

[ letters to the editor ]

## FEMALE VICTIMS OF DOMESTIC VIOLENCE AND ALCOHOL/DRUG MISUSE

### DEAR EDITOR:

There is fairly extensive research literature on the relationship between the use of alcohol or drugs and the perpetration of domestic violence.<sup>1-4</sup> However, the abuse of alcohol and drugs among female victims of domestic abuse rarely has been studied.

Most research examining female domestic-violence victims' use of alcohol/drugs has revealed a relationship. These studies, however, have involved unique samples, potentially compromising the ability to generalize findings to broader populations. For example, in a study of 1,306 South African women,<sup>5</sup> investigators found that victims' acute use of alcohol was

a victim of domestic violence. Finally, among American Indian women at a counseling center, Norton and Manson<sup>8</sup> found that participants with histories of domestic violence were significantly more likely to report problems with alcohol than participants without such histories. In contrast to the preceding studies, in a sample of couples in which the men had been convicted of spouse abuse, Greening<sup>9</sup> found little alcohol misuse among the women victims.

In the current study, we examined the relationship between domestic-violence victimization and self-reported "problems" with alcohol and drugs. Study candidates were women, ages 18 or older, unaccompanied by a male partner at the time of recruitment, who were

participate, for a response rate of 86.3 percent. With regard to race, 80 (70.8%) indicated Caucasian, 24 (21.2%) African American, 7 (6.2%) Native American, 1 Asian, and 1 "Other." Participants ranged in age from 18 to 57 years ( $M=35.98$ ,  $SD=10.43$ ). With regard to marital status, 15.9 percent of the sample were married, 15.9 percent separated, 32.7 percent divorced, 29.2 percent never married, 2.7 percent widowed, and 3.5 percent did not indicate marital status. As for level of completed education, 18.8 percent did not graduate high school, 45.5 percent graduated high school, 27.7 percent had some college experience, 4.5 percent had a bachelor's degree, and 3.6 percent had a graduate degree.

All study candidates were under the care of a single psychiatrist (J.C.), a university-



**THIS STUDY SUGGESTS that compared to women who denied having an alcohol or drug problem, women who reported such a problem had statistically significantly greater scores on violent threats, violent acts, and total domestic violence.**

positively associated with domestic violence. Clark and Foy<sup>6</sup> examined women from shelters and nonresidential community agencies and found a relationship between battering severity and alcohol use by the victims. Among Navajo women in an alcohol treatment program, Kunitz and colleagues<sup>7</sup> found that alcohol dependence was an independent risk factor for being

psychiatric inpatients at an urban community hospital in a mid-sized, mid-western city. Exclusion criteria for this study were cognitive, intellectual, or medical impairment that would preclude the successful completion of a survey booklet. The recruiting physician assessed these criteria. A total of 131 study candidates were approached and 113 agreed to

affiliated physician, and were approached as time permitted (i.e., a sample of convenience). After an introduction to the project and enrollment, each participant was given a research booklet to complete. The research booklet contained a measure for domestic violence, the Severity of Violence Against Women Scale (SVAWS),<sup>10</sup> and the brief queries, "Have you ever had

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**TABLE 1. Results of analyses of variance (ANOVAs) comparing alcohol and drug problem groups on measures of experienced violence from a relationship partner**

	Denied Problem	Reported Problem	F	p<
<b>ALCOHOL</b>				
Mean score on Violent Threats (SD)	41.83 (19.91)	57.16 (20.20)	15.38	0.001
Mean score on Violent Acts (SD)	38.60 (18.90)	51.57 (20.53)	9.69	0.003
Mean of Combined Scores (SD)	80.43 (37.40)	108.73 (42.32)	13.50	0.001
<b>DRUGS</b>				
Mean score on Violent Threats (SD)	44.12 (21.12)	52.81 (19.73)	4.62	0.04
Mean score on Violent Acts (SD)	39.94 (20.52)	50.16 (23.47)	5.73	0.02
Mean of Combined Scores (SD)	84.06 (40.38)	102.98 (41.73)	5.53	0.03

