RELATIONSHIP OF VICTIMIZATION TO ADDICTION

Ways in which victimization may put women at increased risk for substance abuse

It is well-established in research that women frequently respond to the trauma of victimization by “turning inward,” i.e., becoming depressed, experiencing suicidal ideation, making suicide attempts, or using alcohol or other drugs. It’s no surprise, then, that battered women are disproportionately represented in the population of women in chemical dependency treatment programs.(1)

Despite the high correlation that emerges between victimization and substance abuse for women in substance abuse treatment programs, it appears that the incidence of alcohol abuse by battered women is the same or only slightly higher than the incidence among women in general. (2) Even so, there are a number of ways in which victimization and chemical use are related that are important to consider in developing strategies for providing assistance.

- **Coerced or manipulated use by partner.**
  Many victims’ initial or escalated use of chemicals is coerced or manipulated by their abusive partners. Some coercion is overt. For example, some women report being tied down and forcibly injected with drugs. Much coerced use, however, is more subtle. Abusers may pressure victims to use certain drugs in social contexts and “to have fun and party.” Abusive partners may pressure victims to use certain drugs in order to avoid embarrassment in front of their friends. Such pressure is often applied in the form of threats.

  Some battered women are manipulated by their partners into alcohol or other drug use. For example, after an acute incident, the abuser may cajole his partner into using substances as a prelude to sex. Or he may tell her that he heard that certain drugs enhance sex and urge her to use them in order to improve their sex life.

- **Medication for emotional and physical pain.**
  Battered women often begin to use substances in response to their victimization for the same reasons that many women who have experienced other kinds of trauma do---to numb the emotional and/or physical pain of the abuse.

  An important theme that emerges from battered women’s reports about their chemical use is that the drink or drug helped to reduce or eliminate their feelings of fear. Imagine the "magic" in such relief! Battered women negotiate for their safety on a regular basis and often have reason to fear emotional and physical harm on a regular basis. Whatever the drug of choice, if victims find

that the substances help them cope with their fear and manage daily life in the face of ongoing abuse and danger, they may experience substances as something that helps them be safe. (3)

- **Access to prescription drugs.**

  Research suggests that about 70% of all prescriptions for tranquilizers, sedatives, stimulants, and hypnotics are written for women, (4) resulting in women being twice as likely as men to become addicted to prescription drugs in combination with alcohol. The combined use of alcohol and pills by women is a common and potentially lethal combination.

  Battered women often present to the health care system with a wide variety of complaints that are directly related to the stress of living with an abusive partner. Such complaints include, but are not limited to, migraines and other headaches, musculoskeletal complaints, fatigue, insomnia, anxiety symptoms such as palpitations and hyperventilation, gastrointestinal disorders, eating disorders, and chronic pain.

  Very often, when victims present with these symptoms, medical tests fail to identify an organic cause. Although the health care practitioner may be unable to form a diagnosis, s/he most often will prescribe medication for symptom relief. The medication may well provide relief for the victim, not only by alleviating the symptoms she presented with, but by providing relief from the emotional and physical pain of the abuse.

  Ironically, a victim's use of prescription drugs often reinforces her abusive partner's belief that "there is something wrong with her." In fact, it is common for friends and family members to express approval that the victim is on medication because she seems so "high strung" and "nervous."

Additional obstacles for victims who are also alcohol/other drug-involved

- **A victim's chemical use or addiction provides the abuser with yet another weapon he can use as a means to control her.**

  - He may use her substance abuse as the excuse for his violence. "If you weren't such a lush, such a junkie, I wouldn't have to do this."

  - Abusers will also threaten to expose the victim's substance abuse to friends, family members, or to authorities such as Child Protective Services, the police, and/or a Family Court judge who is deciding a custody case.

    - Abusers may expose factual information about the effects of her drug use on her ability to care for the children, or he may simply fabricate information in an effort to undermine her efforts to gain custody of the children.

    - In addition, abusers are often the suppliers of the drug(s) to victims, creating yet another powerful means by which abusers can encourage victims' dependency on them.

- Whether an abuser actively tries to undermine a victim's credibility with authorities or not, **chemically-involved battered women are less likely to be believed or taken seriously by others**. Stories abound of police arriving on the scene of a domestic incident, noticing that the victim is intoxicated, and not taking her call for help seriously. Or a victim, while high, goes to the local probation department to file a petition for an order of protection, only to be told by the attending probation officer to come back when she's sober.

- Chemically-involved women make for extremely unsympathetic victims. While victims of domestic violence are often blamed by others for the abuse, **victims who are also involved with substances are even more likely to be blamed by others**.

