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Addressing intimate partner violence in substance-abuse treatment

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Abstract

As the use of partner-involved therapies for alcoholism and drug abuse become more common in substance-abuse treatment programs, providers are more frequently encountering one of the most challenging and politically charged public health issues of our time: intimate partner violence (IPV). Recent investigations reveal 40–60% of married or cohabiting substance-abusing patients report episodes of partner aggression in the year preceding entry into treatment. In this article, the interrelationship between substance use and IPV is examined, with an emphasis on clinical implications and options for substance-abuse treatment providers who are often called upon to address IPV during the course of working with their patients. We also describe different intervention options for IPV, offer recommendations for substance-abuse treatment providers who work with partner-violent couples, and outline future research directions.

Keywords: Intimate partner violence; Domestic violence; Substance abuse; Treatment

1. Introduction

It is now widely accepted that partner-involved interventions can be among the most effective treatments available for married or cohabiting substance-abusing patients (for a review, see Fals-Stewart, O'Farrell, & Birchler, 2004). Although we have, in the past, lamented that relationship-based treatments have been largely relegated to research settings and are usually not offered to substance-abusing patients entering community-based treatment programs (e.g., Fals-Stewart & Birchler, 2001), this appears to be changing. With the recent availability of downloadable training materials, therapy manuals, on-line continuing education programs, e-mail consultation, and regularly conducted practitioner workshops throughout the United States and abroad, increasing numbers of community-based programs are adopting partner-involved interventions for alcohol- and drug-abusing patients.

Among the most challenging clinical issues faced by therapists who use couples therapy with alcohol- and drug-abusing patients is intimate partner violence (IPV). Unfortunately, IPV among alcohol- and drug-abusing couples is alarmingly high. Studies in this area have consistently revealed that 40–60% of married or cohabiting patients entering treatment for substance abuse reported one or more episodes of partner violence in the year prior to program entry (e.g., Fals-Stewart, Golden, & Schumacher, 2003; O'Farrell & Murphy, 1995). Consequently, as a team that has treated over 1,000 drug- and alcohol-abusing couples in our research protocols and clinical practices over the last decade, we are particularly familiar with the complexities of dealing with physical aggression between partners and have had to address this issue with great regularity. We are also familiar, as well, with the paucity of reliable information in this area.

Thus, the purpose of this article is to explore what is known about IPV, with an emphasis on the relationship between substance abuse and IPV. We also offer recommendations to substance-abuse treatment providers who are faced with this issue. Our recommendations are based either on available empirical evidence; in the absence of relevant research, we draw on our own clinical experiences (and note that accordingly). Finally, we provide recommendations for future research directions to inform the development of best

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practice approaches to treat IPV among alcohol- and drug-abusing patients and their partners.

2. How common is IPV?

Prevalence estimates of physical aggression between partners vary widely, depending on the definition of violence used and the context in which it is measured. For example, according to the Department of Justice, roughly 1,500 instances of homicide and manslaughter between intimate partners occur annually, with more than 1,200 of these involving women as victims (Bureau of Justice Statistics, 1998a). Results of the National Crime Victim Survey (NCVS), a survey of the victimization experiences of a national representative sample of the U.S. population, indicate there are nearly 1 million female victims of IPV each year. Representative surveys of couples, which include less severe instances of aggression, such as single occurrences of pushing or slapping one's partner, suggest rates of any husband-to-wife violence of 15–20% annually (Schafer, Caetano, & Clark, 1998; Straus & Gelles, 1990).

Although most research to date has examined male partner aggression, female-to-male physical aggression is also common, occurring in proportions that are equal to or even slightly higher than male-to-female (e.g., Archer, 2000). However, the consequences of male-to-female physical aggression appear to be greater on the female partners (Cascardi, Langhinrichsen, & Vivian, 1992) and on children in the home (e.g., Margolin, 1998) than female-to-male violence.

3. Are there different types of IPV?

Although often treated and discussed as a unitary, homogeneous phenomenon, IPV encompasses a wide range of physically aggressive behaviors between partners that vary greatly along such dimensions as (a) type and severity of aggression (e.g., a push vs. an injury-inducing beating); (b) frequency (e.g., a single push vs. repeated pushing over an extended time frame); and (c) emotional and physical impact (i.e., aggression that induces fear; O'Leary, 2002). A helpful heuristic typology of IPV that captures these distinctions was put forth by Johnson (1995), in which he describes two types of IPV that appear to be conceptually and etiologically different. *Patriarchal terrorism* is characterized by severe male-to-female physical aggression (e.g., punching, threatening with weapons), with less severe female-to-male violence occurring during the course of these episodes primarily as self-defense. For the female partner, patriarchal terrorism is marked by a high likelihood of physical injury and increased fear of the male partner. The distinctive feature of this severe type of IPV is that the aggression serves the purpose of dominating and controlling the partner. Conversely, *common couple violence* is not because of efforts to exert control or establish patriarchy. In contrast to patriarchal terrorism, it is characterized by episodes of bidirectional partner aggression (that may be initiated by either partner), is mild to moderate in severity, and arises reactively when a conflict escalates. This type of IPV is less likely to cause fear in or endanger the female partner and is less likely to be used as a form of control.

Much of the dialogue and debate about IPV implicitly or explicitly centers on patriarchal terrorism, although it appears that most partners who report and enter treatment for IPV engage in the less severe form (i.e., common couple violence). This is particularly true for violent couples in which one of the partners enters substance-abuse treatment. In our experience, the majority of these couples (i.e., more than 95%) report episodes of partner aggression that are more akin to descriptions of common couple violence than patriarchal terrorism. The clinical importance of this distinction in IPV for the treatment of substance dependence is discussed later.

