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Prevalence and differential profile of patients with drug addiction problems who
commit intimate partner violence

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ABSTRACT

Background and objectives: The objectives of this study were, first, to explore the prevalence of aggressors with lifetime intimate partner violence (IPV) among patients in the Proyecto Hombre of Navarra (Spain) addiction treatment programme; and second, to know the specific and differential characteristics of patients presenting IPV as aggressors. Methods: A sample of 162 patients (119 men and 43 women) was assessed. Data on socio-demographic and substance consumption characteristics, IPV variables, psychopathological symptoms, and personality variables were obtained. The profiles of patients in addiction treatment with and without a history of violence towards their partners were compared. Results: The results showed that 33.6% of people in treatment for addiction had committed violence against their partners. This prevalence was significantly higher ($X^2 = 15.6, p < .001$) in women (63.3%) than in men (24.2%). In the 98.4% of the cases the IPV was bidirectional. Patients with a history of IPV perpetration showed greater severity in substance consumption variables, psychopathological symptoms, and personality traits. Gender, the family scale on the European version of the Addiction Severity Index (EuropASI), and the aggressive-sadistic scale on the Millon Clinical Multiaxial Inventory (MCMI-III) were the main variables related to the presence of IPV as aggressors. Discussion and conclusions: There was a differential profile in patients with IPV perpetration, showing more psychopathological and personality symptoms. Moreover, in this study being a woman was one of the main predictors of committing IPV.

Keywords: Violent behaviour; drug addiction; intimate partner violence; comorbidity; assessment.

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INTRODUCTION

The consumption of alcohol and other drugs in intimate partner violence (IPV) is well documented ¹. Between 50% and 60% of those who commit IPV have problems with alcohol abuse or dependence ²⁻⁴, and approximately 20% of male aggressors abuse other drugs ^{3,5,6}. In addition, there appears to be a strong association between the consumption of these drugs and the severity of violent episodes ⁶.

Some studies have shown that about 20% of the couples in general population have experienced past year physical IPV ⁷. Specifically, the rate of women who have experienced violence committed by a partner at some point in their lives ranges between 16.5% and 30%, while approximately 4% are victims of ongoing abuse ⁸. These episodes can be psychological, physical or sexual in nature. On the other hand, although some studies determining the prevalence of partner aggressors in the general population suggest that men and women are equally violent in intimate relationships ⁹, other studies report that women are more likely to use violence than men ^{10,11}. Specifically, recent studies report a violence rate between 17% (past year)¹² and 27% (lifetime)¹³ in men, and between 31% (past year)¹⁴ and 42% (lifetime)¹³. These data seem to contradict the classical consideration of IPV in which most of the victims are women ¹⁵. Anyway, beyond these contradictory data about prevalence, both male and female aggressors tend to exhibit significant psychological deficiencies that include, for example, cognitive distortions concerning sexual roles and the inferiority of women, communication difficulties, irritability, poor impulse control, alcohol abuse, and pathological jealousy ².

In patients with drug addiction problems high rates of IPV have been found ¹⁶⁻¹⁸. Between 30% and 60% of people in treatment for drug addiction have had episodes of

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violence against their partners during the year prior to the initiation of treatment ^{19,20}. In some studies, the influence of alcohol and other drugs has become clear in the onset and development of violence against intimate partners ^{21,22}. These rates of IPV, when associated with addictions, are significantly higher than those found in the studies conducted in the general population ^{8,23}.

However, no data are currently available in Spain on the existence of a specific profile in patients receiving drug addiction treatment who simultaneously present the problem of IPV perpetration. This lack of data is striking because it is a relevant issue due to its high prevalence in the general population and its clinical interest.

Nevertheless, some international studies seem to identify a more severe profile among drug-addicted patients with IPV perpetration, with more associated psychopathological symptoms, more maladjustment problems, higher levels of anger and greater drug and alcohol consumption ^{17,18}. Consequently, more studies are necessary because this is a problem that often goes unnoticed in treatment programs for addictions, which mainly focus their attention on substance consumption problems.

Therefore, this paper presents two studies that aim to determine the prevalence and differential profile of subjects with lifetime IPV perpetration among people receiving treatment for addiction. The rationale of studying lifetime abuse is the high probability of recidivism among people who have committed IPV in the past ^{3,24}. The aim of Study 1 is to explore the prevalence of intimate partner abusers in patients undergoing treatment for substance addiction and the type of IPV involved (psychological, physical and/or sexual), while the aim of Study 2 is to know the specific and differential characteristics of patients in addiction treatment with a history of IPV as

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aggressors. According to the abovementioned literature, it can be hypothesized that drug-addicted patients of the sample will present with a high prevalence of lifetime IPV perpetration. Moreover, a greater severity of the addiction and more associated problems will be expected in patients with IPV than in those without IPV.