**NOTE: df=1, 106 for each F test**

a problem with alcohol?" and, "Have you ever had a problem with drugs?" As for the SVAWS, this measure is a 46-item, self-report assessment for domestic violence that explores three elements: threats (19 items), acts (21 items), and sexual aggression (6 items). We modified the SVAWS in three ways: 1) We eliminated the items on sexual aggression due to the sensitive nature of these queries, which resulted in a 40-item scale; 2) We reduced the Likert-style response options from 10 to 5, with 1=never, 2=rarely, 3=on occasion, 4=often, and 5=very often; and 3) We revised the qualifier, "over the past 12 months," to "throughout adulthood" to capture the lifetime prevalence of such experiences. The Cronbach's alpha for the Threats subscale was 0.97, the Acts subscale 0.97, and the overall total scale 0.98. Completion of the booklet by participants was assumed to be informed consent. The Institutional Review Boards of

both the community hospital and university approved this project.

With regard to results, scores on the SVAWS Threats subscale exhibited the full range of possible scores (19–45), with a mean score of 48.02 (SD=21.32), as did scores on the Acts subscale (21–105), with a mean score of 23.84 (SD=22.18). The overall score is comprised of the total on both subscales, with a possible range from 40 to 200; actual scores ranged from 40 to 187 (M=91.85, SD=41.67).

A total of 109 women completed the measure of domestic violence and answered the item about alcohol misuse, whereas 108 women completed both the measure of domestic violence and the item about drug misuse. Results of analyses of variance (ANOVAs) comparing mean scores on each measure of domestic violence as a function of drug or alcohol problems are presented in Table 1. Compared to women who denied having an alcohol or drug problem, women

who reported such a problem statistically had significantly greater scores on violent threats, violent acts, and total domestic violence.

To compare those with versus without histories of domestic violence, we decided to use a cutting score of less than 70 on the total SVAWS as the criterion. This cutting score was substantially below both the mean (91.85) and median (90) scores on the SVAWS. Using a cutting score of 70 resulted in 54 women with a history of domestic violence, compared to 45 without such a self-reported history. Rates of self-reported alcohol problems were considerably higher among the group with a history of domestic violence (53.1%) compared to the group without such a history (22.2%),  $X^2=10.48$ ,  $p<0.001$ . Similarly, rates of self-reported drug problems were considerably higher among the group with a history of domestic violence (49.2%) compared to the group

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without such a history (26.7%),  $X^2=5.57$ ,  $p<0.02$ .

These findings indicate that among women psychiatric inpatients, those with histories of domestic violence are significantly more likely to acknowledge histories of both alcohol and drug misuse compared to those without histories of domestic violence. Therefore, among women psychiatric inpatients who report domestic violence, clinicians need to consistently screen for the presence or not of a past or current history of alcohol and/or drug misuse.

The explicit temporal relationship between victim status and alcohol/substance abuse is unclear. It could be that pre-existing alcohol/substance abuse in women heightens the likelihood of linking up with violent male partners. Likewise, acute alcohol/substance misuse by the couple may lower the threshold for violence, resulting in domestic abuse by a male partner. Finally, some data suggest that alcohol/substance abuse may be the aftermath of domestic maltreatment.<sup>11,12</sup> Regardless of the temporal relationship between domestic maltreatment and alcohol/substance use, our clinical recommendations remain unchanged—women with histories of domestic violence need to be evaluated for past or current histories of drug and/or alcohol misuse.

This study has several potential limitations. First, the findings are based upon self-report data, which has its own inherent limitations. Second, the inquiries about alcohol and drug misuse were simple, one-item

self-report queries. Third, this sample consisted of women psychiatric inpatients, and findings may not apply to healthier psychiatric outpatients or non-psychiatric patients. However, to our knowledge, this is the only study to explore among psychiatric inpatients the relationship between domestic violence and the victim's misuse of alcohol and/or drugs. Further research might examine the temporal relationship of drug and alcohol abuse to domestic maltreatment, the existence of this relationship in other clinical and nonclinical samples, and more detailed information about the extent and longitudinal consequences of alcohol/substance misuse in these women victims.

