

# The Relationship Between Intimate Partner Violence and Substance Use

An Applied Research Paper

Echo A. Rivera, PhD

Center for Policy Research in Denver, CO

Heather Phillips, MA

Carole Warshaw, MD

Eleanor Lyon, PhD

Patricia J. Bland, MA, CDP

Orapan Kaewken, BA, LPN

National Center on Domestic Violence,  
Trauma & Mental Health

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# **The Relationship Between Intimate Partner Violence and Substance Use**

## **An Applied Research Paper**

### **SCOPE**

**This paper provides a summary of recent research on the relationship between intimate partner violence and substance use or substance use disorders. Next, caveats for interpreting this body of research are provided. The discussion examines methodological strengths and limitations of the existing research, and concludes with recommendations for future research and practice.**

# INTRODUCTION

Intimate partner violence (IPV) continues to be a pervasive public health and human rights issue. According to a recent survey by the Centers for Disease Control (CDC), 31% of U.S. women<sup>1</sup> will experience physical violence by an intimate partner during their lifetimes and 47% will experience psychological aggression (Breiding et al., 2014). Rates of IPV in same-gender relationships are similar to (or slightly higher than) those found in heterosexual relationships (Walters, Chen, & Breiding, 2013; for more information, please see Allen et al., 2007). IPV is best understood as an ongoing pattern of power and control in romantic relationships that is enforced by the use of abusive tactics, such as intimidation, threats, physical or sexual violence, isolation, economic abuse, stalking, psychological abuse, and coercion related to mental health and substance use (Bancroft, 2003; Johnson & Leone, 2005; Stark, 2007; Warshaw, Lyon, Bland, Phillips, & Hooper, 2014). The use of violent tactics to reinforce an ongoing dynamic of domination and intimidation can have profound effects—it is that pervasive, all-encompassing dynamic that survivors often say is the most devastating (Stark, 2007; Warshaw et al., 2014).

For many people, abuse by a partner is their first experience of victimization; for others, intimate partner violence occurs in the context of other lifetime trauma (Warshaw, Brasher, & Gil, 2009). Research suggests that survivors of IPV often experience multiple forms of interpersonal trauma throughout their lives, including abuse or neglect in childhood, sexual assault, intergenerational trauma, community violence, and/or witnessing family violence as a child (Becker et al., 2010; Chen et al., 2013; Edmund & Bland, 2011; Faulkner et al., 2014; Jackson et al., 2015; Lang et al., 2004). One study found that women who experienced abuse in childhood were 6 times more likely to report adult physical or sexual violence, as compared to women who did not report experiencing abuse in childhood (Kimerling et al., 2007). Furthermore,

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<sup>1</sup> Within heterosexual relationships, IPV is most often perpetrated by men against women (Black et al., 2011; Caldwell et al., 2012). When gender-specific language is used within this brief, it is reflective of the research being cited. This is not meant in any way to minimize or disregard the experiences of trans\* survivors, male survivors, LGBTQI survivors, or survivors in same-gender relationships.

**IPV is best understood as an ongoing pattern of power and control in romantic relationships.**

experiencing forms of societal oppression, such as discrimination based on race or ethnicity, class, sexual orientation, gender identity, immigration status, disability, or age, is often traumatic in itself (Edmund & Bland, 2011) and can limit access to services and supports (Stockman et al., 2015). While many survivors do heal and recover from the effects of IPV, it can have long-term effects on the health and well-being of survivors. Experiencing multiple forms of abuse, trauma, or violence can increase this risk.

Research has documented myriad adverse trauma-related physical and mental health effects resulting from IPV, including chronic pain, injury, depression, posttraumatic stress disorder (PTSD), and substance use (Black et al., 2011; Dutton, 2009; Dutton et al., 2006; Golding, 1999; Jones, Hughes, & Unterstaller, 2001; Phillips et al. 2014). For many survivors who use substances, it is a way to cope with the traumatic effects of abuse (Bennett & O'Brien, 2007; Schumacher & Holt, 2012,

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**For many survivors who use substances, it is a way to cope with the traumatic effects of abuse. Others are coerced into using by an abusive partner.**

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Warshaw et al., 2014, Wingwood et al., 2000). Others are coerced into using by an abusive partner who then sabotages their efforts toward recovery and threatens to undermine them with authorities (e.g., the police, treatment providers, the courts) by disclosing their substance use. These tactics are used to further control their partner and have a chilling effect on survivors' ability to access safety and support and to retain custody of their children (Warshaw et al., 2014). Emerging research demonstrates that substance use coercion is common within abusive relationships (Warshaw et al., 2014). While substance use coercion remains an emerging area of research in itself, it is an important contextual factor to consider when reviewing research on the relationship between IPV and substance use.

**“Substance use” is defined in this brief as the use of alcohol and/or other drugs.** It can be distinguished from “substance abuse,” which is defined variously by researchers and treatment providers, and is based on the quantity consumed or frequency of use. “Substance use disorder” (SUD) is the terminology found in the DSM-V, which combines the previous concepts of substance abuse and substance dependence (American Psychiatric Association, 2013). It should be noted that the terms substance use, abuse, and dependence are used in this paper to reflect those used in the research studies that have been cited.

<http://pubs.niaaa.nih.gov/publications/dsmfactsheet/dsmfact.pdf>

# CURRENT EVIDENCE: CO-EXISTING SUBSTANCE USE AND IPV

This section begins with data on the prevalence of co-existing IPV and substance use or substance use disorders, and then explains what is currently known about the relationship between substance use and experiencing IPV<sup>2</sup>. It also provides a summary of some of the complex issues being grappled with in this area of research, including the temporal relationship between IPV and substance use and the role of potentially confounding factors.