4. Is the relationship between substance use and IPV correlational or causal?

4.1. The controversy

It is now widely accepted that the occurrence of violence between intimate partners is the culmination of multiple interacting contextual, social, biologic, psychological, and personality factors that exert their influence at different times, under different circumstances, acting in a probabilistic fashion (Crowell & Burgess, 1996). Among the various factors that have been proposed in conceptual and predictive models of IPV, substance use is among the most controversial. Although there is a consensus that those who engage in IPV often drink or use drugs and that intoxication often accompanies violence, there is far less agreement about whether use of alcohol and other drugs simply covaries with partner violence, is inherently facilitative or a contributing cause of IPV, or simply an "excuse" for aggression. This debate is not merely an academic exercise; if intoxication is causally implicated in IPV, it would follow that interventions that are successful in reducing substance use could reduce or eliminate the occurrence of partner violence. This begs the questions, "By what criteria should we evaluate the potential causal role of substance use in IPV?" and "Do the results of available investigations support the notion that use of alcohol and other drugs has a causal role in the occurrence of IPV?"

4.2. Evidence of causality in observational and epidemiological studies

As with other research endeavors exploring the links among variables implicated in certain disease and harmful behavioral processes (e.g., cigarette smoking and lung

cancer), ethical considerations and other barriers make it necessary to rely largely on information gathered from observational studies to ascertain potential causal connections. In a landmark article, Hill (1965) outlined several conditions, which have been modified and revised since their introduction, needed to establish a causal relationship between two variables in observational and epidemiological research: (a) consistency of association across multiple studies using different methods; (b) strength of association; (c) evidence of a dose–response relationship; (d) coherence (i.e., is association consistent with a currently accepted theoretical understanding of the relationship between social and biologic processes); (e) evidence of the correct temporal precedence (i.e., the causal variable occurs before the response); (f) experimental evidence indicating that changes in the proposed causal variable yields changes in the outcome; and (g) rejection of plausible alternative explanations. Using these criteria, how strong is the evidence that substance use plays a causal role in episodes of IPV?

4.3. Evaluation of the causal connection between substance use and IPV using Hill's criteria

Results of multiple investigations reveal consistency in the relationship between the occurrence of IPV episodes and alcohol or other drug consumption by the male partner, the female partner, or both. For example, Kaufman Kantor and Straus (1990) found that more than 20% of men and 10% of women were drinking before the most recent and severe act of violence. In the NCVS (Bureau of Justice Statistics, 1998b), over half of the victims of IPV reported their perpetrator had been drinking. Among prisoners convicted of murdering an intimate partner, 45% reported that they were drinking at the time of the incident, with an average blood alcohol concentration (BAC) of three times the legal limit. For married or cohabiting patients entering treatment for alcoholism, the proportion of these dyads reporting at least one episode of IPV in the previous year is four to six times higher than observed in national samples (e.g., Fals-Stewart, 2003; O'Farrell & Murphy, 1995). In addition, the relationship between alcohol use and perpetration of IPV has been found in primary health-care settings (McCauley et al., 1995), family practice clinics (Oriel & Flemming, 1998), prenatal clinics (Muhajarine & D'Arcy, 1999), and rural health clinics (Van Hightower & Gorton, 1998).

Although most studies have focused largely or exclusively on men and their drinking, it also appears alcohol use is associated with increased partner aggression among women. For example, Cunradi, Caetano, Clark, and Schafer (1999) found that couples in which the female partner had alcohol-related problems were six times more likely to experience episodes of female-to-male IPV than couples who reported no female alcohol problems. In a sample of 126 female patients entering substance-abuse treatment, more than half reported they had perpetrated violence against their partners in the previous year (Chermack, Walton, Fuller, & Blow, 2001).

Research examining the link between use of drugs other than alcohol and IPV is not as well developed. However, several recent studies reveal associations between use of certain drugs and partner aggression that are similar to those found with alcohol. Brookoff, O'Brien, Cook, Thompson, and Williams (1997) reported 92% of partners who engaged in IPV used alcohol or other drugs on days of the episode. In a survey of substance-abuse treatment providers, it was estimated that nearly half of substance-abusing men engaged in IPV in their relationships (Bennett & Lawson, 1994); comparable proportions of IPV among men entering substance-abuse treatment have also been reported in other investigations (e.g., Easton, Swan, & Sinha, 2000).

The *strength of association* between substance use and IPV appears to be very robust. Fals-Stewart (2003) found that, for men entering a domestic violence treatment program, the odds of any male-to-female physical aggression were more than eight times higher on days when men drank than on days of no alcohol consumption. In the same report, similar findings were described for a separate sample of married or cohabiting men entering treatment for alcoholism. Comparable results were obtained with another sample of patients who primarily abused drugs other than alcohol, with cocaine use also being most strongly implicated in episodes of partner violence (Fals-Stewart et al., 2003).

There is also some evidence supporting a *dose–response relationship* between substance use (particularly alcohol consumption) and IPV. O'Leary and Schumacher (2003) analyzed this relationship using data collected as part of the National Family Violence Survey and the Nationally Survey of Families and Households. Men in both samples were classified into similar drinking groups, ranging from abstainers to heavy and binge drinkers. For both samples, there was a significant positive linear association between the drinking classification of men and their likelihood of engaging in any IPV. However, the investigators point out that the associated effect sizes were small and the distinctions in drinking patterns may be more related to IPV than incremental increases in quantity or frequency of alcohol consumption.

The relationship between substance use and IPV is theoretically coherent. More specifically, this association is consistent with what has sometimes been described as a *multiple threshold model* (e.g., Fals-Stewart, Leonard, & Birchler, 2005). The model assumes that aggression occurs when the strength of a given provocation exceeds the strength of inhibitions against aggression. There are multiple thresholds in operation because aggressive inhibitions are assumed greater for severe violence than for less severe violence. Intoxication is viewed as leading to a lowering of inhibition against aggression to impairment of cognitive processes (e.g., Chermack & Taylor, 1995), setting the stage for increased likelihood of violence.

