Sonya B. Norman
Kendall C. Wilkins
Kimberly Baeressen
Steven R. Thorp
Regina Huelsenbeck
Erin Grimes
Carie Rodgers
Carolyn Allard

Women's Issues

Drinking Among Female Victims of Intimate Partner Violence

Mechanisms and Intervention

Novinka

WOMEN'S ISSUES

DRINKING AMONG FEMALE VICTIMS OF INTIMATE PARTNER VIOLENCE: MECHANISMS AND INTERVENTION

SONYA B. NORMAN
KENDALL C. WILKINS
KIMBERLY BAERESSEN
STEVEN R. THORP
REGINA HANSEN BECK
ERIN GRIMES
CARIE RODGERS
AND
CAROLYN ALLARD

Nova Science Publishers, Inc.
New York

LIBRARY OF CONGRESS CATALOGING-IN-PUBLICATION DATA

Available upon Request
ISBN: 978-1-61761-332-6

Published by Nova Science Publishers, Inc. † New York

WOMEN'S ISSUES

DRINKING AMONG FEMALE VICTIMS OF INTIMATE PARTNER VIOLENCE: MECHANISMS AND INTERVENTION

WOMEN'S ISSUES

Additional books in this series can be found on Nova's website under the Series tab.

SUBSTANCE ABUSE ASSESSMENT, INTERVENTIONS AND TREATMENT

Additional books in this series can be found on Nova's website under the Series tab.

PREFACE

As many as 1/3 of women in the general population and 50% of women seen in primary care experience abuse by an intimate partner during adulthood. The consequences of having experienced intimate partner violence (IPV) are quite alarming. Female IPV victims represent one of the largest traumatized populations in the United States. More than 60% of women who present to domestic violence shelters meet criteria for posttraumatic stress disorder. Alcohol use among female victims of IPV is common in the form of heavy, moderate or episodic drinking and appears to be both an outcome of and a risk factor for trauma. This book reviews the problems commonly associated with IPV, psychosocial treatments designed to help IPV victims, and research regarding the relationship between drinking and IPV.

CONTENTS

INTRODUCTION

As many as 1/3 of women in the general population (Kubany, Hill, & Owens, 2003; Tjaden, 2000) and 50% of women seen in primary care (Coker, Smith, Bethea, King, & McKeown, 2000) experience abuse by an intimate partner during adulthood. The consequences of having experienced intimate partner violence (IPV) are quite alarming. Female IPV victims represent one of the largest traumatized populations in the U.S. (Council on Scientific Affairs, 1992). More than 60% of women who present to domestic violence shelters meet criteria for posttraumatic stress disorder (PTSD; Saunders, 1994).

Alcohol use among female victims of IPV is common in the form of heavy, moderate or episodic drinking and appears to be both an outcome of and a risk factor for trauma (El-Bassel et al., 2003). Researchers have found that female victims of IPV use drinking to cope with a variety of symptoms associated with trauma and PTSD. Motives for drinking among females with PTSD include coping with anxiety, managing conflict with others, and dealing with sleep problems. Overall, research suggests that drinking is used as a method to cope with psychological distress related to PTSD rather than to create positive experiences. While drinking may serve to decrease the intensity of uncomfortable posttraumatic symptoms, this relief is only temporary. In the long-term, using substances has been associated with increased psychological distress, functional impairments, adverse health outcomes, and greater vulnerability to revictimization. It is important to understand the relationship between drinking, IPV, and IPV-related posttraumatic distress to help prevent and treat alcohol and other trauma related problems in women who have been abused.

In this book, we review the problems commonly associated with IPV, psychosocial treatments designed to help IPV victims, and research

regarding the relationship between drinking and IPV. First, we review the prevalence of drinking and alcohol problems associated with IPV for women who are in the abusive relationship, transitioning out of such a relationship, and women who have terminated the abusive relationship. We then discuss the role of drinking in IPV and in trauma more generally. We review the literature on empirically supported psychosocial interventions for these three stages of IPV (i.e., current relationship, transitioning out, and terminated relationship) and organize our discussion around these three stages as well. Finally, we make recommendations for future research, specifically addressing the need for alcohol-related interventions for IPV victims.

