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**Substance Abuse and Conjugal
Violence : Literature and the
Situation in Quebec**

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**Substance Abuse and Conjugal
Violence : Literature and the
Situation in Quebec**

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PREFACE

The *Comité permanent de lutte à la toxicomanie*'s mandate is primarily to advise the Health and Social Services Minister and the Delegated Minister for Health, Social Services and Youth Protection on the principal strategies to adopt in the fight against substance abuse, and to suggest priorities with regard to action or areas of intervention. In order to fulfill its mandate, the *Comité* studies the evolution of the causes and adverse effects of drug abuse in Quebec. It focuses both on problems linked to the use and abuse of psychoactive substances and on the measures that should be taken to find solutions to these problems. The *Comité permanent* takes into consideration research data, the opinions of the various stakeholders and experts involved in the field, and those of the general population of Quebec.

In keeping with its mandate, the *Comité* regularly undertakes studies aimed at better understanding and clarifying links between drug addiction and certain other problems. In this perspective, it commissioned the study on "Substance abuse and Conjugal Violence". The study's objective is two-fold : to clarify links between the two phenomena and define intervention strategies.

INTRODUCTION

The association between conjugal and familial violence and psychoactive substance use has been documented in both the research and clinical communities involved in these problem areas. As a general rule, two main features mark this relationship. First, there is a strong correlation between conjugal violence and the use of alcohol and, in some cases, drugs. Second, intervention in one problem area is often complicated by the presence of the other problem. Given the added risks and huge human and social costs associated with both behaviors individually or together, a concerted strategy for research and intervention is clearly warranted.

A vast literature exists on alcohol-related violence. Yet, the literature on the conjugal violence-substance abuse linkage is segmented along conceptual (e.g., social, biological, psychiatric), scientific, academic and clinical domains, often with little communication between them. The debate on the intervention strategies for concomitant conjugal violence and substance abuse often has been divisive and ideological. It is with the desire to promote an interdisciplinary and integrative perspective that the *Comité permanent de lutte à la toxicomanie* has commissioned a series of reviews to explore the relationship between substance abuse and the variety of other physical and mental health problems that often accompany it.

The present work targets four main objectives :

1. to provide an overview of the epidemiology of the conjugal violence-substance use phenomenon in Quebec, Canada and the US;
2. to summarize recent theoretical perspectives on the contributory underpinnings of concomitant conjugal violence and substance use;
3. to present data on the present situation in Quebec with respect to the service delivery network positioned to deal with those individuals affected by both conjugal violence and substance abuse;
4. to explore current thinking about how to address both conjugal violence or substance abuse in existing intervention settings.

The data presented in this document are drawn from two principle sources : a) a review of the literature using such databases as Medline and PsychLit, as well as key journals likely to have contributions addressing simultaneous conjugal violence and substance use problems; and b) a survey questionnaire sent to the directors of all organizations in Quebec likely to be involved in either conjugal violence and/or substance abuse as part of their primary mission. The questions employed in this poll were drawn (with permission) from a survey previously conducted by Dr. William Bennett, which explored the level of integration between the agencies well positioned to intervene in substance abuse and conjugal violence in the state of Illinois. In this way, along with key data about how the service delivery network is grappling with concomitant violence and substance abuse, the generalization of the findings could be appraised.

Conjugal violence is but one form of violence that may occur in an interpersonal-familial context. Moreover, many variations of partner violence are known to clinicians (e.g., female-to-male violence, male-to-male, female-to-female violence, and date rape), each with their specific attributes, dynamics and risks. It is beyond the scope of this document to provide an exhaustive review of the epidemiology, etiology, and treatment literatures of the all forms of interpersonal, familial or conjugal violence that may accompany substance abuse. In the context of co-existing substance abuse and conjugal violence, the main focus of this study is adult male-to-female couple violence, arguably the most prevalent form of violence that occurs in the family or couple context. This is not meant to trivialize other forms of partner and familial violence, but rather to delineate a manageable scope for this monograph. In addition, our purview with respect to intervention focuses mainly on secondary and tertiary prevention. Primary prevention in this area, though extremely important, is not targeted.

1.1 CONCEPTUAL AND METHODOLOGICAL ISSUES IN RESEARCH ON SUBSTANCE ABUSE AND CONJUGAL VIOLENCE

A body of literature exists that attempts delineate the scope and character of the substance abuse and conjugal violence linkage. However, the study of these problems is fraught with many methodological challenges that nuance our understanding of the phenomenon. These issues, and the effect they may have on our understanding are discussed below.

1.1.1 Measurement

Both common and distinct factors complicate our ability to clarify the scope and nature of spouse abuse and substance abuse. Among the many factors that may confound attempts to understand the incidence and nature of spousal abuse, differences in the criteria employed to identify conjugal violence and abuse is preeminent (Hegarty & Roberts, 1998). No formal diagnostic classification exists for conjugal violence. One definition of conjugal violence is any use of physical force (minimally at the level of a push or shove) against the spouse or partner. Though arguably possessing some face validity and providing a clear unidimensional and dichotomous framework for establishing violence, this definition has been criticized as being too restrictive (Rosenbaum, 1988). In contrast, Baron (1977) conceptualized aggression as being «... any form of behavior directed toward the goal of harming another living being who is motivated to avoid such treatment». This broader lower threshold framework in the context of battering therefore encompasses other dimensions of behavior that engenders significant harm for another and shares the same aims as physical battering (e.g., control, erosion of self-esteem). Accordingly, Edleson and Syers (1991) included any : a) threats of violence; b) physical violence; or 3) psychological abuse (e.g., inappropriate control) as a threshold for violent/abusive behavior.

Other theorists (Stark & Flitcraft; 1991), while espousing a similar position with respect to abuse, have further elaborated the distinction between physical abuse and battering. According to their purview, spouse abuse is the use of physical force in intimate

relationships among adults. Battering, in contrast, refers to a syndrome of maladjusted behaviors that accompanies spouse abuse that aim at the control and increasing entrapment of one partner over another. Thus, battering is associated with devastating long-term physical and psychological consequences including injury, rape, general medical complaints, isolation, stress-related psychosocial problems (e.g., substance abuse, attempted suicide, depression, anxiety and child abuse) and unsuccessful help-seeking. While either partner may be abused, the control and entrapment that characterizes the battering syndrome has been identified as a problem only in abusive male-to-female relationships.

Given the huge number of behavioral possibilities subsumed under partner abuse (Roizon, 1997), what definition is used will inevitably bear on not only what behaviors are targeted, but the nature of the consequences associated with those behaviors and our understanding of and responses to abuse. For example, a "zero tolerance" definition that includes any and all partner-directed violent acts, from verbal to the most vicious physical assaults, ironically may result in comparable rates of abuse between men and women (Stark & Flitcraft, 1991). Moreover, occasional outbursts from husbands or wives involving violent language may have a significantly different impact on the partner and the family compared to chronic battering and systematic patterns of patriarchal terrorism and/or physical violence. Thus, while an inclusive definition has some intuitive appeal, behaviors that are associated with immediate risks for the safety of the partner and the family may not be differentiated from other abusive acts with less dire consequences (Hegarty & Roberts, 1998).

Clarification of partner violence is further clouded by the fact that behaviors considered "violent" are influenced by legal, cultural and individual factors. For example, sexual abuse does not legally exist within marriage in many cultures, while many women fail to label forced sexual activities within their marital relationship as "abuse". Besides these social and personal sources of bias, the researcher's disciplinary perspective may also influence the purview adopted in the study of abuse. Family violence-oriented quantitative researchers frequently embrace a broader, more inclusive definition involving any act of violence whether verbal or physical. In contrast, feminist-qualitative

researchers tend to focus more on the sexual and emotional substrates of violence, while epidemiologists tend to target more easily quantifiable and obvious forms of physical aggression (Hanneke & Shields, 1985). Overall, these inconsistencies hinder the systematic aggregation of data to clearly map out the extent, nature and consequences of the partner abuse phenomenon.

With respect to alcohol and drug use, the availability and general acceptance of several objective indices of consumption (e.g., blood and urine levels of alcohol) circumvent many of the problems encountered with the measurement of violence. Moreover, valid and reliable measurement based upon self-report, observer reports and the possibility of formal diagnosis based upon established nosology (e.g., DSM IV; ICM-9) have emerged after several decades of research and development. Both the acute and chronic consequences of drinking and drug use may also be documented. However, there is growing concern in the violence research community that other dimensions of use which may be more pertinent to our understanding of the scope and nature of the substance use-conjugal violence nexus (e.g., substance abuse patterns, the context of consumption and expectancies of alcohol's effects) are rarely documented.

The tendency for individuals to minimize problems related to spousal and substance abuse (Edleson & Brygger, 1986; Lindquist et al., 1997) is well documented. Thus, surveys attempting to document the scope of spousal and substance abuse in population and in special samples are likely to underestimate the extent or severity of the dual-problem phenomenon. In the absence of objective measures, even the collection of corroborative data from the spouse about partner violence fails to resolve this dilemma. The often inconsistent reporting of violence between partners poses an additional predicament for investigators : namely, which partner's self-report should we consider as more reliable ? Moreover, the retrospective nature of self-report also may introduce important discrepancies in the accuracy of the data (Leonard & Jacob, 1988), especially given the cognitive disruptions with acute or chronic alcohol and drug use.

1.1.2 Sampling

In studies where the dual-problem phenomenon has been explored, the above difficulties are compounded by a number of additional factors. Empirical study of men with substance abuse and marital violence problems remains relatively scarce. Moreover, the preponderance of studies addressing both substance abuse and violence tend to use small sample sizes or specific samples of convenience (e.g., clinical and forensic samples of men, hospital samples of women). The conduct of research in such clinical settings may introduce additional biases. Accessibility, screening and referral procedures may vary broadly from one treatment setting to another, therefore limiting the pertinence of findings from one site to other settings. Using samples drawn from multiple sites or selecting more homogeneous samples may diminish the impact of this type of sample bias. However, the reliance on "event-based" samples (i.e., samples in which an important "event" has occurred such as treatment, shelters, prison, emergency rooms) may favor observation of more severe substance use and violence problems (Roizon, 1997). Consequently, such confounds may influence our understanding of the actual relationship between alcohol, drugs and conjugal violence (Leonard & Jacob, 1988).

The recruitment of homogeneous samples, while increasing internal validity, does so at the expense of external validity (i.e., the generalizability of the findings from one setting to another). For example, the preponderance of studies targeting the dual-problem phenomenon have focussed on men who abuse only alcohol (Pernanen, 1991). If the use of only alcohol was predominant in the settings where concomitant substance abuse-conjugal violence is investigated, such a purview might be defensible. However, in many of these settings (e.g., substance abuse treatment and prisons), multiple drug abuse has become the norm while the prevalence of "pure" alcoholism has receded (Brochu & Guyon, 1998; Brown, Seraganian & Tremblay, 1994; Roizon, 1997). Moreover, several strands of evidence suggest that the types of substances abused (Bennett et al., 1994) and specific patterns of consumption (Leonard, 1993) may influence the nature and severity of marital abuse as well as other violent behaviors. Although acknowledgment of the heterogeneity of men who batter is also growing (Hamberger & Hastings, 1991), systematic study of more naturalistic samples of men who abuse alcohol and/or other

drugs as well as batter remains uncommon (Gleason, 1997). Overall, the use of both «event-based' samples and/or precise subgroups limit our ability to generalize the findings to all individuals in the community or discern the real relationship between substance use and conjugal violence.

Along with problems of measurement and sampling, epidemiological study of substance use and conjugal violence also suffers from additional constraints. Foremost is the relatively low incidence of important cases of concomitant conjugal violence and substance abuse. As the phenomenon of interest becomes rarer, which may be particularly true when studying a relationship between two simultaneous events, (i.e., substance abuse X conjugal violence), samples would have to be very large to capture sufficient cases. The cost of conducting such a large survey argues against inclusion of relevant questions about concomitant substance abuse and conjugal violence. Added to this problem is the fact that neither violent behavior nor substance use behavior is randomly distributed in the population. For example, both substance abuse and violence are highly correlated with a number of sociodemographic characteristics, including gender, poverty and age (Pernanen, 1991). Consequently, targeting the relationship between substance use and conjugal violence may invariably bias the sampling of relevant cases (Roizon, 1997). Of course, how obtainable such individuals are for surveys is also uncertain.