One of the longstanding arguments against the notion of substance use playing a causal role in IPV has been that studies have failed to demonstrate the *temporal precedence* of alcohol or other drug use in episodes of IPV (e.g., Gelles, 1993). Recently, however, some recent longitudinal studies of alcohol use and IPV have established the appropriate temporal ordering and have shown that IPV episodes tend to occur close in time following drinking and drug use. Fals-Stewart (2003) collected detailed diaries from male partners with a history of IPV, entering either an alcoholism or domestic violence treatment program, and from their female partners, during a 15-month follow-up period. The diaries contained information not only about the occurrence of male-to-female aggression, but also about (a) the time of day these episodes happened, (b) whether the male partner drank alcohol during the same day the violence occurred, and (c) what time of day the drinking occurred. This allowed for a detailed examination of the daily temporal relationship between male-to-female physical aggression and alcohol consumption. Importantly, in both samples, over 80% of all IPV episodes occurred within 4 hours following drinking by the male partner. These findings were replicated in a recently completed investigation (Fals-Stewart et al., 1995); moreover, similar results were found for the temporal association between cocaine and episodes of IPV in a sample of patients who primarily abused drugs other than alcohol (Fals-Stewart et al., 2003).

Although there is little *experimental evidence* that directly addresses the facilitative role of substance use in the occurrence of IPV, the results of available studies exploring alcohol use and aggressive behavior in different contexts provide some support for this relationship. For example, several laboratory experimental investigations have found alcohol consumption by study participants led to increased aggression, as measured by levels of shock administered to a confederate participant (e.g., Bushman, 1997; Richardson, 1981). These consistent results provide important evidence for the link between alcohol use and aggression. However, it is also important to note that these studies are conducted under circumstances that are markedly different from those characterizing aggression between partners in relationships, which may limit their capacity to clarify issues in IPV. Specifically, these investigations usually involve male-to-male behavior (rather than male-to-female), contrived and unnatural aggressive responses (i.e., electric shock), and a very narrow, preprogrammed set of responses from confederates (rather than the natural and wide array of potential dynamic responses between intimate partners in conflict).

Marital interaction experiments, in which partners are asked to discuss major conflict areas, have also been conducted to explore the effects of alcohol on negative verbal behavior. Leonard and Roberts (1998) asked intimate partners to talk about an important conflict and then to discuss their most serious area of conflict after the male partner received either (a) no alcohol, (b) an active placebo, or (c) an intoxicating dose of alcohol. The intoxicating dose of alcohol consumption led to increased negativity over baseline sessions. Neither the no alcohol nor the placebo conditions led to increased negativity. Although there are exceptions (e.g., Frankenstein, Hay, & Nathan, 1982), most studies in this area tend to support the hypothesis that administration of alcohol in the context of marital conflict appears to increase negative interactions (e.g., Jacob, Leonard, & Haber, 2001; Jacob & Leonard, 1988).

Many of the limitations of the laboratory aggression studies noted earlier are not shared by the marital interaction experiments. In particular, the conflicts in the marital interaction studies occur between intimate partners who use a variety of responses they are likely to use in other dyadic conflict situations. However, some limitations of these studies, at least with respect to generalizing to episodes of physical aggression between partners, should be highlighted. Although it is likely that negative verbal behavior is a precursor to escalating conflict, it is not, in fact, physical aggression. Additionally, these investigations examine partners in laboratory settings discussing selected topics for a relatively brief period while being observed and typically videotaped, which are in contrast to naturally occurring interactions between partners over the course of extended periods in their natural environments (e.g., home, neighborhood).

The weakest element of the argument supporting the causal relationship between substance use and IPV is the rejection of plausible alternative explanations. In particular, it may be difficult, if not impossible, to reject the hypothesis that an individual, who—for various preexisting reasons—wishes to engage in violence against their partner, may subsequently drink or use drugs to facilitate such an event. Thus, as opposed to the physiological disinhibition that is assumed in the multiple threshold model described earlier, this conceptualization assumes that individuals consciously drink alcohol or use drugs to be violent and that intoxication provides an excuse for the behavior.

In summary, can we conclude that consumption of alcohol and use of other drugs causes IPV? Given certain ethical and pragmatic constraints, there simply is no design that will definitively demonstrate causality between substance use and IPV; the cross-sectional and longitudinal studies cannot eliminate the possibility that spurious variables account for the observed substance use–IPV link. The available experimental laboratory studies yield results that may not generalize to natural settings. However, as articulated recently by Leonard (2005), the convergence of evidence drawn from many (although individually flawed) sources, intoxication is one of several contributing causes of IPV. However, regardless of whether substance use is viewed as a cause of IPV or simply provides an excuse for the premeditated behavior, the logic of either view suggests that treating the substance use should ameliorate the violence—either by addressing a root cause or by eliminating the planned excuse for violence.

5. What are the treatment options for substance-abusing patients who engage in IPV?

Unfortunately, not much is presently known about the best treatments for IPV among patients entering alcoholism or drug abuse treatment. Comprehensive evaluations of different types of interventions for IPV in general are only now emerging. In the following, we describe some of the typical responses to IPV by substance-abuse treatment programs, as well as less commonly used approaches, and highlight the available evidence for their respective effectiveness.

5.1. "Treatment-as-usual": standard substance-abuse treatment

The elevated prevalence of IPV among men seeking substance-abuse treatment would suggest these programs may represent an important point of entry into the health system for men who engage in partner violence. In turn, some have recommended that substance-abuse treatment programs should conduct regular assessments of IPV and refer candidates to domestic violence intervention programs (Collins, Kroutil, Roland, & Moore-Gurrera, 1997). However, surveys of drug and alcohol treatment agencies reveal that referral to domestic violence intervention programs is rare (e.g., Bennett & Lawson, 1994; McLellan & Meyers, 2004). Individuals entering alcoholism or drug abuse treatment are often not assessed for IPV or, if they are, the assessments themselves are inadequate (Schumacher, Fals-Stewart, & Leonard, 2003).

