domestic violence.

To further demonstrate the simultaneous occurrence of substance use and
domestic violence, a brief analysis (which is presented as antidotal), was conducted on all
clients in a local domestic violence program for the calendar year of 1997. The
classification system used is unique to the particular agency, the data was taken from the
clients' psychosocial intake interview, and the analysis makes no differentiation between
substance use, abuse, or dependency. The unit of analysis was an individual client case.
Three distinct categories were constructed including court ordered primary offenders,
court ordered secondary offenders, and victims. Court ordered primary offenders were
operationally defined as male client offenders of domestic violence. Court ordered
secondary offenders were female client offenders who acted aggressively in self-defense.
Victims were considered female clients who suffered from domestic violence.
Additionally, a frequency system was utilized to measure the simultaneous occurrence of
domestic violence and reported incidence of substance use at the time of the alleged abuse.

The results can be seen in Table 1.1. Twenty-eight (28) of 34 primary offenders
reported substance use at the time of the alleged domestic violence (82%), 8 of 14
secondary offenders reported substance use at the time of the alleged abuse (57%), and 40
of 84 victims of domestic violence reported substance use during the alleged abusive
incident (47%). The total number of all clients in the analysis was 132 (n=132) with a total of 76 clients reporting substance use at the time of the alleged domestic violence (57%). An additional 9 clients reported using alcohol or drugs, but not during the occurrence of domestic violence that brought them into the program. With this inclusion, the total number of clients assessed during 1997 who used alcohol or drugs and also engaged in domestic violence was 85 (64%). Historically, substance use, as well as domestic violence have been under reported (Carden, 1994). Thus, one can only surmise the actual occurrence of domestic violence and substance use. Although these figures and the preceding literature do not imply a causal relationship, they underscore the need for a collaborative and integrative method of intervention.

Table 1.1 Domestic Violence and Substance Abuse

<table>
<thead>
<tr>
<th>Type of Domestic Violence Case</th>
<th>Number of Cases Assessed</th>
<th>Number of Cases Reporting Substance Use at Time of Domestic Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary offender</td>
<td>34</td>
<td>28</td>
</tr>
<tr>
<td>Secondary offenders</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Victims</td>
<td>84</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>132</td>
<td>76</td>
</tr>
</tbody>
</table>
CHAPTER 4

TREATMENT FOR VICTIMS OF DOMESTIC VIOLENCE AND SUBSTANCE ABUSE

An Integrated Approach

Practitioners in the fields of domestic violence and substance abuse treatment share a perception concerning individual responsibility for behavior. In the domestic violence field, the first principle of recovery is that perpetrators of the violence are fully responsible and must be held accountable for their behavior. Blaming the victim, the addiction, external social or environmental pressures, or childhood history is unacceptable and hinders recovery (Carden, 1994).

In the field of substance abuse treatment, clients are expected to accept responsibility for changing their alcohol and drug abusing behavior as a first step in recovery. The foundation of this approach is reinforcing individuals’ sense of self-worth and reassuring that they are indeed capable of meeting this responsibility and beginning a successful recovery (Gorski, 1989). This is a difficult concept to grasp, however, when one assumes responsibility for violence experienced at the hands of a loved one. Clients must be educated to take responsibility for that which they are responsible (their addictions and behaviors) and not to accept the blame for things beyond their control (another’s behavior).
Substance abuse treatment providers must study their own tendencies to blame. Those who are unfamiliar with the mechanisms of denial and adaptation common to most victims of abuse, find it incomprehensible that many battered women stay with their partners. It is important to understand that the highest priority of many battered women is keeping their family together. In addition, many of these women believe that they somehow deserve or cause the abuse and thus can prevent the violence by changing their own behavior (Carden, 1994). The conviction that her attacker would stop abusing her if only she made these changes is often enough to keep a woman in an abusive relationship.

A sense of powerlessness also keeps victims with their abusers (Pagelow, 1992). The battered woman lives in a war zone rarely knowing what triggers the violence, and often there is little, if any, warning of its approach. A great deal of time and energy is spent trying to read subtle clues in the perpetrator’s moods and behaviors in order to avoid potential violence with little success. Living this way can be both exhausting and confusing, and it may leave the victim with a sense of powerlessness and the inability to reorganize her life and make the necessary plans to leave the relationship.

Because of a lack of understanding of the dynamics of domestic violence, many substance abuse programs may fail to respond to the needs of their clients who are also victims of domestic violence. In addition, there are several considerations workers in the field of substance abuse should be aware of when working with victims of domestic violence. Among these considerations are the following. (1) Victims are caught in a continuous cycle in which they live in fear of and are abused by their partner. (2) Many victims have a history of childhood trauma and/or sexual abuse. (3) Victims may feel
overwhelmed with their involvement in multiple systems such as substance abuse programs, domestic violence programs, and the criminal justice system (Pagelow, 1984).

