Identifying and Intervening with Substance-Using Women Exposed to Intimate Partner Violence: Phenomenology, Comorbidities, and Integrated Approaches Within Primary Care and Other Agency Settings

Terri L. Weaver, PhD,¹ Louisa Gilbert, PhD,² Nabila El-Bassel, PhD,²
Heidi S. Resnick, PhD,³ and Samia Noursi, PhD⁴

Abstract

Substance use and/or disorders (SUDs) have been identified as a significant correlate of intimate partner violence (IPV) exposure and present complex issues that intersect with the topography of IPV, attendant mental health, and physical co-morbidities and may pose barriers to primary care- and other agency-based screening and intervention efforts. Despite substantial research indicating significantly higher rates of all types and severity of IPV victimization among women with SUDs and bidirectional associations between partner or self-use of drugs or alcohol and IPV victimization, effective screening, brief interventions, coordinated systems of care, and treatment approaches to address these co-occurring problems remain very limited. We integrated select research examining the intersection of IPV victimization and SUDs and several comorbidities that have significant public health impact and provided recommendations for scaling up targeted interventions to redress these co-occurring problems among women in primary, emergency, and other care settings.

Introduction

THE 2010 AFFORDABLE CARE ACT, section 2713, delineates preventive services for women with private health insurance, including no-cost-share screening for intimate partner violence (IPV). However, executing IPV screening and interventions can become complicated when women present with other comorbidities. Substance use and/or disorders (SUDs) are not only associated with experiencing IPV, but also complicate the topography of IPV¹ with physical and mental health comorbidities.^{2–5} While screening and interventions to address IPV have been developed for different populations in a range of health care settings,⁶ effective screening, brief interventions, and coordinated systems of care to address the needs of women with co-occurring IPV and SUDs remain very limited. To address these gaps, we present a concise integration of selected research examining the intersection of IPV and SUDs and their comorbidities.

Our literature search was targeted, rather than exhaustive, and focused on women with IPV and SUDs. The guiding

aims for this review were to (1) focus primarily on women's IPV victimization and substance use rather than the association between substance use and IPV perpetration; (2) select meta-analytic studies when available to meet the aims of a concise research integration, and (3) emphasize mental and physical health comorbidities that have public health impact. Based on the integrated findings, we provided recommendations for scaling up targeted interventions to redress the co-occurring problems of IPV and SUDs among women in a range of health care settings.

The Intersection of IPV and SUDs

Meta-analytic findings from epidemiological studies document consistent patterns of bidirectional relationships between alcohol use/disorder and exposure to physical or sexual IPV.⁷ Devries and colleagues⁷ conducted meta-analyses from 55 cross-sectional or longitudinal studies available prior to June 2013. Reviewed studies provided estimates of the association between alcohol use or use disorders consistent

¹Department of Psychology, Saint Louis University, Saint Louis, Missouri.

²Columbia University School of Social Work, New York, New York.

³Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, South Carolina.

⁴National Institute on Drug Abuse, National Institutes of Health, Bethesda, Maryland.

with International Classification of Disease^{8,9} criteria and IPV-related physical or sexual assault among women age 15 or older. The authors included general population studies and excluded select population studies, such as treatment samples. Longitudinal studies were considered to provide the strongest most informative methodology. Studies meeting criteria yielded 102 estimates of association. Pooled odds of alcohol use or disorder predicting subsequent IPV were significant (1.27), based on 12 estimates, derived from 7 longitudinal studies. Further, the majority (9/12) of estimates indicated increased odds of subsequent IPV given alcohol use or disorder. The pooled odds of IPV predicting subsequent alcohol use or disorder were also significant (1.25) with 14 of 15 estimates based on 9 longitudinal studies.

Drug use has also been found to increase odds of IPV victimization.¹⁰ Moore and colleagues conducted a meta-analysis using identified studies between 1996 and 2005 that examined associations between drug use and some form of IPV aggression (psychological, physical, sexual). A total of 96 studies were identified that yielded 547 effect sizes. Treatment outcome studies were only included if baseline measures of drug use and aggression were provided. The association between drug use by women and experience of IPV victimization was also described when available. Overall, results indicated a three times greater odds of IPV perpetration in couples where there is drug involvement. Men and women had comparable risks for IPV perpetration and victimization regardless of which partner reported drug use.¹⁰ Authors underscored the importance of considering both distal and contextual factors when exploring gendered reactions to IPV.

