The Detection of Domestic Violence through Routine Screening at Drug and Alcohol Clinics

A report prepared for the Criminology Research Council

Volume 1

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February, 1996

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Acknowledgments

Funding for this research was provided by the Australian Criminology Research Council. The authors would like to thank members of the steering committee and the following research staff for their assistance with the project: Yelena Fridgant, Andrew Greenfield, Glen Smith, Judy Powis, Augustus Norris and Christy Chan.

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Management of the project

A steering committee was established to assist the management of the project. Meetings were convened on two occasions. The first meeting was held on June 7, 1994 and the second on June 30, 1994.

The members of this committee were:

Dr Michelle Gomel:	Principal investigator, Department of Psychological Medicine, University of Sydney.
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Ms Julie Stewart:	NSW Police Service
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Ms Margaret Condonis:	Family therapist, Adolescent & Family Mediation Services
Ms Lyla Coorey:	Head, Department of Social Work, Royal Prince Alfred Hospital

Ethics approval

In early 1994 the administrations of the six clinics in the Sydney metropolitan area, which provide drug and alcohol rehabilitation programs, were approached and asked to participate in the project. Five (St. Edmonds, St. John of God Burwood and Richmond, Wistaria Centre, Phoenix Unit) agreed subject to ethics approval, which was subsequently obtained. The ethics committees were Central Sydney Area Health Service, Northern Area Health Service, Manly Hospital, St Edmund's Private Hospital and the St John of God Hospitals. Ethics approval was also obtained from the University of Sydney ethics committee. The client information sheet and consent form and safety checklist used in the project is reproduced in Volume 2 of the report in Appendix I.

Introduction

For years domestic violence was considered to be a private matter within the family however it is a widespread social problem that occurs amongst all social classes, races, religious groups and family types. In recent times health professionals, have reframed this area as a public health issue. This follows extensive documentation of its prevalence within the community through large population studies, studies in various clinical settings, information obtained through the legal system and government agencies. Social, physical and mental health consequences for victims of abuse have been documented and strategies proposed and implemented to assist in controlling the problem.

In the introduction we provide an overview of the domestic violence area. The major areas covered include epidemiological aspects, the health care setting, characteristics of victims and perpetrators and then specifically aspects of its association with drug and alcohol abuse.

Chapter 1. Epidemiological aspects of spouse abuse

1.1 Definition: What is Domestic violence?

The meaning of the term domestic violence has varied considerably in the literature. This is evident in the breadth of issues it attempts to cover, for example, the gender and age of those involved, socio-cultural factors and the purported function of the violence for both victims and perpetrators. The types of violence experienced can include physical, psychological and sexual, however the term 'domestic violence', has been associated predominantly with the physical aggression occurring within an intimate relationship. Physical aggression is an important component of domestic violence, and also has the most visible effect, but to focus on it exclusively may obscure: (i) the importance of the other forms of violence and (ii) the mental health effects on the person who is being victimised.

Throughout this report the discussion of domestic violence will be limited to the abuse occurring between two adults currently or previously in an intimate relationship. We use the words spouse abuse, partner abuse and domestic violence interchangeably.

1.2 Prevalence

Crime data and homicide

In extreme cases spouse abuse can be lethal. Statistics from a number of countries indicate that female homicide is most frequently perpetrated by family members with spouses representing the largest percentage of offenders (Kruttschnitt & Dornfeld. 1993; Kruttschnitt. 1993). In 1984, almost 25% of all homicide victims in the United States were related to their assailants. Of homicides occurring within the family, 48% involved spouses. Approximately two thirds of this group comprised wives who were killed by their husbands; and the remaining one third were husbands killed by their wives. A large proportion of wives who killed their partners were 'battered women' and did so in response to frequent and severe abuse (Browne & Saqi. 1988).

Cases of spouse abuse leading to homicide represent only a small proportion of the women who are abused by their partner. The majority experience a range of physical injuries and mental health problems which have not been thoroughly documented.

Population surveys

Our knowledge of the extent of spouse abuse is derived largely from surveys conducted in North America. Because physical abuse is more easily defined than the other forms of abuse, the majority of surveys have reported rates for physical abuse. In the Second National Family Violence Survey conducted in the United States in 1985, 16% of married couples reported at least one violent act against their partner in the 12 month period prior to the survey. One third of these couples reported severe violence such as kicking, biting, hitting with a fist, using a knife or firing a gun (Straus & Gelles. 1986). Canadian rates using the same criteria for severe and all levels of violence over a 12 month period were similar (Kennedy & Dutton. 1989).

Heise, Pitanguy, & Germain. (1994) reviewed the data from 34 studies in several countries and found that from one quarter to more than one half of women reported being physically abused by a present or previous partner. Variation in prevalence rates across countries was evident. For example in North Korea, prevalence rates for the use of severe and all levels of violence against women were more than three times higher than those reported in North America.

Chapter 2. Spouse abuse and the health care setting

This section describes the extent of health care utilisation, primarily amongst women who are the victims of violence.

2.1 Health care services: Prevalence and utilisation of services

The physical and mental health problems related to spouse abuse place a heavy burden on health care resources. Using data from the National Crime Survey (NCS) in 1980, it has been estimated that the annual medical care costs directly attributable to domestic violence approximates US$44 million a year. However, because the NCS data are likely to underestimate prevalence and morbidity associated with domestic violence, it has been argued that the estimates should be multiplied by a factor ranging from 10 to 40 (McLeer & Anwar. 1987).

Women who have been abused use a disproportionate share of health services (Jones. 1993). The most frequently used primary health care services are emergency departments and general practice and to a lesser extent antenatal clinics. Roberts, O'Toole, Lawrence, & Raphael. (1993) found that 78% of victims attending an emergency department reported treatment for injuries or health problems related to abuse occurring during the previous year. Approximately 51% had attended a general practitioner, 40.4% had attended a large urban hospital emergency department, 10.6% had attended other hospitals. Victims of spouse abuse may also use tertiary services including inpatient and outpatient psychiatric services, drug and alcohol centres, marital and family therapists and community mental health clinics.

Whilst the above statistics relate primarily to victims of abuse, perpetrators of abuse are also increasingly using the above services, in particular, tertiary services such as community clinics, marital therapy and drug and alcohol services, either as a result of court orders or on a voluntary basis.

Primary health care

Emergency departments: Two major findings have been generated by research in emergency departments. These relate to the high prevalence of women who have ever been abused and the finding that abused women are more likely to present for trauma-related injuries than women who are not abused. In one emergency department study, 14% of persons presenting disclosed a history of domestic violence (Roberts, O'Toole, Lawrence, & Raphael. 1993). Higher rates of 22% were found by Goldberg & Tomlanovich. (1984). Appleton. (1980) reported that 35% of women presenting to an emergency department reported being physically abused by their partner at some point in their relationship. Recently, Abbott, Johnson, Koziol-McLain, & Lowenstein. (1995) found the incidence of abuse amongst women visiting an emergency

department to be 11.7% of women currently in a relationship; the cumulative prevalence was 54.2%. It is difficult to ascertain how representative these studies are and extrapolating the higher rates to the population would probably be unwise. Nevertheless these studies suggest that at least one tenth, and perhaps up to one-quarter, of women attending emergency departments have been abused at some stage during an intimate relationship.

The increased risk of trauma related injuries for women who are being abused has been documented in many studies of emergency departments. McLeer, Anwar, Herman, & Maquiling. (1989), in a survey of female patients, found that 30% of women with trauma-related injuries (excluding natural disasters and motor vehicle accidents) had injuries or symptoms related to physical abuse by a current or previous intimate partner. Goldberg & Tomlanovich. (1984) reported that the domestic violence group had trauma-related complaints significantly more often than the domestic violence-free group.

Women who present with physical injuries at the emergency department represent only a small proportion of women who are currently experiencing domestic violence. Many others are not injured severely enough to require emergency treatment but nevertheless experience physical injuries and mental health problems from the abuse. Frequently, the victim's first point of contact with the health system is through the general practitioner, either for routine health care, or more directly for the treatment of the physical and mental health effects of the abuse (Hamberger, Saunders, & Hovey. 1992).

General practice: Three studies examining the prevalence of spouse abuse amongst general practice patients have been identified. Twenty-eight percent (Gin, Rucker, Frayne, Cygan, & Hubbell. 1991) and 40% (Hamberger, Saunders, & Hovey. 1992) of persons presenting for primary health care disclosed a history of physical abuse during their lifetime. Of these 14% (Gin, Rucker, Frayne, Cygan, & Hubbell. 1991) and 23% (Hamberger, Saunders, & Hovey. 1992) were currently experiencing spouse abuse. In a recent study, Elliott & Johnson. (1995) found that of 42 women interviewed in a family practice clinic, 45% reported experiencing physical, emotional and/or social abuse in their relationships. 36% reported being battered during their lifetimes and 12% reported being currently involved in a battering relationship. As in emergency department research, variation in violence rates across studies most likely reflects differences between the clinics sampled and their patients and the higher rates reported need to be interpreted with caution. Nevertheless, even the more conservative estimate of 14% highlights the need for physicians to be aware that a large number of their patients may be victims of spouse abuse.

Studies of the effects of criminal victimisation demonstrate substantial increases in the amount of primary medical care required by abused women. Koss and her colleagues examined the effects of criminal victimisation on the use of medical services amongst women enrolled in a worksite health maintenance service. In their sample, 29% of assaults and 39% of rapes were perpetrated by partners/husbands or other family members. Medical records indicated that 93% of all crime victims visited their physician during the year following the crime and all had visited during the second

year (Koss, Woodruff, & Koss. 1991). Severely victimised women, compared with non-victims, made visits to physicians twice as frequently in the index year and had outpatient medical expenses 2.5 times higher. During the year of the crime, visits to physicians increased by 15% and 18% from pre-crime levels for assault and rape victims, compared with less than 2% for non-victims (Koss. 1993).

Antenatal: Parsons, Zaccaro, & Wells. (1995) interviewed 290 pregnant women and found that 8.3% had been battered during the current pregnancy; 87.5% of these had been battered before the pregnancy as well. Swanson. (1994) reviewed the literature on abuse during pregnancy and found that abuse was reported in 3% to 8% of pregnancies and in the study conducted by them it was 17%. However, they included sexual as well as physical abuse; the perpetrators were partners (current and past) in 78% of cases. Abuse when pregnant may lead to complications during pregnancy.

Tertiary health care

Psychiatric/counselling services: There have been few studies examining the prevalence of domestic violence and utilisation of inpatient or outpatient psychiatric services, by victims of spouse abuse. Jacobson. (1989) makes the point that physical assault, though not necessarily domestic violence, histories are more common amongst psychiatric inpatients (70%-80%) and outpatients (22%) than in the general population and suggests that the possibility of such a history should always be explored by psychiatric workers.

In the psychiatric inpatient setting Post, Willett, Franks, House, Back, & Weissberg. (1980) examined 60 patients and found that 50% of the women had been battered and 27% of the men reported battering their partners. Carmen, Rieker, & Mills. (1984) examined the relationship between violence and psychiatric illness in a group of psychiatric inpatients and found it to be strong, however the violence included child abuse, incest, and assault or rape occurring outside the family as well as marital violence. Hilberman & Munson. (1978) in a similar assessment of a rural clinic found that half of all women referred for psychiatric consultation were currently in an abusive relationship, that 43% had past histories of abuse and of this group 51% had been the victims of partner abuse. Yellowlees & Kaushik. (1992) in his study of a rural Australian community found that domestic violence occurred commonly in women referred for psychiatric assessment but did not provide prevalence rates for such abuse.

Drug and alcohol services: A number of studies of drug and alcohol services have found a high proportion of perpetrators amongst their clients, well above population norms. Studies report the prevalence of perpetrators to range between 40% and 72% (Lehman & Krupp. 1984; Powers. 1983; Gondolf & Foster. 1991). Although we were not able to identify any studies examining the prevalence of victims within the drug and alcohol setting, studies report a high prevalence of alcohol abuse amongst alcoholic women, for example, 65% (Bishop & Patterson. 1992). These studies are discussed in more detail in chapter 4, however, given the high prevalence rates of

perpetrators in drug and alcohol clinics and victims in the alcoholic population, it is clear drug and alcohol services are utilised frequently.

Family therapy: A study carried out in a family therapy clinic suggested that over two thirds of the couples in marriage and family clinics had engaged in some form of violence in the year prior to therapy (Aldarondo & Straus. 1994).

Community mental health centres: No study to date has examined the prevalence of spouse abuse amongst patients of community health centres, however, given that this is a widely used service by people with mental health problems in the public sector, it is likely that the prevalence is high.

Concluding remarks

It is apparent from the above discussion that domestic violence histories are common in patients seen in both primary and tertiary clinical settings. Data, in particular from general practice, emergency departments, psychiatric counselling services and drug and alcohol clinics, suggest that these services are more frequently utilised by people involved in violent relationships.

2.2 Health professionals' response to spouse abuse.

Despite the fact that many victims of spouse abuse present to primary health care services, health professionals have been slow to recognise and respond to the problem (Kurz. 1987; Stark, Flitcraft, & Frazier. 1979; Burris & Jaffer. 1984). They often fail to inquire about spouse abuse or adequately document information pertaining to the violence even when it is evident.

Emergency department

As few as 4% of abused women attending emergency departments in the United States may be 'recognised' as such by health care workers and offered appropriate treatment. A study by Rounsaville. (1978), in an emergency department revealed that although over half of the women had presented to the same department previously, documentation of the abuse was made in only three cases (15%). Kurz. (1987) found that in 40% of cases where physicians interacted with battered women in an emergency department setting, physicians made no response to the abuse. A recent study (Abbott, Johnson, Koziol-McLain, & Lowenstein. 1995), confirms the low detection rates of domestic violence by staff in emergency departments; only six of the 47 patients (13%) were identified as victims by emergency department staff.

McLeer, Anwar, Herman, & Maquiling. (1989) reported that the use of a spouse abuse protocol in an emergency department increased detection rates from 6% to 30%. However, these rates were not maintained at an eight year follow up; only 8% of victims were identified. The authors argue that it is necessary to institutionalise systems for identifying and treating battered women. It seems that adequate treatment is not ensured even when a protocol for identifying and treating victims is being used.

Warshaw. (1989) found that in 92% of cases the discharge diagnosis did not reflect the presenting problem of spouse abuse, despite documentation or strong indicators for abuse on the woman's chart. Also, in the majority of cases staff did not refer women for consultation, to a psychiatrist or social worker or provide a list of resources and referrals despite these being clearly specified in the protocol.

General Practice

Similar to findings in emergency departments the rate of identification and appropriate response to spouse abuse in general practice is poor. In one study (Hamberger, Saunders, & Hovey. 1992), physicians in a community based practice inquired about abuse in only four percent of patients. Although 14% of patients in three community practices reported being currently abused and had seen a physician in the last year, fewer than 30% of these patients had discussed the abuse with that physician (Gin, Rucker, Frayne, Cygan, & Hubbell. 1991).

Obstetricians

Parsons, Zaccaro, & Wells. (1995) investigated current practices in this area amongst obstetricians. They found that routine screening did not occur even when some obstetricians had undertaken education in the area of domestic violence or acknowledged that they had followed American College of Obstetricians and Gynaecologists guidelines for domestic violence. This fact was also demonstrated by Parsons et al. (1995), who pointed out that none of the pregnant women identified as having been abused in their study, had been evaluated for this by the prenatal care team.

Mental health workers

The rate of identification of cases of domestic abuse and appropriate response by professionals working in the mental health area is poor. For example, Aldarondo & Straus. (1994) and Saunders & Parker. (1989) found that health care workers at community mental health centres were aware of only a small proportion of their clients who were victims of physical assault. Even if specific referrals for psychiatric treatment of the abuse are made, the response of the mental health professional may be affected not only by their attitudes towards the problem but also the resistance shown by many people in seeking assistance from mental health professionals (Bergman, Larsson, Brismar, & Klang. 1987; Hansen, Bobula, Meyer, Kushner, & Pridham. 1987).

Drug and alcohol workers

Despite the strong relationship between domestic violence and alcohol and drug abuse which has been described elsewhere, professionals working in the drug and alcohol area do not generally screen for domestic violence amongst their clients. Lehman & Krupp. (1984) interviewed a group of such professionals and found that although most believed that alcohol was related to domestic violence, only 1 of 10 knew how to identify and manage the problem. A recent review (Bennett & Lawson. 1994) of

substance abuse programs found that only 1 in 10 of such programs formally screened for domestic violence. For the most part, cross-problem evaluation was haphazard and only occasionally were one or two specific questions about partner abuse included in the initial assessment.

Marital and family therapists

A recent survey of family therapists in the U.S. found that 60% did not consider family violence to be a significant problem in their clinical practice and fewer than half of the couples whose relationships were violent, were detected during routine interviews. (Aldarondo & Straus. 1994). Similarly, 362 members of the American Association of Marriage and Family Therapy, were presented with, and asked to describe their intervention in, a family violence case study. 41% did not recognise the presence of domestic violence, 55% saw no reason for immediate action and only 2% reported a potential for lethality (Carden. 1994).

Concluding remarks

These studies make it clear that physicians and other health care professionals do not recognise or respond to the fact that the issue underlying injuries and mental health problems of some women in primary health care is spouse abuse. The failure to acknowledge the experience of their abused patients can by itself cause psychological damage by contributing to the victim's sense of isolation and helplessness (Warshaw. 1989; Khan, Welch, & Zillmer. 1993; Jones. 1993).

This situation may change as recent national (US) directives become established (Worcester. 1992). These require that all accredited hospitals must develop protocols describing how they respond to battered women and how their staff are trained on this issue. Within these protocols, health care workers are expected to identify and refer abused women to appropriate agencies/professionals.

There have been no specific directives to screen and identify perpetrators of abuse in the clinical setting, however, over the past 15 years, treatment programs for perpetrators have been established as more perpetrators are referred for court-mandated treatment or have sought treatment themselves and as community support to address the problem widens. This increased support may bring about change in the health care setting.

2.3 Barriers to case detection and intervention

This section summarises some of the factors that could explain the low rates of detection and intervention for spouse abuse. The overwhelming majority of studies have examined physicians' attitudes and beliefs, however, the results of these studies are also relevant to other health professionals.

Sugg & Inui. (1992) interviewed thirty-eight primary care physicians and asked them to describe spouse abuse cases they had managed, and their perception of their role in identifying and intervening in such cases. Their main finding was that exploring domestic violence in a clinical setting was analogous to 'opening Pandora's box'. Physicians were reluctant to deal with the 'unleashing' of many issues that routine enquires would elicit. They reported feelings of powerlessness, a fear of offending patients and a concern about time constraints. They also expressed a concern about having a 'too close for comfort' relationship with the patient and were less likely to suspect abuse in those patients who came from similar backgrounds to them.

Training in the medical model of disease may interfere with the readiness of physicians to explore the socio-cultural components of health problems (Jecker. 1993; Warshaw. 1989). In the drug and alcohol treatment setting this may occur with the result that physicians and other health care workers view their client as suffering from an illness over which they have no control and that many of the client's problems (including domestic violence) will resolve if they stop drinking. Additionally, there is a reluctance to interfere with family issues which are culturally defined as being private, sacred and hidden from public view (Warshaw. 1989; Jecker. 1993; Kurz. 1990). These and other barriers are described in more detail below.

Attitudes and beliefs

The medical model and role legitimacy: In relation to victims of domestic violence, there is a tendency for physicians to focus on the presenting physical or psychological problem while ignoring the social and cultural circumstances in which it occurs (Warshaw. 1989). As a result, if the patient presents with vague complaints and a physical basis can not be identified, the person may be given a psychological or psychiatric label, for example, 'neurotic' or 'hysterical' (Morrison, Van Hasselt, & Bellack. 1987).