The concept of readiness to change is integral to the successful provision of both domestic violence and substance abuse programs, but it is defined differently in the two fields. In the domestic violence field, the victim is considered to be the best judge of how to manage the violent perpetrator, including when to leave. Just as substance abusers often resume the use of alcohol or other drugs after a period of abstinence, domestic violence survivors often return to their batters after leaving them. Although this may be difficult for many to comprehend or to accept, there is a general understanding in the domestic violence field that it may take time and many contacts before a victim is ready to initiate permanent change.

In the substance abuse field, readiness to change is seen as a proactive process (Miller, 1986). The client must develop and build the skills to enter and engage in treatment. The client must get serious about treatment. In fact, some clients are dismissed from treatment programs because they are not ready to commit to sobriety (Miller, 1986). Domestic violence programs, on the other hand, may put their clients at risk with this approach.

The primary focus of substance abuse programs - beginning recovery and reinforcing the skill needed to make it successful - differs from that of domestic violence programs - interrupting the cycle of violence and helping the client to protect herself and to implement lifestyle changes (Roberts, 1988). The substance abuse counselor must understand the chief concerns of victims of domestic violence who seek shelter and
support in addition to treatment of their substance abuse problems. Understanding these concerns will help the counselor gain a sense of the context in which the substance abuse occurs and ensure for the victims immediate needs of safety and support.

This document proposes that in addition to substance abuse treatment the initial focus of concern for the victim client should be based on three primary goals. (1) To ensure for safety. Whether a client is in inpatient or outpatient treatment, the immediate physical safety of her environment must be continually assessed. (2) To validate and believe her within appropriate limits. Although reinforcement of the counselor’s belief is a critical component of the process, the counselor should remember that substance abusers and individuals in denial are often manipulative. (3) To identify options. The victim of domestic violence needs to be provided all available options to the abusive situation. These options should always be suggested, never mandated. Other goals to be considered while in substance abuse treatment include stabilizing withdrawal symptoms, evaluating and treating any injuries, and attending to immediate emotional symptoms such as anxiety, depression, and PTSD.

This initial focus on the client’s needs can help stabilize her physical environment and symptoms. The treatment provider can then begin obtaining the necessary information about her history and background that will help shape the treatment plan. Clearly, the substance abuse counselor must have a broad base of knowledge and at the very minimum a sensitivity to the issues that surround domestic violence. The counselor who suspects that a client is being abused by her partner must use caution and tact when approaching the subject. One helpful technique is to focus questions on her partner’s behavior in order
to ameliorate any discomfort she may have in talking directly about herself. In addition, counselors should never ask clients about battering when she is in the presence of someone who might be her batterer. In most cases, more information about a victim’s experience will begin to emerge as she gains trust and respect for the counselor. Therefore, assessing for domestic violence should not be viewed as an isolated procedure, but as an integrated and ongoing assessment of the client’s treatment.

When obtaining a history, it is important to discern both past and current patterns of severity and frequency of violent episodes (Carden, 1994). Concurrently, a discussion of substance abuse in the client’s history should cover past and current use, treatment history, and alcohol or other drug use in the family of origin. In addition, patterns and frequency of alcohol or other drug use by both the client and her batterer must be placed in the context of whatever violence and abuse she may have experienced throughout her life in order to better understand the relationship of substance abuse to the violence.

Substance abuse counselors should be aware that often victim clients are not only secretive about the extent of substance use, but also the extent of violence in their lives. Often denial that violence occurs is so pervasive that it has become an element of the victim’s psyche. Additionally, if violence existed in the family of origin, the victim may consider it a normal part of an intimate relationship (Bogard, 1992). Other important factors for the counselor to consider are the victims’ fear for themselves, their children, or other family members. It is quite possible that they have been threatened with the loss of their children or withdrawal of financial support if they tell the truth.
Treatment Planning for the Victim

Based on professional experience in both fields it is believed that substance abuse programs can best serve clients by having established connections with domestic violence referral and intervention services and staff that is not only sensitive to domestic violence issues but familiar with local laws regarding domestic violence. Counselors would better serve their clients by referring to these services when domestic violence is suspected. If a client denies a history of domestic violence and the counselor still suspects it is possible, due to physical or emotional indications, additional attempts to discuss this with the client should be made and documented. Once the victim client enters treatment for substance abuse, it would be appropriate to develop a treatment plan that includes safety and relapse prevention. The needs and concerns particular to victims of domestic violence and substance abuse would then be integrated into each phase of the treatment plan.