1.2 EPIDEMIOLOGICAL AND CLINICAL DATA

With the above methodological considerations in mind, the discussion now turns to a consideration of the available epidemiological and clinical data with respect to conjugal violence, substance abuse, and concomitant substance abuse and conjugal violence.

1.2.1 Spousal abuse

For many of the reasons highlighted above, no periodic, standardized databases on the extent of spouse abuse currently exist. Nevertheless, a number of studies have attempted to estimate the scope of spouse abuse in the community. In the US population, Straus and his colleagues (1980) estimated that between 12 to 20 % of couples experience abuse, 3,8 % of wives are victims of spouse abuse, and 12,6 % of couples have ever experienced

severe violence. Another report has estimated that approximately 30 % of married women and 20 % of unmarried women have been victims of physical abuse perpetrated by their partners at some point in their relationship (Ponzetti, Cate & Koval, 1982). Similar to rates reported by Straus et al., (1980), data garnered from the National Crime Survey (Gauquin, 1977-78; Dutton, 1992) revealed a 3,9 % rate of severe violence perpetrated by husbands on their wives. Elsewhere, the one-year prevalence of conjugal violence in the general population has been estimated at between 16 % (Straus & Gelles, 1990) and 22 % (Meredith, Abbott & Adams, 1986), while a prevalence rate of between 2,1 % to 28 %, depending on definition of domestic violence, has been reported in Australia (Hegarty & Roberts, 1998). Finally, an analysis of U.S. data drawn from a variety of sources, including the Federal Bureau of Investigation (FBI) and the Bureau of Census, revealed that between 1979 and 1981, 8,8 % of all fatal homicides in the US involved a male partner murdering his spouse (Mercy & Saltzman, 1989).

In Canada, the available data on partner abuse is for the most part consistent with those in the US. A survey using the Conflict Tactics Scale conducted in Alberta (Kennedy & Dutton, 1989) estimated an 11,2 % rate of husband-to-wife violence when considering all self-reported aggressive acts. In Quebec, estimates of the incidence of abuse among women in a relationship range from between 10 to 15 %, while approximately 40 % of all women living in Quebec report having experienced sexual or physical abuse in a relationship at some time in their life (Statistics Canada, 1993).

It is estimated that less than 5 % of battered women are detected by their health care professional (Flitcraft, 1990). Thus, precise data of spouse abuse in health settings is difficult to acquire. Nevertheless, the increased awareness of the potential role for primary care settings and professionals in case finding for domestic violence has led to programs of systematic screening (Spinola et al., 1998; Oriel & Fleming, 1998). For example, in a study involving 101 women consecutively admitted for non-trauma in-patient medical treatment in a major urban teaching hospital study, 26 % reported affirmatively when asked a single question : «At any time, has a husband or partner ever hit you, kicked you or physically hurt you ?» (McKenzie et al., 1998). Another study of men presenting for medical treatment in an emergency room setting, 13,5 % of men disclosed having

perpetrated partner violence, with 4,2 % admitting to having committed severe violence (Oriol & Fleming, 1998). Elsewhere, in a review of studies exploring battering in women seeking prenatal care, it was found that between 4 % to 24 % of women reported incidence of violence when asked (El-Bayoumi et al., 1998).

Estimates of the incidence of husband abuse are inconclusive. A comparatively low rate of 0,3 % for male victimization has been posited (Dutton, 1992). In contrast, using a broad range of any aggressive acts, some investigators have estimated equivalent rates of victimization between females and males (Stark & Flitcraft; 1991). Such variations in the rate of female perpetrated violence may be explained by differences in how men and women define "violence" and the reluctance of some men to admit to being battered by their female partners. Irrespective of the comparability of some reports of perpetration rates between males and females, the type of assault and gravity of resulting injury appears significantly related to the gender of the partner who perpetrates the assault. For example, in one study of male victims presenting in emergency rooms, the nature of injuries were characteristically less severe than those typically reported by female victims. Moreover, male victimization often occurred when both partners were abusive (Muelleman & Burgess, 1998). Such findings suggest the possibility that female-perpetrated abuse is often self-defensive in nature. More tellingly, husbands or male intimate partners commit 50 % of all murders perpetrated against women, appreciably more than the 11 % of men murdered by their wives or intimate partners (Statistics Canada, 1993).

While it is beyond the scope of this report to provide a comprehensive review of the epidemiology of conjugal violence in the population, it is noteworthy that risk for domestic violence and associated problems can vary considerably along age, gender, socioeconomic and cultural lines, among other factors.

1.2.2 Substance Abuse

In contrast to spousal abuse, more precise and periodic epidemiological data on alcohol use and abuse are available. Precision in the definitions, concepts and diagnostic criteria of alcohol use, abuse and dependence has contributed considerably to the reliability and utility of data on drinking patterns in the population. According to data gathered from American adults 18 years or older in the National Alcohol Survey of 1990 (Midanik & Clark, 1994), 6,5 % of males and 1,4 % of females reported drinking five or more drinks at least once a week during the previous year. With respect to interpersonal, financial, loss of control of drinking, binge drinking and alcohol-related health problems and accidents, three or more drinking related problems were reported by 9,9 % of males and 5,1 % of females, while two or more social consequences were reported by 16,1 % of males and 9,2 % of the females (Midanik & Clark, 1995). Population prevalence data derived from the Longitudinal Alcohol Epidemiology Survey of 1992 revealed that 4,7 % and 11 % of males and 1,5 % and 4,1 % of females fulfilled the DSM IV diagnostic criteria for alcohol abuse and dependence respectively (Grant et al., 1994).

In Quebec, a recent population survey (Santé Québec, 1995) revealed that approximately 38 % of males and 15 % of females over the age of 15 admitted to having consumed five or more standard drinks of alcohol on five or more episodes in the last year. Moreover, 19 % of males and 7,4 % of females had CAGE scores suggestive of a high risk for negative consequences due to their drinking. Furthermore, 2,5 % of males and less than 1 % of females can be classified as "heavy drinkers" (i.e., consuming 29 or more drinks per week). With respect to illicit drug use, 14 % of males and 11 % of females admit to the consumption of any type of drug. Similar to conjugal violence, it is noteworthy that risk for substance abuse and associated problems vary considerably along age, gender, socioeconomic, cultural and psychiatric characteristics among others.

1.2.3 Concomitant substance abuse and conjugal violence in men

The frequent coexistence of substance abuse and conjugal violence has been documented for some time. For example, in a review of some 52 studies dealing with predictors of

husband to wife violence, alcohol abuse emerged as one of four consistent risk markers (Hotaling & Sugarman, 1986). In a random household survey, 70 % of husbands who had severely assaulted their wives reported being drunk one or more times in the previous year compared to 50 % of men who engaged in more moderate violence and 31 % of men who did not victimize their spouses (Kantor & Straus, 1989). In a study of a sample of males recruited from the community, higher consumption of alcohol significantly differentiated between men who committed domestic violence with those whose violent crime did not involve the spouse (Fagan, Barnett & Patton, 1988). The authors also documented that half of the maritally violent men admitted that drinking was occasionally coupled to marital abuse, while a third reported that alcohol and violence were often or very often coupled. Pernalen's (1991) study of Thunder Bay residents yielded a similar finding; namely that alcohol was found to be present concurrently in about half of all episodes of marital violence.

An extensive clinical literature deals with substance abuse, mostly alcohol, among those in treatment for conjugal violence. For example, one study found that frequent alcohol use by the husband was the most significant predictor of wife battering in a sample of couples seeking psychiatric assistance for marital conflict (Coleman, Weinman & Hsi, 1980). In another study, 68 % of males attending an alcoholism treatment center and who were either married or had been in a relationship for at least three months admitted to having "slapped or pushed their partners one or more times", while another 38 % acknowledged having hit their partners with fists or feet (Powers, Schlessinger & Benson, 1983). In a recent study of men seeking counseling for conjugal violence, 63 % were found to fulfill DSM-III-R diagnostic criteria for a substance dependence while 6 % presented with a substance abuse disorder (Brown et al., 1999a). Moreover, among the men with a current diagnosis, slightly more than half reported a pattern of multiple substance dependency involving both alcohol and other drugs. Only 30 % reported problematic alcohol use alone. By comparison, in an earlier study of men seeking counseling for their abusive behavior towards their partners, 59 % were reported to abuse alcohol while only 18 % were said to abuse other drugs (Fitch & Papantonio, 1983). These findings suggest that the trend for the increased prevalence of multiple substance abuse in contemporary

substance abuse treatment milieus (Miller & Bennett, 1996) is also being confronted in conjugal violence settings.

The relationship between marital violence and substance abuse has been noted in men seeking treatment for substance use disorders as well. For example, a survey of 108 men receiving alcoholism treatment found that 83 % had been violent in a relationship in the past, while 55 % had been violent in the past year (Livingston, 1986). Another series of studies examined violent substance abusers receiving services in either violence or substance treatment settings (Brown et al., 1998). Fifty-eight percent of men in treatment for their substance abuse reported at least one incident of serious physical familial violence in the past year, while 100 % of the men reported one or more battering behaviors.

1.2.4 Concomitant substance abuse and conjugal violence in women

The increased risk of substance abuse accompanying victimization, particularly in women, has also been investigated. In one study, women recruited from substance abuse treatment and AA were compared to a random household sample (Miller, Downs & Gondoli, 1989). Women with alcohol problems were more likely to report being victims of spousal abuse of one form or other, even when other demographic factors and their partners' drinking status had been accounted for. In a sample of abused women seeking health services, 46 % of severely assaulted women had been drunk one or more times in the previous year, compared to 36 % of minor violence victims and 16 % of non-victimized women (Kantor & Straus, 1989). Goldstein and colleagues (1991) found that in a sample of drug users and dealers, 20 % of the females were regular cocaine abusers and 31 % of moderate cocaine users had experienced partner perpetrated violence. According to their data, a similar risk for male drug users does not exist. Overall in women, a history of being battered may be the single most important context yet identified for female alcoholism, with some investigators estimating that it is implicated in about 50 % of all female alcoholism (Hilberman & Munson, 1977-78).

Comparatively less documentation exists concerning female-perpetrated conjugal violence and substance abuse. Despite an awareness of the fact that females are involved in the perpetration of aggression and violence of many kinds and in many contexts (e.g., in gangs, child abuse in family situations), the focus of most of the study of women and substance abuse has been on female victimization. Strands of evidence suggest, however, that in the context of couple violence, women may abuse their partners with comparative frequency, but that this form of abuse poses a less serious risk for men compared to female victims of male violence. What may be more an important consequence of female violence is the response it may provoke from their partners (Stark & Flitcraft, 1991). When a woman engages in physical abuse in a marital conflict, a more dangerous retaliatory response from the male may ensue. Though physical abuse by the woman may mediate the severity of a retaliatory response, care must be exercised not to interpret female initiation of violence as a justified provocation for a male's violent (and more dangerous) response. Rather, this pattern is most likely superimposed on already established pattern of male-to-female spouse abuse.

CHAPTER 2 : SUBSTANCE ABUSE/CONJUGAL VIOLENCE LINKAGE

2.1 EXPLANATORY HYPOTHESES

The literature dealing with aggression and substance abuse is vast. It may be somewhat arbitrary to isolate male battering of their partners when substance use or abuse is involved from the broader issues of the role of alcohol and drugs on violent behavior. Several excellent reviews (e.g., Pernanen, 1991; Stark & Flitcraft, 1991; Holtzworth-Munroe & Stuart, 1994) provide an overview of thinking concerning aggression and conjugal violence in general, as well as in the context of concomitant substance abuse. Despite some overlap between the paradigms used to explain the link between substance use and conjugal violence, a number of distinct models have been proposed. In this chapter, a brief overview of the major models posited to explain concomitant conjugal violence and substance abuse are presented. This is followed by a discussion of the

characteristics of the men and women who are involved in conjugal violence when substance use is present.

2.1.1 Substance abuse and conjugal violence in men

➤ *Feminist perspective*

One feminist position categorically rejects the use of alcohol and drugs as a cause of partner violence, positing that the use of drugs often is used by violent men to rationalize the use of violence against their spouses and to deflect personal responsibility (Stark & Flitcraft, 1991). Furthermore, placing the focus on alcohol and drugs is seen as diffusing and excusing the impact of the patriarchal social and political structure that promotes the systematic abuse of women. A similar argument is the basis of the rejection of any association between psychopathology and conjugal violence. While the feminist model has not been as empirically investigated as some others, a number of common clinical observations provides support for this model with respect to conjugal violence in general. For example, battering marked by excessive and damaging control and entrapment of a woman by a male partner is not seen in other types of abusive relationships. In addition, the rate of abuse against women is higher than those for child or elder abuse. Moreover, women whose status or education is higher than their partners are at greater risk for abuse, perhaps due to the threat this poses to traditional male status and control in the relationship (Stark & Flitcraft, 1991). In contrast, the feminist model's rejection of any relationship between alcohol and drug use with conjugal violence is not empirically supported. While the relationship is neither causal nor simple, the risk for conjugal violence, the severity of abuse, and the success of treatment has been shown to be mediated by alcohol and drug use (Conner & Ackerly, 1994).