## HOW COMMONLY DO IPV AND SUBSTANCE USE CO-EXIST?

The co-existence of substance use and IPV has been established via prevalence estimates from a variety of sources, including national surveys, studies utilizing community samples, and studies of specific groups of people (e.g. IPV survivors; people seeking medical treatment, substance use disorder treatment, or community services). In studies of people who use or are dependent on substances, researchers have consistently found high rates of lifetime IPV (Burke, Thiemen, Gielen, et al. 2005; Cohen et al., 2003; El-Bassel, Gilbert, Wu, et al., 2005; Engstrom, El-Bassel, Gilbert, 2012; Stuart, et al. 2013). For example, in a study of men and women entering substance abuse treatment, 47% of the women reported having experienced victimization by an intimate partner at some point in their lives (Schneider & Burnette, 2009). Another study of women accessing substance abuse treatment services found that approximately 67% reported experiencing physical IPV in the past 6 months (Downs, 2001). In addition, a study of women who use injectable drugs found that 31% reported experiencing physical and sexual IPV in the previous year (Wagner et al., 2009), and a study of women who attended a methadone clinic found that 90% had experienced IPV in their lifetime (Engstrom, El-Bassel, Gilbert, 2012). In all cases, both the past-year and lifetime rates of IPV among people who use substances is considerably higher than those found in recent national surveys (Black et al., 2011; Breiding et al., 2014).

At the same time, many studies have found that women who have been abused by an intimate partner are more likely to use or become dependent on substances, as compared to women who have not experienced IPV (Anderson, 2002; Bonomi et al., 2006; Eby, 2004; Lipsky, Caetano, Field, & Larkin, 2005; Smith, Homish, Leonard, & Cornelius, 2012). This has been established through studies utilizing national or general community samples as well as samples of DV survivors in a

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<sup>2</sup> It is important to note that IPV has been defined and operationalized by the articles cited in a range of ways, some of which do not conceptualize coercive control as central to IPV. An analysis and critique of the measurement of IPV is included in the discussion section of this brief.

variety of settings. For example, a community-based study of low-income women found higher rates of substance abuse among IPV survivors (26%), as compared to those who had not experienced IPV (5%) (Eby, 2004). A 2012 national cohort study of 11,782 women found that, as compared to those with no history of IPV, women with a recent history of experiencing IPV had nearly six times the risk of problematic alcohol use (LaFlair et al., 2012). Similarly, results of a large national survey indicate that IPV survivors are two times as likely as those who have never been victimized to participate in alcohol treatment (Lipsky & Caetano, 2008).

Studies that focus solely on IPV survivors have yielded similar results. One study found higher rates of both past-year alcohol (18.1%) and drug (6.4%) dependence in a community sample of IPV survivors, as compared to the general population<sup>3</sup> (6.6% and 2.6% respectively) (Nathanson, Shorey, Tirone, & Rhatigan, 2012; SAMHSA, 2014). Furthermore, in a study of 174 DV shelter residents, 72% of women screened reported frequent alcohol or drug use, use of multiple substances, or a current alcohol or substance use-related problem (Poole et al., 2008). In 2007, Fowler conducted a study with 102 DV shelter residents incorporating well-validated questionnaires and diagnostic interviews focusing on substance use and abuse. Overall, 67.7% of women met the study's criteria for having a moderate to high risk for past-month substance abuse, and 55%-60% of women met the study's criteria for substance or alcohol dependence. Interestingly, even in this study of DV shelter residents, women's use of cocaine in the past month and women's total number of years of alcohol use were both significantly correlated with physical IPV.

In summary, the data as a whole indicate a high prevalence of co-existing IPV and substance use or abuse. However, the exact prevalence rates of substance use or abuse among IPV survivors vary from 18%-72%, and the prevalence rates of IPV among people using substances vary from 31%-90%. This variance is related to a number of significant differences in methodologies among studies, including the sample assessed (e.g., DV shelter residents, nationally representative surveys, IPV survivors in the community, people who use substances, women accessing methadone clinics); type of substance or substances studied (alcohol versus drugs or other substances); the way IPV is operationalized in each study; and the way that substance use, abuse, or dependence is defined and measured within each study.

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<sup>3</sup> Note: IPV survivors were not excluded from this general population survey and are therefore included in this estimate.

## WHAT DO WE KNOW ABOUT THE RELATIONSHIP BETWEEN IPV AND SPECIFIC SUBSTANCES?

Research has also been conducted on the relationship between IPV and the type of substance or substances used by survivors. Experiencing IPV is associated with increased alcohol use (Golinelli et al., 2008; Stuart et al., 2013; Temple et al., 2008; Wong et al., 2011), and abuse, heavy drinking, or dependence (Boden et al., 2012; Bonomi et al., 2006; El-Bassel et al., 2003; La Flair et al., 2012; Lipsky & Caetano, 2008; Reingle et al., 2012; Reingle-Gonzalez et al., 2014; Smith et al., 2012; Stuart et al., 2013; Vos et al., 2006; White & Chen, 2002). While the above studies found a significant statistical relationship between experiencing IPV and alcohol use, the strength of the relationship varied across studies. However, a recent systematic review and meta-analysis of 55 studies found an overall odds ratio (OR) of 1.80 for the association between adolescent and adult IPV and alcohol use (Devries et al., 2014). In other words, respondents were 1.8 times more likely to report alcohol use when they also reported being abused by an intimate partner.