Safety plan

In the early stages of treatment, the substance abuse counselor should help the victim develop a long-term safety plan by referring the client to domestic violence service providers. If the substance abuse counselor has been trained in the area of domestic violence, the counselor can work with the client to develop such a plan as part of intake. However, domestic violence issues may not surface in the early stages of substance abuse treatment; therefore, the counselor should be prepared to develop a safety plan whenever the need manifests itself. A comprehensive screening tool for domestic violence (see
Appendix B) would be invaluable for substance abuse counselors during the intake process.

One of the purposes of screening for domestic violence is to assess whether the client, or degree to which the client, is in physical danger. It is possible that if safety issues are not addressed the client’s fears and concerns could further exacerbate substance use. Screening for this purpose should be conducted early in treatment and may need to be repeated throughout treatment as circumstances warrant. It may also be important for the counselor to consider that the victim’s sobriety may threaten the batterer’s sense of control and make the victim client more vulnerable to violence. It would be important to address this issue in counseling in order to help the victim client prevent the batterer’s perceptions from interfering with treatment. Although involving the entire family in treatment is usually a precept of a successful treatment plan for substance abuse, in this particular case, immediate family clearly should be involved with great caution due to the fact that it is not a precept of domestic violence treatment plans. Victim’s of domestic violence are often intimidated when in the presence of their abuser; therefore, it would be appropriate to discourage contact with the abuser during this vulnerable time.

Physical health

Domestic violence victims often present with acute injuries (Bennet, 1995). Although the client’s medical needs must be taken care of, it may also be necessary to attend to legal and financial concerns, including health insurance, before health problems can be fully addressed. Additionally, programs must be able to assess the client’s most immediate physical needs, such as extent of injury.
Other health concerns that need attention early in treatment include screening and treatment for pregnancy, HIV infection, and sexually transmitted diseases. These conditions not only require immediate medical attention, but may very well be triggers for a perpetrator to escalate battering when a victim discloses this information. Further, it is quite possible that the victim client may experience an increase in somatic symptoms as emotional issues surrounding the victimization begin to emerge. The victim may find this confusing and frightening, and it would be important for the provider to address these issues before they trigger substance use.

In some victims, anxiety, depression, suicidal thoughts, and sleep disorders may be severe enough to require medication. In such cases, it would be of upmost importance to strike a balance between the need for medication and the avoidance of relapse. A thorough medical and psychological assessment should be conducted before any psychoactive medications are prescribed, and a mental health professional experienced in the use of these medications should be consulted.

**Emotional health**

Many victims of domestic violence experienced emotional and physical trauma both in their current relationship and as children. At times this trauma may be repressed and could possibly surface once the client is in a safe setting, such as an inpatient substance abuse facility (Pagelow, 1992). This can be an overwhelming experience, and only qualified providers should attempt to address this concern when the victim is ready. If the issue surfaces, the provider should allow the client to express her emotions and then supportively redirect her to feasible solutions. Referrals should be made whenever
appropriate for specialized counseling. Staff training is important in this area so that providers can respond effectively in a crisis.

Other emotional areas the provider should be aware of include life event triggers. Substance abuse providers are trained to deal with relapse triggers (events or circumstances that produce cravings and predispose clients to resume use, such as walking through a neighborhood where drugs were once purchased). A victim of domestic violence is vulnerable to an additional set of triggers, such as experiences that may cause her to feel the fear and victimization she experienced when being battered. Abstinence induced stress may trigger victims of domestic violence to experience strong emotional reactions when they stop abusing alcohol or other drugs, which may have been a form of self-medication. The alcohol or drugs may have helped the victim dissociate from both the abuse in her present relationship and her childhood experiences of trauma. This dissociation may have provided her with an effective coping mechanism allowing her to function despite the abuse. Abstinence may very well cause a flooding of emotional and physical sensations. Paradoxically, the very concept of safety may seem unsafe to victims of domestic violence. Feeling safe may be equated with letting one’s guard down and making oneself vulnerable to attack. Survivors are accustomed to always being on guard. The substance abuse provider needs to understand and respect the victim’s concept of safety.

Psychosocial factors

As previously stated, a key aspect for substance abuse is encouraging the client to assume responsibility for her addiction. For a victim of domestic violence, it is critical at
the same time to dispel the notion that she is responsible for her partner’s behavior. She is only responsible for her own behavior. Low self-esteem appears to be a common characteristic of these individuals (Bennett, 1995), and it may hinder recovery by reinforcing the victim’s misperception that the abuse she has experienced is somehow her fault.