Physicians and other care workers are unsure whether, or do not believe that, domestic violence is a legitimate part of their role. There is an underlying reluctance to interfere with issues seen to be private and a fear of offending clients if they inquire about domestic violence. For some, this fear extends to a belief that the therapeutic relationship could be damaged (Sugg & Inui. 1992).

Stereotypes and patient identification: Stereotyping, as well as a tendency of some health care workers to identify with their clients, has been identified to be a barrier to dealing with abuse issues. For example Sugg & Inui. (1992) found that physicians who came from a white middle class background without experience of domestic violence, often assumed that their patients were similar and hence would not be at 'risk'. In contrast, some female physicians expressed fear and vulnerability when confronted with abuse in patients with whom they identified closely. Many physicians reported that they were more likely to ask women of lower socioeconomic status about the presence of abuse (Sugg & Inui. 1992).

Credibility of patients: Health care professionals may doubt the credibility of some of the women who have been abused and require confirmation from another family

member before taking the problem seriously (Sugg & Inui. 1992). This problem is compounded if the client is thought to have a stigmatising condition such as a drug or alcohol problem, a major psychiatric illness or exhibit inappropriate behaviour. Such clients are perceived as less reliable and physicians tend to be less responsive to their needs. Physicians may also become more frustrated and irritated and hence less responsive to women who are evasive about the cause of their injury. In such cases, physicians are less sympathetic and tend to place more responsibility for the abuse on the victim (Kurz. 1990).

Training and skills

Diagnostic ability and diagnostic aids: A major barrier to recognising domestic violence is the tendency of physicians and other primary health professionals to only suspect domestic violence when physical injuries are present. For example, in a study of their attitudes and beliefs, 56% of family practitioners surveyed, cited physical injury to be the factor that would make them suspect abuse; only 1% stated that other less obvious signs such as timidity, withdrawal or defensiveness would cause them to suspect domestic violence (Easteal & Easteal. 1992). The reliance on physical signs as a major indicator of possible abuse results in a substantial proportion of victims not being detected. Physical signs of abuse are not always present or if present are not always obvious. As highlighted by Knowlden & Frith. (1993), if physicians are to be effective in treating domestic violence, they need to both suspect it and look for evidence of it.

Poor self-efficacy: One barrier that has consistently been raised in studies is a sense of helplessness and frustration with the situation (Brown, Lent, & Sas. 1993; Sugg & Inui. 1992; Easteal & Easteal. 1992). Health care practitioners often express the concern that they do not have the training or the skills to deal with the physical and psychological effects of abuse (Sugg & Inui. 1992; Brown, Lent, & Sas. 1993). As a result, in contrast to their management of other illnesses, treating the injury does not get rid of the problem.

Poor outcome expectations: Many health care professionals believe that their efforts in assisting victims are wasted and that their advice is rarely taken (Brown, Lent, & Sas. 1993; Sugg & Inui. 1992). Sugg & Inui. (1992) reported that physicians who expressed a need to control the domestic abuse situation and solve the problem expediently became frustrated when they could not. This was found to be a major barrier to the physician's willingness to address domestic violence issues. This contrasted with those physicians who felt comfortable in dealing with domestic violence and whose beliefs and attitudes were very different; they did not perceive their role as being to fix the problem but rather to validate the patient's feelings, discuss safety issues and to refer the woman to appropriate resources. Rather than expecting a quick resolution of the problem they saw the time frame for change as following a prolonged course.

Concluding Remarks

The barriers described above have been explored and described primarily in relation to physicians, however they are similar in many respects to other health care workers (Tilden, Schmidt, Limandri, Chiodo, Garland, & Loveless. 1994) in a study of 6 disciplines (dentists, dental hygienists, physicians, nurses, psychologists, social workers) found differences in the level of education in the domestic violence area between the disciplines but a shared belief that abuse was infrequent among their patients. Gender was shown to be important in that female practitioners were more likely to adopt a consultative approach whereas male practitioners tended to deal with the issue alone and at times with the family. In all disciplines, professionals did not view themselves as responsible for intervening and this was aggravated by a lack of confidence in the ability of the 'system' to respond effectively if they chose to intervene.

2.4 Health professionals role in spouse abuse

From a public health perspective Flitcraft. (1992) argue that "Domestic violence and its medical and psychiatric sequelae are sufficiently prevalent to justify 'routine screening' of all women patients in emergency, surgical, primary care, paediatric, prenatal and mental health settings" (p. 8).

Physicians

Primary care physicians have an important role to play in the management of domestic violence. In any year, the vast majority of the general population will visit a physician at least once so the opportunity exists for detection and effective intervention. Physicians generally enjoy the trust of their patients and are in a position to hear confidential information about their clients domestic situation, ask questions about problems such as abuse and intervene effectively. Physicians have been encouraged to routinely assess for violence at all types of visits, educate patients about violence and work to prevent the violence that occurs in abusive relationships (Elliott & Johnson. 1995). However from the studies reviewed, it is apparent that education and other strategies are required in the area of domestic violence so that barriers to effective intervention can be overcome. Certainly the various professional medical organisations have recognised the extent of the problem and have formally encouraged their members to become more involved (Anonymous. 1993) .

Mental health workers

In recent years, professionals working within psychiatric services, whether inpatient or outpatient, emergency or community mental health clinics, have come to acknowledge domestic violence as an area in which they should become involved more extensively (Jacobson. 1989). Rather than dealing only with the mental health consequences of the abuse, they have used a broader, multidisciplinary approach involving psychiatrists, psychologists, social workers and nursing staff. Bishop & Patterson. (1992) make

several recommendations which they believe these health care workers should follow when assessing all their patients. These include routine questioning about family violence, to be aware of their own attitudes concerning domestic violence which may interfere with their objectivity and to avoid psychodynamic interpretations which may be attempts to rationalise or deny the existence of the problem. They provide suggestions for effective intervention strategies which may also assist in helping the mental health worker overcome his/her reluctance to become involved with the problem.

Jordan & Walker. (1994) also explored the increasing involvement of community mental health clinics in delivery of services to victims and perpetrators of violence. They found that if the problem was not detected, staff were likely to treat mental symptoms without addressing one of the major causes. They believed that 5 types of service should be provided by, or facilitated through, the clinic: 1. consultation, education and preventive services, 2. crisis care, 3. counselling and clinical services, 4. support services and 5. residential services. They suggested ways in which such clinics could implement these services and the manner in which all staff could become involved. For example, they believed that staff should have a higher degree in the mental health area, receive specialised training in domestic violence and be given ongoing supervision of their case load.

Obstetricians

As the above mentioned prevalence studies have shown, obstetricians are likely to come in contact with many women who have been abused. Parsons, Zaccaro, & Wells. (1995) pointed out the lack of identification of domestic violence in pregnant women and the importance of doing so. This study was followed in 1989 by a position statement in which the American College of Obstetricians and Gynaecologists acknowledged that its members had an important role to play in screening for domestic violence and mailed an educational package covering aspects of domestic violence to all its members.

Nurses

Nurses are uniquely suited to meet the needs of abused women because of their caregiving role, their ability to maintain close contact with clients, their holistic orientation to health and their skills in the area of interpersonal communication. However they often fail to provide adequate care because they do not see themselves as being appropriate persons to intervene (Henerson & Ericksen. 1994). Skoglund. (1992) emphasises the importance of the nurse practitioner in screening for and assessing the extent of domestic violence as a routine part of the role. She makes a point of the importance of nurses being aware of the problem and knowing what resources are available for the abused woman. Interestingly, she does not advocate direct counselling as part of the nurses' role.

Marital and family therapists

Health professionals in this field have a major role to play, given the high prevalence of spouse abuse amongst people presenting for marital therapy. It is important that they are aware of couples in violent relationships and be selective about the type of therapy offered. For example, if conjoint counselling is undertaken too soon the spouse may be placed in physical danger, whether she is living with her partner or not. Safety issues are of paramount importance and should be sufficiently stringent so as to reassure the partner at risk. Nevertheless, this form of therapy at an appropriate stage in treatment, can assist the perpetrator in learning to control his anger in the presence of his partner, who is able to provide immediate feed-back. It can also provide ongoing supervision of the marital relationship (Costa & Holliday. 1993).

Drug and alcohol workers

Health care workers in this area are uniquely positioned to play an important role in the detection and management of domestic abuse problems. Their clients are in a treatment and/or rehabilitation setting, are motivated to obtain assistance to make changes in their lives and may have continuing family involvement. They may, in fact, have sought treatment for their alcohol and/or drug problem because of problems in their domestic relationship. As has been shown above, however, D & A staff have not adopted the management of domestic violence as part of their role.

Concluding remarks

Health care professionals in many clinical settings have the opportunity to play an important role in the detection and management of their clients who are in abusive relationships. Organisations representing professional groups have acknowledged the importance of their members becoming involved in managing the problem, however on an individual level, this does not appear to be happening. This appears to be related to certain attitudinal and belief barriers as well as a lack of education in the area of domestic violence.

2.5 Screening and intervention

Victims

Most professional health organisations recommend routine screening and intervention for victims of spouse abuse (American Medical Association. 1992; American Psychiatric Association, 1993). The American Medical Association. (1992) has reviewed four important areas in which women who have been abused could be assisted. Although these guidelines were developed for medical practitioners they are relevant to all health professionals. They propose routine screening, validation of the experience, careful record keeping and referral. Although not specifically mentioned

in the guidelines, where possible ongoing support and follow-up should be provided even when referral is made to other services.

Routine screening: The identification of victims of spouse abuse is often difficult because of the reluctance of many abused women to volunteer information about the abuse. However, a number of signs may raise the health care professional's index of suspicion. These include physical injury, psychological and somatic complaints.

Abused women are more likely than accident victims to have contusions or minor lacerations to the face, head, breast, chest or abdomen and they are much more likely to have multiple injuries than accident victims. Evidence of old injuries may also be present (Randall. 1990; Morrison. 1988; Anonymous. 1992). However, more frequently women will present with signs of psychological distress such as depression, anxiety and sleep problems and a range of somatic complaints including headaches, muscle aches, abdominal pains; there may be no obvious physical injury (Mitchell & Hodson. 1983; Knowlden & Frith. 1993; Randall. 1990). Because psychological and somatic complaints commonly occur with other life stressors the identification of a woman who is in an abusive relationship is difficult without direct and empathic questioning about her relationship with her partner. The failure to identify abuse as a cause of mental health problems often leads to women being misdiagnosed as having a primary anxiety or depressive disorder or being labelled as "neurotic", "hysterical", "hypochondriac", "chronic somatizer" or "problem patient" (American Medical Association. 1992; Stark, Flitcraft, & Frazier. 1979). These labels impede effective diagnosis and intervention and imply that time spent with the person is not worthwhile (Fullin & Cosgrove. 1992).

If the fact of abuse is established it is essential to obtain a detailed history of the abusive relationship and its physical and mental health impact. Of particular importance is an assessment for depression, anxiety, PTSD, drug and alcohol dependence and suicidal behaviour. Additionally, coping mechanisms and available supports need to be assessed together with safety issues for the woman and any children (McLeer & Anwar. 1987).

Intervention: A powerful intervention in its own right is the validation of the woman's experience. It is important to demonstrate an understanding of the seriousness and effects of the violence, and the difficulties and fears about disclosing abuse (Anonymous. 1992). Acknowledging that spouse abuse is common and that the woman's emotional and behavioural responses are 'normal reactions' to a distressing and fear provoking situation is essential to challenging her own beliefs that she is "going mad" or that she is the cause of the problem.

In treating mental health problems such as anxiety and depression physicians need to be cautious about prescribing medication. Although sometimes there is a need for the short term use of psychotropic medication in conjunction with other interventions (Rounsaville. 1978), its use has to be carefully monitored given the potential for misuse and the increased risk of drug dependency (American Medical Association, 1992). Long term drug treatment is contraindicated and should not be substituted for other forms of intervention (Jecker. 1993; American Medical Association. 1992).

It is important that a range of legal, housing and other service options be presented clearly to the woman, however, it is not advisable to force the woman into an option which she is not willing or ready to accept. The woman's decision should be supported even if the health care worker does not agree with it (Fullin & Cosgrove. 1992; American Medical Association. 1992). It is important to be aware of the woman's low self esteem and challenge beliefs about self blame and responsibility for the violence. Encouraging the woman to build up social supports is also critical.

Referrals can be made to a variety of community based programs designed to assist and support abused women. These include legal services, shelters, support groups and also individual counsellors experienced in the area of domestic violence. Referral to couples counselling is contraindicated because the woman is less able to speak freely and without intimidation (Fullin & Cosgrove. 1992; Anonymous. 1992). If referrals are made it is important to provide the opportunity for ongoing monitoring and support even if the situation has improved temporarily. This provides a secure base for the woman and informs her that the problem is being taken seriously and that there is a willingness to provide long term assistance.

Intervention should include the formulation of a safety plan, particularly for women who are currently living in an abusive situation. Having a bag packed with essential items such as important documents, money, extra set of car keys and clothes for emergencies (Holtz & Furniss. 1993) and developing a signal system with children or neighbours that indicates the need to call the police (Hodges. 1993) are some recommended strategies. Additionally, knowledge of the whereabouts of safe places such as the emergency room, local shelter, a trusted friend's home and police station can help protect the woman and her children from harm (Hodges. 1993).

Documentation of the abuse can be powerful evidence for the woman in legal proceedings. It should cover the current trauma including photographs of injuries (where consent has been obtained), a history of the trauma, mental health sequelae linked to the victimisation, and any referrals made (Holtz & Furniss. 1993; McLeer & Anwar. 1987). Detailed records also provide a basis to review progress and monitor treatment (Anonymous. 1992).

Perpetrators

Whilst routine screening for victims of abuse has been strongly encouraged amongst health professionals, a similar approach for perpetrators has increasingly been seen as desirable but more problematic. As yet there are no established guidelines in this area. However the importance of screening for perpetrators is being reinforced by increased public awareness of the problem of domestic violence and acceptance of the rationale for the treatment of the perpetrator, aided by an increased preparedness on the part of the perpetrator, to volunteer for treatment (Sonkin. 1988). The desirability of screening has been enhanced by the findings of intervention studies which have consistently found that some perpetrators are capable of changing their abusive behaviour at least in the short term (Tolman & Bennett. 1990).

Routine Screening: The identification of perpetrators of domestic violence is usually difficult because of the tendency of the perpetrator to deny a history of abuse, a lack of motivation for treatment, a fear of social stigma, financial considerations and a reluctance to publicly acknowledge violent behaviour. There may however be certain indirect signs which can alert the professional to the existence of abuse. These include the repeated presentation of the perpetrator's partner with signs of abuse, the insistence of the perpetrator to be present during the examination of the partner and a need to dominate and control (eg. speak for) the partner while in the presence of the health care professional. There may also be a history of marital problems, depression and substance abuse (Sonkin. 1988). Socio-economic status should not be considered in the screening process, as perpetrators are found in all levels of society.

The past and present family history of the perpetrator may provide clues as to the presence of possible predictors of abuse. The perpetrator may more easily be asked about issues related to his childhood and adolescence such as witnessing or being exposed to parental violence, antisocial behaviour (eg. truancy), general level of aggression (eg. fights at school), and current problems he may be having with his own children (eg. parental discipline role model).

Intervention: Major problems in carrying out interventions centre around the difficulty in initially attracting battering men to treatment and then keeping them in treatment after they begin. Because of this, it is important that the client is seen alone and should be assured of strict confidentiality. If a history of relationship problems is obtained the client should be encouraged in a non threatening manner to discuss the nature of the problems and any abuse which may have occurred. The professional should be aware that denial, minimisation, and rationalisation may be used as defences and that the perpetrator may fear legal consequences. When the relationship has been established it is important to state firmly that violence is unacceptable and that the client accept full responsibility for any violence which has occurred in the past. Ways of dealing with the abuse should be discussed and the professional should accept the perpetrator's decision concerning future treatment.

The health care professional should also remain aware of the ongoing risk to the perpetrator's partner. He may have to modify the discussion accordingly. With the consent of the perpetrator, the partner should be interviewed, the history confirmed, information on support services provided and specific referrals made.

Treatment options should be discussed with the client. These have become more common in recent years, the main impetus has been increased acceptance of the nee for treatment by the community and increased referral by the courts. As well, many perpetrators are independently seeking assistance for their violent behaviour. The options include self help and other men's groups, individual, couple or family counselling and drug and alcohol treatment. Self help groups are usually highly structured and behavioural in their orientation, use anger and stress management, the development of problem solving skills and examine attitudes towards violence in the home (Sonkin & Dunphy. 1982).

Group programs have been the most widely used treatment modalities. They have generally been cognitive-behavioural in their approach, structured and short-term (8-32 sessions). Couple and family counselling should be used selectively and with the clear objective of stopping the violence and a commitment to work on the relationship. Treatment is usually short-term and uses cognitive behaviour techniques. It is however controversial because of concerns for the victim's safety during treatment, the possibility that the victim will be falsely reassured or alternatively, the risk of overt or covert blaming of the victim.

Legal intervention which predominantly takes the form of arrest and/or restraining order and court mandated treatment may occasionally be required. It is best avoided because it makes the perpetrator's motivation for treatment uncertain, so that voluntary cooperation with treatment is preferable.

Concluding remarks

Women who are in abusive relationships can be assisted in a variety of ways to either leave the relationship, or cope with it if they choose to remain with their partner. Programs are being offered which cater to the diverse needs of women in such relationships. They are effective and have made a considerable impact on overcoming the physical, psychological and social problems associated with domestic violence in the community.

There has been increasing acceptance of the need to provide intervention for perpetrators, although such intervention has not been conclusively shown to be effective. However, some men are capable of changing their abusive behaviour. Treatment should be used in conjunction with the legal system if necessary. The need for treatment should also be reinforced by victim-initiated actions such as real or threatened separation, expressed disapproval by relatives and friends and public education about the problem.

Chapter 3. Characteristics of victims and perpetrators

3.1 Victims

This section reviews the psychological and psychiatric characteristics of women who have been abused. There is considerable evidence that the mental health problems experienced by victims are the result of, rather than a precursor to, the abuse. In a review of the literature, Hotaling & Sugarman. (1986) examined over 400 empirical papers on husband to wife violence. After excluding a number on the basis of methodological criteria they explored the findings of 52 case comparison studies. The only factor associated consistently with being a victim of violence was witnessing violence in the wife's family of origin. The experience of personal violence during childhood was found to be common but not consistent. Traditional sex-role expectation was an important but inconsistent factor which was unable to discriminate victims of abuse from women in highly conflicted but non violent relationships. Factors related to income, educational level and race did not characterise victims.

Psychological and psychiatric characteristics

Our knowledge of the mental health effects of spouse abuse on mental health comes primarily from two areas of research; population surveys and studies of battered women. These studies which are discussed below have demonstrated that the mental health effects are severe and result in a number of clearly identified conditions such as depression, anxiety, post traumatic stress disorder, drug and alcohol abuse as well as a variety of vague psychological and somatic complaints.

Population studies: Gelles & Harrop. (1989) as part of the Second National Family Violence Survey examined the relationship between spouse abuse and psychological distress (stress, depression and somatic symptoms) in a sample of 3,000 female respondents. They found that the severity of abuse was positively associated with the experience of both 'moderate' and 'severe' psychological distress, and was independent of marital distress and demographic variables such as age, sex and education.