➤ *Disinhibition*

One prevalent explanation for the substance abuse-violence linkage is that acute substance use acts to pharmacologically disinhibit violent behavior in males (Pernanen,

1991). In this model the propensity for violence which is otherwise constrained, is caused or heightened by their use of alcohol or other drugs. This causal link between alcohol and violence has been refuted for some time (Coleman & Straus, 1979) based upon a number of common observations : 1) conjugal violence may not entirely disappear even when substance use is terminated, but rather may shift from overt acts of physical violence to more covert psychological battering and verbal abuse (Maiden, 1997); 2) not all men are violent when drinking, but aggressive behavior with drinking is highly variable; and 3) cognitive mechanisms such as expectations about alcohol's effects and social context in which drinking occurred may be far more important (Hamilton & Collins, 1981). A related model has been proposed to account for these observations. The learned disinhibition or expectancies approach (also referred to as "disavowal") posits that individuals learn that they are allowed to behave in an aggressive or abusive fashion under the influence. Since alcohol use confers a "time out", individuals may hit or batter and get away with it (Gelles & Straus, 1979).

The involvement of cognitive factors, specifically expectations of alcohol's effects on a variety of behaviors, has been empirically supported. In a balanced placebo design, subjects were administered either a non-alcoholic beverage or a beverage which contained alcohol, with the beverages contrived so that the alcoholic content would not be apparent. Feedback about the alcohol content of the beverage was provided that was either erroneous or accurate. Irrespective of the actual alcohol content of the drinks, the subjects' perceptions and behavior changed consistent with the feedback about the alcohol content of their drinks (Marlatt & Gordon, 1985). Based upon an analysis of the literature, other authors (Paglia & Room, 1998) have argued that expectancies alone are insufficient to predict aggressive behavior. Overall, these findings underscore the complex web of factors that can interact to influence alcohol's impact on behavior.

➤ *Social information processing*

Another paradigm focuses on the cognitive disruption that alcohol use may engender for social information processing. According to this perspective, alcohol increases the risk of

marital violence by exerting an influence on the perception and interpretation of information, response generation and decision-making, and the subsequent behaviors based upon these processes (Holtzworth-Munroe, 1991). Alternately, alcohol and drug abuse could lead to marital stress, hence increasing the risk for violence.

➤ *Spurious association*

This hypothesis holds that much of the putative association between marital violence and substance abuse may be spurious. From this purview, certain individual, interpersonal and social situations are posited to underlie both excessive substance use and violence in general in the absence of any direct causal linkage between them (Gondolf, 1988). Thus, one problem does not contribute directly to the other problem. Rather conjugal violence and substance abuse are markers that aggregate around one or more underlying characteristic or situation that increases the risk for either substance abuse or conjugal violence, or both. For example, both violent behavior and substance abuse are markers for antisocial personality disorder. A number of investigators (Bennett, 1995; Gondolf, 1988) have posited that at least some dual-problem (i.e., alcohol/substance abuse and violence) men possess an underlying antisocial personality disorder.

➤ *Integrative*

Still others argue that substance use is a not a necessary nor sufficient factor in the etiology of marital aggression (Leonard, 1993). Adopting a more integrative stance, diverse factors including alcohol and drug abuse and family stress from financial problems, are seen as contributing to the risk for marital violence. From a related perspective, Bennett and his colleagues (1994) have enumerated at least nine different variables that have been found to mediate the conjugal violence-substance abuse relationship in men : 1) witnessing spouse abuse as a child; 2) marital conflict over power and control; 3) approval of situational violence against wives; 4) a history of violence outside the family; 5) age; 6) antisocial personality characteristics; 7) non-alcoholic drug abuse; 8) diagnosis of alcohol; and 9) income.

In summary, a number of hypotheses have been proposed to explain the substance use-conjugal violence linkage. However, neither conjugal violence nor substance abuse is a stable, unitary problem. Rather they encompass a vast range of behaviors, consequences and risk factors. Some common elements may emerge from the study of different forms of concomitant substance abuse and conjugal violence. Nevertheless, some investigators counter that a deeper understanding of the substance abuse- conjugal violence linkage will emerge only when research : 1) identifies theoretically or empirically derived subgroups of perpetrators and victims; and 2) accounts for the evolutionary stages in the trajectory from the initial episodes of abuse to the where such behaviors are chronic and stable (Leonard & Jacob, 1988).

2.1.2 Substance abuse and conjugal violence in women

The victimization of women has been the subject of much controversy. Women are frequently blamed for becoming victims of marital violence by both staying in violent relationships and for failing to complete legal proceedings against their violent partners. Psychologically, these observations have been interpreted as indicative of an underlying masochistic personality in battered women (Haver, 1987). However, there is little actual empirical support for a masochistic personality in such women. Women in abusive relationships are a heterogeneous group with respect to personality. Additionally, study of the personality characteristics of women who stay in abusive relationships has failed to convincingly distinguish between the characterological precursors or symptomatic consequences of abuse. In contrast, alternate explanations for why women persist in abusive relationships have been posited. These include : 1) fear of reprisal against them or their children; 2) apprehension that children will be scapegoated; 3) lack of economic opportunity and other material resources (as a consequence of the total control the batterer has over their partner's material and social lives); 4) inappropriate and punitive responses of "helping" institutions; and 5) debilitating psychological and health problems such as intense fear, post-traumatic stress syndrome and a kind of "learned helplessness" as a consequence of chronic battering (Rhodes & McKenzie, 1998).

The tendency to "blame the victim" may be even more pronounced in the case of an alcoholic or intoxicated woman who is also being battered. Strands of evidence suggest that a woman's substance abuse may increase both her risk of being battered (Miller & Downs, 1993) and the seriousness of her injuries (Fagan & Wexler, 1987). Indeed, female substance abusers are more likely to be in relationships with substance abusing males (thus increasing their risk for abuse) compared to male substance abusers (Brown et al., 1995; Stark & Flitcraft, 1991). However, attributions of sexual looseness of an alcoholic woman by the abuser and perceptions of the greater social acceptability of abusing such a negatively labeled woman have been proposed to underlie this relationship (Miller, 1990).

Gender-based stereotypes applied to female substance abuse may extend to those who are positioned to provide "help". For example, therapists working in substance abuse treatment settings in the Netherlands were asked to describe typical male and female patients. Irrespective of the gender of the therapist respondent, female patients were described as being more dependent and masochistic, while male substance abusers were described as suspicious and hostile (DeJong, Van Den Brink & Jansen, 1993). In another study, male respondents were more inclined to disapprove of female drinking in marital violence episodes as compared to male drinking in an analogous situation (Dent & Arias, 1990). Overall, social and gender-based biases, the misattribution of blame and the misinterpretation of women's behavior may further reduce the support and sympathy offered to women suffering from both battering and substance abuse.

Although being involved with a violent spouse is an obvious explanation for a woman's victimization, more recently evidence of a more complex relationship underlying the substance use-conjugal violence linkage in women has emerged. One facet of this relationship is the possibility that present victimization leads to the development of alcoholism and drug abuse in women. Thus, recourse to substance abuse is seen as a mechanism for battered women to cope with their victimization. The role of childhood victimization has also been examined with respect to its role in later substance abuse and victimization as an adult. A history of either physical or sexual abuse as a child (Kunitz et al., 1998; Mullen et al., 1996) has been found to predict later substance abuse as an adult. Two explanations for these observations have been posited. First, because of

victimization, girls may go on to suffer low self-esteem, with alcohol use being an attempt to cope with the negative emotional consequences. The observation that women who have a family history of abuse tend to stay longer in abusive relationships (Gelles & Straus, 1988) appears consistent with this hypothesis. Another hypothesis posits that low self-esteem problems in victimized girls increase the risk of affiliation with delinquent peer groups who engage in the abuse of alcohol and drugs, which in turn contributes to former's risk of substance abuse (Miller & Downs, 1993).

In summary, though females are at greater risk of suffering from substance abuse when experiencing partner violence and battering, explanations for the trajectory from early victimization to later substance abuse problems and victimization have yet to emerge. Clarification of two issues has been posited as important in advancing our understanding in this area: 1) establishing a clear temporal order to the substance abuse-conjugal violence linkage (i.e., that battering precedes the development of substance abuse problems or vice versa); and 2) clarifying the relationship between alcohol and drug abuse with past and present victimization by multiple perpetrators (Miller, 1990).

The phenomenon of female-to-male violence in the context of substance abuse has been alluded to in a previous section. Strands of evidence suggest that substances such as alcohol and cocaine may act to increase the risk for violence in both sexes (Coleman & Straus, 1983). However, whether alcohol contributes to aggressiveness in women in the same manner as it does in men is unclear (Frieze & Schaffer, 1984). Moreover, differences in the socioeconomic context of female violence (i.e., low economic and minority ethnic status), how it is expressed and even its purpose have led some scholars (e.g., Anglin & Hser, 1987; Hien & Hien, 1998) to argue that despite some external similarities, female violence is fundamentally distinct from its male counterpart.

In contrast, more data are available that explore female-to-child violence and substance abuse (e.g., Miller, 1990). However, little systematic exploration of female abuse of a spouse with or without substance use has been undertaken. Several reasons may underlie the scant attention to this form of conjugal violence. These include: 1) the greater relative dangerousness of male-to-female conjugal violence; 2) the challenge to the prevailing

sociopolitical interpretations of conjugal violence (and therefore the jeopardy to the scholar's career) that the study of female-perpetrated couples violence represents; 3) the fear that it may result in "blaming the victim", thus trivializing the more odious problem of wife abuse; 4) the incoherence of female violence with cultural norms that prefer to see women as passive victims rather than perpetrators of violence towards spouses and children; and 5) the ethical and methodological dilemmas that complicate the study of violent or abusive women in a family setting (Hien & Hien, 1998). However, it is also reasonable to hypothesize that female alcohol and other drug use might play a role in how violent events unfold. Overall, the growth in reports of both violence and substance abuse in women, as well as the evidence that even minor violence may contribute to the escalation of couple violence, underline the importance of studying female conjugal violence and substance abuse.

2.2 PORTRAIT OF CONCOMITANT SUBSTANCE USE/CONJUGAL VIOLENCE PROBLEMS

Most of the available data that describes the characteristics of men and women with both substance abuse and conjugal violence problems comes from studies conducted with clinical samples. Thus, it is unlikely that the data derived from such studies represent the totality of the substance abuse/conjugal violence phenomenon. In the following sections, the characteristics of dual problem men and dual-problem women are discussed.

2.2.1 Males

➤ *Dual-problem men vs single problem men*

Most of the data comparing dual-problem men to single problem men come from samples attending either conjugal violence or substance abuse treatment. Consistently, dual-problem men in either violence or substance abuse treatment settings possess attributes that differentiate them from their single problem cohorts. In a study comparing two groups of violent men, one group who repeatedly abused alcohol and another whose alcohol use was sporadic, differences were found in age, socioeconomic status, the victim's alcohol use, level of violence and violence towards children (Eberle, 1982).

Similarly, Hastings and Hamberger (1988) found that among batterers who had contacted a domestic violence abatement program, alcohol use amplified the personality characteristics and depression associated with battering seen in other studies. In a study of men in substance abuse treatment (Brown et al., 1998), as concomitant violence increased, greater interpersonal insensitivity, hostility, suspiciousness, projection of blame, and poorer overall functioning was observed. In a parallel study conducted in domestic violence treatment settings by these investigators, men with a diagnosis of a psychoactive substance abuse or dependence reported more frequent acts of verbal and psychological abuse of their partners, greater hostility and suspiciousness, and more past arrests and convictions for various crimes than their violence-only cohorts (Brown et al., 1999a).