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**Alcohol.** Youth and adults may be 1.8x more likely to use alcohol when they report abuse by an intimate partner.

**Drugs.** Results are mixed, and more research is needed.

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A number of studies also found that victimization by an intimate partner is related to drug use (Bonomi et al., 2006; Burke et al., 2005; El-Bassel et al., 2005; Engstrom et al., 2012; Golinelli et al., 2008; Lipsky et al., 2005; Lipsky & Caetano, 2008; Testa et al., 2003; Vos et al., 2006) and to drug abuse and dependence (El-Bassel et al., 2003; Lipsky & Caetano, 2008; Smith et al., 2012). While most studies reviewed examined drug use in general, a few looked at the relationship between experiencing IPV and the use of specific drugs. For example, a national survey found that survivors were significantly more likely to experience problems related to cannabis, cocaine, and opioid use, as compared to other substances (Smith, et al. 2012). In a longitudinal study of women attending a methadone clinic, those who reported previous IPV were approximately three times as likely to report subsequent frequent heroin use, as compared to women who did not report experiencing earlier IPV (El-Bassel, Gilbert, Wu, et al. 2005). However, overall the findings on the relationship between experiencing IPV and using drugs have been mixed, with marked variation across studies (Burke et al., 2005; El-Bassel et al., 2005; Lipsky et al., 2005; Smith et al., 2012; Stuart et al., 2013; Testa et al., 2003). No recent meta-analysis has tested the relationships among IPV and drug use, abuse, or dependence.



## WHAT IS THE TEMPORAL RELATIONSHIP BETWEEN IPV AND SUBSTANCE USE?

Although it is generally accepted that there is a relationship between IPV and substance use, the direction of this relationship is less clear (i.e., does IPV tend to precede substance use, or does

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**Evidence suggests that the relationship between IPV and substance use may be best categorized as bidirectional.**

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substance use tend to precede IPV?). In general, the findings in the literature are mixed. There is evidence that drug use (El-Bassel et al., 2005; Testa et al., 2003) and alcohol use (Devries et al., 2014; Temple et al., 2008; White & Chen, 2002) may precede abuse by an intimate partner, and that abstinence from alcohol may be related to a reduced risk of subsequent IPV (Cohen, Field, Campbell, & Hien, 2013). Conversely, there is evidence that experiencing IPV is related to later drug use (El-Bassel et al., 2005; Vos et al., 2006) and alcohol

abuse (Vos et al., 2006). However, one study found that alcohol use and abuse were unrelated to subsequent IPV victimization once drug use was accounted for (Testa et al., 2003), and that substance use was unrelated to subsequent IPV in the long term (i.e. 6 years later) (Testa et al., 2003). Other research suggests that IPV and substance use may have a bidirectional relationship. For example, a 2-year longitudinal study utilizing a national sample of women found that following a physical or sexual assault, women's alcohol and drug use increased, even among women with no previous substance use and no prior IPV history; this study also found that women's use of drugs or alcohol is related to an increased risk of experiencing a subsequent physical or sexual assault (Kilpatrick et al., 1997). The authors concluded that the use of alcohol and/or other drugs increases the risk of assault, and assault increases the risk of substance use. In sum, evidence suggests that there is a relationship between IPV and substance abuse, and that it may be best categorized as bidirectional (Cohen et al., 2013; Bennett & O'Brien, 2010; Kilpatrick et al., 1997). The degree of this impact varies, and research has yet to fully untangle the temporal relationship of IPV and substance abuse.

## CAUTIONS FOR INTERPRETING RESEARCH ON IPV AND SUBSTANCE USE/SUBSTANCE USE DISORDERS

While many studies found a relationship between abuse by an intimate partner and substance use or substance use disorders, it is important not to overstate these results. It should be noted that a substantial number of studies also found no relationship between women's experiences of IPV and

alcohol use (Boden et al., 2012; Lipsky et al., 2005), abuse, alcohol dependence (Boden et al., 2012; Burke et al., 2005; El-Bassel et al., 2003; Lipsky et al., 2005; T. Sullivan & Cavanaugh, 2009), or

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other drug abuse (González-Guarda, Peragallo, Urrutia, Vasquez, & Mitrani, 2008; Poole, Greaves, Jategaonkar, McCullough, & Chabot, 2008; T. Sullivan & Cavanaugh, 2009; Testa et al., 2003; Wingwood et al., 2000). For example, one study found that neither the length of abuse nor the severity of injuries sustained predicted regular or heavy alcohol use among IPV survivors (Kaysen et al., 2008). Devries and colleagues (2014) attributed these mixed results to the inconsistent measurement of substance use and abuse.

Overall, these studies controlled for a variety of demographic and potentially confounding factors, including education, race, housing status, childhood abuse, living with someone with problematic substance use, income, and age. The findings were mixed regarding the significance of each potentially confounding factor on the relationship between experiencing IPV and substance use or abuse. Generally, the most consistent finding is that the association between experiencing IPV and substance abuse decreases with age (Bonomi et al., 2006; Golinelli et al., 2008; La Flair et al., 2012; Martino et al., 2005; Testa et al., 2003).