For the purposes of this book, we address female victims of male violence. The review is focused in this way for a number of reasons: 85% of IPV victims are women (Greenfield, 1998), women suffer more severe physical injuries after IPV than men (Golding, 1999), and mental health sequelae for battered men have not been well researched (Golding, 1999). Little is known about mental health consequences of same-sex partner violence (Golding, 1999).

Chapter 1

PREVALENCE OF SOCIAL DRINKING AND ALCOHOL PROBLEMS ASSOCIATED WITH IPV

1. IN THE ABUSIVE RELATIONSHIP

Prevalence of substance use and abuse is rarely assessed while a woman is actively in the abusive relationship. Rather this data is assembled from baseline interviews and self reports when women access services, having left (or in the process of leaving) the abusive relationship. In one study, 72% of women (n=191) entering assorted domestic violence shelters reported substance use in the three months immediately prior to entering the shelter (Poole, Greaves, Jategaonkar, McCullough, & Chabot, 2008). In a sample of 360 women entering various substance abuse treatment facilities, 47% reported they were currently experiencing intimate partner violence (Swan, Farber, & Campbell, 2000). Likewise, of 676 women seeking protective orders (PO) against an abusive male intimate partner for abuse within the last year, 66% met criteria for DSM-IV-TR alcohol abuse/dependence (Shannon, Logan, Cole, & Walker, 2008). The women within this alcohol abuse/dependence group were also significantly more likely to have experienced sexual assault (33.8%) by an intimate partner within the last year than the women who reported some or no alcohol use (20-22%).

2. During Transition from an IPV Relationship

When transitioning from an IPV relationship, women often access services such as domestic violence shelters or substance abuse treatment facilities. This point of contact and the period immediately leading up to it may be the woman's highest period of stress and substance use (Poole et al., 2008). In general, it is estimated that 67-80% of women in substance abuse treatment facilities are victims of IPV (Cohen et al., 2003) and conversely that 25% to 50% of women receiving victim services for IPV have substance abuse problems (Bennett & Lawson, 1994, Downs, 2001; Ogle and Baer, 2003).

3. After Terminating the IPV Relationship

Substance use is 1.5 to 5.5 times more prevalent in women with trauma histories than without (Council, 1996; Najavits, Weiss, & Shaw, 1997). Women who have been victims of IPV are more likely than non-victimized women to have problems with alcohol and illicit drug abuse (Briere & Jordan, 2004; Golding, 1999; El-Bassel et al., 2003). In an emergency room sample of 90 women, El-Bassel and colleagues (2003) found that women who had been abused were more likely than non-abused women to report a history of regular crack, cocaine, and heroin use.

Although the literature overall suggest that having experienced IPV in the past is associated with problem drinking, one study found evidence that substance use decreases significantly shortly after terminating the IPV relationship. Poole et al. (2008) interviewed women (n=125) while they resided in one of 13 domestic violence (DV) shelters and three months after they left the shelter to track their substance use patterns. Women received DV counseling, including either a significant alcohol intervention or no/minimal alcohol intervention, depending on the shelter (no random assignment). Women reported significantly less substance use, specifically the frequency of alcohol and stimulant use, after leaving the shelter regardless of the type of intervention. Poole et al. highlight that this result was consistent for both the minimal alcohol intervention group and the significant alcohol intervention group.

Chapter 2

THE ROLE OF ALCOHOL IN IPV

People who have experienced traumatic events and developed PTSD may seek short-term escape or avoidance of affective states that are unpleasant, and this may take the form of substance use problems (Follette, 1994). The self-medication hypothesis predicts that alcohol use can provide short-term relief from PTSD symptoms and that drinking is thus maintained by negative reinforcement (McFarlane, 1998). However, many individuals report an expectation that drinking alcohol will generate positive physical and emotional feelings, with less emphasis on alcohol's ability to ameliorate negative emotions (Brown, Goldman, Inn, & Anderson, 1980).