To estimate prevalence of SUDs among women with histories of IPV victimization, Golding¹¹ conducted a meta-analysis that included a subset of 10 studies of women and found that alcohol disorder ranged from 6.6% to 44%, with a weighted average of 18.5%.¹¹ Data available from four studies found that drug abuse prevalence ranged from 7% to 25% among women experiencing IPV with a weighted average of 8.9%. Afifi and colleagues utilized data from the National Comorbidity Survey-Replication Study,¹² a representative sample of 5,692 men and women who completed in-person structured diagnostic interviews and an assessment of traumatic event history, and found that the prevalence of past-year SUDs was significantly higher among those with recent physical IPV victimization among both women (3.6% vs. 0.7%) and men (7.1% vs. 1.9%).¹³ A higher prevalence of lifetime and recent IPV has been observed among samples of women seeking substance abuse treatment, with prevalence of IPV ranging from 25% to 57% across treatment samples—or three to five times greater than prevalence observed across nationally representative samples of women.¹

Phenomenology of IPV and SUDs: Exploring Mutual Maintenance via Coercion

Coercion in IPV has been defined as a demand paired with a threatened negative consequence for noncompliance.¹⁴ Authors posit that an abusive partner can set the stage for coercion via (1) facilitating attachment, (2) wearing down the partner's resistance, (3) creating or exploiting partner's vulnerabilities, and (4) creating expectancies for negative consequences.¹⁴ When one or both partners are using drugs,

SUDs may be intertwined with or amplify coercive efforts. Qualitative interviews were conducted with women seeking substance abuse treatment who were also exposed to IPV and their diverse experiences exemplified each of these coercive strategies.¹⁴ Women described various ways in which substance use enhanced sexual intimacy (i.e., facilitated attachment). Verbal coercion (i.e., wearing down partner's resistance) was used by women's partners to exhort them to engage in nonconsensual sex or exchanging sex for drugs. Subsequent episodes of violence were then blamed on the woman's (coerced) sexual behaviors, thus creating and exploiting their vulnerabilities. Other authors note how partners' tactics of controlling access to substances as well as the stigma associated with drug use can solidify relationship dependencies and dampen expectations for institutional help.¹

IPV and SUDs: Mental and Physical Health Comorbidities

Posttraumatic stress disorder (PTSD), physical injuries, and human immunodeficiency virus (HIV) complicate comorbidities of IPV and SUDs, share complex associations with IPV exposure and challenge efforts to cope with IPV and SUDs. Lifetime prevalence of PTSD is estimated to be between 6% and 8%, and roughly 46% of those with PTSD are estimated to have a comorbid SUD.¹⁵ Both PTSD and SUDs are elevated in women with histories of IPV¹⁶ with PTSD evidencing a dose-response relationship with IPV severity.¹¹ SUDs and PTSD may both act to heighten risk of exposure to IPV by impairing judgment, increasing risk-taking, or triggering partner aggression.^{17,18} Growing research suggests that women with PTSD or depression are more likely to continue experiencing IPV, as they may be more likely to miss cues leading to violence and less likely to access resources that may improve safety.¹⁹ Use of drugs or alcohol may serve as a form of self-medication for IPV and PTSD. Peters, Khondkaryan and Sullivan found that substance use expectancies of tension reduction and relaxation were significantly associated with alcohol use, physical and sexual IPV severity, and PTSD total and re-experiencing severity scores.²⁰ Using daily interactive voice response reports, Simpson and colleagues found that greater previous night distress secondary to PTSD nightmares, hypervigilance, and emotional numbing were associated with increased next-day craving, while anger/irritability was associated with lower next-day craving.²¹ This research suggests that important functional associations among the symptoms of each disorder may be observed among women experiencing IPV.

Injuries from sexual or physical IPV among women with SUDs are common. Research suggests that about 4 out of 10 women exposed to physical IPV, and about 1 out of 3 who experience sexual IPV report sustaining an IPV-related injury.^{5,22} Though research is sparse, some evidence suggests that substance use by a woman's partner may amplify her risk for IPV-related injuries.^{23,24} Injuries and other IPV-related health sequelae may increase the likelihood of women accessing health care. Roughly one-third of injured women reported receiving medical care, following sexual or physical assault by a partner.²² In addition, chronic health problems, stress, and health-damaging behaviors may result from injuries from IPV.^{4,16}