The possibility that violent substance abusers found in either substance abuse or conjugal violence programs may share important characteristics has also been investigated. One line of inquiry has posited that dual-problem men in general may be more prone to antisocial personality disorder and narcissistic behavior patterns than their single problem cohorts (Bennett, 1995; Coid, 1982; Gondolf, 1985; Hastings and Hamberger, 1988). In similar fashion, two studies have compared dual-problem men in either substance abuse or violence treatment milieu. In one study that compared men attending violence treatment from those in substance abuse treatment (Stith, Crossman & Bischof, 1991) no significant differences independent of logical sample differences (e.g., more men in violence treatment were married) were uncovered. Notably, the levels of conjugal violence reported did not differentiate between the two settings. However, men with both problems were not specifically targeted for inclusion in this study. In a rare study that did specifically contrast dual-problem men from either treatment setting (Brown et al., 1999b), the dual-problem men in substance abuse treatment showed more predominant substance abuse problems than their dual-problem cohorts in violence treatment. Only a trend was found between the dangerousness of violent behavior and treatment setting. Unexpectedly, the average frequency of partner sexual abuse was actually greater among men in substance abuse treatment as compared to those in violence treatment. These findings support the possibility that the severity of substance abuse but not domestic

violence may more reliably differentiate men in substance abuse treatment than those in violence treatment.

➤ *Type of Substance Use*

Much of the study of dual-problem men involves alcohol abuse. However, in a recent study (Brown et al., 1999a), 52 % of dual-problem men in violence treatment were found to be simultaneously dependent on alcohol and other drugs or several drugs at once. This suggests that the trend towards multiple drug complaints seen in other clinical milieus may be filtering down into conjugal violence settings.

Clarifying the putative role of drug use on conjugal violence is complicated by a number of factors. Different drugs (e.g., cannabis, heroin, and alcohol) may have very different pharmacological actions (e.g., depressive or stimulating) which may in turn be associated with the nature of violence. In addition, when studying the impact of illicit drugs in naturalistic settings, considerable uncertainty surrounds the precise ingredients of the substances consumed. Thus, discerning either the independent or synergistic influence of specific substances on conjugal violence is a bewildering undertaking. Nevertheless, there is evidence that the use of some drugs, such as cannabis and heroin, tends to decrease the probability of conjugal violence in alcoholics and other non-users (Miller, 1990). In contrast, the association between cocaine abuse, especially in its crack form, and conjugal violence has been noted in a variety of populations (Friedman, 1998). However, considerable controversy surrounds how cocaine exerts its influence; that is, whether cocaine's pharmacological effects increase the risk and/or severity of violence, or whether the illegal social circumstances surrounding cocaine use and procurement tend to attract individuals with more antisocial (and "generally violent") tendencies (Denison et al., 1997).

➤ *Severity of substance abuse*

The possibility of a "dose-response" relationship between alcohol and drugs and domestic violence has been explored by a number of investigators (e.g., Denison et al., 1997; Saunders, 1992). However, the data is marked by considerable inconsistency. For example, one study found no significant correlation between the number of alcoholic symptoms endorsed by a sample of older alcoholics on the Michigan Alcoholism Screening Test (MAST) and their scores on the Conflict Tactics Scale (Gondolf & Foster, 1991). Another study failed to find a systematic relationship between quantity-frequency indices of alcohol consumption and the severity of battering, although a diagnosis of alcohol dependence did predict more severe violence (Bennett et al., 1994). Bennett (1995) has also suggested that certain subgroups of male batterers may also fit the Cloninger's Type II alcoholic typology, a male-limited pattern of alcohol abuse characterized by early onset, a more severe presentation, and the presence of history of paternal alcoholism and criminality. Targets of such individuals tend to be not only their partners.

Other studies suggest that the severity of domestic violence may be more associated with the severity of drug abuse than alcohol abuse (Brown et al., 1998; Kantor & Straus, 1989). Finally, there is a possibility that the relationship between substance use and conjugal violence may not be a linear one. A number of studies point to an inverted U relationship between the severity of alcohol use and conjugal violence (Bennett et al., 1994; Coleman & Straus, 1983; Leonard & Jacob, 1997). That is, violence may increase along with increasing levels of alcohol use but diminishes at the highest levels of consumption. A similar relationship between the severity of cocaine use taken with alcohol on conjugal violence has also been noted (Brown et al., 1998). One possible explanation for these observations is that as use increases the perpetrator loses the psychomotor capacity needed to effectively injure his victim.

➤ *Patterns of substance abuse*

This review is concerned primarily with long-standing, problematic alcohol and drug use and conjugal violence. However, among those with chronic histories of substance abuse

and conjugal violence, much variability exists in how alcohol and other substances are consumed. Accordingly, some investigators have explored the specific patterns of chronic consumption, such as binge versus steady drinking, and its relationship to couple interactions. Leonard and Jacob (1988) have speculated that while steady drinking represents a predictable source of stress, which is more easily adapted to the family, binge drinking represents a more disruptive challenge to familial stability and integrity. In support of this hypothesis are data that suggest that an episodic drinking pattern in men is associated with a greater probability of marital aggression (Murphy & O'Farrell, 1994) and an impulsive-aggressive-antisocial personality cluster (Leonard & Jacob, 1997).

Overall, there is conflicting evidence respecting the relationship between conjugal violence and the abuse of different substances. Moreover, the trend towards multiple drug use complicates our understanding of the role of different drugs on spousal abuse. Finally, the lack of a clear dose-response relationship between drug use and conjugal violence underlines the complexity of this interaction.

➤ *Type of violence*

If men who abuse alcohol are recognized as a heterogeneous population, the heterogeneity of conjugally violent men is now also broadly acknowledged (Tolman & Bennett, 1990). Similar to the hypothesis that certain substance abuse typologies may have an impact on the probability of marital aggression, the possibility exists that typologies of violence may be also identified. For example, some authors (Coid, 1982; Shields & Hanneke, 1988) have described the possibility that marital violence in some men is part of a generalized pattern of aggression (i.e., generally violent men) while in other men, their aggression is limited to the abuse of their partners (i.e., domestically violent men). Moreover, there appears to be some consensus that the generally violent men cause the most severe physical injuries in their spouses, consume the most alcohol and possess the least social stability (Gleason, 1997).

2.2.2 Women

In both female alcoholics and victims of conjugal violence, a high rate of post-traumatic stress disorder (PTSD) has been observed. As described by the Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association (1994), PTSD is characterized by a set of symptoms following exposure to a traumatic stressor such as the threat of or actual death of another, military combat, sexual assault, natural and human-caused disasters and accidents. The PTSD syndrome of symptoms consist of persistent flashbacks of the traumatic event, avoidance of reminders of the event, emotional numbing and increased physiological arousal that are present for at least a month and cause clinically-significant distress and dysfunction. In clinical samples of substance abusers, lifetime prevalence for PTSD among women has been estimated to be about 50 %, while 25-33 % may suffer from a current diagnosis of PTSD (Ouimette et al., 1998). Curiously, despite the potential conjuncture between substance abuse, assault and PTSD in women, limited direct study of this triad of related problems has been undertaken. More study of this triple phenomenon is clearly warranted.

CHAPTER 3 : TREATMENT

The potential for treatment of concomitant substance abuse and conjugal violence is arguably vast. Our studies (Brown et al., 1998; Brown et al., 1999a) have established that substance abuse and conjugal violence treatment settings are important natural entry points into the intervention system of individuals grappling with both problems. Therefore, this chapter focuses on the issues involved in the treatment of dual-problem individuals in these two treatment settings. We begin this discussion by a description of the different approaches to the treatment of male perpetrators, female victims and a more brief consideration of the principal components of treatment for substance abuse. Finally, the issues involved in treatment linkage, integrated treatment and some promising models are discussed.

3.1 TREATMENT OF CONJUGAL VIOLENCE

3.1.1 Males

Treatment for conjugally violent men varies broadly along philosophical, strategic, and programming lines. However, most services for men today are offered in a group format, involve same sex therapists, offer a fixed number of sessions, and provide anger-management treatments in combination with other psychological interventions. One of the most widely used models is based on the Domestic Abuse Intervention Project (DAIP). In 1981, an administrative body (DAIP) was forged, in USA, to oversee the provision of perpetrator programs, women's support groups, education and training programs. This intervention model is now known as the "Duluth model". Described as "a comprehensive, cooperative systems approach", it involves a shared victim safety philosophy, case flow monitoring, feedback, and information sharing with the response being maintained by an independent coordinating agency» (ACT, 1999). Treatment typically involves 29 weeks of highly structured closed group sessions and adopts a behavior modification approach. It is now the predominant approach in the domestic violence treatment community and has been officially adopted in a number of American states. However, despite its popularity, reservations concerning the therapeutic underpinnings of the approach have been raised. One criticism is that the "Duluth model" relies heavily on a punitive and shaming approach. Paradoxically, a patriarchal orientation (i.e., emphasizing the application of power and control to dominate or change the other) is adopted to deal with problems caused by a patriarchal social system that encourages abuse (Hoff, 1999).

Several other approaches have emerged. The Domestic Abuse Project is treatment strategy that uses a highly structured group involving 10 to 36 sessions (Edelson & Tolman, 1992). It employs a cognitive- behavioral approach, behavior modification as well as advocacy towards social change. The Battered Women's Alternatives Domestic Violence Treatment Program (BWA) in California uses a predominately psycho-educational approach to its treatment. It addresses men's socialization (e.g., gender roles, view of women, and power and control) in addition to parenting skills, issues of intimacy and abandonment, jealousy and anger (BWA, 1999). These interventions are conducted

over a seven to 52 week period in closed counseling and education groups. Another approach to batterer's treatment is the radical feminist approach espoused by Catholic Social Services of Washtenaw County's Alternatives to Domestic Aggression. This strategy advocates incarceration for perpetrators and the monitoring of all batterer services by women survivors, women's shelters and the feminist community (Hart, 1999).

A local model of violence treatment, the McGill Domestic Violence Clinic (MDVC), men's group differs in several ways from the above approaches. It is structured as an «open» group allowing the men to enter and leave treatment as they see fit after a minimum of 15 consecutive weeks in treatment. The group is co-animated by a male and a female therapist who use process-oriented interventions to minimize both therapist counter-transference as well as client resistance. The group counselor's purpose is to help the client take responsibility for his treatment, which includes challenging other group members, mentoring newcomers and modeling appropriate problem-solving strategies (Caplan & Thomas, 1995). As such, this approach is more broad and eclectic than some other conjugal violence treatments, and includes behavioral, cognitive-behavioral, insight, advocacy and leadership therapy components (Caplan & Thomas, 1998).

The diversity in treatment approaches mirrors an on-going, sometimes rancorous ideological debate within the conjugal violence treatment community. There is growing consensus that both individual behavioral as well as social components underlie conjugal violence. Accordingly, treatment of violent men is increasingly accepted as a legitimate response to conjugal violence. However, there is less clarity as to how to reconcile an individual treatment approach with a more traditional social advocacy perspective that insists on the need for change in all men's behaviors regarding their relationships with women (Edelson, 1995). Accordingly, two related questions remain unresolved : 1) to what degree does individual treatment resolve conjugal violence ?; and 2) does focusing on individual change divert attention away from the need for a more fundamental social transformation with respect to the status of women ?

Very few well-controlled studies have been conducted in order to determine the effectiveness of male batterer programs, as well as the factors necessary to improve the

treatment outcomes (Saunders, 1996). Program evaluation is plagued by several methodological dilemmas such as the lack of established definitions of treatment success and questionable data-gathering techniques (Saunders, 1996). However, some treatment outcome data are available. Levesque and his colleagues (1998) conducted a study involving 258 males in group counseling for batterers. The very modest effect size uncovered in their study (i.e., $ES=0.06$, $p > .05$) as well as in 18 other outcome studies led them to assert that «treatment is only mildly effective, at best». Another study involving 283 males who were randomly assigned to one of three forms of treatment groups attempted to determine the effects of treatment structure on outcome efficacy. The results at the end of six months and 18-month follow-up showed that shorter and more structured treatment programs were consistently more effective in reducing domestic violence. After a 12-session highly structured treatment program, 34.5 % of the men were found to be violent at 6-month follow-up. After 18 months, 50.9 % reported having been violent. In men who received a 32-session less-structured treatment program, 45,9 % were still violent at 6 months, 56,8 % at the 18 month follow-up. Group differences were statistically significant only at the six month follow-up (Edleson & Syers, 1990; Edleson & Syers, 1991). Finally, treatment that encourages the male perpetrator to take responsibility for his treatment and behavior seems to predict better outcomes than approaches that stress punishment and shame (Orlinsky et al., 1994).