METHODS

The protocol for this study was approved by the ethics committees of the Universidad Pública de Navarra and of the Fundación Proyecto Hombre de Navarra. The informed consent was written and signed by all participants.

Participants

The sample consisted of patients seeking treatment for addiction in one of the two programs (outpatient and therapeutic community) of the *Proyecto Hombre de Navarra* addiction treatment program (Spain). These programs have a cognitive behavioural basis and are geared towards abstinence. They are public and attend patients, who are representative of Spanish patients with addiction problems, from all over the region. Every single patient who attended the clinical centre was considered for study inclusion.

Study admission criteria included the following: a) meeting diagnostic criteria for substance dependence disorder according to DSM-IV-TR²⁵, b) being between 18 and 65 years old, and c) giving consent to participation in the study. Exclusion criteria included the following: a) the existence of serious mental illness advising against participation in the study, b) a statement by professionals advising not to interview the patient given his or her stage in the treatment process, and c) the lack of knowledge of the Spanish language.

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Two different studies with different samples were carried out. For Study 1, which aimed to determine the prevalence of lifetime IPV perpetration, all patients (N = 180) who consecutively attended treatment in the period between May and December 2010 were included. Following the above mentioned admission and exclusion criteria, 39 people (18%) were excluded from the study, and 16 (7.4%) refused to participate in it. Therefore, a total of 125 (69.4% of total) subjects were studied. Of these, 76% were men (n = 95) and 24% women (n = 30). The average age of the subjects of Study 1 was 36.4 years (SD = 9.0).

For Study 2, which aimed to compare patients with and without IPV perpetration, 37 patients who had committed IPV and who consecutively attended treatment from January to December 2011 were added. The aim was to achieve a more well-balanced sample size between the groups studied. Thus, a total of 162 (74.7% of the starting sample) subjects were studied in the second study. Of these, 73.5% were men (n = 119) and 26.5% women (n = 43). The average age of the subjects of Study 2 was 36.4 years (SD = 8.9).

Instruments

All the instruments have been selected taking into account the clinical relevance shown in previous studies about IPV perpetration in Spain ^{2,3}.

The General Structured Interview of Batterer Men ²⁴ consists of five sections that collect data on the respondent's demographic characteristics, potential labor problems, child and adolescent development, potential problems of abuse in previous intimate partner relationships, and the current situation with their partners, health status,

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criminal record, and social relations. It also explores psychopathological variables that are usually related to family violence (mainly, jealousy and abuse of alcohol).

The EuropASI ²⁶ is the European version of the Addiction Severity Index scale (ASI) ²⁷. The Spanish version used is by Bobes, González, Sáiz, and Bousoño ²⁸. This interview assesses the need for patient treatment based on seven different areas: a) general medical condition; b) employment and financial situation; c) alcohol consumption; d) use of other drugs; e) legal problems; f) family and social relationships; and g) psychological state. The Interviewer Severity Rating (ISR), which has proven useful in different studies conducted in the treatment context ^{29,30}, has been used. The score for each area ranges from 0 (no problem) to 9 (extreme problem). The higher the score, the more need for treatment.

The Revised Conflicts Tactics Scale-2 (CTS-2) ³¹, which consists of 78 items, measures the degree to which people commit and/or suffer IPV, as well as the use of negotiation to resolve partner conflicts. It consists of five scales: a) reasoning/negotiation; b) physical aggression; c) psychological abuse; d) sexual coercion; and e) injuries. In this study, the last four scales, which are related to violent behaviours and which are simultaneously subdivided into minor and major violent behaviours, have been used. The version with dichotomous responses has been applied (0, absent; 1, present), indicating whether the behaviours that compose the scale have ever occurred.

The Inventory of Distorted Thoughts about Women (IDT-W) ²⁴ consists of a list of 13 binary items aimed at detecting irrational thoughts related to sexual roles and the inferiority of women. A four-point Likert scale, from 1 (strongly disagree) to 4 (strongly

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agree), has been used. The results range from 13 to 52. The higher the score, the more distorted thoughts.

The Inventory of Distorted Thoughts about the Use of Violence (IDT-V) ²⁴ consists of a list of 16 binary items aimed at detecting irrational thoughts related to the use of violence as an acceptable way to resolve conflicts. A four-point Likert scale, from 1 (strongly disagree) to 4 (strongly agree), has been used. The results range from 16 to 64. The higher the score, the more distorted thoughts.