Yet, if alcohol and other drug use are causally implicated in IPV, standard treatment for substance abuse could be an effective intervention for IPV; results of recent studies provide some support for this hypothesis. O'Farrell, Fals-Stewart, Murphy, and Murphy (2003) conducted a study examining IPV among alcohol-abusing men (N = 301) entering a typical outpatient substance-abuse treatment program, which did not focus on IPV. In the year before treatment, 56% of the alcohol-abusing patients had been violent toward their female partners, compared with a rate of 14% in a demographically matched non-alcohol-abusing comparison sample. In the year after treatment, IPV decreased to 25% among all treated patients, but was only 15% among remitted alcohol-abusing patients and 32% among relapsed patients.

Although far less research has been conducted in this area with female alcohol-abusing patients, available results are similar to those obtained with male alcohol-abusing patients. For example, Stuart et al. (2002) examined the effect of intensive alcoholism outpatient treatment on IPV perpetration and victimization among female patients. Results revealed a decrease in both the prevalence and frequency of partner violence after treatment. In addition, women who relapsed during the 1-year posttreatment follow-up period were more likely to engage in IPV than those patients who had not relapsed.

Thus, IPV does appear to decrease after standard alcoholism treatment, especially among patients who did not relapse in the posttreatment period. These findings suggest (but do not prove) that patients who have problems with alcohol or other drugs should receive substance-abuse treatment, at least as a component of an overall intervention for IPV. Unfortunately, the primary limitation of standard substance-abuse treatment as a stand-alone intervention for IPV is that the violence reductions appear to rely on alcohol or drug abstinence. Other factors (e.g., conflict management skills, partner responses to patients' relapses) that may contribute to IPV are, for the most part, ignored in standard substance-abuse treatment. Given the high relapse rates typically reported for patients after substance-abuse treatment, coupled with the many-fold increase in the likelihood of IPV on days of alcohol or other drug use after treatment completion, standard substance-abuse treatment may best be viewed as a necessary, but not sufficient, intervention for patients seeking help for alcoholism or drug abuse who have also engaged in IPV.

5.2. Referral to domestic violence intervention programs

Given the above synopsis, it could be argued that a reasonable approach would be to train substance-abuse treatment programs to assess and accurately identify incoming patients who have engaged in IPV and then refer those patients to domestic violence intervention programs. This would be a comparatively simple approach to implement and would have the important and practical advantage of utilizing partner violence intervention resources in the community, drawing on existing expertise (vs. the development of this expertise among the staff of substance-abuse treatment settings).

There are two critical issues that make the referral strategy approach more problematic, in practice, than it may appear. First, many domestic violence interventions are considered most appropriate for perpetrators of IPV mandated by the criminal justice system to these programs in which a swift and certain court response to violations (e.g., recurrence of violence, failure to participate in the program) can be implemented (Gondolf, 2004; Zubretsky & Knights, 2001). Thus, the potential for legal ramifications serve as a powerful motivator for those referred to these programs to participate. In contrast, patients entering substance-abuse treatment who perpetrate IPV are very rarely mandated by the criminal justice system to also participate in domestic violence intervention programs as part of their substance abuse treatment. A review of our records across multiple community-based substance-abuse treatment programs revealed that less than 2% of patients were mandated to participate also in domestic violence intervention programs. Although most domestic violence programs admit nonmandated patients, available evidence suggests that few substance-abusing patients accept a referral to these programs or those that do typically drop

out very early in the course of the intervention (Schumacher et al., 2003). This very low level of engagement and participation is likely due, in part, to the fact that very few substance-abusing patients are coerced by the criminal justice to participate in these batterer intervention programs. Additionally, in our experience, linkages between domestic violence and substance-abuse treatment programs are usually very poor and thus little effort is made to coordinate effectively the referral process.

However, engaging in efforts to enhance patient participation in domestic violence intervention programs and strengthening referral linkages between these programs and substance-abuse treatment agencies would not address the second issue. More specifically, the evidence for the effectiveness of domestic violence intervention programs in reducing or eliminating IPV has been, at best, mixed. The most common model of treatment for domestic violence in community settings is what is often referred to as gender-specific treatment (GST), based on a feminist psychoeducational approach (McMahon & Pence, 1996). It was originally implemented in the Duluth Domestic Abuse Intervention Project in Minnesota and is frequently referred to as the Duluth Model. These programs emphasize two interrelated themes about IPV: (a) it is a purposeful and systematic behavior by men to exert power and control over their partners and (b) it is a manifestation of the patriarchal structure of society. In turn, male partners must take full responsibility for occurrences of IPV in the relationship and for stopping such abuse, acknowledge and recognize their need for power and control at the familial and societal level, and accept that their abusive beliefs about power and control support and perpetuate aggression in the home. Male-only group formats are used to emphasize men's sole responsibility for episodes of IPV (Yllo, 1993). Perhaps understandably, domestic violence intervention programs place emphasis on accountability and safety for the partner (and other family members), not rehabilitation per se. Additionally, in many programs, accountability is seen as possible "only when there is an ability to impose swift, consistent, and meaningful sanctions for abusive behavior that rests solely, if not exclusively, within the criminal justice system. . ." (Zubretsky & Knights, 2001).

Results of meta-analytic reviews revealed little or no effects for these programs (e.g., Babcock, Green, & Robie, 2004), a conclusion that has been supported by recently completed experimental studies (e.g., Dunford, 2000). However, Gondolf (2004) has pointed out some of the limitations of these studies; moreover, based on the results of multisite evaluation of batterers treatment programs, he concluded these programs have moderate treatment effects. Thus, the central question becomes, "Should substance-abuse treatment providers refer their patients to domestic violence intervention programs if they are of unknown effectiveness and where there is very little acknowledgement of the role of substance abuse in the perpetuation of the IPV?"