Cooper, Russell, Skinner, & Windle (1992) proposed three types of drinking motives based on expectations: (1) social motives, which involve drinking due to custom in a social context or for celebration; (2) enhancement motives, which involve seeking positive affect (e.g., excitement, getting high, having fun); and (3) coping motives ("self-medication"), which involve seeking to reduce negative or painful emotions (e.g., cheering up when feeling down, forgetting worries). Cooper et al. found that enhancement motives and social motives were associated with drinking in social situations, and coping motives were associated with drinking alone. Enhancement motives were also associated with frequent, heavy drinking and use of marijuana, cocaine, and other stimulants, whereas coping motives were predictive of functional impairment and symptoms of tolerance and withdrawal and linked to greater use of barbiturates and tranquilizers. The researchers suggested that drinkers with enhancement motives may have more control over their drinking, perhaps due in part to more social feedback about their behavior.

Grayson & Nolen-Hoeksema (2005) suggest that an emotion regulation model of alcohol problems incorporates both the traditional focus on distress coping motives as well as the enhancement motives, and in testing this model found that indeed drinking with motives for both coping and enhancement partially mediated the association between childhood sexual abuse and drinking problems in women. Also consistent with a broad model of motivations for drinking, women with current PTSD reported greater expectancies that alcohol would reduce tension and had experienced more positive enhancement from alcohol compared to women without PTSD (Simpson, 2003). To underscore the importance of situational factors among women who were substance abusers, both PTSD symptoms and heavy alcohol use were higher in situations of physical discomfort, interpersonal conflict, and unpleasant emotions; PTSD symptoms were negatively correlated with heavy drinking when the women experienced pleasant emotions; and no link between PTSD symptoms and heavy alcohol use was apparent during pleasant social interactions or tempting-to-drink situations (Stewart, Conrod, Samoluk, Pihl, & Dongier, 2000). In a related vein, Marlatt & Gordon (1980) found that most cases of relapse among alcoholic individuals were triggered by negative events, though some were spurred by positive events such as celebrations or social gatherings.

Kaysen et al. (2007) examined drinking motives in a sample of women who had experienced IPV. The investigators limited their analyses to only the coping motives aspect of Cooper et al.'s (1992) model (which they stated was due to high correlations among scales measuring the three constructs and their theoretical interest in the coping scale), and found that coping motives mediated the association between drinking and trauma symptoms. Similarly, Ullman, Filipas, Townsend, & Starzynski (2006) found that women who had experienced sexual assault as adults were more likely to have drinking problems in addition to PTSD (as opposed to PTSD alone) if they believed that alcohol could help them cope and if they drank with the intention of reducing distress. Nishith, Resick, & Mueser (2001) found that coping motives for drinking (but not enhancement or social motives) among female rape victims were specifically associated with sleep disturbances (e.g., insomnia, nightmares, and physical discomfort) rather than with other symptoms of PTSD or depression.

Taken together, these findings suggest that a model of drinking problems among women who have experienced IPV (or other traumatic events) should incorporate motives of coping, enhancement, and social factors.

Chapter 3

PHYSICAL, EMOTIONAL AND FUNCTIONAL SEQUELAE ASSOCIATED WITH IPV

In addition to the role of drinking, it is also important to take into account all of the problems associated with IPV to fully consider how best to treat women who have experienced IPV. In this chapter, we review physical, emotional, and functional problems associated with IPV.

1. PHYSICAL SEQUELAE

Female victims of IPV perceive their physical health as poorer and report more somatic symptoms than non-traumatized women (Campbell, 2002). Women with present or past histories of IPV report higher rates of chronic illnesses including gastrointestinal and gynecological problems, respiratory disorders, migraines and other headaches, sexually transmitted diseases including HIV/AIDS, heart problems, hypertension, arthritis, and diabetes (Campbell, 2002; Campbell, Kub, Belknap, & Templin, 1997; Coker et al., 2000; Leserman, 2007; Salam, Alim, & Noguchi, 2006; Silverman, Decker, Saggurti, Balaiah, & Raj, 2008). IPV victims are more likely to suffer from chronic pain, including chronic pelvic pain, as well (Leserman, 2007; Meagher, 2004; Salam et al., 2006), and if pregnant during the abuse to experience miscarriages (Morland, Leskin, Block, Campbell, & Friedman, 2008).