An important step in moving the victim client toward self-responsibility and empowerment is shifting the focus from the abuser’s behavior to her own. Acceptance of responsibility for herself and her actions is a vital part of the victim’s journey away from the role of victim and toward the role of an autonomous individual who is not at the mercy of external circumstances. A common theme in substance abuse counseling is codependency, and at this particular time it may be important for substance abuse counselors to recognize that the victim may be codependent on her abuser.

When either the victim or perpetrator, or both, abuse alcohol or other drugs, it may be common for the substance abuse to be considered an excuse or explanation for the violence. Many victims of domestic violence, whose batterers abuse alcohol or other drugs, may believe that if only he would stop drinking or using drugs the violence would stop. The same victim may believe that her own substance abuse causes the attacks, either as punishment or by causing the batterer to abuse the substance himself, which in turn causes the violence.

One of the first tasks then would be to help the client realize the batterer is responsible for his behavior and his substance abuse. At the same time, she must begin to take responsibility for her substance abuse and her own behavior. Additionally, the victim
must be helped to move away from viewing herself as helpless and toward a belief in herself as a capable and competent person with the ability to make decisions.

The victim of domestic violence who is recovering from substance abuse may find it hard to make new friends or, in some cases, make a completely new life for herself. Social isolation is common among victims of domestic violence, as perpetrators often curtail their victims' contacts with friends and family members. The victim client therefore needs a very strong support system during this period. She will likely need help and advice about creating a new social life that is not part of the drug culture or past violent relationship. The provider, however, should not make decisions for the client, but should encourage her to find new activities and pastimes and to make decisions about those that will support her recovery.

Decision-making skills

One of the first steps in the process of empowering the client is to help her develop decision-making skills. Often, every aspect of her life has been controlled by the batterer, and her wrong decisions have served as an excuse for the battering (Carden, 1994). The paralyzing effect of being battered for making decisions must be overcome as the victim exercises choices without fear of reprisal. For many victims of domestic violence, decision-making may be a new skill that must be acquired. Although exploring her own wants needs and feelings may be unfamiliar, it can be a stepping stone to making larger and more important decisions. It is wise for the provider to realize the importance of even the most mundane of decisions, and to be patient and supportive during this particular time in order to better facilitate movement toward the ability to make larger decisions.
Two of the more important decisions the victim will have to make are should she continue to socialize with friends with whom she formerly abused alcohol or drugs and should she leave the relationship with the batterer. For many victims, recovery will not be possible without separation from her partner. The toll of abuse may have hindered her ability to make decisions and she is likely to need help. Although it is typical in substance abuse counseling to discourage making immediate major decisions, it may not be the appropriate route when working with victims of domestic violence.

Relapse prevention

Victims of domestic violence who are newly abstinent may feel overwhelmed by pressures such as child care, parenting, employment, transportation, legal matters, and financial concerns. All of these are potential triggers for relapse to which the provider should remain attuned. Continued social support and counseling are important elements in relapse prevention. If the client has the desire to become affiliated with a Twelve step program or a religious organization, it should be encouraged. Conversely, the decision not to pursue these avenues should also be supported.

A client’s ability to effectively parent her children must be assessed carefully. For many mothers, the time spent in treatment may initially provide a respite from the concerns of parenting, and the resumption of child care may present new stresses. Children may be extremely needy after being separated from their mother, and their demands could trigger relapse or even violence on her part.
Victims of domestic violence may need to learn parenting skills for the first time. The provider should ensure that the client gets needed parenting training. Treatment programs without the staff training or resources to provide parenting education should develop linkages with other programs to form a network of support. Whatever its source, the parenting curriculum for the victim client needs to help her learn parenting skills in a way that supports her recovery while also taking into account her status as a victim of domestic violence. These clients and their children commonly have a great deal of suppressed rage, and handling frustration and anger is a crucial life skill that must be addressed in treatment.

In addition, discussing the realities of everyday living and plans for the future that may increase the client's chances of recovery are essential components in designing the treatment plan. Providers should explore with the client her plans for future education and/or employment. Sources of financial support to help the client achieve her goals should be explored through linkages with other agencies. The provider can also help the client develop realistic plans for dealing with any legal issues that may be unresolved and interfering with recovery, such as divorce or child custody issues.

**Issues Concerning Children of Victims that are Substance Abusers**

The substance abuse provider is only indirectly involved with the children, through the mother. The substance abuse provider's responsibility, then, is to understand how to interact with and support the mother. The special problems and needs of the children may not be readily apparent to providers due to their responsibility to the mother and the acute
nature of the mother’s needs. Children’s issues need to be addressed; if left untreated, they can become antecedents to more severe problems, such as conduct disorder or oppositional defiant disorder.