One might contend that even if the effectiveness of these interventions is not proven, it is nonetheless better to provide some form of focused intervention than to do nothing. This assumes the intervention, even an ineffective one, would at least do no harm. However, there are questions about the validity of this assumption. To illustrate, suppose a male perpetrator of IPV completes a domestic violence program. If the perpetrator's partner incorrectly believes participation in the program has reduced or eliminated the likelihood of IPV (i.e., she draws the false conclusion the program is effective in reducing or eliminating the odds of IPV when, in fact, it is not), she may act differently based on this assumption (e.g., she may return to the home if she has left, she may engage in a highly charged argument that she might otherwise have avoided). Again, if there has been no attempt to address alcohol or other drug use, any of the "lessons learned" may be eliminated if substance use occurs. Thus, in this scenario, participation in an ineffective domestic violence program or even one that is marginally effective but has not addressed the role of substance use has served to increase the likelihood of potential harm. Although this scenario may appear artificial, results of a study by Gondolf (1988) may lend some support to this contention. In that investigation, over 6,000 women leaving battered women's shelters were asked whether they intended to return to their abusive partners or to leave them. The strongest predictor of women's decisions was whether their partners were in domestic violence treatment. If the male partners were involved in domestic violence treatment, 53% of the wives planned to return to them; if the male partners were not participating in domestic violence treatment, only 19% of the women planned to return.

5.3. Conjoint therapy

5.3.1. Couple-based interventions for IPV

Among the most controversial and widely debated treatment approaches for IPV are partner-involved conjoint therapies (for an example of the debate, see McMahon & Pence, 1996; O'Leary, 1996). In much of the IPV literature, marital and family therapies for IPV are most often viewed as not only inappropriate, but are also described as ineffective, ethically questionable, and potentially dangerous (e.g., Zubretsky & Knights, 2001). The controversy is derived, in part, from certain assumptions: (a) conjoint therapy models implicitly or explicitly highlight participants' shared responsibility for the behavior, with the victim assuming she is at least partially responsible for her partner's violence and the abuser thus able to conclude he is not fully responsible for his own aggressive behavior, and (b) conjoint counseling encourages honest and open disclosure, which could lead to conflict in therapy sessions that could escalate to violence outside the confines of therapy. As a consequence of these concerns, most states set standards and guidelines that discourage the use of or prohibit funding for any program that offers couples or

family therapy as an intervention modality for IPV (Healey, Smith & O'Sullivan, 1998; Lipchik, Sirles, & Kubicki, 1997; The Commonwealth of Massachussetts Executive Office of Health and Human Services, 2004).

Yet, others have highlighted the potential advantages partner-involved treatments may have for couples who engage in IPV (e.g., Holtzworth-Munroe, Marshall, Meehan, & Rehman, 2003). First, a more complete evaluation of the level and severity of the IPV can be obtained because both partners are providing information in situations in which reports and descriptions of IPV often differ significantly (Schafer, Caetano, & Clark, 2002). Conjoint therapy also provides a safer venue for partners to discuss high conflict and emotionally charged topics; these discussions can also be postponed until the partners meet with the therapist, which can help the partners avoid such topics at home until such time that they have the requisite skills (developed in the course of treatment) to discuss such issues constructively. Partner aggression most often occurs in the context of arguments between partners (e.g., Stamp & Sabourin, 1995) and is often mutual and bidirectional (Vivian & Langhinrichsen-Rohling, 1994). Thus, addressing the interactional nature of the partner aggression may reduce its frequency by altering the interaction patterns that precede it. Because relationship distress is a powerful predictor of partner aggression (e.g., Pan, Neidig, & O'Leary, 1994), improvements in a couple's adjustment (a primary goal of conjoint treatment) should reduce the likelihood of IPV. As reported earlier, female-to-male physical aggression is a fairly common occurrence; thus, stressing nonviolence by both partners and stressing that each of the partners is responsible for his or her own behaviors and acts of violence (vs. the male partners being solely responsible for all IPV episodes) may lead to reductions in IPV in the dyad (Vivian & Heyman, 1996).

With these conflicting theoretical perspectives and contrasts as a backdrop, what does the research reveal? Interestingly, in three studies that compared group GST approaches to conjoint treatment with partner-aggressive men and their partners, both types of treatment led to IPV reductions, but no group differences in violence outcomes were found (Brannen & Rubin, 1996; Harris, Savage, Jones, & Brooke, 1988; O'Leary, Heyman, & Neidig, 1999). Couples recruited for these studies were interested in remaining together and were willing to engage in conjoint therapy; as such, these dyads may be dissimilar from couples in which partners are entering domestic violence programs. However, these couples may not be so different in important respects from couples in which a partner is entering substance-abuse treatment.

5.3.2. Behavioral couples therapy for substance abuse

A conjoint treatment for alcoholism and substance abuse that has received extensive empirical support for its effectiveness is behavioral couples therapy (BCT). BCT is a partner-involved treatment for substance abuse that teaches skills that promote partner support for abstinence and also emphasizes amelioration of common relationship problems in these couples (for a review, see Fals-Stewart, O'Farrell, & Birchler, 2004). With respect to partner violence, non-substance-abusing partners are taught certain coping skills and measures to increase safety when faced with a situation where the likelihood of IPV is increased. In particular, emphasis is placed on using behaviors that reduce the likelihood of aggression when a partner is intoxicated (e.g., leaving the situation, avoiding conflictual and emotionally laden discussion topics with an intoxicated partner).

A series of studies have examined the effects of BCT on IPV prevalence and frequency of IPV among substance-abusing men and their non-substance-abusing female partners. O'Farrell, Murphy, Stephan, Fals-Stewart, and Murphy (2004) replicated, with a large heterogeneous intent-to-treat sample, initial study findings of dramatically reduced male partner physical violence associated with abstinence after BCT (O'Farrell, Van Hutton, & Murphy, 1999). This investigation examined partner violence before and after BCT for 303 married or cohabiting male alcohol-abusing patients and used a demographically matched non-alcohol-abusing comparison sample. In the year before BCT, 60% of alcohol-abusing patients had been violent toward their female partners, five times the comparison sample rate of 12%. In the year after BCT, violence decreased significantly to 24% in the BCT group but remained higher than the comparison group. Among remitted alcohol-abusing patients after BCT, violence prevalence reduced to 12%, identical to the comparison sample and less than half the rate among relapsed patients (30%). Results for the second year after BCT yielded similar findings. Chase, O'Farrell, Murphy, Fals-Stewart, and Murphy (2003) reported similar findings with married or cohabiting alcohol-abusing women and their non-substance-abusing male partners who engaged in BCT.