A recent meta-analysis found significant positive associations between IPV and HIV infection among women.²⁵ This review of 28 U.S. and international studies included a range of designs (cohort, cross-sectional, and case control), that included evaluation of physical, sexual, or any intimate partner violence (combined physical, sexual, and psychological) based on World Health Organization definitions as well as reported HIV infection, confirmed by a laboratory test. History of IPV has been positively associated with factors that potentially increase risk of HIV, including sexual risk behaviors and impaired ability to discuss health concerns and to negotiate with partners surrounding safe sex or protection from sexual transmission.^{1,17} Also noted was the increased risk of sexual transmission if injuries are present during forced sex with an HIV positive partner.^{1,17,25}

Findings across studies suggest that the heightened risk of exposure to IPV that exists among women with SUDs and/or partners with SUDs is also associated with a range of HIV-risk behaviors. These may include unprotected sex, sex with high-risk partners, greater number of sexual partners, sex in exchange for money, and increased prevalence of sexually transmitted infections.¹ Possible mechanisms underlying increased risk behaviors among women and their partners with SUDs include impaired judgment and ability to identify risk for sexual assault and reduced ability to negotiate condom use with partners while under the influence of substances. Unique factors identified with IPV and drug use, specifically, included potential dependence on partners for drug supply, coerced sexual behavior to obtain drugs as well as low status of drug-using women, which could further impede negotiation of condom use by partners.¹

Advancing Screening Tools to Identify IPV Among Women with SUDs

Within health care settings

Despite substantial research indicating significantly higher prevalence of all types and severity of IPV victimization among drug or alcohol dependent women and bidirectional associations between using different types of drugs and alcohol and IPV victimization,^{7,26} the availability and use of effective screening, brief interventions and coordinated systems of care to address these co-occurring problems in health care settings remain very limited. Although several IPV screening tools for women in health care settings have been evaluated and validated over the past decade, to our knowledge, only one IPV screening tool (the Jellinek Inventory for assessing Partner Violence [J-IPV] scale) has been validated with drug dependent women in a drug treatment setting.²⁷ Because the majority of women with SUDs never receive substance abuse treatment, it is important to extend the reach of IPV screening and brief interventions that target women with SUDs to health care settings where women with SUDs are more likely to receive services. Given the disproportionately large number of women with SUDs who receive emergency care services for injuries or medical or psychiatric problems related to IPV,²⁶ it is particularly important to introduce routine screening for IPV among women with SUDs in emergency care settings. Scaling routine screening for IPV in emergency care settings may significantly increase the identification of women with SUDs at risk of IPV and link them to appropriate IPV services and substance abuse treatment.

Further research is needed to investigate the validity of using brief integrated substance use and IPV screening tools to identify women with these co-occurring problems in primary or other health care settings. Research suggests similar organizational and environmental barriers to conducting screening for IPV among women in health care and substance abuse treatment settings that need to be considered when developing and implementing screening tools. These barriers include overburdened staff, lack of private screening space, lack of reimbursement for services, lack of adequate training of staff, lack of access to IPV referrals, and perceived lack of confidentiality.^{28,29}

Given the multiple barriers for providers screening for IPV and substance use in emergency or primary care settings, there may be significant advantages to using self-paced computerized IPV screening tools. Accumulating research among women in health care settings has found that self-paced computerized screening interviews are effective in increasing rates of IPV disclosure.^{6,30,31} However, computerized IPV screening tools have yet to be developed and tested among women with SUDs. Because of fear, stigma and potential legal consequences of disclosing IPV and drug use, self-paced computerized IPV tools may have an added advantage among women with SUDs. Further research is needed to evaluate the feasibility, acceptability, and effectiveness of using computerized versus face-to-face integrated IPV and SUD screening approaches in a range of health care settings. Screening tools for IPV also need to be developed and tested among diverse groups of women with SUDs varying by ethnicity/race, sexual orientation, type of drug, age, relationship status, maternal status, and class.

Researchers document ethnocultural differences with health care and other agency utilization for women experiencing IPV.³² Bent-Goodley³³ reviewed multilevel barriers facing ethnic and sexual minority women experiencing IPV. Individual barriers included the fact that women of color often seek help from informal rather than formal service providers and may report stigma regarding IPV within their respective communities. Institutional barriers included health care and provider stereotypes, lack of cultural competence/language barriers and systemic barriers included disparate treatment provided to impoverished and/or non-English speaking patients.

Conducting assessment, brief intervention, and improved linkage to appropriate services

Research suggests the relationships between IPV and substance use are bidirectional and complex, varying by type and severity of substance use and IPV and whether or not the perpetrator has an SUD. Assessment protocols to identify IPV need to consider different drug risk environments and contexts to inform what type of intervention and services might be needed to best address IPV and SUDs. Given the pivotal role that PTSD may play in increasing risk for IPV victimization and SUDs, assessment protocols should include screening for PTSD and other mental health problems to inform treatment planning. Screening protocols should consider sequencing the screening of SUDs, IPV and PTSD symptoms to inform assessment, treatment planning, and referrals.