3.1.2 Women

Programs for victims of conjugal violence focus primarily on safety, shelter, childcare services, and legal advocacy (Collins et al., 1997). However, in addition, it is felt that battered women, although a heterogeneous group, frequently experience common reactions and develop similar coping strategies in response to the trauma and ongoing victimization. Abused women often suffer a profound sense of betrayal and live in a chronic state of anxiety and fear which may limit their decision making and problem solving abilities (Follingstad et al, 1988). Treatment therefore focuses on : 1) assisting battered women to recognize that they are not responsible for the violence and 2) empowering them to regain control over their lives (Sinclair, 1985).

Groups for battered women emphasize an honest exploration of the battering by attempting to create an empathic and accepting atmosphere. Recognizing that others share their experiences, thoughts and feelings can also have an empowering effect. The group also decreases the isolation that often accompanies battering, while members offer each other reassurance, information, feedback and nurturing. It is believed that once the dynamics of abuse and the effects on their children are acknowledged and the mourning for the loss of the idealized relationship begins, the process of change is better able to proceed (Turner & Shapiro, 1986). Whether the woman decides to remain in the relationship or to leave it, the goal of treatment is to support her move away from victimization by helping her to set realistic goals and teaching her the assertiveness skills she requires to reach those goals.

3.2 TREATMENT OF SUBSTANCE ABUSE

The treatment for alcoholism (or others types of substance abuse) is varied both conceptually and operationally. In general, three phases of treatment can be identified : 1) medical or non-medical stabilization/detoxification; 2) intensive treatment; and 3) aftercare. The first phase involves stabilization of the client following reduction or cessation of alcohol and other drug dependence. This may occur in a hospital setting, but depending on the level of physiological dependence, the drugs abused and the state of health of the individual, stabilization may also not be necessary, or may be carried out in a protected, supportive but non-medical setting.

One of the most popular intervention approaches for the second phase of treatment is the Minnesota model of treatment. Borrowing heavily on Alcoholics Anonymous (AA) principles, patients undergo intensive treatment for about four weeks on an in-patient basis. Working through the steps of AA, induction into the AA self-help movement, pursuit of total abstinence, and therapists who themselves have a history of dependence are specific to this approach.

In contrast to this perspective, the so-called psychosocial, multimodal treatment approach offers a more eclectic collection of interventions. The interventions employed at a given

treatment facility, often determined by therapist expertise and interest, are offered on an in- or out-patient basis depending on the needs of the client and by therapists who are professionally trained social workers, psychologists, nurse-clinicians and physicians.

A prevalent model for more "hard" drug addiction treatment (e.g., heroin addiction) is the therapeutic community. Similar to the Minnesota model for alcoholism, this treatment program is usually carried out on an inpatient basis, involves therapists who are recovered addicts themselves, and attempts to induct patients into on-going Narcotics Anonymous involvement. In contrast, therapeutic communities emphasize intensive group experiences to both address the substance use as well as to confront the value system often adopted by the drug using subculture that are contrary to a sober lifestyle.

Aftercare programs generally follow intensive treatments, and consist of one or two outpatient visits per week with a therapist, over a period of from three months to a year or more. The usual goals of aftercare are the maintenance of gains achieved in intensive treatment, management of reintegration of the individual into a non-drinking environment and lifestyle, management of relapse, and a gradual withdrawal of therapeutic support.

Outcomes from substance abuse may be influenced by a number of factors including the outcome criteria employed (e.g., total abstinence versus significant reduction, improvement in other areas of functioning), follow-up period, and the samples studied (e.g., alcoholics, drug abusers, poly-drug abusers, psychiatric populations). In general, there is evidence for the benefits of treatment over no treatment in most clinical samples. However, complete resolution of substance abuse problems from substance abuse treatment is far from assured. For example, in a study conducted at three public, abstinence-based treatment centers in the Montreal area, abstinence rates after six months were approximately 40 % (Brown et al., 1993). Another study conducted with 12 treatment centers across the province of Quebec showed approximately the same level of abstinence at six, 12 and 24 months (Dongier and Bruce, 1999, unpublished data).

3.3 TREATMENT OF CONCOMITANT CONJUGAL VIOLENCE AND SUBSTANCE ABUSE

Though general agreement exists that alcohol and drug use plays a contributory role in conjugal violence, a paradigm to convincingly explain the underlying linkage does not yet exist. The risk and severity of conjugal violence does increase with alcohol and some drug use. At the same time, the role of substance abuse in the risk or severity of conjugal violence has been estimated to contribute only about 20 % of the prediction of violence (Kantor & Straus, 1989). The independence between conjugal violence and substance is further underlined by the lack of a convincing cause-effect relationship between the reduction of drinking and drug use or attendance in some kind of treatment and subsequent levels of conjugal violence (Stark & Flitcraft; 1991). Nevertheless, one immediate upshot of the absence of a cohesive paradigm linking the treatment of concomitant conjugal violence and substance abuse is that counselors confronted with dual-problem individuals are left to make important decisions with little evidence to go on (Roizon, 1997).

The importance of both the conjugal violence and substance abuse treatment settings as entry-points for dual-problem individuals has been established (Brown et al., 1998; Brown et al., 1999a). Nevertheless, little systematic examination of concomitant substance abuse and conjugal violence in the treatment outcome of men or women from either substance abuse treatment or violence intervention. However, a widely held clinical assumption is that unresolved substance abuse will compromise any intervention for conjugal violence (Bennett, 1995; Saunders, 1996). One study has been published that presents support for this contention. In a study of men undergoing substance abuse treatment, conjugal violence was seen to abate but not disappear. Rather, the most violent forms were replaced by more verbal and less dangerous forms of abuse (Maiden, 1997).

Despite the dearth of data, both the resolution of substance abuse problems prior to violence intervention and the benefits of coordinated treatments for dual-problem individuals is generally acknowledged. In this context, the results of a recent study that explored the status of coordinated treatment efforts with regards dual-problem men in the state of Illinois are noteworthy. A poll conducted with directors from both treatment milieus sought to clarify the status of coordinated action for the treatment of dual-problem men and women who were both victimized and had substance abuse problems (Bennett &

Lawson, 1994). The main findings of their poll were the following : 1) cross-problem screening was haphazard in both milieus, with little recourse to systematic or valid detection and problem characterization. Comparatively, domestic violence programs did less cross-problem screening than substance abuse treatment program; 2) in-house expertise in the cross-problem was often severely limited; 3) while some attempts at linkage with the other treatment settings were found, more effort in consulting the other setting was found among the family violence professionals; 4) when systematic screening was undertaken, referral practices were uneven in both settings. However, violence treatment professionals were more likely than those in substance abuse treatment (95 % versus 77 %) to refer clients to the other treatment modality.

3.4 RESULTS OF A POLL ON THE STATUS OF TREATMENT LINKAGE FOR SUBSTANCE ABUSE AND CONJUGAL VIOLENCE IN QUEBEC

In order to gain a deeper insight into the situation in Quebec, a poll was conducted with conjugal violence and substance abuse treatment milieus. We targeted the attitudes held by personnel and services provided in each setting for the cross problem. As well, we queried the respondents from both milieus concerning the amount of linkage with the other milieu, and what obstacles they felt were significant in reducing the level of treatment coordination. Though ongoing data collection and more thorough analyses of the data are anticipated, below we present our preliminary results.

3.4.1 METHODOLOGY AND SITES

In replication of the study by Bennett and Lawson (1994), this study employed similar questionnaires and administered them to various substance abuse and violence treatment centers throughout the 18 regions of the province of Quebec. Two separate questionnaires were formulated and sent to substance abuse treatment centers and domestic violence treatment centers (See Appendix 1 and 2).

The centers were identified using various reference sources including : 1) the *Régie régionale de la Santé et des Services sociaux de Montréal*; 2) the *Répertoire des*

ressources en toxicomanie au Québec 1998 issued by *Association des intervenants en toxicomanie du Québec* (AITQ); 3) the *Regroupement provincial des maisons d'hébergement et de transition pour femmes victimes de violence conjugale*; *Association des ressources intervenant auprès des hommes violents*; 4) *Fédération de ressources d'hébergement pour femmes violentées et en difficultés du Québec*; and 5) *Le Passant – Ressource pour hommes de la Haute-Yamaska*.

3.4.2 Procedure

The questionnaires were mailed along with a cover letter, a consent form explaining the study and procedures, the limits of confidentiality, and a self-addressed prepaid envelope. Once filled out, the questionnaire and signed consent form were mailed back to the Douglas Hospital Addiction Research Program. Approximately one month after the initial mailing date all the centers were mailed a reminder card in case they have forgotten to send the questionnaires back, or in case they have not received one at all. This was also an opportunity to send them another copy if the original was misplaced or to encourage them to participate in the study if they had not done so up until that time.

3.4.3 Measurement

The two questionnaires provided qualitative and quantitative data. They were created as forms that could later be read by Teleform, a computer software used to automate data seizure from paper-and-pencil questionnaires. After the hardcopy of the questionnaires were received by the research team, they were scanned to a central computer which then automatically processed them. Once verified, the results were entered into a database for further analysis.

3.4.4 Results

Twenty-nine violence treatment centers and 57 substance abuse treatment centers of the 144 and 311 treatment centers, respectively, mailed back their responses. The province of Quebec is divided into 18 regions. The distribution of responses from the alcohol treatment centers were the following : the Bas Saint-Laurent (10,5 %), Québec (14 %), Mauricie Bois-

Francs (12,3 %), Montréal (10,5 %), Chaudière-Appalaches (8,8 %), Lanaudière (10,5 %), and Montérégie (10,5 %). Similarly for the violence treatment centers, respondents were fairly spread throughout the province with treatment centers concentrated in the regions Bas Saint-Laurent (10,3 %), Québec (13,8 %), Montréal (24,1 %), Montérégie (10,3 %).

Although the questionnaires were addressed to the directors or coordinators of the treatment centers, other personnel often filled them out. The respondents of the substance abuse treatment centers could be divided into the following six job titles : clinicians (including therapists and counselors), 33,3 %; coordinators, 10,5 %; directors, 42,1 %; human relations departments, 5,3 %; medical staff, 5,3 %; and other, 3,5 %. The respondents of the domestic violence treatment centers could be divided into the following five job titles : clinicians, 24,1 %; coordinators, 34,5 %; directors, 27,6 %; medical staff, 3,4 %; and other, 10,5 %. The majority (56,1 %) of respondents of the substance abuse treatment centers was female.

3.4.5 Substance Abuse Treatment Settings

➤ *Attitudes about conjugal violence*

One striking finding was with respect to responsibility for violence. In response to a statement that the fault for male-to-female conjugal violence may be attributed to the man, approximately 42 % disagreed. Another statement that proposed that violent men should be held responsible for their abusive behavior because they could have anticipated it elicited 22 % disagreement among respondents. When asked whether men are responsible for their conjugal violence because they choose to be violent, approximately 41 % disagreed. Finally, 23 % disagreed when asked whether the responsibility of conjugal violence rests with the aggressor. In contrast, when asked whether battered women are responsible for their victimization because of their behavior prior to an attack by their partner, 42 % felt this was true nearly 50 % of the time, while 9 % felt it true more than half of the time. Finally, when asked whether the occurrence of conjugal violence resulted from the personality traits of the female victim, 30 % agreed.

➤ ***Extent of concomitant substance abuse and conjugal violence problems in substance abuse treatment***

The average percentage of men possessing both problems was placed at approximately 30 % by respondents from the substance abuse treatment milieu, while the mode, or the most frequently endorsed percentage category, was 10 %. In contrast, the average percentage of women thought to be victimized among their female clients in treatment was approximately 40 % (mode = 30 %).

➤ ***Extent of Service linkage***

Approximately 60 % of respondents stated that they sometimes or often use services for battered women. With respect to the utilization of treatments for violent men, the inverse was true with approximately 60 % stating that their center rarely or never makes use of these violence programs. Concerning direct contact with personnel from violence treatment settings, 60 % of respondents stated that they had little or no contact with their colleagues in the other milieu. Similarly, approximately 9 % of respondents indicated that an informal or formal service agreement existed between their service and women's treatment or shelter facilities. In contrast, 88 % said they had no formal or informal agreement with the other service.

With respect to services offered to clients in substance abuse treatment, 39 % of the respondents said that their centers offered individual counseling for victims, while 21 % offered group therapy. For violent men, 19 % said they offered therapy or an educational program, while 23 % offered individual consultations.