Psychiatric symptomatology using the General Health Questionnaire (GHQ) was assessed in a representative sample of 1516 women in New Zealand. An additional randomly selected subsample was assessed using the short form Present State Examination (PSE). Sixteen percent of the sub-sample had been hit and physically abused as an adult but only three percent reported being current victims of domestic violence. Women who reported a history of abuse had significantly higher GHQ and PSE scores, and were more likely to be identified as a psychiatric case by these measures. Women who had been hit on three or more occasions had significantly higher scores on the PSE than women who had been hit on one or two occasions;

suggesting a positive association between the frequency of abuse and mental health problems. Given that only a small proportion of women were currently experiencing abuse, these results point to lasting mental health problems despite cessation of the abuse (Mullen, Roman-Clarkson, Walton, & Herbison. 1988).

Ratner. (1993) examined the impact of spouse abuse on the mental health status of women in a representative community sample. Three groups of women were compared, those who were physically abused, those who were psychologically, but not physically, abused and those who were not abused within the previous year. Physically abused women, most of whom were also abused psychologically, reported more somatic complaints and had higher levels of anxiety and insomnia and more symptoms of depression than the non-abused and psychologically abused group. However, the significant effect of psychological abuse on mental health was also apparent. When compared to women who were not abused, women who were abused psychologically but not physically demonstrated significantly higher scores on the somatic complaints and the anxiety and insomnia subscales of the GHQ. Alcohol abuse as assessed by the CAGE questionnaire differed significantly between the three groups of wives. While only 2.4% of the non-abused wives were found to abuse alcohol, the percentage of physically and psychologically abused wives who did so was 16% and 11% respectively.

While population studies have established that female victims of spouse abuse experience mental health problems significantly more often than women who are not abused, these studies have used global measures of psychopathology and do not provide diagnoses. The next section will review studies of battered women. Although less representative of the population of abused women, they provide us with a better understanding of the types of mental health problems experienced.

Studies of battered women: Victims of spouse abuse are at significant risk of developing a lifetime mental disorder (Koss, Woodruff, & Koss. 1990; Gleason. 1993; Mullen, Roman-Clarkson, Walton, & Herbison. 1988). A recent study reported that 73% of women seeking assistance for battering were suffering from major depression; this compared with community norms of seven percent (Gleason. 1993). Other psychological disorders reported included post traumatic stress disorder (36% vs 1%), generalised anxiety disorder (45% vs 3%), various phobias (19%-73% vs 8-15%), obsessive compulsive disorder (40% vs 3%), alcohol abuse (34% vs 4%) and drug abuse (34% vs 4%).

Post traumatic stress disorder (PTSD) which is characterised by fear/avoidance, affective constriction, disturbances of self-concept/self-efficacy and sexual dysfunction has been identified as a key mental health problem affecting women who have been abused by their partner and also women who have been victims of other violent crimes by strangers (Koss, Woodruff, & Koss. 1990). The effects of the trauma upon spouse abuse victims may be even worse than those experienced by victims of crime by strangers. Firstly, they may be exacerbated by the occurrence of ongoing abuse. Secondly, the perpetrator is someone whom they may trust, love or depend on (American Medical Association. 1992).

Suicidal behaviour is more prevalent amongst battered women than non-battered women and appears to be a direct consequence of the abuse. In fact, Stark & Flitcraft. (1988) identify battering as the single most important factor leading to suicide attempts by females. They report that battered women are 4.8 times more likely than non-battered women to attempt suicide and that the difference in relative risk emerges after the first reported episode of abuse.

Many studies report on the increased likelihood of mental health problems such as depression and PTSD as the severity of physical abuse increases (Astin, Lawrence, & Foy. 1993; Follingstad, Neckerman, & Vormbrock. 1988). Although the effects on victims' mental health are long lasting, studies have shown that, for some women, symptoms of depression and PTSD may decrease in severity with the passage of time since the last episode of abuse (Astin, Lawrence, & Foy. 1993; Walker. 1984).

The battered women described in these studies had all sought assistance for the abuse and consequently may represent the more severely affected. Not all abused women can be considered to be battered and not all women who are battered have a well defined mental disorder. Often victims of spouse abuse present to their doctor with vague health complaints long before they acknowledge the presence of violence or otherwise seek help (Knowlden & Frith. 1993). They may present with a variety of psychological and somatic symptoms that are difficult to diagnose. However, these are of sufficient severity to affect their quality of life and hence warrant intervention. Examples include the milder forms of anxiety and depression, problems with low self-esteem and complaints of headache, abdominal discomfort. palpitations, diarrhoea, insomnia and chronic pain states (Knowlden & Frith. 1993; Mitchell & Hodson. 1983). Recognition of these symptoms can assist the early identification and treatment of spouse abuse victims and may also prevent the development of more serious mental health problems.

3.2 Perpetrators

There have been few general population studies examining the psychological characteristics of perpetrators; most of the studies have examined clinical populations, for example, perpetrators presenting for court mandated or volunteer treatment, and drug and alcohol treatment (Dutton. 1986). Information about perpetrators has also been elicited from abused women's descriptions of their partners and from battered women seeking refuge in shelters (Follingstad & Breiter. 1994). While the psychological problems experienced by victims of abuse are thought to be a consequence of the abuse, there is general consensus that for the majority of men in treatment for their abuse, the personality traits or discrete psychological/psychiatric problems predate the abuse (Tolman & Bennett. 1990).

In their extensive review of the literature examining risk factors of abuse Hotaling & Sugarman. (1986) found that men who abused their partner were more likely to have witnessed and/or experienced parental violence, tended to abuse alcohol and were found in all socio-economic levels. In general, perpetrators were more likely to have been involved in other forms of antisocial behaviour than men who had not been

violent towards their wives, to have been violent with their children and other non family members, to have been generally aggressive and to have had a criminal arrest record.

Specific psychiatric illness

The psychiatric illness found most consistently in perpetrators is depression. Studies have generally shown that the risk of depression is high (Hamberger & Hastings. 1986; Hamberger & Hastings. 1986; Saunders & Hanusa. 1986). In studies of 1200 randomly selected community members using the Diagnostic Interview Schedule, (Bishop & Patterson. 1992; Bland & Orn. 1986) found that the diagnosis of depression was one of only three diagnoses found to correlate with assault of a family member, the others being antisocial personality disorder and alcohol abuse. The odds for major depression were, in fact, increased by a factor of 7.8. In a similar study Swanson, Holzer, Ganju, & Jono. (1990) found that subjects with affective disorders had elevated rates of violent behaviour. However Dinwiddie. (1992) found in his study which paralleled the study of Bland and Orn in many respects, that affective illness was virtually never seen in perpetrators without the presence of antisocial personality disorder, alcoholism or both. Whilst acknowledging the importance of treating the depression, all emphasise the importance of holding the perpetrator responsible for his behaviour.

Anxiety disorders are generally not mentioned as being experienced by perpetrators. It has been shown however, that compared to age-matched controls, perpetrators have higher levels of anxiety and dysphoria in general and more somatic complaints (Hamberger & Hastings. 1991).

(Dutton. 1995) in a recent study of 132 perpetrators compared with 44 non-abusive controls found that perpetrators exhibited psychological profiles similar to groups of men suffering from post-traumatic stress disorder. Perpetrators also had experienced more trauma symptoms related to childhood experiences of abuse than controls. The authors comment that men suffering from PTSD from other causes, eg. post combat, are also significantly more likely to exhibit antisocial behaviour and the possibility is presented that PTSD may be a mediating variable between childhood abuse and adult perpetration of partner abuse.

Whilst there is no psychotic disorder specific for perpetrators (Russell. 1988), they may occasionally be suffering from a psychotic illness such as paranoid schizophrenia, in which delusions of jealousy can lead to violence. (Swanson et al. (1990) using the Diagnostic Interview Schedule in a community sample, found that subjects with a diagnosis of schizophrenia had elevated rates of domestic violence, though not as high as subjects suffering from drug and alcohol problems. Similarly, persons who are intellectually retarded, who suffer from chronic organic brain syndromes or metabolic states such as thyrotoxicosis, may display irritability or poor anger control leading to violence (Tolman & Bennett. 1990). Such pychopathology, whilst uncommonly found, does need to be excluded when assessing and managing perpetrators.

Personality traits and characteristics

Recent reviews of intrapersonal and interpersonal characteristics (Morley. 1994; Follingstad & Breiter. 1994) of wife abusers have found them to commonly suffer from one or more of the following traits: low self-esteem with high levels of dependency on and jealousy of their partners; a fear of intimacy; feelings of inadequacy as a male; a need to be in control; rigidity and resistance to change; poor impulse control and low frustration tolerance; low assertiveness; underdeveloped communication skills; a tendency to minimise and rationalise their abusive behaviour.

The role of anger control in men who abuse is uncertain. Research suggests that perpetrators are more hostile and angry than non-violent men but do not differ significantly from generally violent men (Tolman & Bennett. 1990). Maiuro, Cahn, & Vitaliano. (1986) found that batterers were more hostile than non-violent controls, whilst Hamberger & Hastings. (1991) found that men in their sample who batter did not have an anger problem; in fact they scored lower on the Novaco Anger Scale. Recent work by Jacobson, Gottman, Waltz, Rushe, Bacock, & Holtzworth Munroe. (1995), has defined a group of batterers whose level of anger measured physiologically, decreases as marital conflict develops. Some argue that where anger exists, this may be self-generated to rationalise the abusive behaviour.

It has been shown that men exposed to abuse as a child, either as a victim or witness are more likely to use violence in their adult intimate relationships (Rosenbaum & O'Leary. 1981; Forsstrom-Cohen & Rosenbaum. 1995), but the mechanism of the effect is unclear. Shields, McCall, & Hanneke. (1988) described the exclusively domestically violent man as more likely to have experienced violence as a child than either non-domestically or generally violent men. In her review of the literature in this area, Carden. (1994) found that whilst many studies supported the fact that there was a strong relationship between experiencing and being exposed to parental violence as a child, and abusing a partner as an adult, such childhood experiences did not support an assumption of direct or inevitable causality.

Personality Typologies

The personality profile of the perpetrator has been likened to that of the schizoid/borderline (asocial, withdrawn, moody, hypersensitive, volatile, high levels of anxiety and depression, alcohol problem) or antisocial/narcissistic (uses others to satisfy his needs, dogmatic, demanding, threatening and aggressive) type (Hotaling & Sugarman. 1986). Bland & Orn. (1986) found in their community sample, that the odds for a diagnosis of antisocial personality disorder were increased by a factor of 8.2 in men abusing their wives. Men suffering from antisocial personality disorders may however be over-represented because they are more likely to be in court-mandated treatment or to have sought treatment for other related problems such as substance abuse.

In their study of 105 men attending a treatment program for wife abuse, Hastings & Hamberger. (1988) also found that the schizoid/borderline and antisocial/narcissistic personality types were commonly found in spouse abusers. However, they described a

third category, the dependent/compulsive type (tense, rigid, ingratiating, low self-esteem, strong dependency need, low anger, moderate depression) which did not occur as frequently but was still found in substantial numbers. In a later study (Hamberger & Hastings. 1991) they assessed 129 perpetrators who were either in treatment, (alcoholic or not), and obtained through community sampling. They were able to show that batterers had more borderline characteristics than non-violent controls, and that alcoholic batterers had the highest MCMI elevations of all groups. Only 13% of the batterers showed no obvious psychopathology.

Gondolf. (1987) interviewed a population of battered women in refuges. On the basis of these interviews, he proposed 4 subgroups of perpetrators, the sociopathic, antisocial, chronic and sporadic. The sociopathic were the most violent both in and out of the home and were most likely to abuse alcohol or drugs. This subgroup appeared to be consistent with a diagnosis of antisocial personality disorder. The other subgroups represented decreasing levels of abuse.

Dutton. (1988) assessed 182 men referred for treatment for severity and generalisability of violence, sex-role stereotyping, decision-making power, level of conflict, anger, jealousy, depression and alcohol use. He found 3 types of perpetrators, the first being the most severely violent both in and out of the home, who also abused alcohol and who had been abused during childhood. The second type scored high on depression, jealousy and anger and the third type was characterised by men with moderate levels of anger and depression, who occasionally abused alcohol and who restricted their violence to the home. This last group also reported the highest degree of marital satisfaction.

Recent research has suggested the possibility of a physiologically based typology of perpetrators. Gottman, Jacobson, Rushe, et al. (1995) studied 60 severely violent couples and identified a subgroup (20%) of batterers (Type I) who paradoxically "calm down " as they begin to argue with their wives. They used the physiological measure of heart rate reactivity during the first 5 minutes of the marital conflict interaction and found that it decreased in this group, when compared to a second group (Type 2) where it remained constant or increased. The first group of men also differed from the other maritally violent men in a variety of ways. They were more belligerent and contemptuous, more likely to be violent outside the marriage and reported violence between their parents. Almost all were antisocial, aggressive-sadistic and drug addicts. At 2-year follow-up, this group had a separation/divorce rate of zero compared to the other group. Gottman does however make the point that the numbers involved in the study are small and the study needs to be replicated. The issue of whether the heart-rate reactivity marker is genetically determined or is a learned response to childhood exposure to violence in the family of origin, remains unclear, however Type I batterers may habituate to parental violence and cope with the stress of the family environment by not responding physiologically. Alternatively, these men could also have learned this process in the course of several relationships with women as a means of being in control during arguments.

These results are consistent with previous studies (Bland & Orn. 1986; Gondolf. 1988; Caesar. 1988) and suggest the existence of two broadly defined groups of batterers,

those who are severely abusive and violent outside the marriage and those who are generally not violent outside the marriage. However all of the above mentioned research points to there being a group of batterers whose abuse is severe, associated with drug and/or alcohol abuse, general aggression and the diagnosis of antisocial personality disorder.

Chapter 4. Alcohol, other drugs and spouse abuse

The study of the role of alcohol and drugs has been identified as an important area of research that could potentially clarify some of the causes of spouse abuse. Interest in the alcohol area has been stimulated by the widespread belief that violence in the family is related to the abuse of alcohol and also by the results of surveys and case study research. Examination of the association between drug use and spouse abuse is a relatively newer area of research, however, some interesting findings are emerging.

In this chapter three areas of research are reviewed: i) alcohol use of violent men and abused women ii) drug use of violent men and abused women and iii) other potentially interrelated factors.

4.1. Alcohol abuse

Perpetrators

Two large scale surveys in the US (Roscoe, Goodwin, & Kennedy. 1987; Coleman & Strauss. 1979) have contributed to our knowledge of the relationship between alcohol and spouse abuse. Both studies found that frequency of drunkenness for husbands was associated with abuse of their partners. For example, Coleman and Strauss found that rates of violence were 15 times higher for couples in which the husband was reported to be drunk often, as opposed to never drunk in the previous year. In the second survey (Roscoe, Goodwin, & Kennedy. 1987), alcohol had been consumed immediately prior to violence in 24% of incidents of spouse abuse. Close to 50% of binge drinkers had consumed alcohol prior to a violent incident compared with 19% of infrequent drinkers.

In a recent study, Barnett & Fagan. (1993) found that maritally violent men had higher overall alcohol consumption than non-violent men. While the groups did not differ in terms of the frequency of drinking, differences emerged in the quantity of alcohol consumed. In this study 28% of violent men and one-fifth of abused women reported their partners drinking often or very often during abusive incidents.

Alcohol abuse can be described in terms of intoxication or chronic abuse. It is reported frequently that perpetrators are intoxicated prior to spouse abuse incidents. In their review of 15 studies published prior to 1980, Lewis, Pincus, Lovely, & Spitzer. (1987) estimated that alcohol was present in 25 to 50% of all wife beating incidents. Rates identified by Tolman & Bennett. (1990) in a review of studies published between 1980 and 1988 were higher. The mean incidence rate for alcohol intoxication at the time of battering was 61% with a range between 53% to 70%. The rate reported varied according to whether the batterer or victim reported the data. Mean intoxication rates were 66% and 56% when reported by batterers and women respectively.

Many studies have also demonstrated chronic alcohol abuse to be common amongst perpetrators. Van Hasselt, Morrison, & Bellack. (1985) reported significantly higher scores on the Michigan Alcoholism Screening Test for physically abusive males compared with men in maritally discordant but non violent relationships and satisfactorily married men. Hall. (1987) found that physically abusive men not currently in therapy for the abuse had significantly higher scores on the MAST compared with physically abusive couples in therapy, maritally dissatisfied but non-violent couples and satisfactorily married couples.

A study carried out by Stein. (1987) indicated that of men seeking counselling for their domestically abusive behaviour, 59% abused alcohol. Alcohol abuse rates in the study carried out by Stith, Crossman, & Bischof. (1991) were slightly higher with 64% of batterers undergoing treatment for violence identified as being alcoholic using the MAST. In the review of studies between 1980 and 1983, Tolman & Bennett. (1990) reported that on average 53% of perpetrators were reported to abuse alcohol. However, in this study the numbers of perpetrators abusing alcohol differed according to who reported the data (Tolman & Bennett. 1990). When perpetrators were asked about their alcohol abuse, 36% of perpetrators reported that they abused alcohol. Victims reports of alcohol abuse in their partner were higher at 67%.

In a study of 484 men in the community Leonard, Bromet, Parkinson, Day, & Ryan. (1995) found that spouse abuse was related to a recent diagnosis of alcohol misuse (pathological consumption plus social consequences of drinking) or alcohol dependence (one of the two criteria plus signs of dependence). The diagnosis of alcohol dependence was associated with fights since the age of 18 but the diagnosis of alcohol misuse was not. Also, their results indicated that the critical factor associated with spouse abuse was a history of alcohol abuse rather than total consumption during the previous month.

Two studies have surveyed alcoholics in VA inpatient rehabilitation programs for alcoholism. In the first study, involving 77 male alcoholics, 68% reported having slapped or pushed their partners one or more times, and 32% reported having hit their partner with fists or feet (Powers. 1983). The second study, involving over 200 patients also revealed high rates of violence. Close to forty percent of patients reported assaulting their wives in the previous year; 20% of patients reported the use of severe violence. The authors argued that the reported incidence of spouse abuse was likely to be underestimated. For example when a subsample of wives/partners were interviewed, rates of assault were reported to be 1.6 times higher than rates reported by their male partners (Gondolf & Foster. 1991).

Victims

Whilst the above studies have examined alcohol use in abusive men, another group of studies, have examined spouse abuse in women undergoing treatment for chronic alcohol abuse. Rates of spouse abuse are high amongst this population. In a survey of 100 wives of alcoholics, (Scott cited in Lehman & Krupp. 1984) 72% reported being threatened with violence, 45% were beaten and 27% had experienced potentially

lethal attacks from their husbands. Other studies of alcoholic women have also demonstrated an association between alcohol abuse and battering (Haver. 1987; Miller, Downs, & Gondoli. 1989). For example, Bergman cited in Bishop & Patterson. (1992) found that 65% of a sample of alcoholic women had been battered at some time compared with 24% in a control group seen in a surgical emergency department (Bishop & Patterson. 1992).

There have been relatively fewer studies directly examining the use of alcohol by abused women and of those studies conducted, the results are mixed. In the study by Barnett & Fagan. (1993), females who had been abused by their partners drank significantly more alcohol than women who were happily or satisfactory married. The pattern of drinking differed for the abused women and their partners. While significantly more partners than women drank prior to the abusive event, a higher proportion of abused females (48%) than males (24%) drank after the abusive event.

The results are less clear when a maritally discordant control group of women is used for comparison. For example, Hall. (1987) demonstrated alcohol problems in physically abused women to be no different from groups of women who were either maritally satisfied or maritally dissatisfied. Van Hasselt, Morrison, & Bellack. (1985) also report no significant differences in alcohol use between three groups of women; women who were in abusive relationships, women who were maritally discordant but in non violent relationships, and women who reported being satisfactorily married. Alcohol use was measured using the MAST, a quantity frequency index of alcohol consumption as well as an index of impairment assessing behaviour problems arising from alcohol use. MAST scores were noticeably higher for the abused women than the other two groups. In fact the mean score of 5.33 is above the cut off score of 5 indicative of alcoholism. Failure to find a significant difference may have been due more to insufficient power of the study to detect such a difference than to the absence of such a difference.