The Symptom Checklist (SCL-90-R) ³² is a self-administered questionnaire for general psychopathological assessment. It consists of 90 items using a five-point Likert scale, from 0 (nothing) to 4 (extremely). The questionnaire aims to reflect the symptoms of psychological distress. It consists of nine primary symptom dimensions:

somatisation, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Additionally, it offers three global indices that reflect the level of overall severity of the subject: the Global Severity Index (GSI), which reflects overall symptom severity, the Positive Symptom Distress Index (PSDI), which indicates symptom intensity, and the Positive Symptom Total (PST), which includes the number of items answered with a score different from 0. In this study, the percentiles of each dimension have been considered.

The Millon Clinical Multiaxial Inventory (MCMI-III) ³³ is a clinical questionnaire used to assess general psychiatric disorders, including personality disorders. It consists of 175 dichotomous response items (true/false) that provide information on 11 basic personality scales (schizoid, avoidant, depressive, dependent, histrionic, narcissistic, antisocial, aggressive-sadistic, compulsive, passive-aggressive,

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and self-destructive), three pathological personality scales (schizoid, borderline and paranoid), and 10 clinical syndromes (anxiety, somatoform, bipolar disorder, dysthymia, alcohol abuse, drug abuse, posttraumatic stress disorder, thought disorder, major depression, and delusional disorder) .

The State-Trait Anger Expression Inventory (STAXI) ³⁴ consists of 10 items related to state-anger (intensity of the emotion of anger in a particular situation) and another 10 that refer to trait-anger (individual disposition to feel anger). Scores range from 10 to 40 on each scale. The higher the score, the greater anger.

The Barratt Impulsiveness Scale (BIS-10) ³⁵ aims to assess the degree of impulsivity of the subjects. It consists of 33 items scoring from 0 to 4 on a five-point Likert scale. The total scale ranges from 0 to 132. The higher the score, the greater impulsivity.

The Maladjustment Scale ³⁶ reflects the degree to which the problem of each patient affects different areas of everyday life. It consists of six items ranging from 0 (nothing) to 5 (extremely) on a six-point Likert scale. The total scale range is 0-30. The higher the score, the higher the level of maladjustment.

Procedure

Once the clinical sample was selected using the criteria described above, the assessment of the sample was carried out before beginning the treatment for addiction. All patients were interviewed by clinical psychologists who had ten or more years of experience in assessing and treating addictions. Self-report measures were administered with paper and pencil with the presence and support of the interviewers.

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In Study 1, the presence of lifetime IPV perpetration and the type of violent behaviour taking place among patients with addictive disorders attending intervention programs was assessed. The General Structured Interview of Batterer Men ²⁴ was conducted, and the CTS-2 was administered.

In Study 2, socio-demographic characteristics, substance consumption patterns, and associated psychopathological symptoms were evaluated. For this purpose, three assessment sessions were conducted on a weekly basis with each patient. In the first session, the presence of lifetime IPV as aggressor was assessed by conducting the General Structured Interview of Batterer Men ²⁴ and completing the CTS-2, as well as data related to consumption of substances (EuropASI). In the second session, the two questionnaires that assess the psychopathological and personality variables (SCL-90-R and MCMI-III) were completed. In the third session, questionnaires that assess other personality characteristics (anger and impulsivity) and maladjustment were administered.

Having assessed all patients, two groups were formed according to the presence or absence of IPV perpetration. This research considered that a patient had a history of violent behaviour when meeting one of the following criteria: 1) the recognition by the patient of IPV as aggressor; 2) a positive score on some specific scales of the CTS-2 (severe physical aggression, severe sexual coercion, item 15 of minor sexual coercion, minor injuries, and severe injuries); 3) having been reported in the past for a crime of IPV; 4) having a restraining order based on IPV; and 5) the existence of IPV informed by the therapeutic team responsible for drug addiction treatment. In case of doubt or

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conflict, this last criterion prevailed. Information about criteria 3 and 4 was provided by the Legal Service of the treatment programme.

Data Analysis

Descriptive analyses were performed for all variables. In the bivariate analysis between patients with and without a history of IPV as aggressors, χ^2 or the Student's *t* test for independent samples were used, depending on the nature of the variables analysed. Effect size (Cohen's *d* or *w*) and statistical power (alpha = 0.05) for all of the analyses were provided. Regarding multivariate analysis, a logistic regression analysis (forward method) was conducted to determine which specific factors were most important for differentiating between the two groups studied. A difference of $p < .05$ was considered significant. All statistical analyses were performed using SPSS (vs. 15.0) software.