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## CONTINUED INAPPROPRIATE USE OF THE TERMS “TYPICAL” AND “ATYPICAL” ANTIPSYCHOTICS

### DEAR EDITOR:

The terms *typical* or  
*conventional* antipsychotic and

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*atypical* antipsychotic should be retired and replaced by *first-generation antipsychotic* (FGA) and *second-generation antipsychotic* (SGA), respectively.

*Second-generation* does not refer merely to the chronology of introduction of these medications (though in general they have been more recently introduced). Rather, the differences between the FGAs and SGAs are so marked in mechanism of action, efficacy, and adverse effects that we are justified in referring to them as a new generation of antipsychotics. A MEDLINE search showed that the earliest reference to a newer antipsychotic as *atypical* was in 1975 when the term *atypical neuroleptic* was used<sup>1</sup> (really a misnomer, since the term *neuroleptic* referred to the high propensity of the FGAs to cause extrapyramidal adverse effects). The earliest paper<sup>2</sup> that referred to these medications as *second-generation* was in 1979. However, 25 years later both terms, *atypical* antipsychotic and *second-generation* antipsychotic, are used in the literature based on the arbitrary preference of the authors. The former term is still used much more frequently to describe these medications.

A PubMed search of MEDLINE limiting the articles to English and 2005 resulted in 374 articles using the older terms and only 97 articles using the terms FGAs or SGAs. Thus the older terms, *typical* or *atypical* antipsychotics, continue to be used much more frequently, the reasons for which are not apparent to us.

The term *serotonin-dopamine antagonists* is also inappropriate because the distinctive features of these medications are not necessarily related to antagonism of these receptors.<sup>3</sup> Also amisulpiride, an SGA, does not bind to serotonin receptors, and aripiprazole is a partial agonist at D2 and 5-HT1A receptors.

The term *atypical* now also seems odd because new prescriptions for SGAs greatly outnumber those for the FGAs.<sup>4</sup> Between 1997 and 2000, of the visits at which any antipsychotic was prescribed, the percentage of outpatient visits when an FGA was prescribed declined from 48 percent in 1997 to 29 percent in 2000.<sup>5</sup>

Journals should uniformly adopt the more appropriate terms *first-* and *second-generation* antipsychotics since “atypicals” are really “typicals” now.

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## SUPPORT SYSTEMS AND ABSTINENCE IN ADDICTION

### DEAR EDITOR:

In previous studies, social support has been described as an individual's belief that he is cared for and valued as a member of a system or network of common and mutual concerns.<sup>1</sup> This perception of support is thought to be related not only to its actual availability, but also to the criteria that individuals use in interpreting the supportive behavior. It can either be seen as functional or structural, where the quality of the support is considered and can be categorized in a variety of ways (usually seen as “networks”) in such a manner as to indicate connections to the individual's employment, drug, and personal systems.

Research has shown that social support can play a significant role

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in drug addictive behaviors, as well. The people involved in one's supportive "network" can either promote or attenuate substance use. Social support is also associated with behavioral change. In a recent article, Brown and Riley<sup>1</sup> state that social support is associated with lower rates of drug up-take, less illicit use, fewer relapses, and more positive treatment outcomes. Good connective social support from nuclear family members has been shown to reduce drug use among adolescents. For adults, positive support has also been shown to be related to a reduction in drug use behaviors even years later.

mental health infrastructures, such as physical fitness, mental health issues, stress management, nutrition, family lifestyle development, conflict resolution, and alcohol-and drug-free choices, appear to protect against the negative factors associated with substance abuse. They appear to strengthen and broaden an underlying wellness principle connected to healthier lifestyles consistent with prevention and antidrug use norms. In the quest for continued abstinence among substance abuse users, supportive roles held by the nuclear or extended family, co-workers, church members, or social peers may involve an

both drugs and alcohol, with more than half having histories of substance use greater than 20 years. For voluntary abstinences, 25 percent had abstinences of 6 to 12 months, and a little over a third of the group had abstinences greater than 48 months.