It has been clearly demonstrated that children who live in a household where one parent is battered by another are at increased risk of being battered themselves (Dutton, 1992; Egeland, 1988). Even if children of domestic violence are not themselves abused, they are at risk of either emotional harm or of thinking that violence is a viable solution to problems. As was previously stated, violence is a learned behavior. Girls that grow up watching their mothers being abused are likely to end up in the same type of relationship, and boys who watch their fathers abuse are likely to abuse.

Ideally, substance abuse programs will establish collaborative relationships with child protective services (CPS) and domestic violence programs. These programs can provide case management services such as respite care, home aid, and parenting skills training that are beyond the scope of most substance abuse programs.
CHAPTER 5

TREATMENT FOR PERPETRATORS OF DOMESTIC VIOLENCE
AND SUBSTANCE ABUSE

An Integrated Approach

There are two major reasons why substance abuse providers would benefit from addressing the domestic violence of clients who batter their partners. First, attending to domestic violence may increase the client’s likelihood of recovery from addiction. It is possible that the behavior of a perpetrator client can interfere with his treatment for substance abuse, and conversely, his substance abuse can interfere with interventions aimed at changing his violent behavior. Second, attending to domestic violence saves lives. It is a moral responsibility.

Providers of substance abuse treatment can benefit from understanding some of the psychological underpinnings of a batterer’s behavior. Although there is no one type of batterer or one reason for battering, certain psychological themes tend to be common among this population. Researchers have tentatively identified three types of violent perpetrators (Gondolf, 1988; Hamberger & Hastings, 1986; Holxworth-Munroe & Stuart, 1994; Saunders, 1992). Typical batterers are generally violent only within their families. They do not show signs of heavy substance abuse, do not tend to engage in seriously violent acts, and have no significant mental disorders. Dysphoric or borderline batterers
have moods that are tied to the behaviors of their partners. Such a batterer will refrain from hurting his partner if he perceives her as being good, but will become violent if she is bad. This type of batterer is emotionally volatile; has some mental health problems, such as antisocial personality disorder, depression, or anxiety; and he may be a substance abuser. He may be under the care of a physician or in mental health therapy. He may have difficulty attending or completing a batterers’ program without receiving additional mental health services. Violent/antisocial batterers perpetrate violence in their families as an extension of their violent and antisocial behavior against society in general. Often these individuals are heavy substance abusers. Typically, they are dishonest about their violence and have a history of arrest. They also have little empathy for others, limited self-insight, and no feelings of guilt or remorse for their actions. Nearly half (49 percent) of male inpatient alcoholics meet diagnostic criteria for antisocial personality disorder (Hesselbrock, 1985). In addition, although batterers are not easily distinguishable from nonbatterers on measures of psychopathology and tend to be heterogeneous as a group, they do seem to have higher levels of pathology than the general population (Tolman & Bennett, 1990).

Issues of power and control are at the core of the batterer’s psychological reasons for using violence. Self-help organizations, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), have traditionally emphasized that the substance abuser is powerless over the substance they abuse. A batterer in substance abuse treatment, however, may twist the concept of powerlessness to evade responsibility for his violent behavior. Batterers may consider themselves powerless and use this to justify their
exercise of control over others. Often, batterers view themselves as victims of powerful social forces or discrimination and blame their partners, their stress, or their financial situations for the feelings of powerlessness that feed violence. In addition, both substance abusers and perpetrators are likely to be in denial about their problems. The need to control may become intertwined with the need to deny, and the perpetrator may come to believe that it is acceptable for him to behave in a violent manner.

The provider should emphasize to the perpetrator client that power and control, which has been previously demonstrated to be linked to substance abuse, are not only manifested physically. In addition to inflicting physical pain and injury, a perpetrator may also abuse his partner psychologically and emotionally. A batterer attempts to control the thoughts and feelings of the partner by monitoring her behavior, making her accountable for his emotional highs and lows, denigrating her, criticizing and blaming her, and calling her names. These types of abuse often accompany physical violence to some degree as well.

After a perpetrator’s rehabilitation has begun and he has stopped using physical violence against his partner, he may begin, continue, or increase psychological or emotional abuse. This nonphysical abuse targets the victim’s sense of self-esteem, well-being, and autonomy. Additionally, it can be used to control the victim’s actions and functioning in everyday life, it can take the form of isolation, and it can be expressed as the “silent treatment.” The provider should be aware that any treatment to the batterer’s abuse of his partner, or his own substance use, that does not concomitantly address issues of
power and control may allow the batterer to become active at these nonphysical kinds of manipulation and exacerbate both problems.