Fals-Stewart, Kashdan, O'Farrell, and Birchler (2002) examined changes in IPV among 80 married or cohabiting drug-abusing patients and their non-substance-abusing female partners randomly assigned to receive either BCT or individual treatment. Although nearly half of the couples in each condition reported male-to-female IPV during the year before treatment, the number reporting violence in the year after treatment was significantly lower for BCT (17%) than for individual treatment for the male partner only (42%). Mediation analyses indicated BCT led to greater reductions in IPV because participation in BCT reduced drug use, drinking, and relationship problems to a greater extent than individual treatment.

In the course of BCT, non-substance-abusing partners are taught certain coping skills and measures to increase safety when faced with a situation where the likelihood of IPV is increased. In particular, emphasis is placed on using behaviors that reduce the likelihood of aggression when a partner is intoxicated (e.g., leaving the situation, avoiding conflictual and emotionally laden discussion topics with an

intoxicated partner). Thus, BCT is designed to reduce partner violence in these couples even when relapse occurs. In contrast to traditional individual treatment for substance abuse, BCT does not rely exclusively on abstinence as the mechanism of action for nonviolence.

Importantly, BCT is designed to reduce partner violence even when relapse occurs (i.e., as noted earlier, non-substance-abusing partners develop safety plans, are taught strategies to interact with their intoxicated partners, etc.). In contrast to traditional individual treatment for substance abuse, BCT does not rely exclusively on abstinence as the mechanism of action for nonviolence. In turn, we would expect differences between traditional substance-abuse treatment and BCT in the likelihood of IPV on days of substance use.

The results of a recent pilot study provided initial support for this hypothesis. Fals-Stewart (2004) randomly assigned couples with an alcohol-abusing male partner and recent history of IPV to one of three treatment conditions: (a) BCT, (b) individual-based alcoholism treatment for the male partner only, and (c) a psychoeducational attention control treatment for couples. During the year after treatment, the likelihoods of IPV on days of substance use for couples in the three conditions were compared. All of the treatments were equally effective in reducing male-to-female physical aggression on days in which the male partner did not drink. However, on days of male partner drinking, the likelihood of male-to-female physical aggression was significantly reduced (i.e., 51% lower on average) for couples who received BCT compared to the couples in the other conditions.

5.4. Individually based integrated substance-abuse and IPV interventions

Although the association between substance abuse and IPV has been firmly established, comparatively little research has been conducted examining interventions designed to address both substance use and IPV, either within domestic violence intervention programs or substance-abuse treatment settings. However, there are important exceptions. Two nationally recognized integrated treatment programs are the Dade County's Integrated Domestic Violence Model (Goldkamp, Weiland, Collins, & White, 1996) and Yale's Substance Abuse Treatment Unit's Substance Abuse–Domestic Violence (SATU-SADV) Program (Easton & Sinha, 2002). The Dade County program is a specialized treatment that addresses substance-abusing behaviors and issues of aggression and anger directed at intimate partners as resulting from the need for power and control. Goldkamp et al. (1996) evaluated treatment outcomes and same-victim reoffending for participants attending the integrated program and compared those findings to those of participants who were attending a program that was not dual-focused. Results showed that the integrated treatment program was more successful in maintaining attendance in treatment and obtained lower rates of same-victim reoffending.

Yale's SATU-SADV Program is also an integrated approach to treating partner violence and substance abuse, which uses a cognitive–behavioral coping skills approach that also incorporates specific interventions that target violent behavior. The SATU-SADV is delivered in a 12-session group format and teaches coping skills that promote abstinence (e.g., dealing with cravings, negative moods, stress) and nonaggressive responses to conflict (e.g., healthy communication skills, negotiation methods, problem-solving strategies). Preliminary data indicate that this model increases patients' motivation to engage in positive behavior change, improves compliance with treatment, and decreases both anger and alcohol consumption.

6. Future directions and recommendations

Based on our own research and that of others, as well as our experience dealing with IPV among patients who enter treatment for substance abuse, we now offer our conclusions to regarding the state of the art in several areas as well as some recommendations for future research.

6.1. Comprehensive evaluation of IPV among married or cohabiting patients entering substance-abuse treatment is needed

Given the prevalence of partner violence among married or cohabiting alcohol- and drug-abusing patients, substance-abuse treatment programs need to employ standardized assessments for the presence of IPV. IPV evaluations are very poorly done in most substance-abuse treatment programs; consequently, patients who engage in IPV go unidentified, and providers are often surprised at the prevalence and frequency of IPV when it is evaluated properly. Several options for assessing IPV are available. The revised version of the Conflict Tactics Scale (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) is the most commonly used IPV measure and evaluates not only physical aggression between partners, but also partners' use of negotiation, sexual coercion, psychological aggression, as well as the occurrence of injury. The CTS-2 is comparatively brief, and we have found it to be easily understood by patients and its completion has not met with much resistance. Although more labor-intensive and time-consuming, the Timeline Follow Back Interview for Spousal Violence (Fals-Stewart, Birchler, & Kelley, 2003) is a calendar-based interview that provides not only information about prevalence and frequency of physical aggression between partners, but also allows for examination of temporal patterns and the co-occurrence of other behaviors that may also be coded on the calendars (e.g., drinking or drug use). Several other IPV measures and interviews are also available, many of which are described in a recently

published handbook for practitioners and researchers (see Rathus & Feindler, 2004).