In some cases, significant findings were rendered non-significant when other factors were accounted for in the statistical model, including cohabitation without marriage (El-Bassel et al., 2003; Lipsky et al., 2005; Testa et al., 2003) and previous IPV within the relationship (Testa et al., 2003). Interestingly, one longitudinal study controlled for victimization history and found that previous IPV was associated with greater odds of subsequent IPV by the same partner than was women's own substance abuse (Testa et al., 2003). In other words, abusive partners' previous perpetration of IPV—not survivors' substance use—was related to abusive partners' later perpetration of IPV. These findings suggest that in looking at the relationship between substance use and IPV, it is generally more appropriate to assess characteristics or behaviors of abusive partners, as well as their access to their partners or ex-partners, than to examine the characteristics or behaviors of survivors.

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**Abusive partners' previous  
perpetration of IPV,  
not survivors' substance use,  
was related to abusive  
partners' later perpetration of  
IPV**

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# ADDITIONAL FACTORS THAT MAY AFFECT THE RELATIONSHIP BETWEEN IPV AND SUBSTANCE USE

## MENTAL HEALTH CONDITIONS, INCLUDING DEPRESSION AND POSTTRAUMATIC STRESS DISORDER (PTSD)

Studies have consistently documented higher rates of trauma-related mental health conditions among survivors, as compared to those who have not experienced IPV (Beydoun et al., 2012; Dutton et al., 2006; Jones et al., 2001; see Phillips et al., 2014 for a review). Depression and PTSD are among the most common trauma-related mental health effects of experiencing IPV (Nathanson et al., 2012; Vos et al., 2006). Recent studies suggest that women who have experienced IPV have nearly three times the risk for developing major depressive disorder (Beydoun et al., 2012) or PTSD (Fedovskiy et al., 2008), as compared to women who have not experienced IPV. While research has consistently found elevated rates of PTSD and depression among survivors of IPV, rates are even higher among survivors who experience other types of trauma in addition to IPV (Beydoun et al., 2012; Black et al., 2011; Fedovskiy et al., 2008; Houry et al., 2006).

Evidence suggests that IPV, the use of substances among survivors, and trauma-related mental health conditions tend to co-exist, and that the relationships among these factors are both complex and interrelated (Connelly et al., 2013; Golder et al., 2012; Jaquier et al., 2015; Paranjape et al., 2007; Peters et al., 2012). Some evidence suggests that PTSD may mediate the relationship between IPV and problematic substance use (Sullivan & Holt, 2008). For example, a 2009 study by Sullivan and colleagues found that IPV was not directly (i.e., independently) related to drug or alcohol problems. However, they did find that PTSD mediated the relationship between physical and psychological IPV and problematic drug use. In other words, higher levels of physical and psychological IPV were related to an increased risk of PTSD, and higher levels of PTSD were related to higher risk of drug-related problems. Notably, in this analysis, PTSD did not mediate the relationship between IPV and alcohol-related problems.

Research also suggests that depression may play a role in the relationship between IPV and substance use. A large nationally representative survey of women found that experiencing IPV was related to an increased risk of having more severe problems related to alcohol use; however, in each case, this relationship was partially mediated by depression (La Flair et al., 2012). In other words, depression may be a salient factor in the development of alcohol-related problems among

survivors. In another study, women who reported IPV but no alcohol-related problems were 4 times more likely to report moderate or severe depressive symptoms as compared to women who reported no or low levels of IPV and no alcohol-related problems. Likewise, women who reported alcohol-related problems but no IPV had a similar risk ( $OR=4.3$ ) of moderate or severe depressive symptoms. However, women who reported both IPV and alcohol-related problems were over 8 times more likely to report moderate to severe depressive symptoms (Paranjape et al., 2007). This suggests that IPV, alcohol-related problems, and depression may have cumulative effects.

Several studies suggest that survivors may use substances as a way to cope with ongoing violence and mental health symptoms (Clements, 2004; Martino et al., 2005; Peters et al., 2012; Schumacher & Holt, 2012; Sullivan et al., 2009; Wingwood et al., 2000). However, survivors may use substances to cope with a range of interconnected stressors, including ongoing IPV and chronic mental health concerns such as PTSD and depression, as well as problems associated with housing or finances, limited social support, effects of childhood and other forms of trauma, and physical health conditions<sup>4</sup> that interfere with daily life (Poole et al., 2008). These life stressors are interrelated. For example, survivors dealing with trauma-related mental health concerns may use substances in part to manage anxiety or depression, yet substances

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### **Survivors who use substances and experience mental health concerns may face additional barriers to accessing supports and services.**

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may exacerbate existing mental health concerns over time (Sullivan & Holt, 2008) or increase survivors' risk of harm from their abusive partner, which may further worsen survivors' overall mental health (Bennett & Bland, 2008). These interrelated factors also may affect survivors' ability to access services and supports. Survivors experiencing isolation related to the combination of IPV, mental health concerns, and substance use may be less likely to seek assistance because of fear of arrest, deportation, or referral to a child welfare agency (Bennett & Bland, 2008). Also, due to the stigma that surrounds substance use, mental health concerns, and IPV, survivors may not be seen as credible when they do try to access sources of support—either informal (e.g., friends, families) or formal (e.g., substance use treatment agencies, DV shelters, healthcare organizations).

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<sup>4</sup> There is a growing body of research on the co-existence of positive HIV serostatus, substance use/substance use disorders, and IPV, which is referred to in the literature as the SAVA syndemic. All three factors have profound and synergistic effects on the health and well-being of women. The complexity of these issues merit more in-depth discussion than the scope of this paper allows. For a review of the SAVA epidemic, please see: Illangasekare, S., Burke, J., Chander, G., & Gielen, A. (2013). The syndemic effects of intimate partner violence, HIV/AIDS, and substance abuse on depression among low-income urban women. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 90(5), 934–47. doi:10.1007/s11524-013-9797-8.