In a review of local substance abuse programs, treatment for issues of anger appear to be typical. Although anger is certainly a common emotional theme among violent perpetrators, a perpetrator’s violence is not caused solely by anger. Rather, as previously discussed, the overriding issues for the batterer are exercising control over his partner. While the perception may exist that a perpetrator’s gaining control over his anger means control of the violence, in reality anger may only be one antecedent for his violence, and addressing the anger is not the same as addressing the violence.

**Treatment Planning for the Perpetrator**

Once again substance abuse providers can best serve their clients by having a clear understanding of domestic violence. This period of non-violence and abstinence from substance use may be extremely critical. In contrast to the popular notion of a cycle of violence in which a battering episode is followed by a period of remorse some batterers use the postviolence period as an opportunity to blame the victim for starting the abuse or to abandon her, or both (Walker, 1979). This is particularly true for more severe batterers, among whom substance abusers are overrepresented (Roberts, 1988). For this reason, many domestic violence programs believe focusing on the batterer’s attitude toward his partner in particular, and women in general, is critical. The batterer is also encouraged to recognize that, because he has the power to stop his behavior, violence is a choice.
Crisis intervention

Like any client entering substance treatment, the violent perpetrator may be in a crisis state when he first presents for services. He may have been referred to treatment by the courts after being arrested for drug and/or violence related charges, or he may have been abandoned by a battered spouse seeking safety for her children and herself.

Because such an individual tends to defer responsibility and to project his anger on others, the crisis situation that brought the client into treatment, may spur a violent incident at home. For this reason, treatment providers should try to ensure the safety of those who have been or may become his victims, in particular his partner and children, during any crisis that occurs while in treatment. Additionally, the provider will better facilitate the perpetrators chances of sobriety by controlling for domestic violence issues.

Family members, and especially the client's partner, need be consulted regarding what is best for their safety, and extreme caution and tact should be used to avoid further endangering the victim(s). In addition, providers would do well if they worked with the partner or partner's advocate to develop a safety plan that includes logistics for leaving the home quickly, financial resources, and the provision of basic needs on short notice.

Assessing and monitoring

It is not known what percentage of men seeking treatment for substance abuse engage in violence toward their partners. Because many of the risk factors for substance abuse are also risk factors for violence, it would be ideal to have all clients in substance abuse treatment programs screened for a history of abusive behavior. To initially gauge the possibility that a client is using violence, the counselor can ask whether he thinks...
violence against a partner is justified in some situations. This is the concept of "circumstantial violence." The counselor can then ask questions to assess the client's sense of self-efficacy and self-control. If the counselor appears to normalize violence, it may open the door for the client to respond truthfully. Additionally, avoiding the implication that substance abuse is the cause of violence is an important issue with both perpetrators and victims of domestic violence. The counselor must neither directly or indirectly support any notion that domestic violence is caused by substance abuse.

Because batterers tend to shift responsibility and blame onto others, the degree to which a client begins to assume responsibility for his actions can serve as a barometer for his treatment progress. To that end, assessment and monitoring can be incorporated into the treatment plan. The provider can achieve this by incorporating a "no violence contract" with clear sanctions for violations (see Appendix A) and an assessment tool that focuses on all aspects of domestic violence (see Appendix B).

Chain of events and emotions

Because abstinence, and the heightened sensitivity and irritability that often accompany it, may actually make a batterer more volatile, substance abuse providers must explore the context in which the perpetrator uses alcohol and drugs. During screening and throughout treatment, attempts should be made to identify the chain of events and emotions that precede and/or accompany particular instances of substance abuse and violent behaviors. Questions that may aid the provider include the following. (1) Exactly when during a particular instance of substance abuse does the violence occur? (2) What
substances are being used before the violent act? (3) What feelings precede and accompany the use of alcohol or drugs?

By understanding the dynamics of intoxication and abstinence as a precursor to violence, the provider can formulate a treatment plan that incorporates strategies for ensuring the safety of the victims by helping the batterer focus on modifying the behaviors and events that precipitate substance abuse and violence. The focus in treatment must be on encouraging the perpetrator client to develop enough self-awareness to recognize and control the emotions that contribute to his behavior.

Ongoing support

Over the years, the substance abuse treatment field has grown and developed into a national network of Twelve Step groups, church affiliations, and social support systems. In contrast, there are no ongoing organizations that support change for men who batter. Although some batterers may enter an aftercare program following treatment, most do not. Widely scattered groups called Batterers Anonymous (BA) (Goffman, 1984) have not been embraced by domestic violence workers, because of their emphasis on participant anonymity which is incompatible with the focus on accountability. Moreover, BA groups are regarded by some as dangerous unless the perpetrator has completed a batterer’s program, and in fact, such groups may promote misogyny. Although this may not be their intent, it may very well be their outcome. Any referral to such a program by a substance abuse provider should be made with great caution, if at all.