The mechanisms by which IPV affects physical health are not fully understood. Some physical sequelae have an obvious direct link. Forty-two

percent of women who reported a physical assault by a partner sustained an injury in a nationally representative large scale phone survey study (Tjaden & Thoennes, 2000). These injuries take many forms, including traumatic brain injury. Seventy-four percent of battered women in one study sustained one partner-induced brain injury from their partner, and 51% sustained multiple brain injuries (Valera & Berenbaum, 2003). Many abusers become most violent when they are at risk of losing control over their victim (Fleury, Bybee, & Davidson, 1998). Therefore, women can be especially at risk when trying to leave the abuser. In a study of IPV victims in transition shelters, 92% had received blows to the head in the course of battering incidents, 68% had been severely shaken by the partner, and 40% had lost consciousness (Jackson, Philip, Nuttall, & Diller, 2004. According to the national data collected by the Centers for Disease Control and Prevention (2003) about 1,300 women lose their lives as a result of IPV in the U.S. each year. Another national data collection agency reported that more than 3 women are murdered by intimate partners every day (Bureau of Justice Statistics Crime Data Brief, 2003).

In addition to physical health problems directly related to injury, researchers have posited that the long-term stress of IPV may contribute to the development or exacerbation of physical health problems (Coker et al., 2000; Norman et al., 2006; Sutherland, Bybee, Sullivan, 2002). Initial research has revealed that PTSD symptoms mediate the association between IPV and proinflammatory cytokine levels (Woods et al., 2005). Researchers also have found a relationship between IPV and higher levels of evening cortisol and morning and evening dehydroepiandrosterone (DHEA), controlling for other potentially confounding factors including age, smoking, medications, lifetime history of victimization, and mental health status (Pico-Alfonso, Garcia-Linares, Celda-Navarro, Herbert, & Martinez, 2004). An association has also been shown to exist between trauma exposure and engaging in more negative health behaviors and fewer positive health behaviors (Lang et al., 2003). For example, IPV victims are more likely than women without abuse histories to engage in risky sexual behaviors (Rodgers, Norman, Thorp, Lebeck, & Lang, 2005).

2. EMOTIONAL SEQUELAE

The most prevalent mental health consequences of IPV are PTSD and depression (Marais, deVilliers, Moller, & Stein, 1999). Up to 90% of female victims of IPV have been found to meet criteria for PTSD at some time in

their lives (Astin, Lawrence, & Foy, 1993; Eisenstat & Bancroft, 1999; Fedovskiy, Higgins, & Paranjape, 2008; Gallop & Everett, 2001; Gorde, Helfrich, & Finlayson, 2004; Humphreys, Lee, Neylan, & Marmar, 2001; Jones, Hughes, & Unterstaller, 2001; Saunders & Kindy, 1993; Saunders, 1994; Stein & Kennedy, 2001). This prevalence rate is especially alarming when compared to lifetime estimates of PTSD in the general population, which are as high as 8-12% (Golding, 1999; Kessler et al., 2005). Lifetime prevalence of clinically significant depression symptoms have been reported to be as high as 70% in IPV victims (Briere & Jordan, 2004; Campbell et al., 1997; Helfrich, Fujiura, & Rutkowski-Kimtta, 2008; Gerlock, 1999; Golding, 1999; Peterson, Gazmararian, & Clark, 2001; Roberts, Lawerence, Williams, & Raphael, 1998; Stein & Kennedy, 2001; Zlotnick, Johnson, & Kohn, 2006), which stands in stark contrast to the 12% found in women in the general population (Kessler at el., 2005). Additionally, as many as 13% of IPV victims have comorbid PTSD and MDD (Stein & Kennedy, 2001).