RESULTS

Prevalence and characteristics of IPV perpetration

The results of Study 1, in which the first 125 patients who consecutively attended treatment were assessed, showed a prevalence of lifetime IPV perpetration of 33.6% ($n = 42$). Significant differences were observed based on gender ($X^2 = 15.6$, $p < .001$): in the case of women, the rate of IPV perpetration was 63.3% ($n = 19$), whereas in the case of men, it was 24.2% ($n = 23$).

Regarding the type of IPV, all participants who endorsed violent behaviours were involved in some type of psychological aggression ($n = 42$), 85.7% in physical aggression ($n = 36$), and 40.5% in sexual assault ($n = 17$). A total of 69% ($n = 29$) had caused injuries to their intimate partners.

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Moreover, in the 98.4% of the cases the aggressors had also been victims of IPV. In these cases the IPV was bidirectional.

Comparison between groups with and without IPV perpetration

The results of Study 2, in which 162 subjects were assessed, showed a differential profile between patients with and without a history of IPV as aggressors. Regarding the socio-demographic variables, the predominant profile in the sample was a person of 36.4 years, unmarried, and with a primary educational level (Table 1). The only significant difference was observed in sex distribution: the proportion of women was much higher ($X^2 = 14.0$; $p < .001$) in the group with violent behaviours (41.4%) than in the group without violent behaviours (15.2%).

---TABLE 1 HERE---

Regarding substance consumption patterns, cocaine and alcohol were the main substances that caused entry into the treatment program. There were no significant differences between groups in the substance that motivated treatment.

Regarding the severity of consumption, assessed by the need for treatment in the different categories considered by EuropASI, subjects in the total sample had the highest scores on the family/social, the consumption of alcohol and other drugs, and the psychiatric categories (Table 2). The group with a history of IPV perpetration obtained high scores in all categories, with statistically significant higher scores in the medical ($t = 2.0$; $p < .05$), use of other drugs ($t = 2.1$; $p < .05$), and family/social ($t = 4.1$; $p < .001$) categories than the group without IPV.

On the other hand, the group with IPV perpetration showed significantly more distorted thoughts about women than the group without IPV ($t = 2.5$; $p < .05$).

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However, there were no significant differences between groups in the distorted thoughts on violence.

---TABLE 2 HERE---

In regard to the psychopathological variables, the results of the SCL-90-R showed a moderately high level of psychopathological symptoms. The highest scores appeared on the GSI and the PST and on the dimensions of psychoticism, interpersonal sensitivity, depression, and paranoid ideation. The group with IPV perpetration had significant higher scores than the group without IPV in the GSI ($t = 2.1; p < .05$), PST ($t = 1.9; p < .05$) and in the scales of interpersonal sensitivity ($t = 2.1; p < .05$), depression ($t = 2.3; p < .05$), anxiety ($t = 1.9; p < .05$), hostility ($t = 2.0; p < .05$), and psychoticism ($t = 2.1; p < .05$).

Regarding the scales assessed by the MCMI-III, the high scores obtained for the total sample on the scales of substance dependence, alcohol dependence, and antisocial tendency are prominent (Table 3). People with a history of IPV perpetration scored significantly higher than those without IPV on the following scales: antisocial ($t = 3.3; p < .001$), aggressive (sadistic) ($t = 4.2; p < .001$), negativistic (passive-aggressive) ($t = 2.9; p < .01$), paranoid ($t = 3.1; p < .01$), dependence on alcohol ($t = 2.4; p < .05$) and other substances ($t = 2.3; p < .05$), posttraumatic stress disorder ($t = 2.4; p < .05$), and delusional disorder ($t = 2.0; p < .05$).

---TABLE 3 HERE---

Regarding the other personality variables, there were differences in trait-anger ($t = 3.1; p < .01$) measured by STAXI and in the levels of impulsivity ($t = 2.0; p < .05$) recorded by the Barratt Impulsiveness Scale (BIS-10), being significantly higher in the

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group with a history of IPV perpetration than in the group without IPV. Finally, the Maladjustment Scale reflected differences between the two groups in the degree of involvement of the problem spreading to different areas of everyday life, with the highest scores in the group with a history of IPV as aggressors ($t = 2.0$; $p < .05$).

Multivariate analysis

The logistic regression analysis showed that the three variables that best predicted belonging to the group of violent patients were gender (female), family scale of the EuropASI (high score), and aggressive-sadistic scale of the MCMI-III (high score). These three variables correctly classified the presence/absence of IPV in the 70.4% of cases (Table 4).