Although research suggests that screening for IPV among women poses little risk or harm and is acceptable to women,³⁴

recent randomized controlled trials found that screening without linking women to appropriate services has no effect on improving quality of life and safety.^{35,36} This research suggests that routine screening for IPV in the absence of a routine intervention is not effective in reducing IPV mortality and morbidity.³⁴ A recent systematic review of 16 “brief” (described as 3 or fewer hours of contact) IPV interventions delivered in health care settings identified several common components: safety planning, increasing motivation, and setting goals to reduce IPV and improve safety, linking women to IPV-related services and increasing social support.³⁷ Because of significant methodological limitations, only six were included in the effectiveness review.³⁷ The outcomes of these interventions were mixed. The most consistently positive results were for increased use of safety behaviors (four out of six studies).³⁷ Two found significant reductions in exposure to IPV. Only one study found enhanced use of IPV related services.³⁷ This systematic review suggests that there remains a significant gap in research to identify effective brief interventions that may be scaled up in health care settings. To our knowledge, there are no such promising brief interventions, which have been found to be effective in addressing IPV among women with SUDs in health care settings.

Advancing evidence-based differential integrated interventions

Intervention approaches are needed to address the specific different combinations of substance use and IPV, with which women may present. Using drugs or alcohol as a way of coping with the pain or as a result of PTSD from IPV might suggest the need for a trauma-informed intervention that will improve self-regulation and coping skills to deal with negative thoughts and emotions.³⁸ Given the high rate of HIV and STIs among women with co-occurring IPV and SUDs, interventions need to consider the unique challenges women with SUDs encounter in protecting themselves during risky sexual or drug-related situations with abusive partners.¹

A recent meta-analysis of integrated IPV and substance abuse interventions among women identified 11 intervention studies that met review criteria.³⁹ All interventions were conducted with substance abuse treatment populations. Only two of the intervention studies found significant effects for reducing IPV;^{40,41} however, one of these had a small sample size ($n = 34$)⁴⁰ and one lacked a control group.⁴¹ Nine of the 11 studies tested trauma informed group-based intervention models (i.e., Seeking Safety, Trauma Recovery Empowerment Model [TREM] and the Triad Group model). The effect sizes on reducing IPV and substance use in these trauma-informed studies ranged from no effect to small size effects.³⁹

If mutual IPV is present generally, or specifically, if a woman and her partner are engaging in mutual IPV because they are experiencing withdrawal or fighting over drug supply, they may benefit from a couples-based intervention that addresses couple communication. Some preliminary research suggests that couple-based approaches may be promising by improving couple communication skills, negotiation skills, and problem solving skills to address these co-occurring problems.^{42,43} Although couples-based interventions have evoked considerable controversy in the IPV field, dyadic approaches have been found to be effective and safe in re-

ducing IPV.⁴⁴ A recent study that evaluated a group-based mutual IPV prevention intervention among 121 treatment mandated couples found that couples who had been assigned to receive the group-based mutual IPV prevention intervention for both partners reported fewer acts of male perpetration of violence on the Revised Conflict Tactics Scale at the 12-month follow up compared with couples where one or no partners received the group prevention intervention.⁴⁵ A meta-analysis of 12 randomized controlled trials found that couple-based treatments were more effective than individual treatments in reducing frequency of drug or alcohol use.⁴⁶ Future research is needed to further identify whether couple-based integrated IPV and SUD prevention approaches are safe and effective in health care and other settings.

Future Directions of Intervention Research

To our knowledge, there are no research studies that have evaluated evidence-based brief or extended integrated interventions that are designed to identify and address IPV among women with SUDs in health care settings. Future research needs to adapt and test the effectiveness of evidence-based brief IPV interventions in health care settings for women presenting with SUDs. Adapting and testing brief and extended interventions for ethnic minority women and women with same sex partners remains a critical area for future research. Services and implementation research using mixed methods approaches are also needed to identify multilevel factors that may facilitate or impede how organizations may implement such interventions. This research will inform future efforts to scale up these interventions to redress the co-occurring problems of IPV and SUDs among women in primary and emergency care settings.

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Address correspondence to:
Terri L. Weaver, PhD
Department of Psychology
Saint Louis University
3700 Lindell Boulevard
Morrissey Hall
Suite 2729
Saint Louis, MO 63108
E-mail: weavert@slu.edu