Prevalence of anxiety disorders are as high as 54% in women with IPV histories (Helfrich et al., 2008; Gerlock, 1999; McCauley et al., 1995; Roberts et al., 1998) compared to 14% in women the general population (Kessler et al., 2005). Higher rates of insomnia, somatic symptomatology, hopelessness, dissociation, and suicidality, and lower self-esteem have been reported in women who have experienced IPV compared to non-abused women (Briere & Jordan, 2004; Golding, 1999; Hathaway et al., 2000; Herbert, Silver, & Ellard, 1991; Matud, 2005; Zlotnick et al., 2006). Female victims of IPV also are at a greater risk than women in the general population of having severe mental illness. In a study of women residing in a DV shelter 23% of residents reported having bipolar disorder compared to 0.7% of women in the general population; 14% had a personality disorder versus 0.6% of all U.S. women; and 3% had a diagnosis of schizophrenia and 8% paranoid or delusional disorder compared to 0.1% and 0.3%, respectively, in the general population of women (Helfrich et al., 2008).

3. Functional Sequelae

Another area of difficulty for IPV victims is daily functioning. IPV exposure is related to degree of impairment (Coker et al., 2000; Zlotnick et al., 2006). Thirty-five percent of women in a DV shelter identified themselves as disabled, compared to 4.6% American women in general (Helfrich et al., 2008). Women who experience IPV exhibit greater difficulty finding or keeping work, and decreased productivity, compared to U.S.

women overall (Gilson, DePoy, & Cramer, 2001; Helfrich et al., 2008; Lloyd, & Taluc, 1999; Riger, Raja, & Camacho, 2002; Wettersten et al., 2004; Wisner, Gilmer, Saltzman, & Zinc, 1999). Interpersonal problems are more commonly reported by IPV survivors and women in the general population (Helfrich et al., 2008). Compared to non-abused women, women who have experienced IPV are four times more likely to report housing instability, controlling for age, race and ethnicity, marital status and, notably, poverty (Pavao, Alvarez, Maumrind, Induni & Kimerling, 2007).

This functional impairment has been attributed to IPV correlates, including the common psychological sequelae mentioned earlier. Depression and anxiety disorders are associated with functioning difficulties and PTSD especially so (Byrne & Riggs, 1996; Norman, Davidson, & Stein, 2007; Rapaport , Clary, Fayyad, & Endicott, 2005; Stein, Walker, Hazen, & Forde, 1997; Zatzick et al., 1997). Among IPV victims in one study, those with PTSD reported more problems with physical functioning, mental health, vitality, role limitations due to emotional health, and social functioning, after controlling for SES, age, depression symptoms, and extent of abuse (Laffaye, Kennedy, & Stein, 2003). In another study, PTSD was found to mediate the relationship between IPV severity and resource loss (Johnson, Zlotnick, & Perez, 2008).

Other common characteristics of IPV victims that appear to contribute to functioning difficulties include isolation, guilt and shame, and learned helplessness. Women in abusive relationships are frequently isolated, either as part of the pattern of abuse or out of shame and embarrassment of their situation. As a result, women who are able to leave abusive relationships often find themselves without social support (Howard, Riger, Campbell, & Wasco, 2003). But even when social support and other resources are available, abused women appear to have a diminished ability to access and utilize them effectively (Perez & Johnson, 2008).

Women in abusive relationships learn helplessness, which can interfere with their ability to leave the abusive relationships and to function effectively once out. Abusers often try to control even the minutia of their victim's actions and behavior, thus, after leaving the relationship women may find themselves struggling to problem solve or take care of daily responsibilities independently, including finding and keeping employment and parenting (Kubany et al., 2003). Compared to women in the general population, IPV survivors tend to be less assertive, be less likely to advocate for themselves, exhibit fewer help-seeking behaviors, and have decreased ability to effectively use available resources (Foa, Cascardi, Zoellner, & Feeny, 2000; Kubany et al., 2003; Kubany et al., 2004). Researchers also