  In one study, a group of men and women were shown four versions of a domestic violence assault: in one version, both the victim and abuser were intoxicated; in the second, only the victim was intoxicated; in the third, only the abuser was intoxicated; and in the fourth, neither had been drinking. In each case, participants were asked to assign personal blame for the assault on the appropriate party or parties. Although the abuser was assigned most of the blame in all cases, when the victim was drinking, whether or not the abuser was drinking, she was assigned more of the personal blame than if she was sober. When the abuser was intoxicated, however, he was assigned less personal blame than when he was sober. This is a good illustration of the double standard that still exists that holds women who use alcohol more accountable for their partners' violence, and that holds men who use alcohol less accountable.(5)

- **Enormous gap in emergency services**. Many, perhaps most, emergency domestic violence shelters will not admit victims who are currently under the influence of substances. In addition, many shelters have policies that do not allow access to chemically dependent victims unless they have been clean for 30-90 days. The lack of emergency shelter services is a national problem and one that the existing service system has yet to solve.

- **Lack of available child care**. Victims may be particularly reluctant to enter chemical dependency detox or treatment (especially in-patient treatment) unless they have a safe and secure placement for their children. Few treatment programs provide child care support. Often, the choices available to a victim are limited to leaving the children in the care of her abusive partner, or voluntarily signing the children over temporarily to the care of the state, both of which may present significant risks to her and her children.

- **Use of chemicals can compromise cognitive functioning and motor coordination, making victims less able to develop and implement safety-related strategies**. A victim under the influence of substances may be less able to identify cues or indicators in the escalation phase of the pattern of abuse, to defend herself against a physical assault, to make judgments about her need for medical attention, or to make and use a safety plan.

- **Chemical use may increase a victim's risk of contracting HIV**. There is a well-documented and direct connection between HIV and substance abuse. The three easiest ways of transmitting HIV through drug use are sharing needles and drug works, such as cotton and the water or cooker; not using new works when injecting drugs; and not cleaning works with bleach or another recommended method between episodes of use.

  Abusers often use their own HIV+ status or the HIV+ status of their partners as a mechanism of control, threatening to reveal the victim's status, using it as an excuse for violence, and withholding access to necessary medications or medical treatment.

  Further, being HIV+ may create additional obstacles to victims in their efforts to achieve health and safety. For example, they may be even more dependent on the abuser for financial and medical support, or may face discrimination in their attempts to get help.

Implications For Intervention
Despite the enormous obstacles that chemically-involved battered women face, they still reach out for help to a wide variety of systems, including the domestic violence and substance abuse systems. Unfortunately, these two service systems are often unprepared and ill-equipped to respond to their dual needs for safety and sobriety.

Limitations of the "sobriety first" approach
Traditional intervention with chemically-involved victims is often based on the assumption that abstinence must occur before safety-related concerns can be addressed. It is helpful to examine what happens to a victim when such a "sobriety first" approach guides the intervention process.

- When a chemically-involved victim is motivated to seek help for safety-related needs, she must confront the reality that many residential shelters are not available to her. In some instances, domestic violence programs will allow victims to enter the shelter if they agree to be abstinent for the period of time they reside there.

  Domestic violence programs may also require victims to get an evaluation at a local substance abuse treatment program and to follow through with any subsequent recommendations the treatment program might make with regard to the substance abuse problem.

  The problem with imposing these requirements is that some victims are simply unwilling or unable to trade their substance use for residential domestic violence services, especially if their use has helped them cope with the violence, fear, and emotional pain. As a result, they are often cut off from safety-related services.

  Even those who agree to the admission conditions are unlikely to be able to sustain abstinence for the duration of their shelter stay, and are therefore at extremely high risk for either continuing to use or, if in a recovery program, at high risk for relapse. Such a lapse is likely to result in their discharge from shelter.

  In addition, victims who are not involved with chemicals often have a difficult time living in a communal setting and fulfilling all of the responsibilities attached to that. They're often in crisis, depressed, afraid, hurt, and confused. For many victims who are involved with chemicals, the drug provides them with a feeling of safety and security. It may medicate their feelings and mediate their fear. The expectation that they give up the drug may present them with what seems to be an impossible choice.

- Some chemically-involved victims seek help from, or are mandated into, substance abuse treatment programs. Often, intakes to treatment programs do not include an assessment for adult domestic violence. Victims therefore often remain unidentified as they participate in the treatment program. Even when they identify domestic violence, substance abuse treatment providers often still assume that victims must be abstinent before they can address their safety-related concerns.

  Imagine, then, a victim of domestic violence who is still in a relationship with an abusive partner, engaging in a recovery program, keeping a regular schedule of treatment programming and appointments, abstaining from alcohol or other drug use, attending AA meetings, working the program, getting self-focused, and

practicing emotional detachment. Her abusive partner might respond in the following ways.

- **Increased violence and coercion**
  Abusers are typically very resistant to their partners' attempts toward independence of any kind. Abusers may respond to their partner's recovery efforts by re-establishing their control through the use of intensified violence and coercion.