Of the original 100 patients, nine claimed that they stayed clean on their own without any specific support. This group was slightly older ( $52.2 \pm 6.5$ ), predominantly African American, all unemployed, and predominantly drug or drug/alcohol users. Seventy-eight percent had years of use greater than 21, and 44 percent greater

**Our study, as anticipated, showed that patients who have support system reinforcement demonstrated a higher rate of abstinence and maintained longer periods of abstinence. Patients with stable environmental factors, such as employment and living arrangements, had longer abstinence rates than those who did not.**

These support factors may occupy the very core of the patient's day-to-day experiences. They include but are not limited to adequate living situations, active church affiliations, nuclear familial support, prescribed medication, social affiliations, and economic stability. In substance abuse treatment clinics, it is generally emphasized that some sort of supportive system be a part of follow-up care after detoxification and rehabilitation. The development of supportive systems and services that promote good physical and

acknowledgment of these roles as a crucial part of treatment or post-treatment work.<sup>2</sup> In this current study, we used variables, such as church affiliation, family and social support, aftercare (Addiction Recovery Unit care [ARU]), and medication as indicators of support services.

We recruited 100 male patients ranging in age from 33 to 65 years. Sixty-six percent were African American, 88 percent were currently unemployed, 45 percent had no stable residence, and 39 percent were intravenous drug users. Sixty percent used

than 30 years. Fifty-five percent were homeless, two percent had no history of abstinences greater than six months, and 44 percent had abstinences lasting longer than 48 months.

In the larger support system group ( $N=91$ ), the mean age was  $48.3 \pm 6.3$  years. They were also predominantly African American and had an injection use history of 36 percent. Seventy-nine percent were unemployed and 84 percent were drug or drug/alcohol users. Fifty-four percent (54%) had use greater than 21 years, 26 percent greater

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than 30 years, and 40 percent were homeless. Thirteen percent had no sustainable abstinences greater than six months, but 31.9 percent had abstinences lasting longer than 48 months.

Significant correlations at the 0.05 level (2-tailed) were seen between age, employment, and years of use. Longest abstinence and sponsor had a negative significant correlation with longest abstinence and on-my-own. Support group, injection drug use, and medication also had a significant correlation with family and sponsor.

Our study, as anticipated, showed that patients who have support system reinforcement demonstrated a higher rate of abstinence and maintained longer periods of abstinence. Patients with stable environmental factors, such as employment and living arrangements, had longer abstinence rates than those who did not.

Similar studies<sup>3,4</sup> showed patients who remained in environments where they were continuously exposed to drug use were less likely to decrease their drug use. Wasserman<sup>3</sup> observed that in opioid-maintained treatment participants with a dual diagnosis for cocaine (with higher levels of abstinence-specific general support) were more likely to be cocaine abstinence at follow up. Empirical data from other studies identify abstinence-specific social support models as being consistent with cognitive behavioral and relapse prevention models for substance abuse treatment and validate the effects of treatment, which

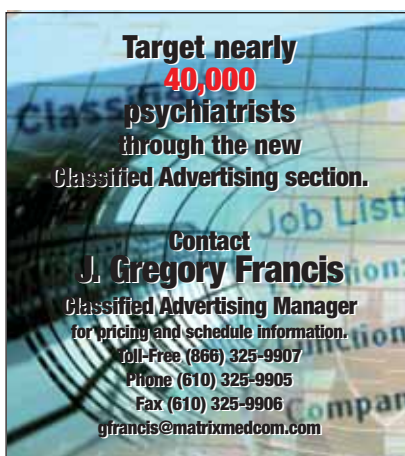
focuses on patients' social patterns as abstinence specific influences. The decision to stop using drugs was typically associated with cognitive emotional experience, which included small personality and behavior changes, thereby creating a more favorable climate for drug cessation.<sup>5</sup>

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