Concluding remarks

The large variability in results for studies examining alcohol intoxication or chronic alcohol abuse and its association with partner violence is largely the result of differing and often inadequate methodology used to explore the relationship between these variables. Relatively few studies define terms such as violence, alcohol use and alcohol abuse and few make a distinction between the acute and chronic effects of alcohol. Additionally, standardised assessment procedures to measure alcohol and violence related variables are used infrequently. Finally, the population under examination for many studies is highly select and this problem is compounded by the limited information provided on characteristics of the study population (Lewis, Pincus, Lovely, & Spitzer. 1987).

Nevertheless, despite methodological limitations the finding of an association between alcohol and spouse abuse is consistent both in terms of intoxication and chronic alcohol abuse. However, at this stage it is unwise or premature to assume a casual relationship between either of these variables and spouse abuse. For both men and

women, alcohol intoxication may be an immediate precursor to spouse abuse, however, the majority of incidents do not involve alcohol prior to the violence (Roscoe, Goodwin, & Kennedy. 1987). Moreover, women are more likely than men to drink after the abusive incident. Others have argued that perpetrators become intoxicated prior to the abuse to rationalise and excuse the violence (Matchett, Burrows, Clarke, et al. 1988; Barnett & Fagan. 1993; Miller. 1990). Finally, alcohol intoxication in either men or women, may be a proxy for chronic alcohol abuse. Because alcoholics are more frequently drunk than non-alcoholics, any observed association between spouse abuse and intoxication can be attributed to the longer term drinking problem rather than to intoxication per se (Martin. 1992). Indeed many of the studies reviewed above have shown chronic alcohol abuse to be a characteristic of perpetrators (Tolman & Bennett. 1990; Van Hasselt, Morrison, & Bellack. 1985; Hall. 1987; Stein. 1987).

The relationship between chronic alcohol abuse and spouse abuse is also complicated. Chronic alcohol abuse may lead to violence against partners, but other explanations are equally or more plausible. For example, it has been argued by many that perpetrator's chronic abuse of alcohol and violence against his partner, are two co-existing problems. A similar argument can be made for victimised women who chronically abuse alcohol. It has been suggested, however, that abuse of alcohol by women and victimisation by their partner may be related in an indirect way. Specifically, women who abuse alcohol may be more likely to enter a relationship with a partner who also abuses alcohol, and hence are at greater risk of being victimised.

4.2. Drug abuse.

One factor, that has not been explored extensively, is the association between drug abuse or combined drug and alcohol use and domestic violence. There are however, several studies which have been reported. Stein. (1987) found that of men seeking counselling for their abusive behaviour, 18% abused other drugs in addition to the 59% of violent men who abused alcohol.

In the study by Roscoe, Goodwin, & Kennedy. (1987), mentioned previously, the role of the illicit drug use was assessed in addition to alcohol use and other variables. It was noted that drunkenness by wives and husband, husbands' illicit drug use, wives' acceptability of violence under some occasions (violence norms), and wives' exposure to father to mother violence were all significant predictors of minor violence against wives. For severe violence against wives, only husbands' illicit drug use, low family income and wives' exposure to father to mother violence during childhood were significant predictors; neither husbands, or wives' drunkenness were predictors (Kantor & Straus. 1989). However, this study did not report on the relation between combined drug and alcohol use and violence.

Roberts. (1988) examined the relationship between battering and combined drug and alcohol abuse. Over two hundred intake records of male batterers who had charges filed against them were examined. Nearly one-third of batterers abused drugs other

than alcohol; one in five batterers abused both alcohol and drugs. Of the 168 batterers only 51 did not have a drug or alcohol problem. While 60% of the battered women indicated that the abuser was under the influence of alcohol during the battering incident for which charges were filed, 70.5% reported that the abuser was under the influence of alcohol and/or drugs. Batterers were divided into two groups; those that committed severe offences involving bodily harm and those that committed less severe offences such as slapping, pushing, kicking and hitting. 73% of the batterers who did not abuse alcohol or drugs committed the less severe offences. Equal numbers of men who abused alcohol only, committed severe and less severe offences. Men who were charged with the more violent offences that resulted in physical injury were more likely to have either a drug problem or a dual alcohol and drug problem, than those charged with less severe violent offences. For example, batterers committing the more severe offences were much more likely to abuse drugs (19%) than batterers committing the less severe offences (6%). Batterers committing the more severe offences were also much more likely to have combined drug and alcohol abuse (49%) than batterers committing the less severe forms of violence (22.4%).

Miller. (1990) examined the effect of perpetrator alcohol and drug problems on spousal violence in a parolee population. Neither the drug or the alcohol problems independently contributed to the level of parolee-to-spouse violence but the interaction effect, alcohol by drugs, did contribute significantly. The presence of alcohol problems was related to the degree of parolee-to-spouse violence when there was no drug problem. When the parolee had drug problems, his alcohol problems had no impact on parolee-to-spouse violence. In this study, the effect of the victim's alcohol and drug abuse on spousal violence was also examined after controlling for the perpetrator's alcohol and drug problems. The only significant finding was the interaction of parolee alcohol problems by spouse alcohol problems. More violence was initiated by the parolee in couples in which either or both had high levels of alcohol problems. The presence of problems in both members of the couple however did not inflate the level of violence any more than if only one member had reported high levels of alcohol problems.

Concluding remarks

Drug abuse of perpetrators and victims in relation to spouse abuse has received relatively little attention until recently. Drug abuse alone, or combined drug and alcohol abuse appears to be associated with the more severe assaults against female partners. However, there does not appear to be any relationship between women's drug use and spouse abuse.

Despite the relationships found between alcohol and drug use and spouse abuse, there are a large number of men and women who abuse alcohol and drugs yet are not perpetrators or victims of spouse abuse. In other words, not all men who abuse alcohol and drugs are violent towards their partners and not all women who abuse alcohol and/or drugs are victimised.

To explain this anomaly, it is necessary to examine the role of other intervening or mediating factors. For example, a history of parental alcoholism or family violence during childhood is commonly associated with both alcohol and drug abuse and spouse abuse as an adult. These factors may even be causally associated with spouse abuse, with alcohol and drug use presenting as correlates only. The next section summarises studies exploring the role of childhood exposure to violence and the development of antisocial personality disorder in an alcohol and drug abusing population.

4.3. Other interrelated factors

Kroll, Stock, & James. (1985) found that male alcoholics who had experienced physical abuse during childhood were much more likely to perpetrate violence against their partner compared with a control group of alcoholic men without histories of child abuse and an age-matched group of non-alcoholics; fifty-six percent of alcoholics who had been abused had perpetrated violence against their partner compared with only 6% in the control group (Kroll, Stock, & James. 1985). It is of interest to note that the violence perpetrated was not exclusively against the partners. For example, thirty-eight percent of this group also perpetrated violence against authority figures compared with only 3% of controls.

Gondolf & Foster. (1991) in their study of male patients attending an alcohol rehabilitation program found that patients who came from both alcoholic and violent families were almost twice as likely to report wife abuse during the previous year than patients who had come from alcoholic families only (56% vs 31%).

A history of parental violence during childhood has also been shown to be common amongst female alcoholics in abusive relationships (Haver. 1987; Miller, Downs, & Gondoli. 1989; Miller, Downs, & Testa. 1993). Haver. (1987) interviewed 44 female alcoholics of whom half reported violence during childhood, either between their parents or between themselves and their parents. Fifty-five percent of the women also reported alcoholism in one or both parents. The results of the study also indicated that the more severe the violence during childhood, the greater the likelihood that the woman entered into one or more violent relationships as an adult.

Similar conclusions can be reached from other studies (Miller, Downs, & Gondoli. 1989; Miller, Downs, & Testa. 1993). Compared with a community sample of women, alcoholic women reported significantly more stressors such as divorce and death in their family of origin, more negative verbal interactions and moderate and severe violence from their father. They were also more likely to have at least one alcoholic parent. In adult life, alcoholic women were more likely than the community sample to report that their spouse had perpetrated moderate and severe violence and that their spouse abused alcohol (Miller, Downs, & Gondoli. 1989). The relationship between experiences of childhood victimisation was explored further by Miller, Downs, & Testa. (1993). They found that childhood victimisation had an independent effect on the development of women's alcohol problems after controlling for demographic and family background including alcohol-related problems in one or

both parents. Similar results were obtained by (Ireland & Widom. 1994) who found a relationship between childhood victimisation and adult arrest for alcohol and/or drug related problems.

The results of these studies suggest that childhood experience of parental violence increases the risk that alcoholic men will perpetrate violence against their partner and also the risk that alcoholic women will be victimised by their partner. The findings also raise the possibility that spouse abuse and alcohol abuse are co-existing rather than causal factors and that each may be related to the experience of violence during childhood. However, it is also possible that the effects of childhood abuse lead to the development of antisocial personality disorder, resulting in the development of alcohol problems and spouse abuse as an adult.

One prospective study has highlighted the role of childhood victimisation on the development of alcohol and drug related problems (Ireland & Widom. 1994) and a second has highlighted the role of early aggressive behaviour on adult alcohol use and alcohol related violence (White, Brick, & Hansell. 1993). Unfortunately, neither examined the relationship between childhood variables and spouse abuse as an adult. The first study (Ireland & Widom. 1994) examined the relationship between early childhood victimisation and subsequent arrest for alcohol and or drug related problems. After controlling for demographic variables, it was found that the association between childhood maltreatment was a significant predictor of adult arrests for drug and alcohol related offences. A large part of the effect was mediated through a history of juvenile delinquency. Abused and neglected children were more likely to become delinquents, who in turn were more likely to be involved in alcohol or substance misuse.

The second study (White, Brick, & Hansell. 1993), examined the interrelationships between alcohol use and aggressive behaviour for 218 males at the ages of 12, 15 and 18 years. Aggressive behaviour at an early age was associated with an increase in alcohol use and alcohol related aggression at an older age. However, levels of alcohol use were not significantly related to later aggressive responses. The authors concluded that early aggressive behaviour is predictive of later alcohol related problems and that alcohol related aggression is committed by aggressive people who also drink alcohol.

An alternative interpretation of the relationship between exposure to family violence during childhood, subsequent alcoholism and spouse abuse, is that the relationship is in part due to genetic factors. These may lead to the development of an antisocial personality disorder and associated spouse abuse and alcoholism, which may be independent of the experience of violence during childhood. There appears to be some evidence that genetic factors are related to the development of alcoholism (Anonymous. 1992) and to antisocial personality disorder. (Cloninger, Bohman, & Sigvardsson. 1981), found that male alcoholics with high rates of criminality transmitted a higher risk of alcoholism to their sons than alcoholics with lower rates of criminality. Characteristics of this group, which Cloninger has named type 2 alcoholism, include an early onset of alcohol problems, being male, socially disruptive when drinking, and experiencing parental alcohol abuse. In contrast, type 1 alcoholism, which is not associated with familial alcoholism, is characterised by a

later onset of problems, psychological rather than physical dependence and guilt about alcohol use. Other investigators have challenged the specifics of Cloninger's classification. In a recent study (Babor, Hofmann, Delboca, et al. 1992) two subtypes of alcoholics were identified. The first subtype (type A) was characterised by later onset, fewer childhood risk factors, less severe dependence, fewer alcohol related problems, and less psychopathological dysfunction. The second subtype (type B), was characterised by the earlier onset of alcohol problems, childhood and familial risk factors, familial alcoholism, more severe alcohol dependence, polydrug abuse, a chronic treatment history and greater psychopathology. Although there were many similarities with the Cloninger classification, important differences were evident. In contrast to the type A alcoholic, Cloningers's type I alcoholic was characterised by loss of control and more anxiety and depression. However, the most important difference was that in the classification of Babor et al. 1992), both Type A and type B alcoholics applied to men and women, while in Cloninger's classification, type II characteristics were limited to male alcoholics only (Babor, Hofmann, Delboca, et al. 1992).

It is of interest that some recent research has identified two sub-types of batterer that are remarkably similar to the subtypes found for alcoholics. As discussed in section 3.2 Gottman, Jacobson, Rushe, et al. (1995) distinguished two groups of batterers based on their heart rate reactivity when discussing with their partner issues causing conflict, in a laboratory situation. One group of men (Type I) were characterised by a decrease in heart rate below baseline levels, while the other group (Type 2) demonstrated increases in their heart rate. When compared to type II batterers, Type I batterers were found to be more emotionally violent towards their wives and more violent towards other people including strangers, bosses and friends; they were also more likely to be drug dependent. They scored higher on scales reflecting antisocial behaviour and sadistic aggression, had witnessed more parental violence during childhood and had lower dependency needs than the type II men (Gottman, Jacobson, Rushe, et al. 1995). A larger number of type I batterers committed the more severe forms of violence against their wives.

Concluding remarks

As the above discussion has shown, the childhood experience of, or exposure to parental violence is associated with the later development of domestic violence, in perpetrators and victims who abuse alcohol and/or drugs. Parental alcohol and drug abuse is also more common amongst these clients. It is possible that chidhood abuse leads to the development of anti-social personality disorder which may be associated with alcohol problems and spouse abuse in later life and that alcohol/drug abuse and spouse abuse are independent problems. Others have suggested that genetic factors may mediate the development of both alcohol problems and aggression. Alternatively, there may be a direct causal relationship between alcohol use and spouse abuse in later life, although many argue that this is unlikely.

The interrelationships do, however, appear to be important and further work needs to be undertaken to more fully elucidate them. They have potential significance in defining groups in the community who are at risk for the development of substance and/or domestic abuse problems and whose management priorities could more easily be determined.

Chapter 5: The project

5.1. Background

Drug and alcohol treatment centres have potential as a setting to research issues related to domestic violence as well as its association with alcohol and other drugs. Additionally, these centres provide the opportunity to identify and assist victims and perpetrators of partner abuse.

The relationship between domestic violence and alcohol abuse has been a focus of attention for some years. Surveys in the US have found that partner abuse is frequently associated with alcohol intoxication and chronic alcohol abuse. The range varies for both factors from 50% to 70%.(Tolman & Bennett. 1990; Roscoe, Goodwin, & Kennedy. 1987; Stein. 1987). Fewer studies have examined alcohol use in women who have been abused, however, a positive association between alcohol abuse and battering has been observed in some studies (Barnett & Fagan. 1993; Bishop & Patterson. 1992; Haver. 1987; Miller, Downs, & Gondoli. 1989).

Although the association between alcohol use and domestic violence, in particular for perpetrators is strong, much of the research has methodological problems. Studies rarely define terms such as violence, alcohol use and alcohol abuse and rarely distinguish between alcohol's acute and chronic effects. Additionally, standardised assessment procedures to measure alcohol and violence related variables are used infrequently. Finally, many studies do not systematically report characteristics of the study population.

Given the higher prevalence of DV and alcohol abuse, D & A centres have potential as a setting for the secondary prevention of domestic violence. Clients can be screened routinely for abuse and assistance offered. However despite these opportunities most staff in drug and alcohol treatment centres do not systematically address the issue of domestic violence. To a great extent, this is likely to be related to attitudinal, belief and structural barriers.

We have only been able to identify three studies examining the attitudes, beliefs and response of D and A staff in the area of domestic violence. As discussed in chapter 2, (Gondolf & Foster. 1991) reviewed case records of 25 men who had perpetrated violence against their partner and who were undergoing rehabilitation in a VA alcohol rehabilitation program. Domestic violence was detected for 20% of the sample only. (Lehman & Krupp. 1984) interviewed ten professionals in the alcohol field and ten in the domestic violence field. The majority of workers in the alcohol field believed that alcohol caused domestic violence; only one alcohol worker knew how to identify and treat domestic violence.

In a recent study (Bennett & Lawson. 1994) the attitudes and beliefs of 249 drug and alcohol staff (53 programs) towards factors impairing cooperation between clinical dependency and domestic violence services were examined. The most important barrier to

cooperation between these two services was their different treatment philosophies. In D& A centres, staff believe that addiction is a disease process beyond control of the addict, while in battering programs, staff believe that perpetrators are fully responsible for their actions. Staff screening for domestic violence was found to be haphazard and dependent on self-report by the client.

5.2. Project Aims

This project examines a number of issues related to domestic violence. Firstly, it explores staff knowledge, attitudes, beliefs and practices in the area of domestic violence and assesses the effect of an educational package developed specifically to address and modify these beliefs and practices. Secondly, it examines the prevalence of domestic violence amongst clients of drug and alcohol clinics. Thirdly, it explores psychodemographic characteristics of the clinic population and in relation to identified victims and perpetrators of domestic violence using standardised measures of alcohol abuse, violence and psychological characteristics. Specifically the major aims were to:

In relation to clinics and their staff

(i) to determine the individual clinic philosophy and procedures in the area of domestic violence and assess the attitudes, beliefs and practices of staff in this area.

(ii) to examine attitudes, beliefs and practices of staff in relation to identification and intervention for domestic violence.

(iii) to develop an educational program to better inform staff about domestic violence, to increase detection rates and management responses.

(iv) to encourage the adoption of changes to intake procedures and the addition of a clinical program component for clients and staff to address domestic violence issues.

(v) to evaluate the effect of staff education and changes to intake procedures and clinical programs on staff attitudes, beliefs and practices.

In relation to clients of the clinics

(i) examine the prevalence of victims and perpetrators of partner abuse amongst clients of drug and alcohol clinics.

(ii) to develop a psycho-demographic profile of clients of the clinics. This included information on demographic factors, personal and family histories in terms of drug and alcohol use, current or past medical and psychiatric illnesses, psychological characteristics and childhood exposure to and experience of violence.

(iii) To develop a psychodemographic profile of those clients who were identified to be perpetrators or victims of domestic violence.

(iv) to examine the relationship between alcohol and drug abuse and involvement in partner abuse either as a perpetrator or victim.

5.3. Major phases and research approach

There were 2 major phases of the research. The first phase, the project preparation phase, involved the development of four questionnaires/interviews and the development of a training program for staff on domestic violence. The interviews/questionnaires that were developed included i) a structured interview to assess D and A clinic treatment orientation, policy and procedures for dealing with domestic violence, ii) a questionnaire to assess knowledge, attitudes, beliefs and practices of staff in the area of domestic violence, iii) a questionnaire checklist used to assess reported cases of abuse in the medical records of clients presenting to the clinics for treatment. This determined more objectively staff practices in recording information about domestic violence and iv) a structured interview and associated self completion section to assess psychodemographic characteristics of clients of the clinic.

Finally, an educational program about domestic violence was developed for staff of the clinics. It included the presentation of a video, a didactic teaching session, role plays and the provision of written material including resource information on available referral services for staff. Information and resource materials were compiled from existing material on domestic violence for clients and were distributed to staff at this meeting.

The project implementation and evaluation phase involved the administration of the relevant questionnaires to clinic directors, staff and clients at baseline. Additionally, client records were assessed at baseline to obtain objective information on staff documentation of domestic violence. Following the baseline assessment a two hour education and training program on domestic violence was provided to staff. Follow-up assessment of staff attitudes and beliefs and practices was undertaken approximately 12 months following the baseline assessment. Client records were also reviewed 12 months following baseline assessment to examine changes to staff assessment and documentation of domestic violence for clients of the clinic.

The major phases of work and the overall research approach are schematically represented in Figures 1 and 2.