## ABUSIVE PARTNERS' SUBSTANCE USE

The relationship between survivors' use of substances and experiences of IPV may be mediated by the substance use of their abusive partners. This is not to imply that substance use causes the perpetration of IPV—a more nuanced explanation and review of the relationship between substance use and IPV perpetration is beyond the scope of this brief and can be found elsewhere (Bennett & Bland, 2008; Humphreys, 2005). While one study found that the risk of IPV is additive when both survivors and their abusive partners use substances (Golinelli et al., 2008), the results are difficult to interpret as the analysis did not take coerced use or self-medication into account. However, other studies have found that IPV survivors report higher rates of substance use or abuse by their intimate partners, as compared to women who have not experienced IPV (42%-72% vs. 7%-15%, respectively) (Eby, 2004; Lipsky et al., 2005). Lipsky and colleagues (2005) initially found that women's drug use was associated with a 5.4 times increased risk of victimization. However, when women reported that their partners drank heavily, they were 5 times more likely to also report experiencing IPV. Thus, once abusive partners' substance use was accounted for, women's drug use was no longer associated with any significant risk of victimization. Similarly, women who reported that their partners use substances during sex were nearly 4 times more likely to also report IPV victimization, as compared to women who reported that their partners do not use substances during sex (González-Guarda et al., 2008). Notably, in this sample, women's substance use during sexual intercourse was unrelated to being abused. This is of particular interest given the elevated prevalence of women being pressured into using substances as part of coerced sexual activity (Warshaw et al., 2014).

## DISCUSSION

In general, there is evidence that IPV and substance use/substance use disorders tend to co-exist. However, merely focusing on IPV and substance use or substance use disorders may be misleading in its simplicity (Humphreys, 2005) as depression, PTSD, a history of experiencing IPV, and partners' substance use/substance use disorder may all be relevant to this topic. A more detailed discussion of the strengths and limitations of this body of research are presented next, along with cautions for interpreting it, followed by recommendations for practice and research.

### STRENGTHS AND LIMITATIONS OF EXISTING RESEARCH ON IPV AND SUBSTANCE USE

There are a number of strengths in the existing research on co-existing IPV and substance use. Several studies utilized a longitudinal design, which provided some insight into the temporal relationship between IPV and substance use or the development of substance use disorders (Boden et al., 2012; Cohen et al., 2013; El-Bassel et al., 2005; Engstrom et al., 2012; Kilpatrick et al., 1997; Martino et al., 2005; Reingle et al., 2012; Stuart et al., 2013; Temple et al., 2008; Testa et al., 2003; Vos et al., 2006; White & Chen, 2002). Another strength of this body of research is the range of samples and populations from which data are gathered. Nationally representative surveys, community samples, women seeking treatment for substance use disorders, and IPV survivors from the community were represented across these studies. Several studies included LGBTQI survivors (Bonomi et al., 2006; Burke et al., 2005; El-Bassel et al., 2005; Engstrom et al., 2012; Poole et al., 2008; Stuart et al., 2013; Wagner et al., 2009) and racially and ethnically diverse samples (Cohen et al., 2013; El-Bassel et al., 2003, 2005; Engstrom et al., 2012; Lipsky & Caetano, 2008); others conducted purposeful sampling of women of color (Burke et al., 2005; Golinelli et al., 2008; González-Guarda et al., 2008; Illangasekare, Burke, Chander, & Gielen, 2013; Wong et al., 2011) or low-income women of color (Burke et al., 2005; Golinelli et al., 2008). People who have been marginalized often have limited access to resources because of the effects of structural oppression. It is important that they are well represented in any research on IPV, substance use, and/or substance use disorder treatment, as structural oppression affects their access to, and experiences of, treatment and intervention.

The current research on co-existing IPV and substance use has several limitations, some of which have already been discussed (e.g., neglecting the role of partners' substance use). Three broader limitations are discussed next: (1) inadequate conceptualization and measurement of IPV, particularly the lack of measurement of coercive control and coercion related to substance use; (2)

inconsistent measurement of substance use and substance use disorders; and (3) lack of inclusion of LGBTQI survivors of IPV in research on trauma and substance use.

## Strengths of the Existing Research

- Many studies utilized a longitudinal design to better understand the temporal relationship between IPV and substance use
- Studies were conducted with a range of samples, including: women receiving substance use disorder treatment, community samples, survivors utilizing shelter services, and nationally-representative samples
- Some studies focused on groups underrepresented in this area of research, including racially and ethnically diverse samples

## Limitations of the Existing Research

- Inconsistent conceptualization and measurement of IPV
  - Many studies focused on decontextualized violent acts while neglecting coercive control
  - Many studies relied on the Conflict Tactics Scales (CTS, CTS-R)
  - Studies utilized a range of timeframes of IPV victimization (e.g., past 6 months, past year, lifetime), making it challenging to draw comparisons between studies
- Highly varied measurement of substance use and substance use disorders
  - Studies focused on varying points along the substance use-abuse-dependence continuum
  - Studies explored a range of substances, all of which have different use and addiction profiles
  - Studies utilized assessed substance use using a variety of measures that ranged from dichotomous variables to well-validated scales
  - Studies used different timeframes for substance use, abuse, or dependence
- Lack of inclusion of LGBTQI survivors of IPV in research on trauma and substance abuse
  - Some studies excluded LGBTQI survivors
  - Some studies did not specify whether LGBTQI survivors were included