➤ ***Obstacles to linkage***

The most frequently endorsed obstacles to better linkage were competition for resources and funds (i.e., 65 %); the qualifications, training and experience of personnel in women's

treatment and shelters (i.e., 35 %); and the beliefs and attitudes of the personnel in women's programs (i.e., 37 %).

3.4.6 Female shelters and treatment centers

➤ *Extent of concomitant substance abuse and conjugal violence problems in female shelters*

When respondents were asked about the incidence of substance abuse among the women attending their program, the average percentage of concomitant problems was estimated at 25 % (mode = 30 %).

➤ *Extent of substance abuse services offered*

When asked about whether in-house expertise existed with respect to evaluation and treatment of substance abuse problems in their facility, 76 % of respondents indicated that no such expertise existed. Moreover, 88 % of the respondents indicated that no regular treatment or AA intervention was provided. In the small number of cases where intervention for substance abuse was offered, it was on an optional basis.

With respect to screening procedures, 56 % of the female shelters appear to offer a systematic protocol for detecting substance abuse problems (see Table 1). When considering what use is made of this data, 44 % of the respondents indicated that if a substance abuse problem is detected, then that client is referred elsewhere, while another 8 % stated that admission into their treatment would be contingent on concurrent engagement in some kind of substance abuse treatment.

Table 1 : Screening procedures for alcohol and drug abuse in violence treatment settings

Response category	Female shelters and Support groups (%)	Male treatment Centers (%)
Intake assessment and referral	44	20
Intake assessment and conditional acceptance to program if seek substance abuse treatment	8	
Admit problem and / or observing attitude and	16	80

behavior		
No procedure described	32	

➤ ***Extent of Service linkage***

When asked whether other substance abuse treatment facilities were utilized, approximately 50 % of the respondents indicated that services were sometimes or frequently used. In 40 % of the cases, an informal or formal agreement existed between their facility and a substance abuse treatment setting. Furthermore, in 28 % of the female shelters, regular or frequent encounters occurred between personnel from their facility and those of a substance abuse treatment center. Almost half of the shelters made use of facilities for the treatment of conjugally violent males, while 52 % had an informal or formal link with such settings. Finally, 70 % of the shelters felt that their clients would benefit from closer links with the substance abuse treatment milieu.

➤ ***Obstacles to linkage***

With respect to opinions about the conflicts between the two milieus that may act as obstacles to cooperation, the most frequently endorsed reason was competition for resources and funds (i.e., 48 %). This was followed by the beliefs and attitudes of the personnel in substance abuse treatment programs (i.e., 36 %); the qualifications, training and experience of personnel in women’s treatment and shelters (i.e., 28 %); and finally the perceptions of philosophical differences (i.e., men must take responsibility for behavior versus acceptance of loss of control) between the treatment settings (i.e., 35 %).

3.4.7 Male conjugal violence treatment

➤ ***Extent of concomitant substance abuse and conjugal violence problems in male conjugal violence treatment***

When respondents were asked about the incidence of substance abuse among the men attending their program, the average percentage of concomitant problems was estimated at 40 %.

➤ *Extent of substance abuse services offered*

When asked about whether in-house expertise existed with respect to evaluation and treatment of substance abuse problems in their facility, 80 % of respondents indicated that no such expertise existed. Moreover, all of the respondents indicated that no regular treatment or AA intervention was provided. With respect to screening procedures for the cross problem, 80 % of the respondents stated that no systematic screening was undertaken, but rather depended on the disclosure of the client, or clinical observations (See Table 1).

➤ *Extent of Service linkage*

When asked whether other substance abuse treatment facilities were utilized, approximately 80 % of the respondents indicated that services were sometimes used. In 80 % of cases, an informal or formal agreement existed between their facility and a substance abuse treatment setting. Also, in 40 % of the conjugal violence treatments, regular encounters occurred between personnel from their facility and those of a substance abuse treatment center. Sixty percent of the shelters felt that their clients would probably benefit from closer links with the substance abuse treatment milieu.

➤ *Obstacles to linkage*

Two areas were identified as probable sources of conflict that prevented linkage between the two settings. One area was the primary focus on substance abuse of substance abuse treatments (i.e., 40 %). The other involved philosophical differences, with the feminist model of conjugal violence posing problems for better links.

3.5 DISCUSSION OF THE FINDINGS

3.5.1 Substance abuse treatment

A major finding from the poll conducted at substance abuse treatment centers was that considerable disagreement was uncovered concerning the responsibility for violence. Approximately 40 % of the respondents were reluctant to endorse the idea of responsibility being placed upon the male perpetrator. Alternatively, the respondents felt that the responsibility for women's victimization often could be attributed to the woman, either through their behavior immediately prior to an aggression or some personality attribute that would attract or provoke violence from their partner. These findings suggest that mitigating circumstances, including alcohol and drug abuse, as well as provocation from the female, may be used by substance abuse treatment personnel to rationalize male violence towards women.

Curiously, the proportion of substance abuse professionals who are reluctant to ascribe responsibility for spousal abuse on the violent male substance abuser may be in fact higher than in the general population. Paglia and Room (1998) conducted a poll among over 900 males and females in Ontario exploring their belief and attitudes with respect to the alcohol and aggression relationship. Though more than 75 % of the sample believed that alcohol caused aggression, a majority (92 %) believed that an intoxicated person is still responsible for any behavior. The reasons underlying the discrepancy in the attribution of responsibility for violence between this community sample and a sample of substance abuse professionals are speculative. However, it is possible that the continued popularity of both the disease model of alcoholism in men as well as the masochistic underpinnings of women's victimization in substance abuse treatment settings has contributed to this discrepancy. Accordingly, in substance abuse treatment settings the responsibility attributed to an individual for abusive behavior would more likely be diminished when substance abuse is involved, while women who are abused would more likely be seen as using provocation to fulfill a masochistic need. If this hypothesis were true, it would mean that progress in society's thinking concerning key concepts of

conjugal violence has lagged in the professional treatment community positioned to treat many affected individuals.

Another finding was the tendency to underestimate the prevalence of concomitant problems in substance abuse treatment settings (i.e., on average 30 %, although most respondents set the percentage at 10 %). Data from the studies cited in this review suggest that the prevalence of physically violent men at approximately 50 %, while the prevalence of abuse including both non-physical and physical battering may be much higher. This discrepancy is likely to reflect the lack in many centers of a systematic and effective screening protocol. A number of studies have shown that asking key questions of both perpetrators and victims of violence may be sufficient to elicit reports of violence, especially if: 1) clinicians are able to overcome their own reticence to broach the issue and 2) are sensitive to issues faced by victims and perpetrators of abuse, such as shame, fear of reprisals, police involvement, and family breakup (McCauley et al., 1998). Our study conducted in substance abuse treatment settings (Brown et al., 1998) asked males about their behavior in their relationships. By ensuring confidentiality, we were able to detect a high rate of battering behavior amongst these men. The development of a number of instruments such as the Conflict Tactics Scale (Straus et al., 1996) and the recognition of the importance of creating an appropriate environment for disclosure should improve the detection of both physical violence and battering behavior in substance abuse treatment milieu.

The results of the poll also indicated that abused women in substance abuse treatment seem to be more readily detected and provided with referrals to violence services and support as compared to the violent men in treatment. Sixty percent of respondents stated that they often use shelters for abused women, while only 40 % stated that they ever used violence treatments for their male clients. As well, more services are offered to victims of violence than to male perpetrators. One hypothesis for these discrepancies is that substance abuse treatment centers often have a therapist(s) (especially female) sensitive to women's issues, including victimization, who is motivated to explore these issues. An analogous forum for the exploration of male issues, specifically involving inappropriate interpersonal relationships, may be offered less often. This may reflect the

fact that the pervasive causal assumption in substance abuse treatment about violence still involves the disinhibition hypothesis (i.e., if substance abuse is curtailed, conjugal violence will disappear). A number of other findings revealed in the poll would tend to reinforce the persistence of this erroneous assumption. These included : 1) the confusion concerning responsibility for violence among males; 2) the lack of any formal or informal inter-treatment agreements between the two settings; 3) the absence of in-house expertise in the cross-problem; and 4) suspicions about the qualifications, training and attitudes of personnel in the violence treatment sector.

3.5.2 Women's violence treatment

The poll data suggest that women's shelters and intervention sites suffer from the lack of in-house expertise about substance abuse. Perhaps as a reflection of this lack of knowledge, there is also a tendency to underestimate the actual incidence of substance abuse or dependence among their clientele. In contrast, compared to substance abuse treatment settings, there are more settings who have informal or formal treatment linkages to substance abuse treatment sites. Moreover, the majority of sites polled had some kind of systematic screening protocol in place, with the main purpose appearing to be the exclusion through referral.

3.5.3 Men's violence treatment

Similar to the responses from personnel at both substance abuse and female violence treatment centers, there was the tendency to underestimate the incidence of concomitant substance abuse and violence problems. Their estimate, at 40 % contrasts with the findings of researchers (e.g., Connor & Ackerly, 1994) who have found the incidence rates at between 60 and 70 %. Moreover, little in-house expertise or systematic screening occurred. Problem identification occurred only if the client admitted to the problem or possessed obvious clinical signs of substance abuse. Respondents from this milieu, however, reported comparatively higher levels of use and contact with substance abuse treatment settings than the other settings.

All milieus felt that better coordination would probably be a benefit for their clients. At the same time, the respondents from all of the treatment milieus felt that competition for resources was the main obstacle to better cooperation. It is unfortunate that an obstacle to better linkage is the perception that there is a competition between the networks. This may reflect the need for treatment settings to clearly delineate a specific problem area that is sufficiently independent of other problem areas to warrant a separate budget envelope. How to rationalize support for one problem area yet provide a comprehensive treatment program that recognizes the multidimensional nature of clients' problems - without being accused of encroaching on another network's territory or engaging in the duplication of services - is not easily resolvable.

Mutual suspicion with respect to the attitudes and beliefs of personnel in the other milieu was also cited as an obstacle. This finding underscores the ideological differences typically found between the two milieus. These include the focus on individual versus social change, the disease model of alcoholism versus the feminist perspective of male responsibility, and substance abuse as a cause of violence (disinhibition) versus the spurious relationship ("alcohol as an excuse") viewpoint. Though none of these viewpoints have unequivocal empirical support, ideological posturing tends to resist concepts such as client heterogeneity, the need to adapt treatment to individual client needs, and the benefits of an evidence based approach intervention; that is, contemporary notions that favor a multidisciplinary approach to treatment.

3.6 PRACTICAL IMPLICATIONS

Although both substance abuse and conjugal violence settings are entry points for dual-problem individuals, it is likely that when systematic and sensitive screening procedures are not carried out, many cross problems slip by undetected. The dearth of treatment evaluation data prevents us from knowing what impact a persisting cross problem may have for the success of treatment for either conjugal violence or substance abuse. However, in the case of domestic violence, the failure to detect a concomitant and current conjugal violence problem in a substance abuse treatment setting may contribute to the ongoing risk of spouses and family members. Ironically, given the possibility of a non-linear relationship between the severity of substance abuse and the dangerousness of conjugal violence previously noted, there is even reason to believe that a dual-problem man whose substance abuse is resolved may in some cases be a less impaired spouse batterer.

The lack of in-house expertise poses its own risks. While probing into family violence may be both unfamiliar as well as anxiety producing for many unprepared substance abuse clinicians (Shapiro, 1982), it may also be seen as of secondary importance to substance abuse counselors. Violent behavior, if detected, may be attributed to the presumed disinhibitory effects of alcohol and/or drugs. According to this assumption, if the underlying substance abuse were controlled, conjugal violence would be expected to spontaneously resolve (O'Farrell & Choquette, 1991; Suissa, 1994). As discussed in a previous section, there is currently little support for the disinhibition hypothesis that predicts a cessation of violence with cessation of substance use. In the case of women undergoing substance abuse treatment, evidence has been presented that suggests that by their own substance abuse and reticence to leave an abusive relationship, women may be held responsible for their entrapment in an abusive relationship. Yet our poll results suggest that this belief remains fairly robust - considerable blame is placed on the victim for male violence, either from her behavior or some personality feature.