PROJECT PHASES

PHASE 1: Project Preparation (April - August 1994)

1. Development of questionnaire to assess staff attitudes, beliefs and practices in relation to DV

2. Development of a checklist to identify reported cases of abuse in the records of previous D & A clients

3. Development of questionnaire to assess clinic orientation, policy and procedures in relation to DV

4. Development of educational program on domestic violence for D & A staff

5. Development of structured interview and questionnaire for clients to:

   (i) assess the prevalence of domestic violence amongst D & A clients and
   (ii) complete a profile of D & A clients who are perpetrators and/or victims of abuse

6. Packaging of resource kit for identified victims and perpetrators of abuse

PHASE 2: Project Implementation (August 1994- August 1995)

1. Baseline assessment of staff knowledge, attitudes, beliefs and practices

2. Baseline assessment of reported cases of domestic violence in client records

3. Implementation of educational program for D & A staff

4. Conduct of interviews with D & A clients to

   (i) determine the prevalence of domestic violence and
   (ii) to complete a psychological profile of clients who perpetrate abuse or who are victims of abuse
   (iii) to examine the relationship between alcohol abuse (chronic & acute effects) and domestic violence

5. Nine month follow-up assessment of staff knowledge, attitudes, beliefs and practices (three months following completion of client interviews).

6. Nine month follow-up assessment of reported cases of domestic violence in client records (three months following completion of client interviews).

PHASE 3: Project Evaluation (September - December, 1995)

This phase involves the statistical analysis of project results, the preparation of the major report and preparation of papers for publication in scientific journals.

Figure 1. Project phases

RESEARCH APPROACH

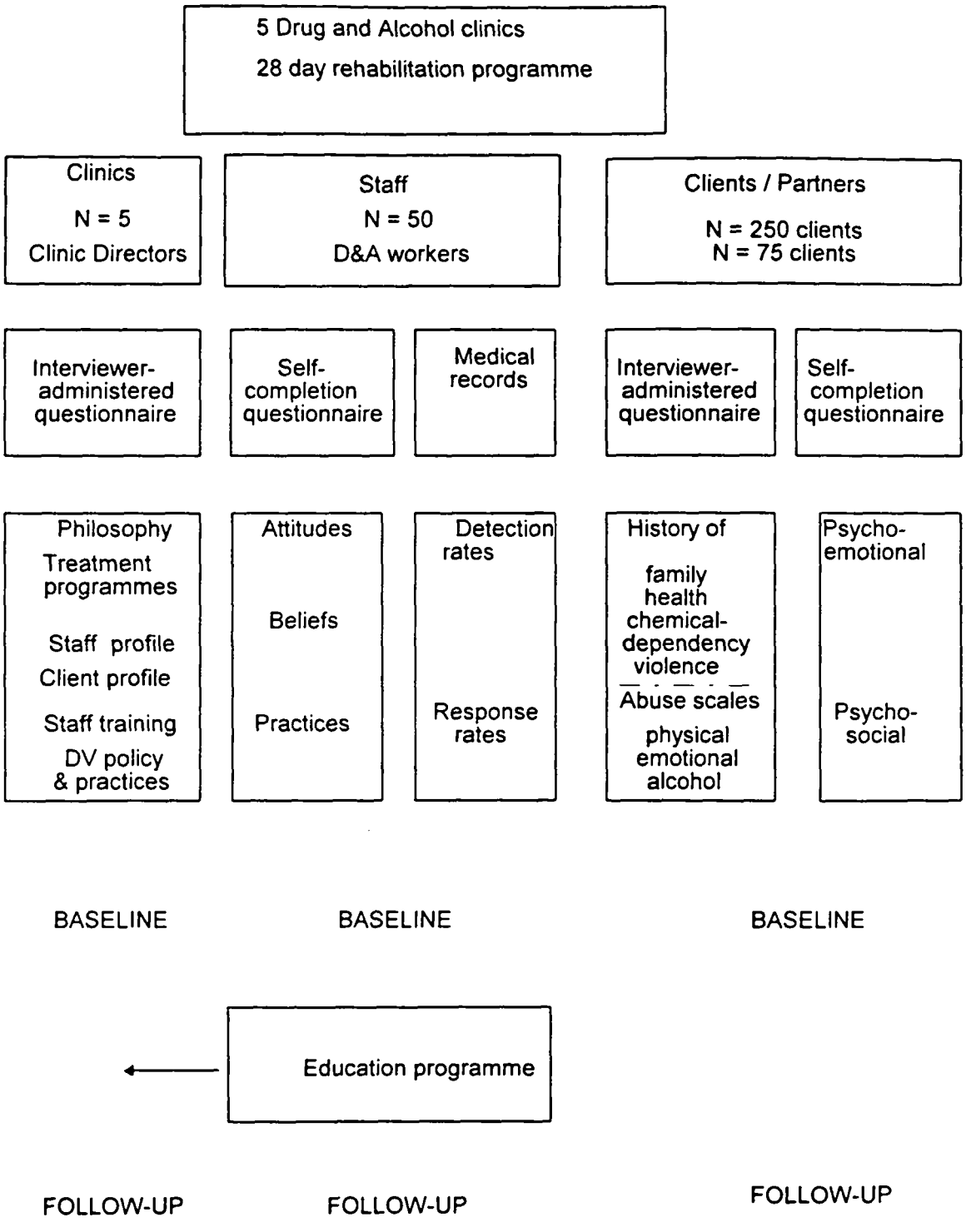


Figure 2. Research approach

PART 1: Staff Profile

Chapter 6: Staff attitudes, beliefs and practices at baseline and following implementation of an educational program

6.1. Introduction

In chapter 2 we reviewed the literature on the attitudes, beliefs and practices of staff in relation to domestic violence. There is a paucity of such information in the drug and alcohol field, however of those studies conducted results indicate poor response rates and a reluctance to become involved in the area.

This chapter reports the procedure undertaken to explore these issues in the staff of five drug and alcohol clinics. Additionally, it describes the development, implementation and evaluation of an education and training program in the area of domestic violence. The results of this work are presented in the following chapters.

6.2. Procedure

Six drug and alcohol rehabilitation clinics were approached to participate in the project; one private clinic declined involvement, the major reason being concern about client acceptance of the project and procedures. Three (St Edmund's Hospital, Eastwood, St John of God Hospital, Burwood and Richmond) of the participating clinics were in the private sector; the remaining two were in the public sector (Wistaria Centre, Cumberland Hospital, Phoenix Unit, Manly Hospital).

Baseline assessment of clinic policies and procedures

The clinical director at each of the five participating clinics was approached for an interview; all agreed. The structured interview examined a number of factors at the structural level likely to influence the detection and response practices of staff in relation to DV. These factors included the treatment orientation of the clinic, the existence of a policy and procedures for dealing with domestic violence as well as the availability of staff training programs on DV. The interview instrument is reproduced in Appendix 2 (Volume 2).

Baseline assessment of staff knowledge, attitudes, beliefs and behaviours

Arrangements were made to meet with staff at each of the clinics to introduce and discuss the project. At this meeting questionnaires examining attitudes, beliefs and practices were distributed to staff (see Appendix 3, Volume 2). Staff returned the questionnaire to the

clinic contact person in a sealed envelope; names were optional, however an identifying number was used to monitor the return of questionnaires and to allow an assessment of change from baseline and follow-up assessments.

The self-completion questionnaire was developed by the investigators and piloted with 20 staff working in the drug and alcohol area but not directly involved in the project.

The staff questionnaire examined basic biographical and demographic factors, previous education or courses undertaken in the area of domestic violence and knowledge, attitudes, beliefs and practices in relation to domestic violence.

The knowledge, attitude and belief section examined staff's understanding of domestic violence, prevalence rates and other epidemiological aspects of domestic violence. Other questions examined beliefs about causal and contributing factors, the physical and psychological effects of abuse and beliefs about appropriate treatment procedures.

Also included in this section were questions examining their beliefs about the role that D& A clinics should have in dealing with either victims or perpetrators of spouse abuse and beliefs about appropriate referral services for clients in a violent relationship. Current clinic procedures in dealing with domestic violence and factors that staff believed to act as barriers to addressing spouse abuse issues within the clinic were also assessed .

Staff were asked how knowledgeable they felt they were in the area; their willingness, confidence, satisfaction and effectiveness in dealing with spouse abuse issues for victims and perpetrators was also assessed. A further extension of this assessment was the inclusion of a scale to measure staffs beliefs about their knowledge, willingness, confidence, satisfaction, effectiveness, perceived level of support in dealing with spouse abuse issues.

The final section of the questionnaire examined staff practices in relation to spouse abuse. The areas covered included: initiation of spouse abuse issues with clients and reasons for the initiation, staff response to disclosure of a client being either a victim or perpetrator and details of the assessment undertaken for identified victims and perpetrators. Finally, questions examined procedures for documenting abuse and any agencies used as a referral source.

Baseline review of client medical records

Medical records of at least 50 clients attending each clinic four months prior to the introduction of the project were assessed; a total sample of 289 client records. This provided an additional and more objective assessment of baseline staff practices in relation to the detection and magnet of domestic violence.

The measurement instrument was essentially a composite assessment check list developed from the standard intake forms used in each of the clinics. It included questions on client demographics, reason for admission, Drug and Alcohol history, psychiatric and legal history, childhood history of abuse and whether the client was currently a victim or

perpetrator of abuse. Additionally, information was obtained on where reported abuse was documented ie. initial or in progress notes, and what, if any, action was taken. The instrument is reproduced in Appendix 4 (Volume 2).

Staff intervention

Education session

Staff were invited to attend a formal group teaching session at which attendance was voluntary. The teaching session was held approximately one month after the distribution of staff questionnaires. The length of the educational session, which varied across clinics, ranged between two to three hours.

The components of the group teaching session held in each clinic were:

i) a video presentation (Just Another Domestic, NSW Police department)

ii) a didactic lecture which included material relating to general attitudes and beliefs about domestic violence, beliefs about the treatment of victims and perpetrators, role legitimacy, role adequacy and resources and support services. Topics covered included common myths, the nature and extent of domestic violence, the effects of the violence on perpetrators and victims, the role of drug and alcohol workers, assessment of DV amongst D and A clients (screening, raising the topic) and appropriate responses (assessing extent, immediate and ongoing risk, exploration of options, documentation, provision of resource materials, referral and follow-up).

iii) role plays to introduce skills to screen, assess, and intervene for victims and perpetrators of domestic violence.

iv) the distribution of an educational manual reviewing the material covered in the lecture and resource information on available services for victims and perpetrators of abuse (Appendix 5, Volume 2).

Ongoing feedback

Following the initial educational program staff were given regular feedback on the course of the project and encouraged to discuss problems as they arose. This continued for a period of 9 months.

Discussions on modifications to clinic intake assessment and treatment program

At the completion of the client interviews at each clinic, approximately eight months after baseline assessment, the investigators met with the clinic directors to encourage modifications, where necessary, to the initial intake assessment form. The aim was to introduce specific questions on domestic violence **(Appendix 6)**. Clinic directors were also encouraged to implement a regular group therapy session which dealt with conflict in relationships. One clinic reported that they already included such sessions in their existing program however several did not.

Follow-up assessment

Twelve months following baseline assessment, the staff questionnaire examining attitudes, beliefs and practices in relation to domestic violence was readministered. Participants were able to return the questionnaire to the clinic contact person or by a self-addressed envelope to the investigators. Client medical records for admissions during the preceding three/four month period were also reviewed using the previously developed checklist/questionnaire.

Participation and follow-up rates

A total of 68 staff members were eligible for the baseline assessment of knowledge, attitudes, beliefs and practices in relation to domestic violence. Of these 14 refused to complete the questionnaire, leaving a total sample of 54 which comprised 79.4% of the eligible population.

Thirty-seven staff members attended the education session which comprised 54.4% of the eligible population. Those staff members who were unable to attend the educational session were distributed the relevant written information and had the opportunity to view the video.

At follow-up 35 staff were eligible to complete the follow-up questionnaire; the remainder had resigned from their clinic. 18 staff members completed the follow-up questionnaire; this comprised a participation rate of 33.3% of those completing the baseline questionnaire and 51.4% of the eligible population at follow-up. Due to funding restraints, analyses of the data have not been completed. However, analyses of changes in staff practices were analysed using data from client medical records at baseline (N=289) and follow-up (N=184).

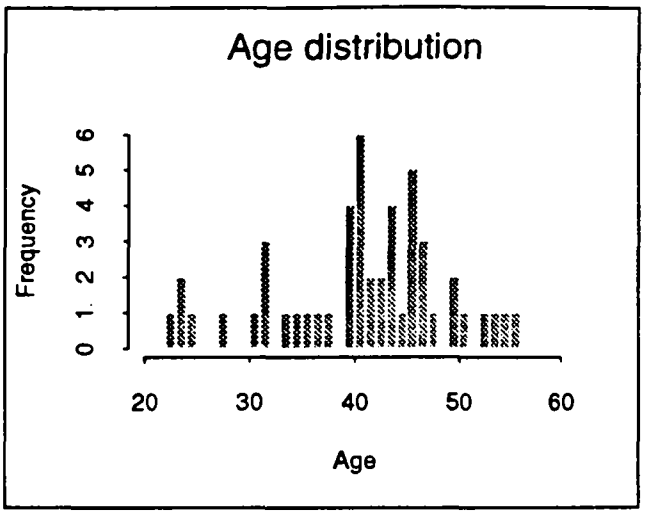
Chapter 7. Respondent information

The first ten questions sought demographic, professional and educational information about the respondents. 54 cases (respondents) were available for analysis.

7.1 Demographic information

Age

The mean age of the 53 respondents for whom age was recorded was just over 40 years, ranging from 22 to 56.



Sex

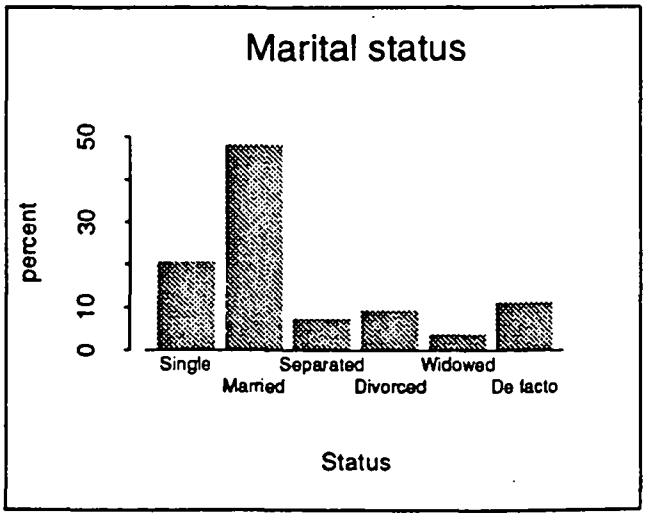
72% of the respondents for whom this information was recorded were female.

Country of birth

As the majority of respondents were born in Australia or the United Kingdom, all other places of birth were aggregated into a single category. 70% of the 53 respondents answering this question were born in Australia, with 15% each being born in the UK and other countries.

Religious affiliation

Christian (47%) and Catholic (47%) were the two most common affiliations in the 47 responses. The number of non-Christian religious affiliations stated was so small that these were aggregated into Other (6%).

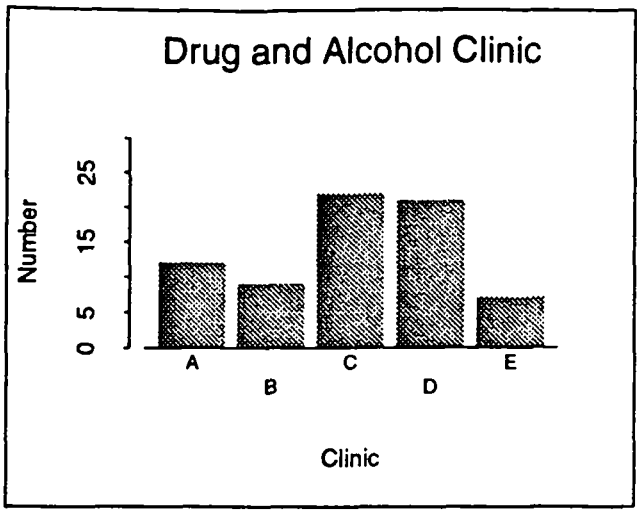


Marital status

The largest group of the 54 respondents answering this question were married, with the next largest group being single. Over half of the respondents were either married or in a *de facto* relationship.

7.2 Professional information

The drug and alcohol clinics surveyed included one in a large, semi-rural community to the northwest of Sydney (Clinic A), three in the western area of Sydney (Clinics B, C and D), and one in a relatively affluent beach suburb (Clinic E).

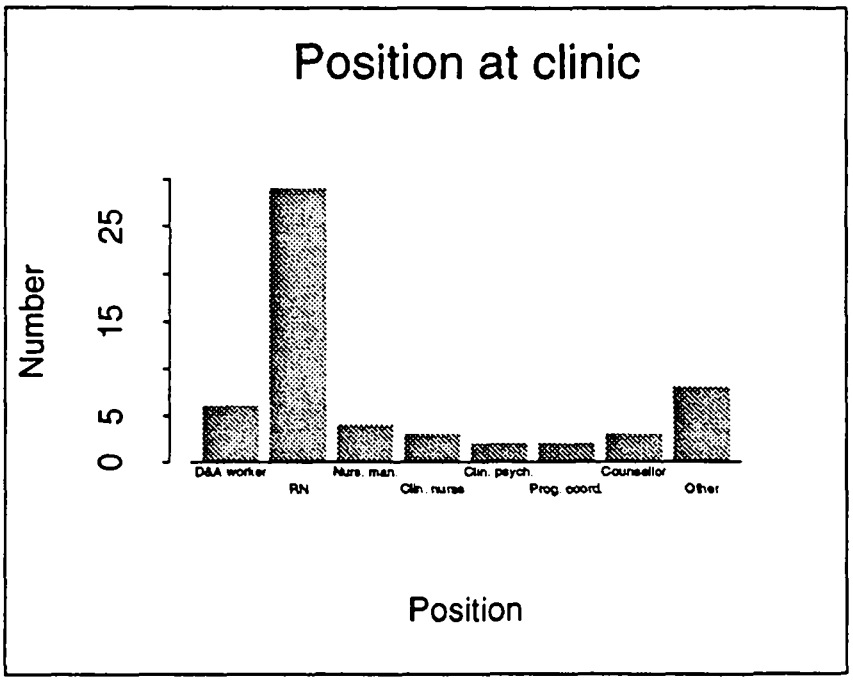


Clinic

The two clinics with the largest number of the 71 respondents answering this question were Clinics C and D. Clinic E had the smallest number of respondents.

Position

The most common position was that of Registered Nurse, with just over half of the 49 respondents for whom this data was available listing this position.



Length of service at clinic

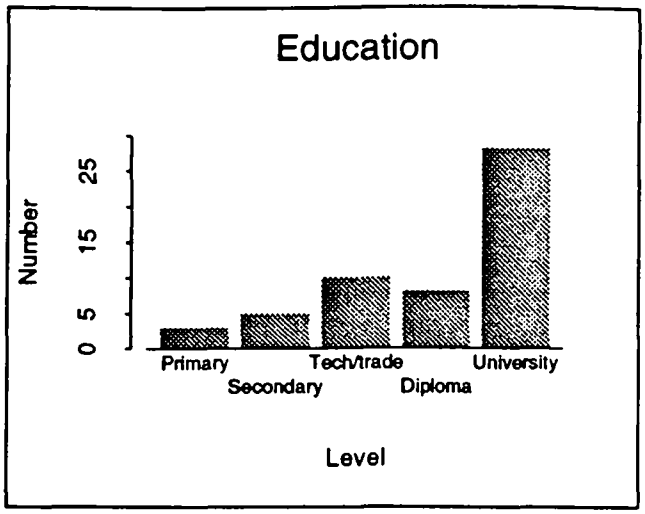
54 respondents had spent a mean of just over 3 years at their present clinic, ranging from 2 months to 13 years.