- **Sabotage**
  Some abusers will actively sabotage their partners' recovery. Sabotage can take many forms.

  - An abuser may renege on child care, preventing the victim from keeping appointments or going to meetings.

  - He may keep alcohol in the house, saying he's "not the one with the problem."

  - He may restrict access to the resources the victim needs in order to comply with her treatment plan---transportation, child care, and health insurance.

  - The abuser may use emotional manipulation---"I know your recovery program is important to you, but I'm getting concerned about the kids. Your being away from them so much is really taking its toll on them."

  - The abuser may make accusations of infidelity regarding the victim's relationship with self-help group members.

  - Abusers may also coerce the victim into using substances.

A victim might respond to the escalation of violence and coercion in the following ways.

- Victimization is one of the strongest predictors of relapse for women. If a victim of domestic violence began or escalated her use of substances in response to the trauma of victimization, she may "pick up" in response to re-victimization as a way to cope with the emotional and physical pain.

- Additionally, if a victim realizes that she was safer from her abuser's coercion and violence before recovery, she may be motivated to "pick up" again and to leave treatment.

A substance abuse counselor might respond to this client who is not following through on her treatment plan in the following ways.

- May reinforce the importance of compliance with the treatment plan without recognizing the danger that compliance creates for the victim. As a result, the victim may internalize blame and guilt, and feel additionally pressured to give priority to treatment over safety.
- May perceive and treat client as "resistant" or "non-compliant," unwilling to do what it takes to get sober.
- May terminate client from treatment.

A victim's participation in substance abuse recovery services may precipitate increased violence. Increased violence may precipitate relapse. When we limit ourselves to a "sobriety first" approach, we may fail to provide any meaningful assistance and may, in fact, increase the danger to victims.

Importance of dealing with both problems concurrently

- Domestic violence and chemical dependency are both life-threatening and should therefore be parallel priorities in all of our interventions with chemically dependent victims of domestic violence.
- Imposing a specific chronology of care (“abstinence first”) on chemically dependent victims may undermine their abilities to get either safe or sober.
- We need to be willing to engage with chemically dependent victims of domestic violence wherever they are.
    - If their priority is safety, we can encourage them to consider how their chemical use is a potential obstacle to safety.
    - If their priority is substance abuse recovery, we can encourage them to consider how their safety-related needs may be a potential obstacle to recovery.
- If a chemically dependent victim is participating in both substance abuse and domestic violence services at the same time, we need to be prepared to help reconcile the differences in the two systems’ approaches to providing help.

Recommendations for substance abuse treatment counselors

- Conduct private, routine screening for domestic violence at intake.

- When domestic violence is identified, collaborate with victim in evaluating the impact of treatment strategies on her safety, develop treatment plans that give priority to safety-related needs, and pro-actively assist victims in developing short- and long-term safety plans.

- Recognize that, at times, legitimate survival and safety strategies employed by victims (such as resistance, non-compliance, and dishonesty) may conflict with recovery strategies. Acknowledge this and discuss it with the client. Recovery strategies and activities should be continually reviewed and modified, as necessary, to reflect a victim's ongoing safety-related needs.

- Domestic violence advocates and substance abuse treatment counselors should cultivate cooperative relationships with each other, make cross-referrals, and assist clients in linking with services.

- Victims of domestic violence should be provided with a safe (gender and culturally affirmative) environment to discuss their safety-related needs, such as in women-only groups with female leaders, and should be offered female clinicians, if desired.

Endnotes

(1) Bergman, G., Larsson, G., Brismar, B., et al. "Battered Wives and Female Alcoholics: A Comparative Social and Psychiatric Study." *Journal of Advanced Nursing*. 14:727-734. Cited in *Practical Approaches in the Treatment of Women who Abuse Alcohol and Other Drugs*, Center for Substance Abuse Treatment. Rockville: MD. 1994.

(2) National Women Abuse Prevention Project. *Understanding Domestic Violence*. Washington, D.C. 1989.

(3) Minnesota Coalition for Battered Women. *Safety First: Battered Women Surviving Violence When Alcohol and Drugs are Involved*. Minneapolis: Minnesota Coalition for Battered Women. 1992.

(4) Public Health Service. *Women's Health Report of the Public Health Service Task Force On Women's Health Issues*. DHHS Pub. No. 85-50206. Washington, D.C.: U.S. Government Printing Office. 1985.

(5) Richardson, D., and Campbell, J. "Alcohol and wife abuse: The effect of alcohol on attributions of blame for wife abuse." *Personality and Social Psychology Bulletin*, 6: 51-56, 1980.

Adapted from: *Adult Domestic Violence: The Alcohol/Other Drug Connection Trainer's Manual*, Theresa M. Zubretsky, New York State Office for the Prevention of Domestic Violence, July 1999.