A number of batterer’s intervention programs, are beginning to offer aftercare services. Some are experimenting with mentors, who serve similar roles as sponsors in
Twelve Step programs. In this approach, a former batterer, under the supervision of a batterers' program or shelter that ensures his accountability, mentors a recent graduate from a batterers' program. Although these services are now being offered, it must be noted that attendance appears to be minimal.

Friendships with members of the same sex may be seen as a positive expression of self-development in both male and female clients being treated for substance abuse. Providers must be on the alert, however, for signs of collusion among male perpetrator clients. Although such bonds often help clients, in some cases, violent behavior can be instigated or condoned among perpetrator clients who reinforce each other's excuse making tendencies.

Relapse prevention

While working to identify high risk situations for violence, care must be taken not to enable the perpetrator to shift responsibility for his action to triggers. Permitting a batterer, for example, to identify certain behaviors by his wife which set him off may encourage victim blaming, raise the risk to the victim, and perpetuate denial of responsibility.

Relapse triggers for substance abuse are in some ways similar to those for violence. It is generally understood that people, places, and things associated with drug use put the substance user at high risk. In addition, personal problems, such as job loss or divorce may precipitate a relapse for both substance abuse or violence. The provider must be aware of these precipitants and know that the potential for violence toward the victim is always present.
An examination of the client’s role as a parent is essential to understanding his violent and addictive behaviors, because a batterer may use alcohol, drugs, or violence to respond to conflict within the family structure. As was previously established, domestic violence and substance abuse run in families. Young children can learn violent and addictive behaviors from parental role models. One of the challenges in substance abuse treatment then is to raise the awareness of the perpetrator client concerning the impact of his violence and substance use on his children’s future behavior and to help him discover other, nonviolent models of manhood to provide his children.

The effects of the perpetrator’s violence and substance abuse on his children has important implications for his treatment plan. Although family therapy is often an effective component of substance abuse treatment, this approach is inadvisable for the violent perpetrator until he has learned to take responsibility for his behavior and has learned how to respond to crisis without using violence. Until the perpetrator has reached this point in his self-awareness, he should be treated independently of other family members.
CHAPTER 6

DISCUSSION

General Discussion

The prevalence rates that examine the simultaneous occurrence of domestic violence and substance abuse have been clearly demonstrated in the literature. Based on this information, domestic violence may have significant effects on victim’s and perpetrator’s recovery from substance abuse. For this reason, all clients who present for substance abuse treatment services should be assessed for current and past domestic violence experiences. Similarly, clients entering domestic violence support settings should be assessed for substance abuse.

Although this document focused attention on the substance abuse provider, its intention was to heighten awareness and educate. Substance abuse counselors are required to be certified by the state. Academia is not a necessary requirement in that certification. Domestic violence providers, on the other hand, are generally educated at the masters level in one of the social sciences and are also required to fulfill requirements in practical field work. This would give the domestic violence provider a distinct advantage in assessment and treatment. Although this may be true, the domestic violence provider must
also be sensitive to issues concerning substance abuse and be prepared to counsel or refer when necessary.

The disagreement between experts in the fields of substance abuse and domestic violence can inhibit the exchange of essential information to the detriment of the client’s recovery. This document attempted to reconcile those disagreements by providing suggestions for assessment and intervention. Currently, domestic violence and substance abuse treatment function as parallel programs within the social services system. Explicit in this document is the need for dialogue between the two fields. An open line of communication and cooperation would greatly enhance the responses of both programs to the problems of substance abuse and domestic violence.

In addition, to effect lasting change and reduce morbidity, providers working in both fields must accept the fact that the two problems often exist together, recognize the importance of a holistic treatment approach, be willing to set aside turf issues, and learn to collaborate effectively on the client’s behalf. Impediments to systemic reform are scattered throughout substance abuse and domestic violence programs, and in the public and private funding organizations supporting them. The insistence on identifying a single problem as primary or the need to conceal a problem in order to receive services can complicate admission to treatment, interfere with the development of appropriate treatment plans, and ultimately derail progress. This document suggests that only a unified system can interrupt the cycle of violence, fear, intimidation, guilt, and relapse to substance abuse that jeopardizes the possibility of full recovery.