Length of time in the Drug and Alcohol field

54 respondents had been in the drug and alcohol field for an average of over 4 years, ranging from 2 months to 20 years.

7.3 Educational information

Respondents were asked to indicate the highest level of schooling that they had completed, and also to list the qualifications that they held.

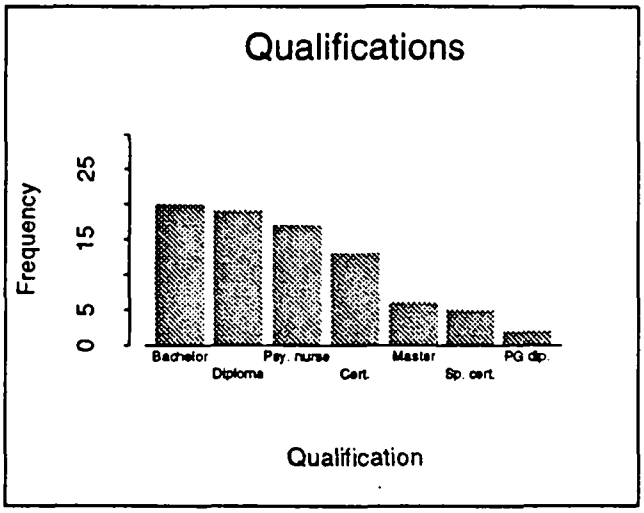


Educational attainment

Most of the 46 respondents who answered this question had completed a university course.

Professional qualifications

The most common professional qualification given was a **Bachelor's degree** (20), followed by a **diploma** (19). **Psychiatric nursing** (17) was also common, as was a non-specified **certificate** (13) or **specialist certificate** (5). Post graduate qualifications, such as a **Master's degree** (6) or **postgraduate diploma** (2) were less common.



Specialist courses

Respondents were asked to give details of any courses they had attended which were concerned with a range of topics relevant to domestic violence. The most commonly mentioned specialist courses were **seminars** (42), with **workshops** (37) almost as common. A non-specific **course** (28) or **counselling** (20) accounted for the remainder of course types listed in the answers.

Spouse abuse in tertiary studies

Respondents were asked whether the topic of spouse abuse had been covered in any of their tertiary courses. Of the 53 respondents who answered this question, 38 did not recall any coverage of spouse abuse, 12 did, and 3 couldn't remember.

Of those respondents who recalled that spouse abuse had been covered in a tertiary course, the most common type of course was **nursing** (6). **Welfare studies** (2) were less commonly

mentioned, but **other** (5) courses made up a substantial number. The information was typically on **domestic violence** (7) although **other** (5) topics were mentioned almost as often.

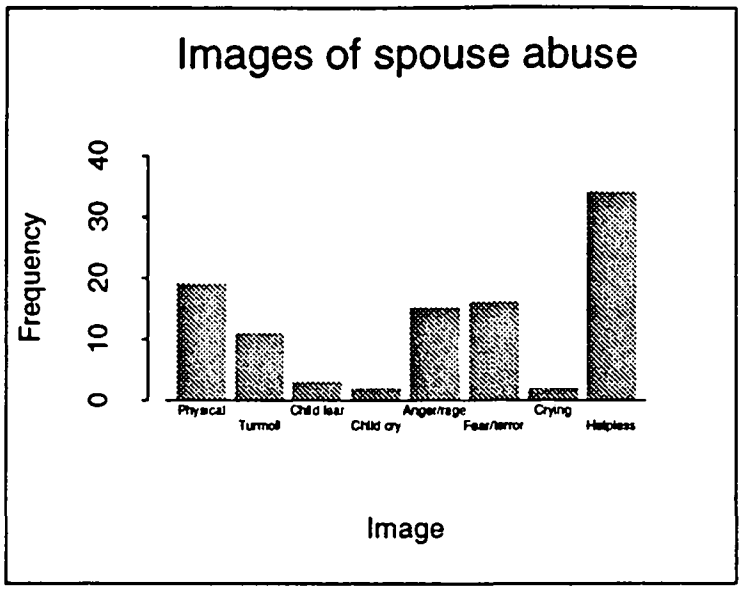
Chapter 8. Concepts of spouse abuse

The next twenty questions were broadly concerned with a number of concepts of spouse abuse that the respondents may have had. Some of these were open-ended questions, which allowed the respondent to give individual answers.

8.1 Images and understanding of spouse abuse

Two questions asked the respondents to describe **visual images** which they associated with **spouse abuse**, and their **understanding** of the term before they were given the definition which was to be used in further questions.

Images

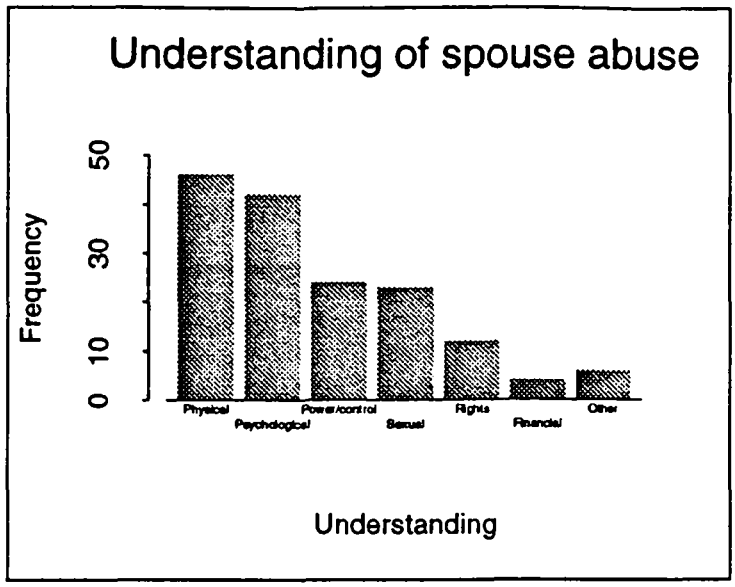


The images described were categorised as **physical**, **psychological** or **sexual**. 41 of the 53 respondents whose images could be so classified gave **physical** images, while 25 gave **psychological** images. Only 7 gave **sexual** images.

The most frequent image mentioned was **helplessness** (34), followed by images of the **physical effects** (19) of spouse abuse. Images of **anger/rage** (15), **fear/terror** (16) **noise and turmoil** (11) were common, while those of **children's fear** (3), **children's crying** (2) and **crying** (2) occurred less frequently.

Understanding

Most frequently mentioned were **physical abuse** (43), **psychological/emotional abuse** (42) and **sexual abuse** (23) aspects of the abuse itself. Issues from which abuse might stem, e.g. **power and control** (24) were less frequent, as were ethical implications such as **violation of rights** (12). Another aspect of spouse abuse, **financial abuse** (4) was uncommon, and there were a few responses classed as **other** (6).



Chapter 9. Beliefs on prevalence of spouse abuse

After giving the respondent the following definition of spouse abuse:

> *Any situation where one person, the perpetrator, attempts to control another person, the victim, through threatened or actual physical, emotional and/or sexual abuse; the two people are, or have been, intimate partners.*

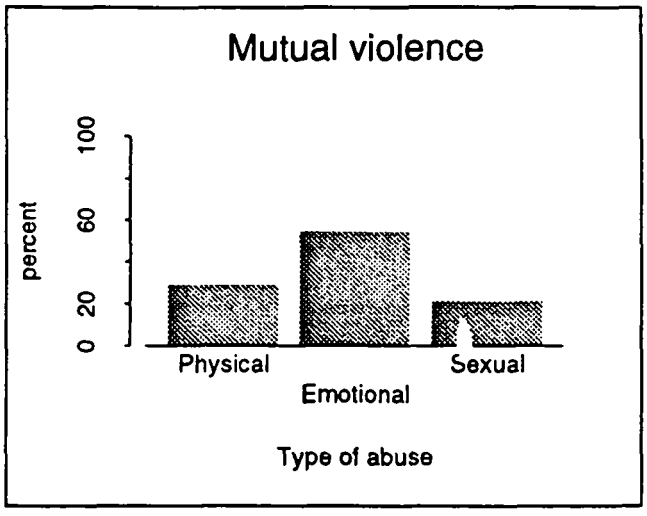
six questions were asked which sought information about the beliefs of the respondent with regard to the occurrence of spouse abuse. These included questions about the overall prevalence of spouse abuse in Australia, the chronological pattern of such abuse, and its relative prevalence in different ethnic and socioeconomic groups.

9.1 Prevalence of spouse abuse in Australia

The first three questions in this section asked for estimates of the percentage of Australians who were in a relationship in which spouse abuse occurred. The questions sought estimates for relationships in which both partners were perpetrators (Mutual violence), one partner was a victim, and one partner was a perpertrator respectively.

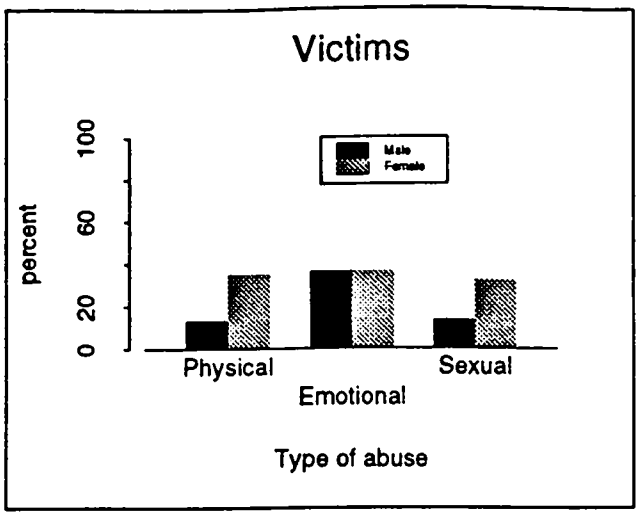
Both partners perpetrators

Estimates ranging from 2 to 65% of the Australian population were given for persons in a relationship in which both partners inflicted **physical abuse** on each other, with an average of 29%. The estimates given for **emotional abuse** ranged from 5 to 100%, with an average of 54%. Similar estimates for **sexual abuse** ranged from 2 to 60%, with an average of 21%.



One partner a victim

In this question, separate estimates were to be given for **males** and **females** on the three defined types of abuse that they might suffer.

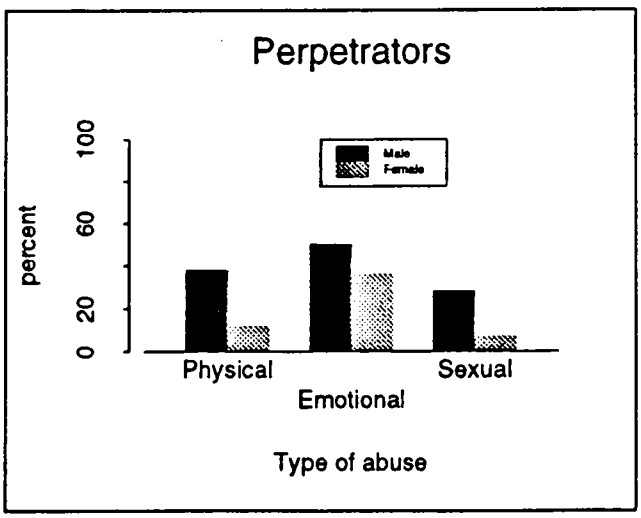


Male victims: The average estimate for the percentage of male victims of **physical abuse** was 13%, ranging from 1 to 60%. The average estimated percentage of male victims of **emotional abuse** was approximately three times as high, at 36%, ranging from 1 to 100%. The percentage of males suffering from **sexual abuse** was estimated at an average of 13%, ranging from 1 to 60%.

Female victims: The average estimate for the percentage of female victims of **physical abuse** was higher than that for males at 35%, ranging from 4 to 95%. The average estimated percentage of females who are victims of **emotional abuse** was again higher, at 36%, ranging from 10 to 100%. The percentage of females suffering from **sexual abuse** was estimated at an average of 32%, ranging from 8 to 95%.

One partner a perpetrator

As in the previous question, separate estimates were to be given for **males** and **females** on the three defined types of abuse that they might inflict upon their partner.



Male perpetrators: The average estimate for the percentage of male perpetrators of **physical abuse** was 38%, ranging from 4 to 95%. The average estimated percentage of male perpetrators of **emotional abuse** was somewhat higher, at 50%, ranging from 10 to 100%. The percentage of males inflicting **sexual abuse** was estimated at an average of 28%, ranging from 5 to 95%.

Female perpetrators: The average estimate for the percentage of female perpetrators of

physical abuse was much lower than that for males at 12%, ranging from 0 to 60%. The average estimated percentage of females who are perpetrators of **emotional abuse** was again higher, at 36%, ranging from 3 to 100%. The percentage of females inflicting **sexual abuse** was estimated at an average of 7%, ranging from 0 to 30%.

9.2 Chronological pattern of spouse abuse

Respondents were offered a choice of one of four categories to describe the **typical pattern of spouse abuse over time**. Two thirds (67%) of the 54 respondents answering the question felt that spouse abuse **escalates**, while another 22% felt that it **continues in the same way**. Only 3 respondents felt that spouse abuse **diminishes over time**, and the same number selected **don't know**.

9.3 Prevalence of spouse abuse in different socioeconomic groups

Respondents were asked whether spouse abuse, in their opinion, was more prevalent in some socioeconomic groups, and if so, which groups.

Prevalence

Over half (59%) of the 54 respondents answering this question felt that spouse abuse is **equally common** in all socioeconomic groups. Another third (33%) felt that is **more common in some** groups, while 7% felt that they **didn't know**.

Socioeconomic groups with higher prevalance

Of those respondents who felt that spouse abuse was more common in some groups, the majority felt that **lower socioeconomic groups** (17) had a higher prevalance, while only 1 respondent felt that **white collar workers** had a higher prevalence. Three respondents nominated **other groups**.

9.4 Prevalence of spouse abuse in different ethnic groups

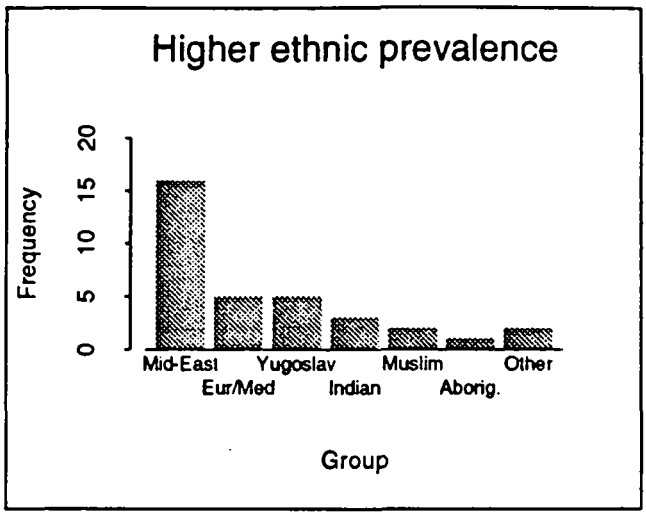
Respondents were also asked whether spouse abuse was more prevalent in some ethnic groups, and if so, which groups.

Prevalence

Under half (41%) of the 54 respondents answering this question felt that spouse abuse is **equally common** in all ethnic groups. Almost half (46%) felt that is **more common in some** groups, while 13% felt that they **didn't know**.

Ethnic groups with higher prevalance

Of those respondents who felt that spouse abuse was more common in some groups, the majority (16) felt that **Middle eastern** had a higher prevalance, with 5 respondents each nominating **European/Mediterranean** and **Yugoslav** groups. **Indian** groups were chosen by 3 respondents, while **Some Muslim** and **Aboriginal** groups were listed by two and one respondents respectively. **Other** groups were chosen by two respondents.



Chapter 10. Beliefs on antecedents and effects of spouse abuse

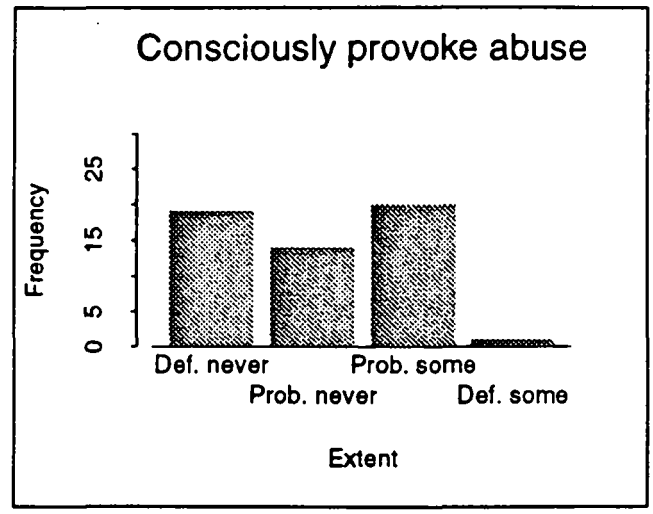
The next six questions attempted to elicit information about the factors which the respondents believed contributed to spouse abuse. These included **victim behaviour, relative responsibility, psychological/social** factors, **family history, psychiatric/personality** factors and **inability to terminate abusive relationship** and **methods of dealing with spouse abuse.** Three questions dealing with the **effects of spouse abuse** and **acceptability of the use of force** are also discussed.

10.1 Victim behaviour

Respondents were asked to indicate the extent to which the behaviour of victims of spouse abuse corresponded to four statements about that behaviour. Four categories were available; **Definitely never do, Probably never do, Probably sometimes do** and **Definitely do sometimes.**

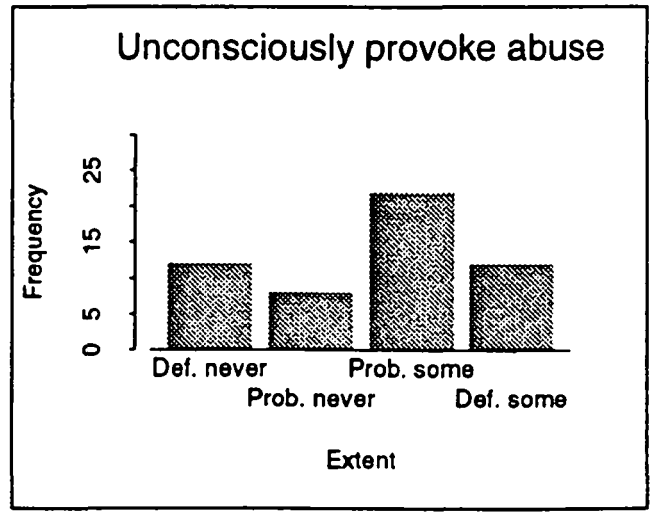
Consciously provoking abuse

The extent to which victims **consciously provoke abuse** was judged variously by the 54 respondents answering this question, with almost all responses falling fairly equally in the first three categories. Only one respondent felt that victims **definitely sometimes** provoke abuse.



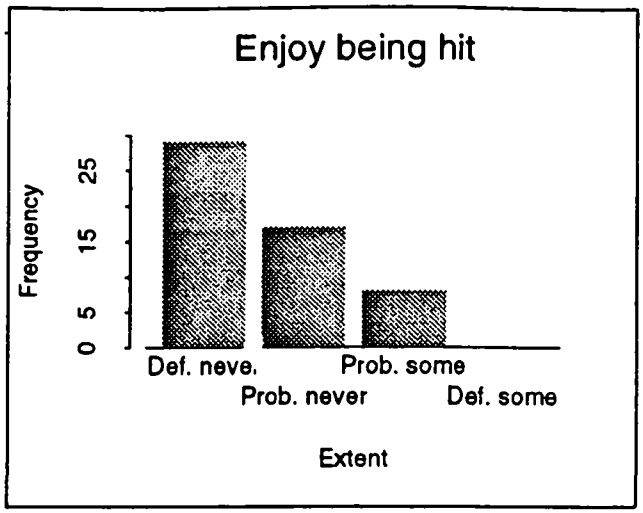
Unconsciously provoking abuse

The extent to which victims were thought to **unconsciously provoke abuse** was again widely varied, but thought to be much more common. The largest group of the 54 respondents answering this question agreed that victims **probably sometimes** provoke abuse.