Some have questioned both the validity of assessment and referral procedures employed in many conjugal violence milieus as well as the manner in which such information was

utilized (Bennett & Lawson, 1994). Our poll indicated that screening for alcohol and drug abuse often results in referral or conditions being placed on access to treatment or support. However, there is little justification for referral to intensive treatments or AA by conjugal violence counselors for all individuals suspected of substance abuse. The assessment and treatment of substance abuse disorders have undergone profound transformations over the past decade. The substance abuse clinical and research communities have moved away from "one size fits all" perspectives that advocate referral to AA-type interventions and total abstinence treatment goals for all substance abusers. More flexible and adapted intervention strategies based upon the nature of substance abuse problem, the attributes of the individual and their readiness for change are now being actively advocated and empirically explored (American Psychiatric Association, 1994; Project MATCH Research Group, 1997). Immediate redirection to substance abuse treatment as a precondition for being admitted into violence treatment (Conner & Ackerly, 1994), irrespective of the nature and severity of the substance use, is not likely to be an effective intervention strategy (Bennett & Lawson, 1994). More ominously, such strategies may inadvertently place obstacles in the path between dual-problem men and access to necessary violence treatment. Consequently, by focussing on their substance abuse as an exclusion criterion, on-going abuse of their female partners may be perpetuated while substance abuse treatment is sought.

3.7 INTEGRATION OF TREATMENT FOR SUBSTANCE ABUSE AND CONJUGAL VIOLENCE

Integrated treatment approaches (i.e., multidisciplinary treatment under single program leadership) are generally accepted as the optimal treatment approach for substance abuse and the other health problems that tend to cluster around it (el-Guebaly, 1993). There are several models of integrated treatment, including the provision of simultaneous treatment services in one setting, sequential treatments in one setting, and multidisciplinary treatment navigated by a case manager. Given the common co-occurrence of conjugal violence and substance abuse problems, it seems reasonable to ask whether an integrated approach to treatment for these problems might not also be warranted.

Unlike the treatment of other comorbid problems linked to substance abuse, a cohesive, effective and evidence-based paradigm for providing integrated treatment for substance abuse and conjugal violence has yet to emerge (Collins et al., 1997). A number of conceptual and practical issues may underlie this lack of a comprehensive clinical response to this dual-problem phenomenon. One issue involves the disparate ideologies that underlie current approaches to the treatment of these problems. The substance abuse field continues to be dominated by the 'disease concept' of alcoholism, which seeks to facilitate help-seeking through a reduction of personal responsibility, social stigma, guilt and denial (Miller & Hester, 1989). Attributing many of the negative consequences and behaviors associated to alcohol and drug abuse to the effects of intoxication and dependence may diminish the pertinence of additional treatment for conjugal violence in individuals undergoing substance abuse treatment.

In contrast, the broader political and socio-economic purview of violence posits that wife battering is a manifestation of the gender inequality underlying most societal establishments (Laughrea, Bélanger & Wright, 1996). The male batterer is encouraged to both take personal responsibility for his abusive behavior as well as renounce any social sanction of loss of control for any reason, including from alcohol and drug intoxication. Despite the widespread belief that an unresolved substance abuse problem compromises violence treatment, there is a reluctance to acknowledge any putative relationship between the two problems. The main reason for this is based upon the fear that alcohol and drug use could be used as an excuse for violent behavior by the male perpetrator (e.g., "I was drunk") (Bennett & Lawson, 1994). In women's shelters, evidence of persistent substance abuse often results in expulsion (Collins et al., 1997). Such policies, though based upon the reasonable intent to provide a protective environment, may have the unfortunate result of punishing men and women for their substance abuse. Given the ambivalent role of substance abuse in violence treatment, the absence of a clear approach to coordinated or integrated treatment is hardly surprising.

Other more logistic obstacles may preclude the credible targeting of the cross problem in either substance abuse or violence settings. For example, the intensity and duration of treatment typically provided for substance abuse and conjugal violence vary greatly.

Moreover, group intervention for substance abuse remains the most prevalent modality of treatment. The appropriateness of such mixed group treatment modalities to clinically explore conjugal violence, given the important presence of violent men and victimized women in substance abuse treatment, is questionable. At the same time, other factors detected in our poll, such as intersectorial competition for scarce resources and the tendency to focus on single problems to rationalize funding and resources, also hamper the development of coordinated treatment strategies (Bennett & Lawson, 1994; Collins et al., 1997).

Nevertheless, some investigators have proposed different paradigms for the provision of integrated intervention. Connors and Ackerly (1994) have provided a thoughtful exploration of the potential of providing specialized treatment for alcohol-related battering. Citing the usual ideological discrepancies and the potential for confusing the client, these investigators have rejected the feasibility of coupling alcoholism treatment based upon the disease model of alcoholism (i.e., consistent with the Minnesota model, AA and 12-Step approaches to treatment) with conjugal violence intervention. In addition, the desirability or feasibility of combining treatments where one intervention (i.e., substance abuse treatment) often is offered on in-patient basis is questioned. Similarly, these authors argue that the feminist ideological standpoint of many conjugal violence treatments, where any relationship between substance use and conjugal violence is dismissed as spurious or an excuse, also discourages integration. Alternatively, these authors cite studies that support the efficacy of a cognitive-behavioral approach for the treatment of both substance abuse and conjugal violence. In addition, several other advantages of this strategy are posited, including : 1) the same elements of cognitive-behavioral intervention, including stress management, relaxation techniques, communication skills, anger management, and relapse prevention strategies are pertinent to both problems; 2) ideological discrepancies between treatments are avoided; and 3) components of the cognitive-behavioral approach are currently used in both treatment settings. Some data are emerging that provides support for this approach to treatment linkage. For example, men undergoing behavioral couples therapy have been found to both reduce their drinking and the physical abuse of their spouses (O'Farrell et al., 1998).

While preliminary, these findings point to the possible benefit of marital therapy for both problems, at least for intact couples.

In a review of the status of linkage between the two treatment communities in the U.S., Collins and his colleagues (1997) reiterate the belief that unresolved substance abuse is likely to represent a major impediment to effective conjugal violence treatment. At the same time, they note that depending on whether one is considering perpetrators or victims, the most appropriate model of linkage would probably be different. They argue that given the dearth of empirical data about the treatment of both problems within one programmatic context, or the current absence of a coherent paradigm to guide an integrated treatment approach, the most appropriate strategy would be a brokering or case management approach. This might involve one individual overseeing the assessment of all problems, setting treatment priorities, making appropriate referrals, ensuring that referrals are followed, providing a link between different treatment resources, and monitoring treatment outcomes.

Based upon the findings emerging from another literature, the provision of simultaneous treatment for conjugal violence and substance abuse in one setting may not be an insurmountable problem. Support for the effectiveness of very brief counseling (i.e., several minutes to four sessions) for moderate to severe substance abusers has been accumulating over the past two decades (Holder et al., 1991). In a recent prospective multi-site study, brief interventions consisting of four one hour sessions yielded equivalent outcomes compared to far more intensive traditional intervention approaches (Project MATCH, 1997). If the ambiguity surrounding the role of substance abuse in conjugal violence can be resolved, such brief approaches for the simultaneous treatment of substance abuse in conjugal violence settings offer intriguing possibilities.

Effective screening and evaluation may be effective interventions in of themselves. Several studies in the substance abuse field have supported the possibility of significant behavioral change with clear feedback and advice for change (Miller & Rollnick, 1991). Many substance abusers possessing heavy drinking family and social backgrounds remain unmotivated or fail to seek treatment for their problems due to poor problem recognition.

Attempts to refer an individual who has little insight into the severity of his problem are not usually effective. The variability of what constitutes violence even in authoritative circles has been noted. Thus, the confusion surrounding the behavioral threshold that must be surpassed for conjugal violence to be identified by either the perpetrator, the victim or the clinician, is hardly surprising (Hanneke & Shields, 1985). Accordingly, objective and systematic screening, evaluation and feedback has been posited as a means of increasing problem recognition and motivating individuals to initiate conjugal violence treatment as well (Bennett, 1995). Given the pertinence of motivation to the treatment of both conjugal violence and substance abuse, a motivational approach seems to hold promise for the treatment of both problems.

Initiatives involving systematic screening in other health care delivery settings, such as community primary care centers and hospital emergency rooms, have produced promising results. Contrary to the assumption that individuals dealing with conjugal violence are reluctant to admit to abuse, men and women are prepared to admit to abuse in their relationship if handled in an empathic and caring fashion (McCauley et al., 1998). Moreover, case finding leading to the possibility for further intervention has been significantly improved with systematic screening (Alpert et al., 1998; Oriel & Fleming, 1998). While to our knowledge, no systematic investigation of the effectiveness of systematic screening has been undertaken in a substance abuse treatment setting, such an approach seems a promising way to initiate a coordinated treatment for both problems.

Unfortunately, getting specialized health care providers to change their understanding and therapeutic approach to certain sensitive and uncomfortable issues is not always straightforward (WHO, 1996; Alpert et al., 1998). Even when state laws are invoked to make the reporting of conjugal violence mandatory, the assessment and reporting practices of frontline health professionals may fail to change (Sachs, 1998). In Quebec, the position of the Ministry of Health (*Bill 120 : Quebec Ministry of Health, 1990*) in this regard is clear. Specialized health services must : 1) individualize treatment plans based upon the distinct needs of the client (Article 72); and 2) actively utilize the different resources in the health service network to realize therapeutic outcomes (Article 75). With respect to conjugal violence in particular, the Ministry has recognized the need for : 1)

more coordination between the different sectors of the health service to meet the ensemble of needs of those affected by conjugal violence (Measure 47); and 2) a uniform and cohesive response to conjugal violence in all of the sectors of intervention (Measure 54) (*Politique d'intervention en matière de violence conjugale : engagements des ministères et de leurs réseaux, Quebec Ministry of Health, 1995*). Despite these clear guidelines, the systemic changes needed to improve the detection and treatment of concomitant conjugal violence and substance abuse have lagged.

Several factors may dissuade counselors or organisms to willingly change their procedures. With respect to systematic screening, the on-going confusion surrounding what behaviors constitute abuse and the discomfort that both substance abuse and family violence elicits has been noted. However, other issues may also contribute to the reticence to screen for concomitant problems, including : 1) misunderstood and exigent legal protocols for reporting abuse; 2) the perceived risks for both the client and therapist with strict conformity to the law; 3) fear of losing the client from therapy due to fear of the consequences of disclosure (e.g., retaliation, family break-up); 4) reduction of client willingness for honest disclosure; and 5) the fear of reducing therapeutic rapport (Durham, 1998; Emery & Laumann-Billings, 1998; Hyman, 1996; Spinola et al., 1998). These complex legal, ethical and clinical issues would need to be thoroughly addressed, with the safety and well-being of all concerned being of paramount importance, before any changes in clinician behavior could be expected to occur.

In summary, examples of treatment linkage for concomitant substance abuse and conjugal violence are limited. Linkage is fraught with a number of complex obstacles. The lack of an empirically supported paradigm has not helped. Nevertheless, the data emerging from some preliminary attempts at integration are promising. Better coordination between the two milieus may require keen attention to how entrenched attitudes may be altered and clinical-legal dilemmas resolved. In the following section, we attempt to integrate our findings and present some avenues for future development and research in this area.

CHAPTER 4 : RECOMMENDATIONS

In this final chapter, the discussion centers on recommendations for future action in the area of concomitant substance abuse and conjugal violence. It is certain that much needs to be done in each intervention area independent of the cross problem. In our review, given its focus on the recent literature and the present state of practice, progress in the way in which both substance abuse and conjugal violence are treated is not readily apparent. Significant progress has surely been made. In similar fashion, attempting to articulate recommendations also risks not acknowledging the efforts of individual health care providers and health service delivery settings to better address the needs of their clients grappling with both problems. We simply cannot be aware of all that has been done or is being done on the individual, local or network levels of intervention. We also acknowledge that many feel that the systematic abuse of women, and what is required to achieve societal change, is not compatible with an individual change purview with respect to conjugal violence treatment. Our position is that both social and individual changes are necessary. However, we focus on the necessary changes needed on an individual level towards the safety of women and children. Accordingly, this chapter will attempt to highlight what we feel are legitimate avenues for future efforts in improving services and care of these individuals.