## Inadequate conceptualization and measurement of IPV

The most pervasive limitation across studies is the inadequate conceptualization and measurement of IPV. For the most part, the measurement of IPV did not include or take into consideration the overarching pattern of coercive control that is central to IPV, and instead focused on a decontextualized subset of violent acts. For example, some researchers defined IPV solely in terms of physical violence (Anderson, 2002; Golinelli et al., 2008; La Flair et al., 2012; Lipsky & Caetano, 2008; Martino et al., 2005; O'Leary & Schumacher, 2003; Reingle et al., 2012; Smith et al., 2012;

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**Studies on IPV and substance use largely focused on a decontextualized subset of violent acts in defining IPV, neglecting the role of coercive control.**

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White & Chen, 2002) or discrete acts of physical and sexual violence (Boden et al., 2012; Burke et al., 2005; Cohen et al., 2013; El-Bassel et al., 2003, 2005; Lipsky et al., 2005; Reingle-Gonzalez et al., 2014; Stuart et al., 2013; Vos et al., 2006; Wong et al., 2011). Although adding measures of sexual violence has been an improvement over studies assessing only physical violence, ongoing coercive control and other nonphysical tactics perpetrated by abusive

partners or ex-partners were notably absent. Only a few studies assessed both physical violence and psychological abuse (Testa et al., 2003; Wagner et al., 2009) or physical, sexual and psychological IPV (Engstrom et al., 2012; González-Guarda et al., 2008; Peters et al., 2012; Poole et al., 2008; T. Sullivan & Cavanaugh, 2009; T. P. Sullivan & Holt, 2008; Temple et al., 2008).

The timeframe of victimization also differed across studies, from “lifetime” victimization (Bonomi et al., 2006; Burke et al., 2005; Engstrom et al., 2012; Testa et al., 2003; Vos et al., 2006; Wong et al., 2011); victimization in the previous six months (Engstrom et al., 2012; Golinelli et al., 2008; Nathanson et al., 2012; Peters et al., 2012; Stuart et al., 2013; T. Sullivan & Cavanaugh, 2009; T. P. Sullivan & Holt, 2008); in the past year (Boden et al., 2012; Connelly et al., 2013; El-Bassel et al., 2003; La Flair et al., 2012; Lipsky & Caetano, 2008; Testa et al., 2003; Vos et al., 2006; Wagner et al., 2009); and in the past five years (Bonomi et al., 2006). Many of these studies relied on one of the two versions of the Conflict Tactic Scale (CTS; Straus, Hamby, Boney-McCoy, & Sugarman, 1996; Straus, 1979) to measure IPV. The CTS is a widely used, standardized checklist of violent and aggressive behavior. The CTS, however, does not measure coercive control. As such, the CTS has been heavily criticized for lacking precision or accuracy in the assessment of IPV (Hamby, 2014; Hardesty et al., 2015; Myhill, 2015). Of the 27 studies discussed in the paper, only six used a measure that included at least one item that was intended to assess nonphysical/nonsexual domination or coercive control (Bonomi et al., 2006; Peters et al., 2012; Poole et al., 2008; T. Sullivan & Cavanaugh, 2009; T. P. Sullivan & Holt, 2008; Temple et al., 2008). None of these



studies included substance use coercion in their analysis. This inadequate measurement of IPV means that this body of research ultimately explains very little about the predictors and consequences of co-existing IPV and substance use disorders.

Additionally, some researchers tested the relationship between survivors' use of aggression and their substance use. However, these studies neglected the crucial role of ongoing coercive control and frequently relied upon data collected through the administration of the CTS to both partners in a relationship. These studies tended to frame IPV as either a "mutual violence" phenomenon or ignored the power-based context of IPV (see Myhill, 2015 for further information). Neglecting to include ongoing coercive control dynamics, some researchers found a relationship between survivors' aggression toward partners and their drug or alcohol use, abuse, or dependence (Boden et al., 2012; Lipsky & Caetano, 2008; Martino et al., 2005; Reingle et al., 2012; Smith et al., 2012; White & Chen, 2002). This can be potentially misleading, as research consistently demonstrates that survivors' use of aggression is connected to their partners' IPV perpetration (Caldwell et al., 2012; Swan & Snow, 2006). For example, a study found high IPV victimization rates among 105 women who were arrested for domestic violence, in batterer intervention programs, and also met criteria for hazardous drinking (Stuart et al., 2013). Specifically, 73% of these women reported experiencing physical IPV, and 29% reported experiencing sexual IPV (Stuart et al., 2013). Thus, understanding women's use of aggression within intimate relationships and substance use must be grounded in an understanding of coercive control.