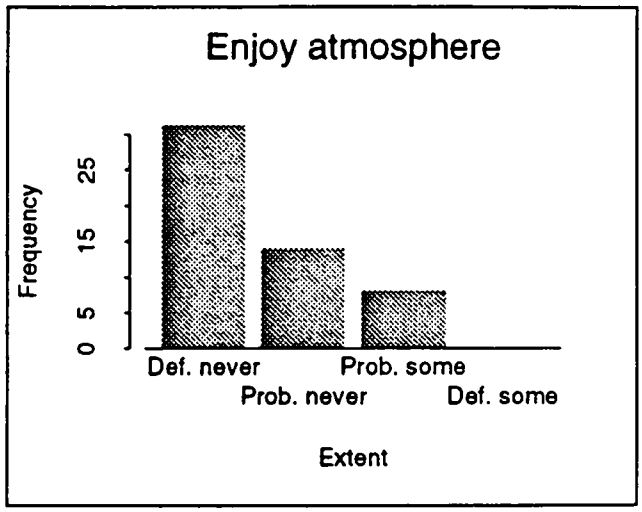
Enjoy being hit

The extent to which victims **enjoy being hit** was felt to be much less, with the majority of the 54 respondents answering this question feeling that they **definitely never** do so. No respondents felt that victims **definitely sometimes** enjoy being hit.



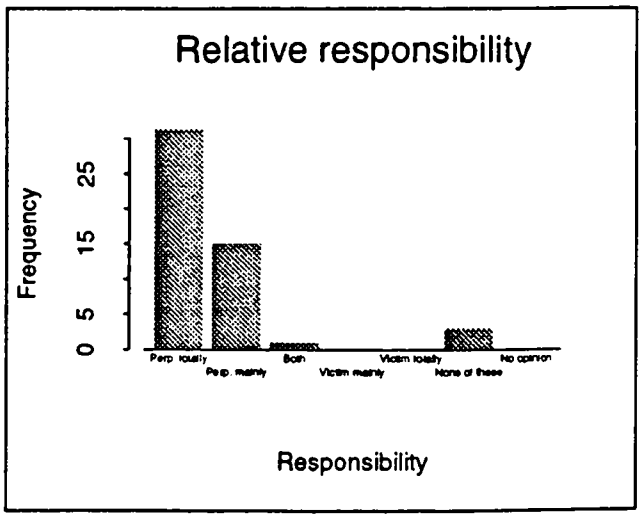
Enjoying atmosphere of abuse

The extent to which victims **enjoy the atmosphere of abuse** was felt to be even less than they **enjoy being hit**. Again the majority of respondents answering this question felt that they **definitely never** enjoy this, and none felt that they **definitely sometimes** do.



10.2 Relative responsibility for abuse

Respondents were asked to select one statement from a list of seven which described the relative responsibility of perpetrator and victim for **most cases** of spouse abuse. From the illustration at the right, it is obvious that the 49 respondents who answered this question attributed responsibility for spouse abuse almost completely to the **perpetrator**, with only a single respondent selecting the **both** option. A few felt that **none of these statements** described the relative responsibility in most cases.

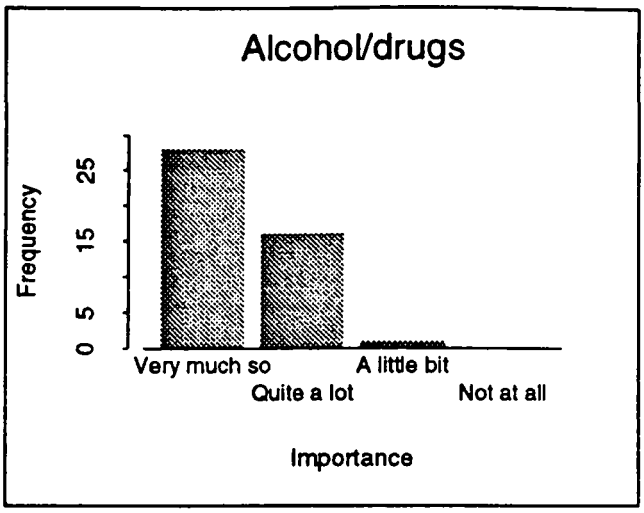


10.3 Factors important in the occurrence of spouse abuse

Five pharmacological, psychological or social factors were presented to the respondents, for each of which they were to select one of four levels of importance ranging from **very much so** to **not at all**. They were also asked to rank each factor's relative importance from 1 to 5.

Alcohol/drugs

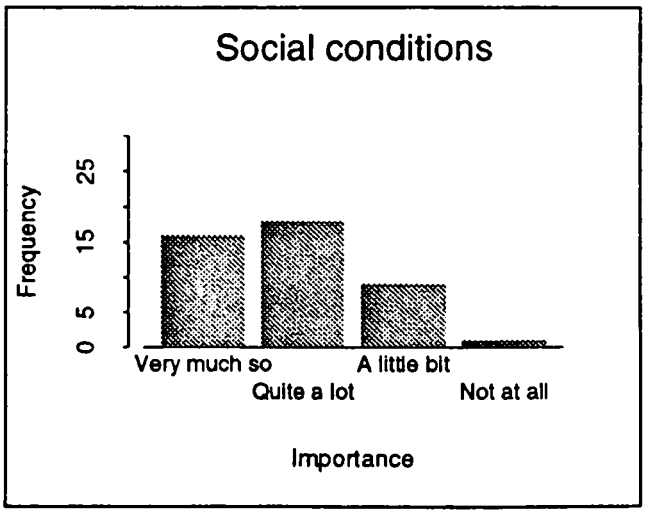
Alcohol/drugs was felt to be an important factor contributing to spouse abuse, as the majority of the 45 respondents choosing an option selected **very much so**, with all but one of the remainder selecting **quite a bit**. **Alcohol\drugs** received the highest mean rank of 2.05, which was significantly different from the average of the other mean ranks (Z=3.16, critical Z=3.06).



Social conditions

A number of social conditions were listed, such as **unemployment, lack of social or family support, poverty** and **financial problems**.

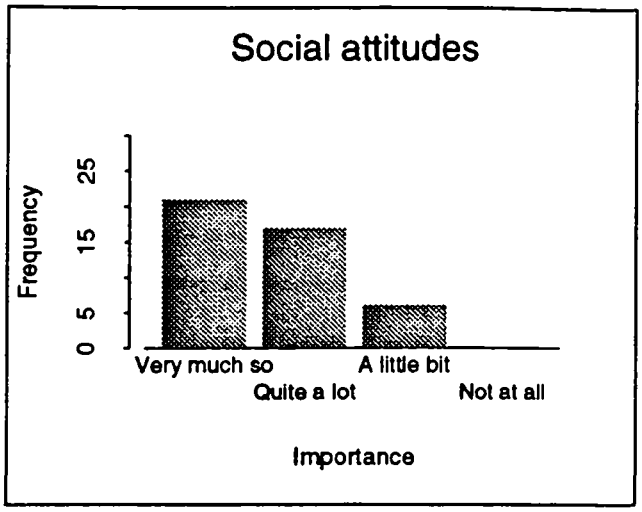
Social conditions were judged less important by the 44 respondents choosing an option than alcohol/drugs, although most of the responses were in the two most important categories. The mean rank of **social conditions** as a contributing factor was 2.97, the lowest of all factors.



Social attitudes

A number of social attitudes were also listed, such as **little respect for women, men's ownership of women** and **patriarchal concepts.**

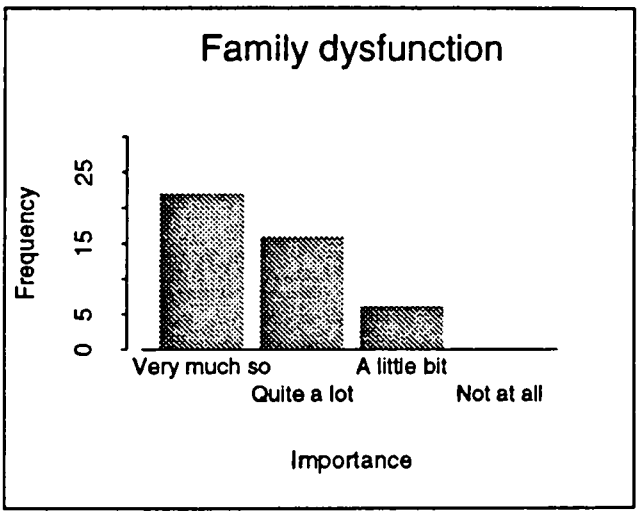
Social attitudes were judged to be more important than social conditions by the 44 respondents answering this question. The mean rank of **social attitudes** as a contributing factor was 2.25, the second highest.



Family dysfunction

Family dysfunction was represented by problems such as **poor negotiation** and **poor communication skills.**

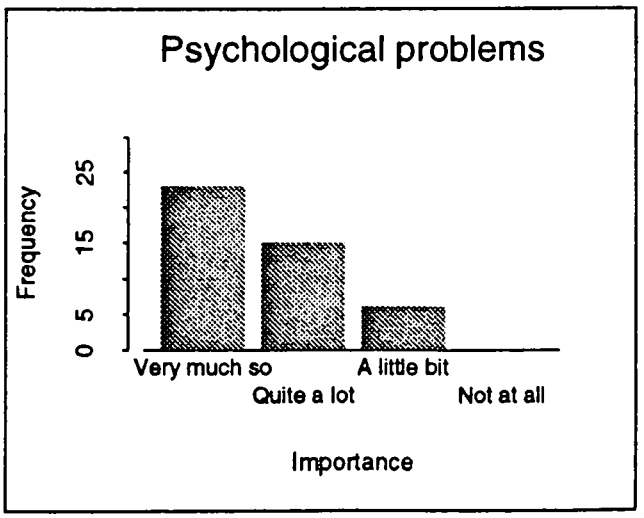
Family dysfunction was judged as slightly more important than social conditions by the 44 respondents. The mean rank of **family dysfunction** as a contributing factor was 2.76.



Psychological problems

Psychological problems such as **emotional immaturity, difficulties in forming relationships, traumatic or deprived childhood** and **personality factors** were listed.

Psychological problems were ranked in the middle of the factors listed by the 44 respondents. The mean rank of **psychological problems** as a contributing factor was 2.44.

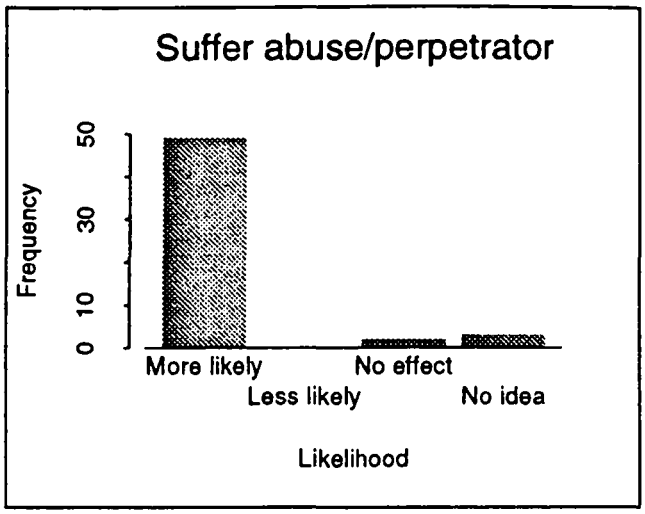


10.4 Family history

The contribution of family history was limited to four types in this question. The respondents were asked to indicate how likely those **suffering abuse** or **witnessing abuse** as a child were later to **perpetrate abuse** or **suffer abuse**. Four categories of likelihood were available; **more likely, less likely, no effect** and **no idea**. 54 respondents answered the four parts of this question.

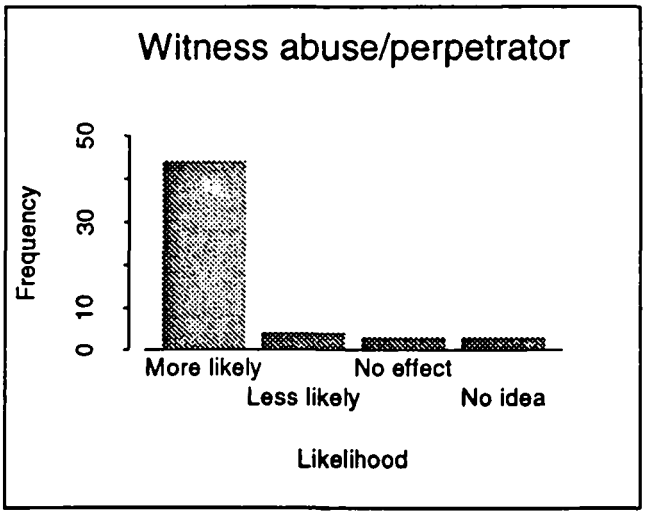
Suffer abuse/perpetrator

Suffering abuse as a child was thought to increase the likelihood that a person would be a **perpetrator** later in life by almost all of the respondents answering this question. No respondents felt that such experience would make it less likely that a person would become a perpetrator, indicating that there was no feeling that a person would avoid the type of behaviour that was suffered as a child.



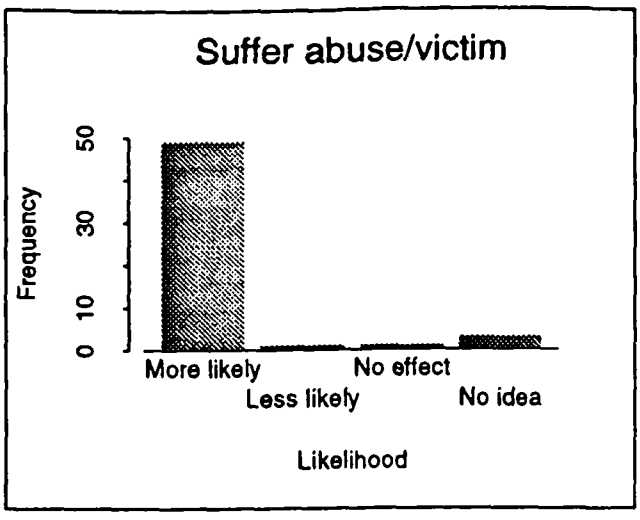
Witness abuse/perpetrator

While the overwhelming majority of the respondents who answered this question felt that **witnessing abuse** as a child would increase the likelihood of a person becoming a **perpetrator** of spouse abuse, a small number of respondents felt that such experience would lead to a person later avoiding such behaviour.



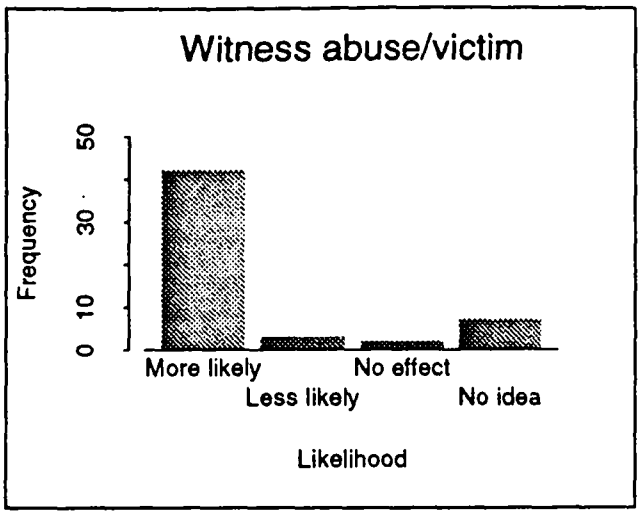
Suffer abuse/victim

Again, the great majority of respondents felt that **suffering abuse** as a child would increase the likelihood that a person would become a **victim** of such abuse later in life. The choices **less likely** and **no effect** were chosen by only one respondent each.



Witness abuse/victim

While the previous pattern was still evident in the responses to this question, there were fewer respondents who felt that **witnessing abuse** as a child would increase the likelihood of becoming a **victim** later in life.

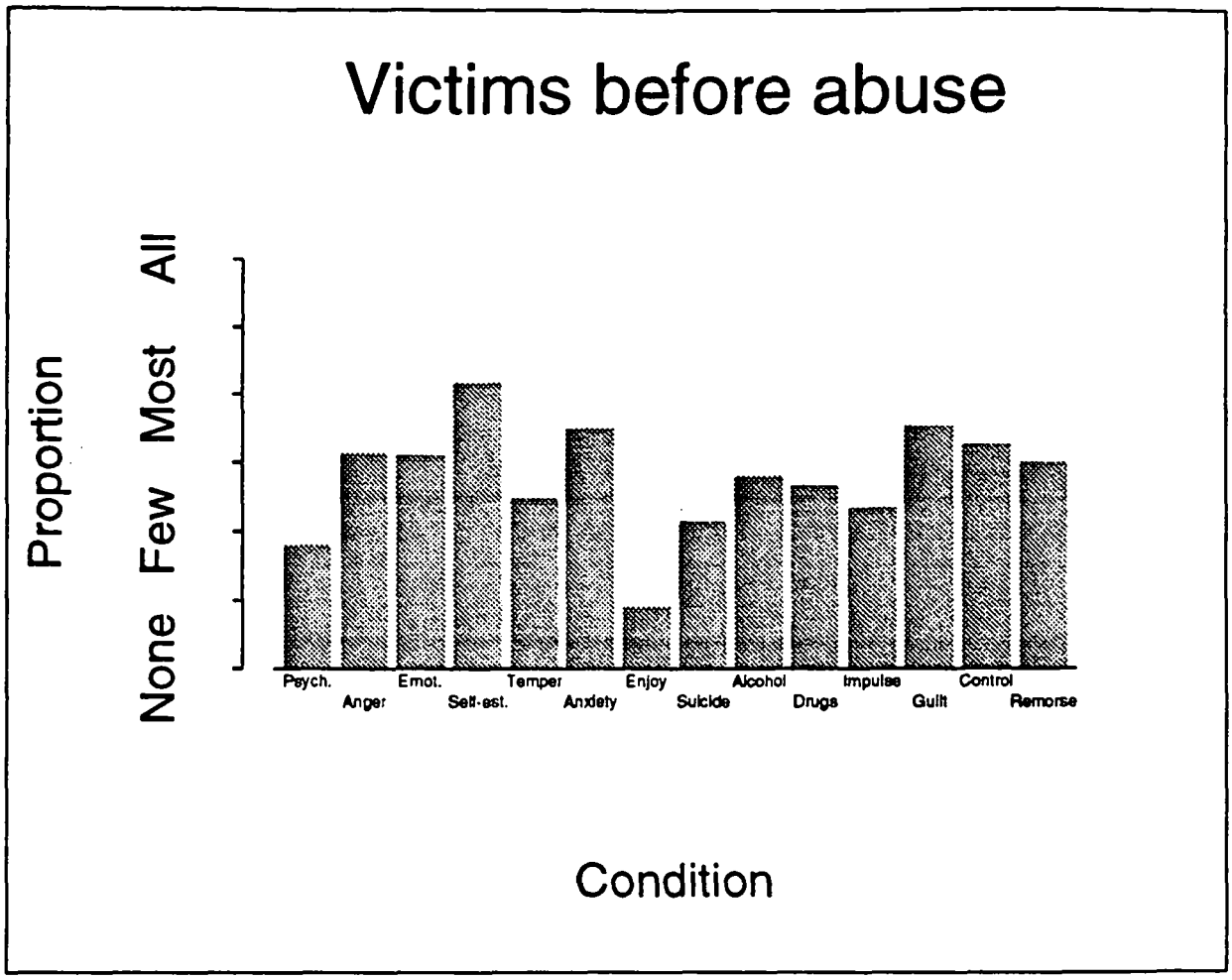


10.5 Psychiatric/personality factors

Three identical lists of fourteen conditions related to psychiatric and personality problems were provided for the respondents to indicate what proportion of **victims before the abuse began, victims after the abuse began** and **perpetrators** they felt were subject to each condition. The five categories of proportion were: **all, most, only a few, none** and **no idea**. The results of these three sets are presented as profiles composed of the mean proportions of those respondents who provided estimates for each condition. For some conditions, such as **impulse disorder**, there were substantial numbers who selected the option **no idea**.