6.2. Reducing or eliminating drinking and drug use is necessary, but is not sufficient

Once IPV is identified among alcohol- or drug-abusing patients entering treatment, addressing the substance-use problem effectively is critical; available evidence provides some support for the notion that substance use is causally implicated in episodes of IPV and reducing drinking or drug use decreases the odds of partner aggression. Although standard substance-abuse treatment does appear to reduce the reoccurrence of IPV significantly, we believe it is not sufficient as a stand-alone treatment for IPV, at least, as it is typically delivered, because the observed positive effects on IPV rely primarily on abstinence, which is too often not achieved or maintained. Thus, paradigmatic changes in the standard care model that increase the likelihood of long-term abstinence (e.g., moving from the current state-of-the field acute care model of addiction treatment to a long-term continuing care model) might also have the added effect of reducing IPV. Additionally, because relapse is so common, interventions that are likely to lead to reduced odds of IPV, even during episodes of drinking or drug use, are also needed.

6.3. Conjoint therapies may be an effective treatment option for many partner-violent couples with substance-abuse problems

For most couples with a partner entering treatment for substance abuse, available research indicates partner-involved conjoint interventions may be effective treatment options. Although we recognize this assertion deviates dramatically from the prevailing clinical practice and conventional wisdom, research findings simply do not support current policy positions. More specifically, the results of several studies suggest that participation by drug- and alcohol-abusing couples in at least one type of partner-involved intervention for substance abuse, BCT, results in clinically and statistically significant reductions in IPV. Based on these positive empirical findings, it is inappropriate to dismiss this intervention option for this serious public health problem on conceptual grounds only. In particular, the evidence from studies of at least one conjoint therapy (BCT), where an IPV focus is combined with an abstinence focus, suggests there are some conditions where conjoint therapies can be a substantial improvement over conventional choices.

Because of the clinical and public safety importance of these issues and the still small number of studies that have examined these issues, it is imperative that more research be done to elucidate the critical features of any IPV intervention that are both necessary and sufficient to reduce the target symptoms and to protect all parties in the process. With appropriate safeguards and notwithstanding theoretical concerns, the substance-abuse treatment field would be well-informed by a comprehensive randomized clinical trial comparing a combined partner-involved/IPV treatment with other intervention methods (e.g., standard substance-abuse treatment, standard substance-abuse treatment plus referral to domestic violence intervention programs), in terms of the interventions' mechanisms of action, violence outcomes, substance use, their co-occurrence, and so forth. We need to evaluate not only the comparative safety of partner-involved therapies for married or cohabiting substance-abusing patients, but also for whom and under what circumstances such interventions may or may not work. Also, it will be important to develop and validate early indicators of treatment failure, to minimize any potential harm from an ineffective intervention.

With respect to safeguards, we concur with other IPV investigators (Holtzworth-Munroe et al., 2003; O'Leary, 2002) that conjoint therapies, including those used for substance abuse, may not be the most appropriate strategy for couples in which partners engage in severe forms of IPV (i.e., patriarchal terrorism). Indeed, partner-involved intervention studies we have conducted with drug- and alcohol-abusing couples and other research on the application of conjoint therapies with IPV in general have excluded patients for a range of potentially dangerous practices (shown in Table 1). Yet, it is important to emphasize that we have rarely excluded substance-abusing couples on these grounds.

On occasions when we have encountered this form of IPV among patients, we recommend that referral to and participation in a batterers program be included as part of the formal treatment plan developed within the substance-abuse treatment program. In turn, if these patients do not attend the batterer treatment programs, as outlined in their treatment plans, we recommend discharge from the substance-abuse treatment program for failing to follow treatment guidelines and notification of the referral source. In all such cases we have encountered to date, they have been referred to treatment by an agent of the criminal justice system (e.g., probation department, judge). Thus, discharge from substance-abuse treatment led to legal sanctions for these patients.

Table 1
Conjoint interventions for substance-abusing patients who have engaged in IPV: Exclusion criteria

1. One or both partners report fear of injury, death, or significant physical reprisal from their significant other.
2. Severe violence (defined as resulting in injury and/or hospitalization) has occurred within the past 2 years.
3. One or both partners have been threatened and/or harmed by their significant other using a knife, gun, or other weapons.
4. One or both partners are fearful of participating in couples treatment.
5. One or both of the partners want to leave the relationship due, in whole or in part, to degree and severity of partner aggression.

Yet, despite the conventional clinical wisdom that referral to batterers intervention is the best approach to treat severely violent couples, it is not at all apparent that such strategies are particularly effective. Thus, we believe that far more research is needed to develop and evaluate intervention strategies for alcohol- and drug-abusing couples in which partners engage in severe IPV. As an example, it remains unclear if certain elements that are used as part of partner-involved interventions to address violence may be integrated into standard batterers treatment, at least in some form or variation, to make the latter more effective. In particular, for partners who are committed to remaining together, teaching partners of men who engage in severe forms of partner violence some strategies to reduce the likelihood of violence may be helpful. It is plausible that these skills can be effectively taught to each of the partners in conjoint sessions or in separate individual therapy sessions.

6.4. Develop and evaluate interventions for IPV that can be integrated into substance-abuse treatment programs

Although use of partner-involved treatment as an intervention for substance abuse is becoming more common, it is presently not offered in most community-based addiction treatment programs. Moreover, some substance-abuse treatment programs that do offer conjoint treatments may nonetheless be uncomfortable with offering these to couples with histories of IPV for the reasons outlined above. Recommendations for these settings, in terms of how to best address IPV when it is identified, are difficult to make because research on different approaches lags very far behind the needs of the substance-abuse treatment community. However, given the very high drop-out rates of patients referred from substance-abuse treatment programs to batterer treatment programs, coupled with concerns about their effectiveness, it is difficult to make a general recommendation that the best plan of action is referral to these programs.

We believe that most substance-abuse treatment programs will need to develop a strategic plan to address IPV, in terms of strengthening referral linkages to other providers or develop requisite expertise among program staff to treat partner violence. The current programmatic stance observed in most substance-abuse treatment settings is implicitly a "don't-ask, don't-tell" approach; IPV assessments tend to be very cursory and only a small proportion of patients who engage in partner violence are identified. However, the problem is clearly of sufficient size and scope, affecting not only the substance-abusing patients, but also their family members and the community in general, that strategies need to be implemented to address this issue within these programs.