- **Raise the awareness and competence of professionals working in natural entry points for substance abuse and conjugal violence problems**

Our review has underscored the enduring gender-based stereotypes and erroneous assumptions of causality with respect to the substance abuse-conjugal violence linkage. Our poll and the data cited from other studies suggest that such misinformation is pervasive in the two treatment communities positioned to deal with substance abuse and conjugal violence. These misconceptions are also present in other natural entry points to the health system, such as frontline health services and hospital emergency rooms. Irrespective of the mechanisms of causation, the presence of one problem should be understood as a strong predictor of the other problem. However, if in substance abuse treatment settings conjugal violence continues to be seen as inextricably linked to substance abuse, in either men or women, it is unlikely that sufficient attention will be paid to the systematic screening for and timely intervention against conjugal violence. On the other hand, if the ideological refusal to acknowledge the contribution of substance abuse to conjugal violence persists, an opportunity to detect, systematically evaluate and effectively treat substance abuse may be lost. Two obvious areas for consciousness raising and improving the quality of interventions may be mentioned : 1)

the inclusion of the conceptual and clinical facets of the substance abuse and conjugal violence linkage in the curriculums of training programs of health care professionals; and 2) the provision of on-going training for professionals in natural entry points for these problems, such as in primary care, substance abuse and conjugal violence settings.

- **Favor the implementation of brief but efficient, valid and sensitive screening and evaluation protocols for the cross problem in substance abuse and conjugal violence treatment settings**

In both the substance abuse treatment and conjugal violence fields, important advances in the development of brief, yet effective screening and evaluation methods to characterize these problems have been made. Very brief screening questionnaires, such as the Alcohol Dependency Scale (Horn et al., 1984), the Drug Abuse Screening Test (Skinner, 1982), and the AUDIT (Babor et al., 1992), are available in both French and English and are easily administered, scored and interpreted. The Conflicts Tactics Scale (Strauss et al., 1996) has been developed to characterize conjugal violence and battering. A francophone version (Rinfret-Raynor et al., 1989) has also been developed and validated. Given the reliability, ease of use and low cost of these instruments, in addition to the risks engendered by the failure to detect either problem, there seems little reason for not adding these brief instruments to the assessment batteries employed by these settings.

The ready adoption of objective and valid assessment protocols is not assured in either substance abuse or conjugal violence treatment settings. In this way, the two milieus share a common history and dilemma : the development of treatment programming based upon ideological principals (e.g., the feminist position and the disease concept) has not favored the integration of the more recent, evidence-based developments in assessment and treatment. This is especially true when such innovations are not readily compatible with traditional treatment philosophies. The lack of interest in many of these settings for research also does little to motivate them to employ the objective assessment instruments that could appraise the benefits of treatment for their clients.

A fairly recent development in the U.S. is noteworthy. Substance abuse treatment centers are now required to provide objective evidence of the effectiveness of their interventions as a

prerequisite for on-going public funding. This has promoted the adoption of a standardized, multidimensional assessment instrument, the Addiction Severity Index (McLellan et al., 1980), by the public substance abuse treatment settings in many states. This is arguably a heavy-handed strategy to encourage the utilization of a standardized assessment protocol. However, such measures are sometimes necessary to overcome organizational ideologies that resist change- regardless of the potential benefits for the client.

- **Encourage creative attempts at developing viable integrated treatment strategies**

Given the present dearth of empirical data, providing integrated treatment for linked substance abuse and conjugal violence problems opens the door to innovative approaches to treatment programming. We have presented both the risks and paradoxes of the prevalent parallel treatment approach to linked substance abuse-conjugal violence problems. We have also discussed some innovative attempts to orchestrate integrated treatment. For example, for some conjugal violence victims and perpetrators in treatment, brief treatments for their substance abuse may be feasible. Other treatment approaches, such as those based upon the cognitive-behavioral viewpoint, may be tailored to address both substance abuse and conjugal violence in men, effectively sidestepping any philosophical conflict or confusion for the client. In the case of substance abuse, for some clients a goal of a significant reduction in their substance use may also be feasible and more attainable than total abstinence. Similarly, in conjugal violence, equating all forms of abuse as equivalent, and therefore needing a comparable intensity of treatment, may limit the range of integrated treatment. Any attempts at integrating treatment should be orchestrated in a context where the safety of family members is paramount. Inevitably, selecting clients who might most benefit from a specific model of integrated treatment requires the use of the objective standardized assessment protocols discussed above.

Government support for such research and development projects into such integrated approaches to treatment would encourage university-based clinical training milieus, and substance abuse and conjugal violence settings in partnership with researchers to explore their feasibility and efficacy. Given the nascent level of development in this area, the willingness to fund feasibility trials, without necessarily embarking on a full outcome evaluation, seems

appropriate. By specifically targeting this area for exploration, as has occurred in the substance abuse area with respect to comorbidity, greater interest in a multidisciplinary approach to treatment could emerge.

- **Apply the principals of organizational change and transfer of technology principles to encourage changes in entrenched clinical practice in both milieus**

The substance abuse research community and service delivery sectors have traditionally not communicated with each other (Brown, 1995). A number of contextual factors, both human and situational, have been identified as contributing to this gap. For example, the views held by both the public and by health professionals concerning the etiology, course and treatment of substance use and conjugal violence problems remain heavily influenced by both moral and ideological perspectives. Such pervasive and entrenched values may be difficult to overcome when attempting to introduce an innovation that overtly runs contrary to many of these beliefs. The context of change in the conjugal violence setting seems similar.

Overcoming obstacles to change is often even more problematic in substance abuse and conjugal violence treatment settings. In an organizational system where past personal history is often a valued credential in a non-professional intervention agent (Brown, 1995), treatment innovations that diverge from meaningful personal experiences (typically Alcoholics Anonymous involvement; having a history of being victimized) may be viewed with considerable skepticism. Moreover, many innovations may be contrived for intervention agents who have a more academic and psychological purview of the addictions as compared to paraprofessional staff (e.g., recovering substance abusers). Consequently, these innovations may not be sufficiently accessible to the very audience counted upon to implement them (Kavanaugh, 1995).

While pre-existing or traditional values and belief structures extant in an organization may influence the transfer of an innovation, other contextual factors may also play a role. One such factor is *organizational readiness to change* (Backer, 1995). Successful technology transfer may depend on how well several human factors intrinsic to organizational readiness to change have been recognized and addressed. These include : 1) the rewards or negative

consequences of change for the individuals within an organization, 2) perceptions regarding the availability of resources needed to support the innovation, 3) the fears, anxieties and resistance that typically accompany the prospect of change, and 4) the importance of participation of the individuals affected by change in the change process. Given these challenges, both programmers and researchers involved in developing more effective intervention approaches to linked substance abuse and conjugal violence problems might be well advised to integrate principals of organizational readiness to change in their action plans.

SUMMARY

Methodological shortcomings plague the study of concomitant substance abuse and conjugal violence problems. Little consensus exists concerning what behaviors indicate conjugal violence, while the continued reliance on alcohol-only users in many studies does not reflect contemporary trends towards multiple substance use patterns. Detection based upon self-report is vulnerable to under-reporting. Finally, the reliance on samples found in clinical settings or after a specific event has occurred, such as substance abuse treatment or an emergency room visit, may not encompass the full range of possibilities with respect to concomitant substance abuse and conjugal violence. Despite these shortcomings, in both community and clinical samples substance abuse, especially alcohol, has been established as one of the most consistent and important predictor of conjugal violence in men, while alcohol abuse in women increases the risk of victimization at the hands of male partners. Less is known about the role of different drug abuse in the occurrence of these linked problems, but concurrent cocaine abuse has been found in large proportions of male perpetrators of conjugal violence and female victims. Finally, the prevalence of both problems have been linked to several common characteristics, including age and poverty.

It is uncertain to what degree the mechanisms underlying the substance abuse-conjugal violence linkage are distinct from the broader problem of the role of substance use and violence. Nevertheless, a number of hypotheses have emerged to clarify the putative association between substance abuse and conjugal violence. In men, four models have been proposed. A feminist model rejects the contribution of alcohol or drugs to conjugal violence, countering that this excuses the systematic abuse that women endure as members of a patriarchal social and political structure. Another paradigm, the disinhibition model, posits that the disinhibitory effects of alcohol and drugs cause conjugal violence. Though widely discredited, this model remains popular in many substance abuse settings. The spurious association model proposes that there is no direct causal link between these two problems, but rather both disorders are manifestations of certain individual, interpersonal or social situations. Finally, the integrative model posits that neither alcohol or drug use is a necessary or sufficient factor in the etiology of conjugal violence. Rather it is the convergence of certain factors such as age, family history and stress, antisocial personality features, poverty in addition to substance abuse that may promote conjugal violence.

In women, a number of explanatory models have also been forwarded. A masochistic personality coupled with the sexual looseness attributed to female drinking is seen as provoking victimization. Though popular, there is little data to support these notions. Another model attempts to explain the risk of alcohol abuse in adult women following childhood victimization. Lowered self-esteem, affiliation with deviant peer groups and the use of alcohol to cope has been posited to contribute to later substance abuse. Overall, despite the articulation of these explanatory models, a clear causal mechanism has yet to emerge. Moreover, much variability is seen in the individuals and problems afflicted with both problems. Thus, it is unlikely that any one model will adequately explain all possible types of concomitant substance abuse and conjugal violence problems.

Descriptive study of men with concomitant substance abuse and conjugal violence has sought to clarify whether these problems interact to influence the severity of either substance abuse or conjugal violence. In clinical samples, men with both problems generally show greater disturbances in psychosocial and psychological functioning compared to men with either one or the other problem. Furthermore, more dangerous violence is associated with more severe substance abuse problems, while different substances may act to increase (e.g., alcohol, cocaine) or diminish (e.g., cannabis, heroin) the risk or severity of violence. Similarly, the pattern of substance use may contribute to the dangerousness of conjugal violence. Episodic binge drinking has been associated with more severe disruption in family functioning, and a greater probability of marital aggression than a steadier pattern of consumption. In women, a high risk of post-traumatic stress disorder has been associated with both alcohol abuse and conjugal violence.

Several different approaches exist for the treatment of either substance abuse or conjugal violence. With respect to concomitant substance abuse and conjugal violence, despite their frequent co-occurrence, no specific treatment model has emerged. Thus, as important entry points into the health system for dual-problem individuals, substance abuse and conjugal violence treatment centers are left to devise treatment strategies without the benefit of either a comprehensive conceptual or evidence-based treatment paradigm.

A study conducted in the US as well as a poll conducted in Quebec investigating the degree of coordination between the two clinical milieus in treating concomitant substance abuse and conjugal violence problems yielded several common conclusions : 1) little coordination exists between the two treatment communities; 2) in-house expertise for the other problem in each milieu (e.g., conjugal violence in the substance abuse treatment setting) is often seriously limited; and 3) intervention for the cross-problem may be limited to referral, with referral practices being inconsistent and based upon dubious screening methods. While there was general recognition for the desirability of better coordination between the two treatment networks, a number of obstacles were cited, including : 1) competition for scarce resources; and 2) mutual suspicion of the compatibility of the different treatment ideologies thought to exist in either setting. The lack of a comprehensive treatment strategy may have important consequences for those suffering with both problems, such as : 1) undetected concomitant problems; 2) on-going risk and treatment complications engendered by the unaddressed ‘other’ problem; 3) screening strategies that fail to distinguish between different types of substance abuse and conjugal violence problems; and 4) referral strategies that are often punitive and diminish the accessibility to needed intervention services.

Integrated treatment approaches for substance abuse accompanied by other mental health problems are considered, both scientifically and politically, the optimal manner in which to orchestrate effective intervention for multiple co-occurring problems. Integrated treatment models for substance abuse and mental health problems may inspire attempts to plan and orchestrate a comprehensive treatment response for substance abuse and conjugal violence problems as well. Some data are emerging that suggest that the conceptual and logistic obstacles to integrated treatment for these problems may be surmountable. The availability of valid and easy-to-use screening procedures, the potential for brief yet effective interventions for substance abuse and conjugal violence problems, and treatments that may diminish both substance abuse and conjugal violence problems open the door to innovative approaches to integrated treatment.

Recommendations

- Raise the awareness and competence of professionals working in natural entry points for substance abuse and conjugal violence problems.
- Favor the implementation of brief but efficient, valid and sensitive screening and evaluation protocols for the cross problem in substance abuse and conjugal violence treatment settings.
- Encourage creative attempts at developing viable integrated treatment strategies.
- Apply the principals of organizational change and transfer of technology principles to encourage changes in entrenched clinical practice in both milieus.

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APPENDIX 1

***Questionnaire employed in the poll investigating attitudes
of professionals in substance abuse treatment settings***

APPENDIX 2

***Questionnaire employed in the poll investigating attitudes of
professionals in conjugal violence treatment settings***