## **Inconsistent measurement of substance use, abuse, dependence, and substance use disorder**

Issues related to the definition and measurement of substance use, substance abuse, substance dependence, and substance use disorder were similarly complex. For example, changes in conceptualizations of substance use disorders over time have contributed to cross-study differences in definitions and measurement.<sup>5</sup> In addition, researchers often focused on different aspects of the substance use/abuse/dependence/disorder continuum, again leading to variation in measurement across studies. In this sample, there were approximately 11 measures and categorizations of alcohol use, abuse, and dependence, and 14 for drug use, abuse, and dependence. To illustrate how problematic this can be when comparing results across studies, consider the following: Some studies used well-validated scales of substance dependence, while a

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<sup>5</sup> As noted previously, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders as an overarching category that includes: alcohol, tobacco, cannabis, stimulant, hallucinogen and opioid use disorders. A person is considered to have a substance use disorder when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and inability to meet major responsibilities at work, school, or home. Studies in this review often focused on particular forms of substance use as well as using older terminology that was appropriate at the time the research was conducted. <http://www.samhsa.gov/disorders/substance-use>

number of other studies dichotomized drug use as 1) never used any drugs of any kind over the lifespan or 2) used any kind of drug at least once over the lifespan. Devries and colleagues (2014) noted this problem in the study of alcohol in their meta-analysis. This presents a significant challenge to researchers interested in the co-existence of IPV and substance use, and future research is needed on the appropriate measurement of substance use and substance use disorders.

## **Lack of inclusion of LGBTQI survivors of IPV in research on trauma and substance use**

Some studies focused solely on heterosexual relationships and excluded LGBTQI survivors (Anderson, 2002; El-Bassel et al., 2003; Peters et al., 2012; Smith et al., 2012; T. Sullivan & Cavanaugh, 2009; T. P. Sullivan & Holt, 2008; Testa et al., 2003). Other studies did not specify whether people in same-gender relationships were included or excluded, thus rendering the experiences of LGBTQI survivors as invisible (Boden et al., 2012; Cohen et al., 2013; Eby, 2004; Golinelli et al., 2008; Illangasekare et al., 2013; La Flair et al., 2012; Lipsky et al., 2005; Lipsky & Caetano, 2008; Martino et al., 2005; Reingle-Gonzalez et al., 2014; Smith et al., 2012; Temple et al., 2008; Vos et al., 2006; White & Chen, 2002; Wong et al., 2011). Overall, even basic research on the relationship between IPV and substance use or substance use disorders among LGBTQI survivors is limited. Future research is needed more generally in this area, as well as on the intersections of IPV, substance use, discrimination and homophobia, and other forms of lifetime trauma among LGBTQI survivors.

## **RECOMMENDATIONS FOR SUBSTANCE USE DISORDER TREATMENT PROVIDERS**

It is important to acknowledge that most women do recover from abuse and demonstrate remarkable resilience in the face of significant barriers related to ongoing IPV. At the same time, survivors may also seek professional assistance to address substance use problems that interfere with daily life or contribute to mental or physical health concerns. Trauma-specific interventions provide promise for addressing a range of trauma-related mental health and co-occurring conditions (Dass-Brailsford & Myrick, 2010; Fowler & Faulkner, 2011; Macy & Goodbourn, 2012). However, the approaches used in such interventions may not always be helpful to survivors (Macy & Goodbourn, 2012; Warshaw et al., 2013). Without addressing the specific needs of survivors who are also dealing with an abusive partner, substance use disorder treatment may not be accessible or effective, or may even place survivors at greater risk for harm.

These intersecting issues are best addressed through gender-responsive coordinated, collaborative, or integrated services (Bennett & Bland, 2008; Bennett & O'Brien, 2007; Bennett & O'Brien, 2010;

Dass-Brailsford & Myrick, 2010; Downs, 2001; Fowler & Faulkner, 2011; Macy & Goodbourn, 2012; Schumacher & Holt, 2012) and gender-responsive peer supports that ideally are also culturally relevant and trauma-informed. To date, there are two gender-responsive trauma-informed substance use disorder treatment programs that have been rigorously evaluated with promising results: Women's Integrated Treatment (Covington, Burke, Keaton, & Norcott, 2008) and Seeking Safety (Najavits, 2007). However, studies on the effectiveness of modifications or adaptations for IPV survivors are still needed. A recent systematic review of trauma-focused interventions for IPV survivors (Warshaw, Sullivan & Rivera, 2013) identified only one that was developed specifically for survivors dealing with a substance use disorder: *Relapse Prevention and Relationship Safety* (RPRS; Gilbert et al., 2006). RPRS showed some promise in addressing women's substance abuse and IPV victimization (Gilbert et al., 2006).

In addition, there are a number of integrated services programs with a goal of addressing both substance use disorders and IPV. For example, the Integrated Services Project (ISP) at the University of Northern Iowa provides intensive technical assistance, training, and support to paired substance use disorder treatment providers and DV organizations in the same catchment area over a 2-year period (Downs & Rindels, 2014). It has had significant successes in addressing the complex needs of survivors who use substances and receive services from DV programs or substance use disorder treatment agencies. In summary, while there are both promising and evidence-based models for addressing both substance use disorders and IPV, there is currently a need for additional trauma-informed interventions that specifically address substance use disorders among IPV survivors, particularly interventions that are culturally specific and trauma informed. Published research on and evaluations of these interventions is also needed.