---TABLE 4 HERE---

Due to the influence of gender, differential logistic regression analyses were conducted on men and women in the sample. The results showed that, in the case of men, aggressive-sadistic (high score) and substance dependence (high score) scales of the MCMI-III predicted belonging to the group of IPV perpetrators. These variables correctly classified the presence/absence of IPV in the 72.3% of cases. In the case of women, family scale of the EuropASI (high score) and aggressive-sadistic scale of the MCMI-III (high score) predicted belonging to the group of IPV perpetrators. These variables correctly classified the presence/absence of IPV in the 75% of cases.

DISCUSSION

In the first study, 33.6% of patients being treated for addiction had a history of IPV perpetration. This result confirms data from previous studies that found a close relationship between the two phenomena (IPV and addictive behaviours)^{5,6,21,22}. For

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example, the rate of IPV among men in treatment for alcohol disorders was 42% in the study of Taft et al.¹⁸ and 21.5% in the study of Kraanen et al.²⁰. These rates are significantly higher than those found in studies conducted in the general population^{8,23}. Consequently, IPV is a prevalent phenomenon among patients undergoing treatment for drug addiction^{17-19,37}. These results are clinically relevant because the presence of IPV often goes unnoticed in treatment programs for addictions, which mainly focus on consumption problems.

A result that is particularly striking is that in the case of women with addiction problems, nearly two in three (63.3%) have committed IPV. This figure is significantly higher than that found in men (24.2% of cases) and doubles the rate of female aggressors found in the general population (31%, according to Palmetto et al.,¹⁴). Although traditionally IPV has been associated with a male-perpetrator and female-victim pattern, an increasing number of studies have also shown the presence of violence committed by women against men^{15,38}. Certain studies even indicate a higher prevalence of these violent behaviours in women than in men¹⁰ and the existence of a differential profile by gender¹¹. In the present study, being a woman is one of the main predictors of committing IPV among the patients in the sample. From a clinical point of view, this finding is relevant because both addiction and violence programs are generally focused on men.

In this regard, studies that examine the differential profile by gender show that women who attend programs for drug addiction present a more severe profile than men do³⁹: worse employment situation and more labor problems, as well as more need for treatment in the medical, family, social and psychiatric areas. Consequently, a high

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proportion of women have particularly difficult partner relationships derived from drug consumption. This could explain the differences by gender found in the study. Anyway, this is only a mere hypothesis that should be tested in future studies.

Moreover, there are frequently situations of IPV in which the woman is both aggressor and victim. In fact, a similar result, with high rates of bidirectional IPV, has also been found in the study by Palmetto et al.¹⁴. In these cases, the therapeutic intervention should aim at both controlling the development of violent behaviour and learning coping skills for the violence received.

In any case, the clinical impression shows that the profile of the aggressor found in this study differs from the traditional abuser profile related to gender violence³. Far from being an abuser with a continued pattern of violent episodes, the profile consists in a pattern of sporadic, bidirectional IPV and is usually associated with episodes of substance abuse.

Regarding the comparison of patients with and without a history of IPV perpetration carried out in Study 2, the results show the existence of significant differences in some of the studied variables. Therefore, there seems to be a differential profile in those patients in addiction treatment with a history of violence against their partners. In particular, they are people with more maladjustment problems, with more psychopathological symptoms and personality problems. The results of this study indicate a strong relationship between greater severity and personal destabilisation that arises from addiction and the commission of IPV. These data support those obtained in studies conducted with abusers without addiction problems, in which the perpetration of

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IPV is associated with increased associated psychopathology and personality problems^{24,40}.

This study has certain limitations. First, due to its exploratory and descriptive nature, the specific causal role of substance consumption in the development of IPV cannot be established. Second, our study included patients who sought treatment at a specialised centre. Undoubtedly, this created a bias that prevents us from generalising the results to all patients with drug addiction problems. Third, it would be interesting to have a larger sample, which would enable the exploration of the possible association between the substances consumed and the commission of IPV. In this study, for example, subjects with a history of IPV perpetration consumed more cocaine, and subjects without a history of IPV consumed more alcohol. These data, which are not significant, suggest that the type of substance used can influence the act of committing IPV, as some authors have suggested⁶. A larger sample size would make it possible to explore this issue more thoroughly. Finally, due to the high frequency of violent behaviours found in the women in this study, a larger sample of women would be necessary to compare the results according to gender.

Regardless of these limitations, according to the results obtained treatment programs for drug addiction may be a suitable context for identifying the presence of IPV perpetration⁴¹. The detection of this type of violence in people with addictive disorders is critical because they have a differential specific profile and, therefore, may require specific therapeutic strategies, such as the development of integrated interventions that address both problems (addiction and IPV) jointly, as different authors have recommended^{42,43}.

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DECLARATION OF INTEREST

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this paper.

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