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Limitations

The most obvious limitation to this document is its reliance on self-reports. Individuals have the tendency to either underreport or overreport certain facts. The high rate of reported substance use among perpetrators, for example, may be due to other factors such as an excuse for their violent behavior. Additionally, although clients may be attempting to be accurate, their perception of past events may be distorted. In its appeal for an integrated approach to treatment, other limitations of the document include: it focused more on the substance abuse provider than the domestic violence provider, it did not address substance abuse needs, it was more concerned with the victim of domestic violence than the perpetrator of domestic violence, and the brief analysis was conducted solely in a domestic violence setting. One can only hypothesize that research in a substance abuse setting would yield supporting data. There are many additional factors to be taken into account that include the cost of an integrated program, cost to educate staff, funding issues, political and philosophical differences in existing programs, and confidentiality issues in sharing information across the two fields. Clearly, there is work to be done on both sides of the issue.

Implications for Social Work

Social workers have historically worked with at-risk and vulnerable populations. It appears that a vast population is at-risk of substance abuse and domestic violence. Neither problem discriminates. They reach across all social, economic, ethnic, and religious lines. Due to the unique nature of social work, the social worker may come in contact with these populations more than any other provider and should be prepared to accommodate their...
needs, whether as a client advocate, a case manager, or a counselor. This document attempted to remain consistent with the themes of contemporary social work by including concepts of family centeredness, accountability, self-determination, individual therapy, and family intervention. It attempted to heighten the awareness of the social workers within these demanding fields. Social workers are involved at the micro, mezzo, and macro levels of intervention. This places them in a position to assist in bringing about change in public policy such as court mandates for substance abuse and domestic violence. Additionally, it heightens public consciousness. These are necessary elements of implementing a collaborative and integrative program proposal like the one presented in this document.

Future Research

The fields of substance abuse and domestic violence are relatively new fields, particularly domestic violence. In fact, treatment for perpetrators of domestic violence has only developed in the past ten years. Given the newness of these social issues, research in both of these areas are of paramount importance.

Providers in each field should become familiar with the many facets of the counterpart programs. It is important that social workers are aware of the impact brought on through these dual diagnoses and the effects that the specific criteria play in the treatment of clients.

The phenomena of simultaneous occurrence of the dual problem is an issue that demands future research in areas such as continuous monitoring, and conducting comprehensive program and outcome evaluations. Further research could benefit the field in performing more rigorous experimental designs that include an adequate sample size as
well as random sampling and control groups. Additionally, the possibility of associated factors such as gender issues, homelessness, persisten poverty, transience, and the overall erosion of the quality of life in particular communities may be endless and must be taken into account. Moreover, the need to construct a working definition of such terminology as power and powerlessness as well as the need for a unified model of intervention further underscores the need for future research. Until that time, the veil of uncertainty that surrounds these phenomena will persist.

Summary

The objective of this document was to propose a collaborative and integrative method of intervention to help clients and providers in the fields of substance abuse and domestic violence. Programs that address both issues relating to domestic violence and substance abuse are non-existent. Foresight and diligent planning can result in a strong collaboration between the two fields. This collaboration could serve as the first step toward addressing both current and future issues related to domestic violence and substance abuse. Additionally, it would facilitate the development of treatment plans for substance abuse clients who are either victims or perpetrators of domestic violence by incorporating all the issues surrounding both sets of problems. Treatment planning is not effective without consideration of all the factors that have a bearing on successful client outcomes. For example, although client safety would be of paramount importance, issues regarding sobriety and self-determination cannot be overlooked. In addition, domestic violence programs must become active in the community response to substance abuse, and
substance abuse programs must become active in the community response to domestic violence. This can only be accomplished through a collaborative and integrative method of intervention.
APPENDIX A

Client “Non-Violence” Contract

1. I will not threaten or commit any form of physical, sexual, or psychological violence against any member of my family.

2. I acknowledge and accept that I have engaged in violent behavior and it is my responsibility to change this behavior.

3. I understand that staff and contractors are mandated by law to report to the proper authorities any threats of child abuse or other violent behavior that may put myself or others at eminent risk.

4. I acknowledge that staff will share information with the victim, court, and other agencies as determined relevant for my assessment and treatment.

5. I agree to participate fully in therapy by talking openly and processing personal feelings.

6. I understand that any violation of the “non-violence” contract will result in court notification.

7. I understand the purpose of this contract is to eliminate threats and physical violence in my home. To that end, I will accept responsibility for identifying those factors that have contributed to past violent behavior and for learning new skills to deal with anger, frustration, and conflict.
APPENDIX B

History of Physical Violence

Please describe the most recent incident of physical violence you have been involved in:

Please describe the first incident in which you or your partner used physical force:

Describe the most severe and serious incident of physical force:

Describe any incidents that have caused injury:

What is the frequency of those incidents:

Describe any other incidents in which there was physical force against another person:

Describe any incidents of sexual coercion, forced sex, or rape:

Do you feel frightened at home?

If yes, how often, and describe the circumstances:

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BIBLIOGRAPHY


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