Furthermore, there are factors specific to ongoing IPV that influence survivors' access to, and outcomes of, substance use disorder treatment. A study of National Domestic Violence Hotline callers found that approximately 15% had attempted to seek help for substance use, and of them, 60% reported

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## Abusive partners may:

Undermine a survivor's efforts to achieve sobriety

Isolate a survivor from sources of support

Use a survivor's dependence on substances as a way to further their control

Use stigma around substance use to call a survivor's credibility into question, including in custody cases

Implicate a survivor in illegal activities, thus limiting access to law enforcement

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that their partner/ex-partner prevented or discouraged such treatment (Warshaw et al., 2014). It is essential that substance use disorder treatment providers understand that abusive partners often actively undermine a survivor's efforts to achieve sobriety, isolate a survivor from sources of support, and use a survivor's dependence on substances as a way to further control them. Abusive partners may also use the stigma around substance use to call a survivor's credibility into question, including in custody cases; or implicate a survivor in illegal activities, thus limiting access to law enforcement. Overall, substance use coercion has a chilling effect on survivors, limiting realistic options for creating a different life. The implications of substance use coercion may extend to a survivor's ability to access economic support, employment, or social support. This is in addition to the stigma that many people experience regarding substance use, as well as trauma-related feelings that may emerge as a result of being victimized and controlled (Warshaw & Brashler, 2009).

### **Recommendations for substance use disorder treatment providers**

- Ensure services are culturally relevant and trauma informed
- Incorporate gender-responsive coordinated, collaborative, or integrated services
- Utilize gender-responsive peer supports
- Understand IPV-specific factors that influence survivors' access to, and outcomes of, substance use disorder treatment

### **Gender-responsive coordinated, collaborative, or integrated services**

#### **Gender-responsive and trauma informed**

- Women's Integrated Treatment (Covington, et al., 2008)
- Seeking Safety (Najavits, 2007)

#### **IPV-integrated**

- Integrated Services Project (University of Northern Iowa; Downs & Rindels, 2014)

## **RECOMMENDATIONS FOR RESEARCH**

To date, the research in this area has largely focused on establishing a statistical relationship between IPV victimization and substance use; however, less research has been conducted to explore the underlying mechanisms that facilitate or affect this relationship. Future research is needed to develop a more nuanced and comprehensive understanding of the relationship between

IPV and substance use or substance use disorders. The following recommendations focus on ways that research in this area can be more accurate, comprehensive, and reflective of the diverse experiences of survivors who are dealing with substance use disorders.

Future research should begin by improving the measurement of IPV within studies. While the CTS is widely used and considered a standardized measure, it has been critiqued for being outdated and ill-equipped for measuring IPV as defined by coercive control (Hamby, 2014; Hardesty et al., 2015; Myhill, 2015). However, there are a number of scales that may be used in lieu of or in conjunction with the CTS in future research. These include: Women's Experiences with Battering scale (Coker, Pope, Smith, Sanderson, & Hussey, 2001); Sexual Experiences Survey (Koss, Gidycz, & Wisniewski, 1987); Psychological Maltreatment of Women Inventory (Tolman, 1989); Economic Abuse Scale (Adams et al., 2008); and Use of the Children Scale (Beeble, Bybee, & Sullivan, 2007). As compared to the CTS, these scales more accurately measure nonphysical and coercive IPV tactics and are more likely to yield more accurate information. Furthermore, as research on substance use coercion and mental health coercion is currently underrepresented in the literature, there are no validated tools available for measuring these tactics (Warshaw et al., 2014).

Furthermore, we recommend that future research extend beyond an individual-level conceptualization of the relationship between IPV and substance use. Rather than research that focuses simply on associations between demographic factors (e.g., educational level, age) and individual health behaviors, conditions, or characteristics (e.g., substance use, depression) of survivors and/or abusers, the field needs research findings that can be used to improve practice, policy, and research. Topics of particular interest include:

- The role of social support in the context of IPV and substance use/substance use disorders
- The ways that substance use coercion tactics limit survivors' access to law enforcement; one study found that police who responded to domestic violence calls were more likely to arrest women who were intoxicated than women who were not, even when they were identified as the victim (Houry, Reddy, & Parramore, 2006)
- The role of historical trauma, colonization, structural violence, and insidious trauma on survivors' use of substances and their experiences of trauma and IPV
- Culturally specific approaches to substance use disorders and IPV
- The intersection of IPV and substance use, with an emphasis on sexual coercion in the context of substance use.

Across all topics, future research should ensure that the experiences of people traditionally underrepresented in research and interventions—LGBTQI survivors, people of color, survivors who are immigrants or refugees—are well represented in their studies. These directions for future research would provide the field with a more comprehensive understanding of the relationship between IPV and substance use and substance use disorders.

## Recommendations for Research

- Improve IPV measurement by utilizing measures that include nonphysical and coercive IPV tactics
- Conduct research that extends beyond the individual-level
- Contribute to the improvement of practice and policy

## CONCLUSION

While most studies indicate a bidirectional relationship between IPV and substance use/substance use disorders, only a few elucidate the role IPV actually plays in survivors' use of substances. Depression, PTSD, partners' substance use/substance use disorders, and ongoing IPV victimization are important to consider, but more research is needed on these intersecting factors. Most studies failed to consider the role of coercive control (especially substance use coercion) on survivors' use of substances, which is partly due to the limited measures of IPV that are available. Future research must assess IPV as defined by an ongoing pattern of coercive control, including coercion specifically related to substance use. Furthermore, future research must incorporate a more nuanced understanding of trauma in the relationship between IPV and substance use/substance use disorders. This includes the complex intersections between substance use/substance use disorders and historical trauma, structural violence, IPV, and other forms of interpersonal trauma. Practitioners and social service systems must continue to develop coordinated, collaborative, or integrated treatments that are gender-responsive, trauma informed, culturally attuned, and specifically designed to address the needs of IPV survivors. Finally, practitioners and researchers must consider factors beyond the individual level that will improve policy and practice and ultimately promote IPV survivors' empowerment, healing, and well-being.

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