With that said, it is unfortunate that very little research is available to guide providers on treating IPV among individual patients entering substance-abuse treatment programs. As noted previously, Easton and Sinha (2002) have begun using cognitive behavioral treatments for partner violent men entering substance-abuse treatment, the results of which have shown some promise. This approach emphasizes anger management, conflict resolution, and problem-solving, which is consistent with behaviorally based interventions for IPV in general. The grace therapy model (Ronel, 2000), developed as a group treatment for male substance abusers, uses the tenets and principles of 12-step programs (Alcoholics Anonymous) to also address issues associated with domestic violence. The model focuses on powerlessness, control, spiritual imbalance, and recovery from both addiction and healing from violence (Ronel & Claridge, 2003). Preliminary studies have also begun on the use and efficacy of motivational interviewing methods with partner violent men entering alcoholism treatment (e.g., Schumacher, 2004). Unfortunately, all of these efforts are in their infancy and more empirical work is sorely needed in this area. However, the integration of substance-abuse and batterers treatment is a welcomed research direction and continued development and evaluation of substance-abuse treatment programs that included specialized interventions to address IPV is an important programmatic line of research that, in the future, will likely provide important information to community providers.

Thus, drawing largely on our own clinical experience, we recommend that treatment providers include regular checkups about verbal and physical IPV as part of standard counseling sessions with substance-abusing patients, as they typically do for substance-use lapses and relapses. Highlighting the link between intoxication and violence with these clients is also critical, emphasizing behaviors that may reduce violence when they are sober (e.g., time out, disengaging from an escalating conflict) and when they are intoxicated (e.g., contacting an identified support person, contacting the counselor or the treatment program). Additionally, most programs provide for some family-involved assessments and treatment sessions. These can be used to provide the non-substance-abusing partners with local referral information and to teach some strategies to reduce the likelihood of violence (e.g., not arguing with someone who is intoxicated, developing a safety plan).

6.5. Examine the role of female-to-male IPV among substance-abusing couples

To date, the majority of IPV research has focused on male-to-female physical aggression. However, as we have highlighted, female-to-male IPV is also very common. We need a better understanding on IPV by female partners in their relationships, how much of it is defensive responding, and how much of it is unidirectional versus interactional. Anecdotally, among our couples in which only the male partner uses alcohol or drugs, both partners often report that

female partners often physically aggress against their spouses out of frustration for continued substance use or relapse, which can set the stage for reprisals (either immediately or at a later time). Understanding the interactive and dynamic nature of female-to-male and male-to-female physical aggression among partners would likely serve to reduce IPV in general in our couples.

6.6. Domestic violence programs need to address and treat substance-abuse behavior more proactively

We have emphasized recommendations and guidelines for substance-abuse treatment providers who encounter patients who have engaged in IPV; of course, many providers working in domestic violence intervention programs encounter individuals who have problems with alcohol or other drugs. It is well beyond the scope of this review to make recommendations to the IPV treatment community; suffice to say that given the disappointing outcomes of batterer treatment programs, development of new therapies, with an emphasis on empirical evaluation of their efficacy, is clearly necessary (Holtzworth-Munroe, 2001). The preponderance of the evidence would suggest that effective substance-abuse treatment could play a role in reducing IPV. We are aware of new research programs exploring the integration of substance-abuse interventions into batterer programs (e.g., Stuart, 2004; Murphy, 2004) and await the outcomes of these trials.

6.7. An expanded research agenda on IPV and substance abuse is needed

Finally, all of this begs a critical question, "Why is research lagging so far behind the needs of the substance-abuse treatment community on an issue of such public health significance?" The research and treatment communities each bear some responsibility for this. First, substance-abuse treatment providers and programs have not raised IPV as a primary concern because they believe that "their plate is full." They are being asked not only to address substance use, but also psychiatric comorbidity, legal issues, medical problems, educational and vocational deficiencies, and so forth. Adding an issue as complex and controversial as IPV appears overwhelming. However, we hope this article has highlighted the need for and responsibility of substance-abuse treatment programs and providers to address this issue.

Second, we also believe that investigators who wish to conduct research on IPV often confront reviewers and evaluators who see the inherently high risk of the topic, which, in turn, overshadows most other considerations. The consequences of treatment failure are very salient in IPV research. Although well intentioned, it is important to emphasize that doing what we have been doing in most substance-abuse treatment programs (e.g., standard substance-abuse treatment without attention to IPV, referral to domestic violence programs with very high drop-out rates and mixed IPV outcomes) is also placing patients and their families at risk. With all efforts to protect patients and their families notwithstanding, the research community needs to iteratively develop and evaluate treatments for IPV that can be integrated into substance-abuse treatment programs and recognize there are risks in this effort—but no more so than the status quo. Additionally, investigators need to be given the necessary financial resources to do so, without which only very small studies can be realistically conducted. IPV treatment research is fundamentally about harm reduction, attempting to ascertain which treatments result in the greatest reductions in partner aggression. However, short of complete separation of partners (e.g., incarceration), partner aggression is likely to occur among some couples regardless of the intervention used. Investigators need to find interventions that reduce partner aggression; those who evaluate research projects need to recognize that investigations in this area are intrinsically filled with high risk. But with the questionable efficacy of different intervention approaches for IPV, this is all the more reason for this topic to become the focus of increased research and funding.

7. Conclusion

In closing, some of the conclusions we have drawn and the recommendations we have made are likely to draw criticism. However, one assertion on all would likely agree is that concerted efforts to develop and evaluate new treatments for IPV among substance-abusing patients are long overdue. Debate about these crucial public health and social policy issues is of enormous import and arguments need to be decided based on the weight of the scientific evidence rather than ideology. Unfortunately, science sometimes lags far behind the pressing needs of the treatment community. Ultimately, finding and implementing the most effective intervention and treatment methods will lead to the greatest level of safety for patients, their partners, and their families—which is a goal to be embraced by all treatment programs and providers.

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