Victims before the abuse began

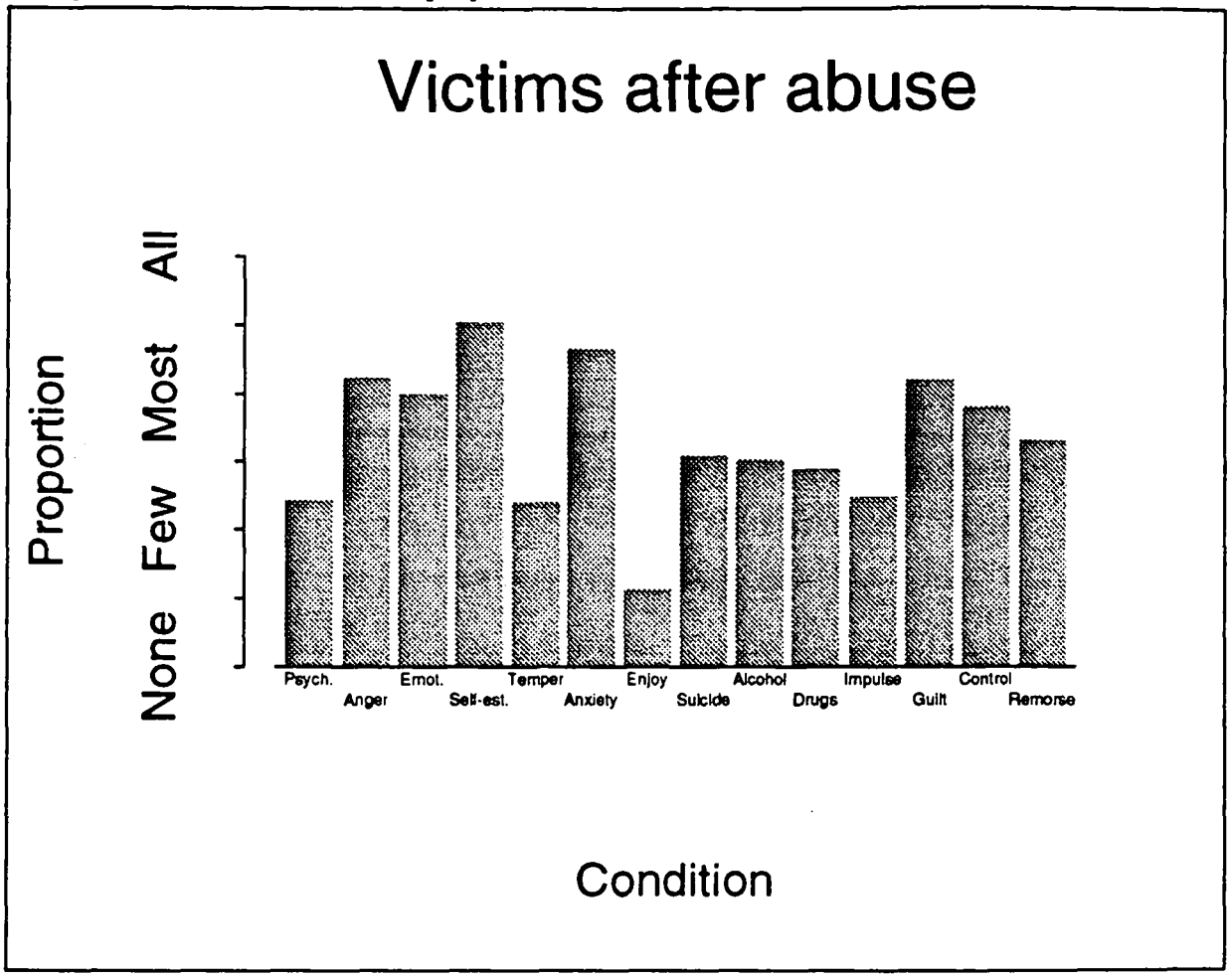
At least 52 respondents selected a category on all of the descriptors. Victims before the abuse began were characterised by **low self-esteem, anxiety** and **guilt/shame**. Very few were felt to **enjoy the abuse** or to have a **psychiatric illness**.



Psych. - Psychiatric illness
Anger - Very angry
Emot. - Emotionally disturbed
Self-est. - Low self-esteem
Temper - Uncontrollable temper
Enjoy - Enjoy the abuse
Alcohol - Alcohol abuse
Drugs - Drug abuse
Impulse - Impulse disorder
Guilt - Feel guilty/ashamed
Control - Fear loss of control
Remorse - Feel remorseful

Victims after the abuse began

At least 50 respondents selected a category for each of the descriptors. Victims after the abuse began were still characterised by **low self-esteem, anxiety** and **guilt/shame**. Very few were felt to **enjoy the abuse** or to have a **psychiatric illness**. Perhaps the most apparent change was the increase in the proportion that were felt to be **have suicidal tendencies**.



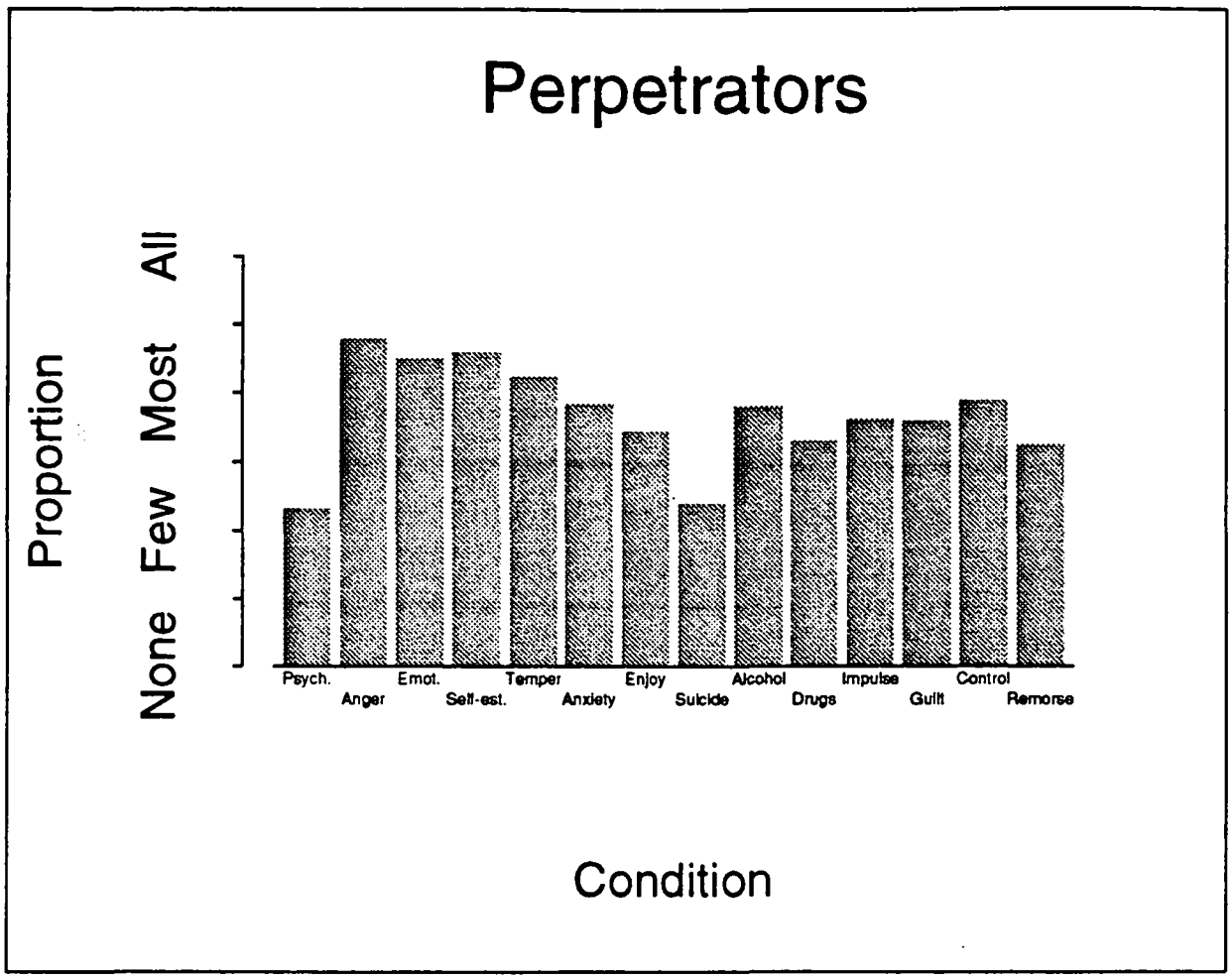
Psych. - Psychiatric illness
Self-est. - Low self-esteem
Alcohol - Alcohol abuse
Guilt - Feel guilty/ashamed

Anger - Very angry
Temper - Uncontrollable temper
Drugs - Drug abuse
Control - Fear loss of control

Emot. - Emotionally disturbed
Enjoy - Enjoy the abuse
Impulse - Impulse disorder
Remorse - Feel remorseful

Perpetrators

At least 53 of the respondents selected a category for each of the descriptors. Perpetrators were characterised by **low self-esteem, emotional disturbance, uncontrollable anger** and **fear of loss of control**. Few were felt to be **suicidal** or to have a **psychiatric illness**.



Psych. - Psychiatric illness
Self-est. - Low self-esteem
Alcohol - Alcohol abuse
Guilt - Feel guilty/ashamed

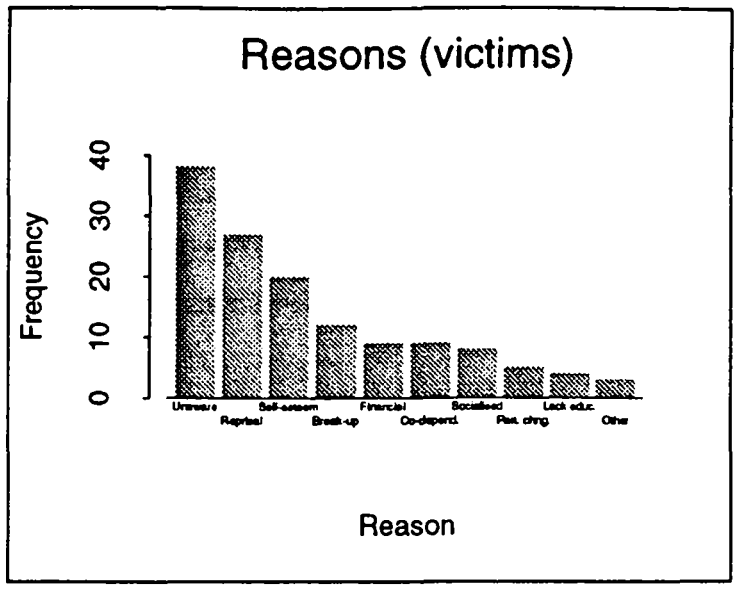
Anger - Very angry
Temper - Uncontrollable temper
Drugs - Drug abuse
Control - Fear loss of control

Emot. - Emotionally disturbed
Enjoy - Enjoy the abuse
Impulse - Impulse disorder
Remorse - Feel remorseful

10.6 Inability to terminate abusive relationship

This question was also divided into two sections, one for **victims** and one for **perpetrators.** 52 respondents completed the question.

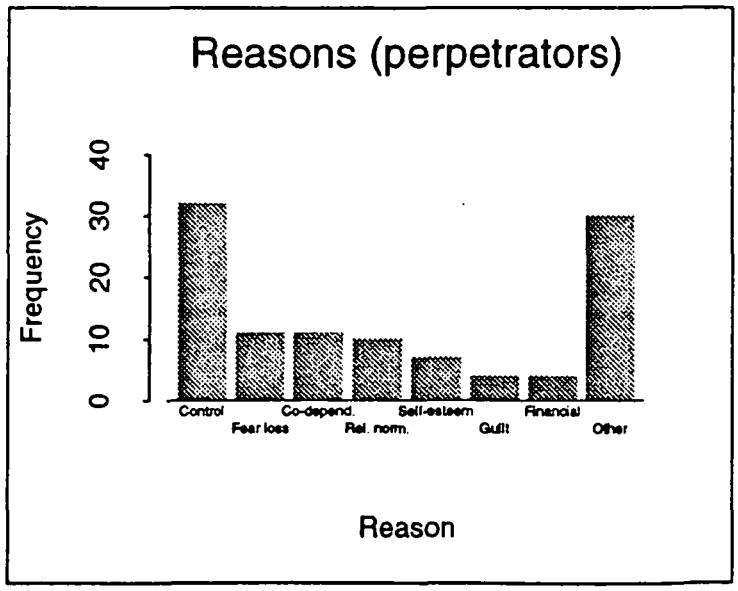
Victims



Proportion of victims finding leaving difficult: All 54 respondents who answered this question felt that **many find it difficult**.

Reasons for not leaving abusive relationship: The most common reasons cited were **unaware of support/services** (38), **fear of reprisal/retaliation** (27), and **low self-esteem/shame** (20). **Fear of family break-up** (12), **financial difficulties** (9), **co-dependent** (9) and **socialised through exposure** (8) were also common, with **belief that partner will change** (5) and **lack of education/awareness of rights** (4) making up the remainder of reasons.

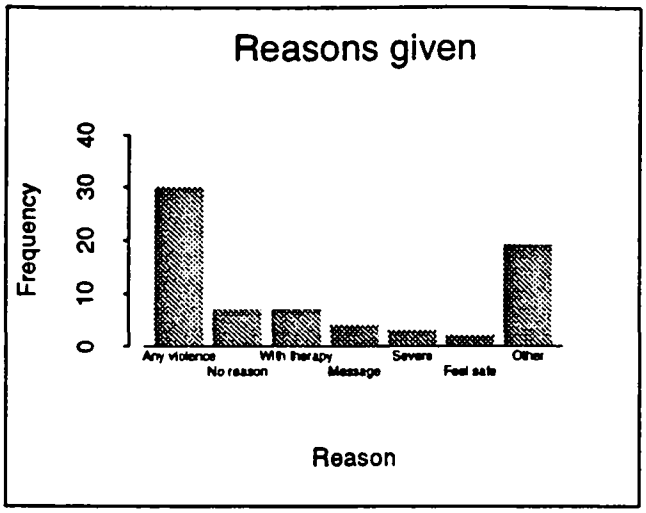
Perpetrators



Reasons for not leaving abusive relationship: Respondents felt that the most common reason for perpetrators not leaving abusive relationships was **control/power issues** (32). **Fear of loss of relationship/children** (11), **codependency** (11) and the perception that the **relationship was normal** (10) were also often mentioned. **Low self-esteem** (7), **feelings of guilt/remorse** (4) and **financial reasons** (4) were less common. A number of unclassified **other** (30) reasons emerged as well.

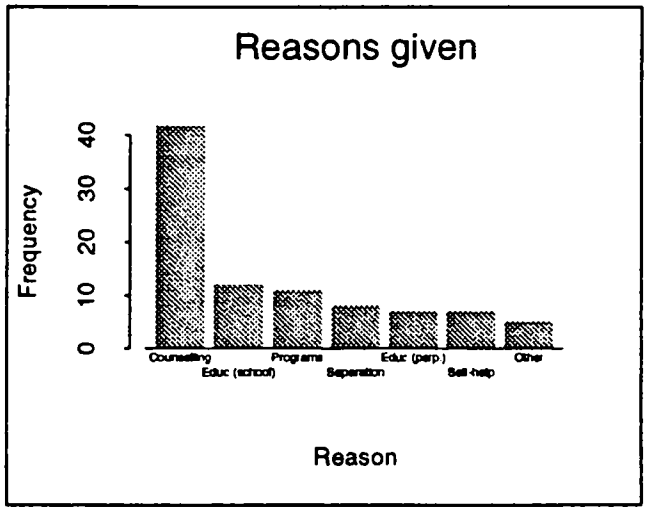
10.7 Methods of dealing with spouse abuse

Spouse abuse as a legal matter



All of the 54 respondents who answered this question felt that spouse abuse should be viewed as a legal matter. The most common reason was that **any act of violence should be viewed in a legal context** (30). Seven gave **no reason**, while seven felt that legal status should be in **conjunction with therapy or counselling**. The statements **if abuse becomes severe/life threatening** and **needed as a message to perpetrator** were given by three and four respondents respectively, while the **right of victims to feel safe** was mentioned by two. Nineteen gave unclassified **other** reasons.

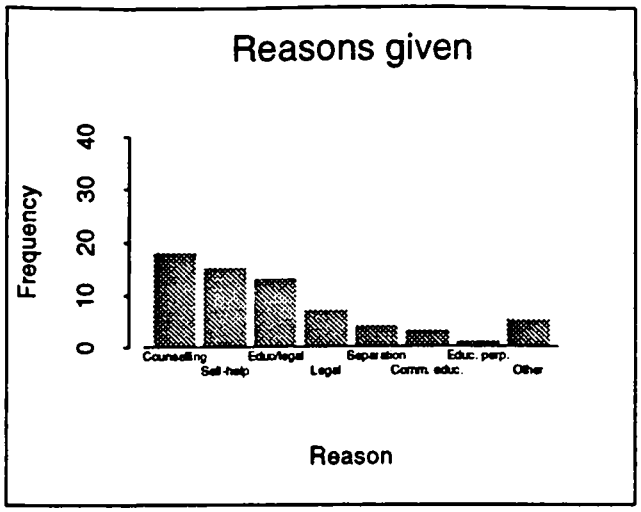
Other ways of dealing with abuse



The most frequently mentioned alternative was **counselling/therapy** (42), with **self-help groups** (7) also mentioned. **Education (school)** (12) and **education/support for perpetrator** (7) were commonly mentioned. Substance **treatment programs (e.g. alcohol)** (11) and **separation** (8) were put forward by some. Five unclassified **other** alternatives were given.

Most effective way to deal with spouse abuse

Counselling/therapy (18) and **self help/support groups** (15) were again the most often mentioned effective way to deal with spouse abuse. Educational methods such as combined **education/legal/therapy** (13), **education for perpetrator** (1) and **community education** (3) were also frequently mentioned. **Legal intervention** (7) and **encouraging victim to leave** (4) also appeared. Five **other** ways were given.



10.8 Effects of abusive relationship on victims

The overwhelming majority (49) of the 54 respondents who answered this question felt that **long-term damaging psychological effects** on victims resulted from spouse abuse. Five felt that **short-term damaging psychological effects** occurred.

10.9 Acceptability of the use of force

Separate questions were asked for the use of force by males on their partner, and by females. As such opinions might be affected by the sex of the respondent, the proportions of answers were compared by sex.

Acceptability of the use of force by a man on his partner

Over half of the 54 respondents answering this question felt that there were no circumstances in which it was acceptable for a man to use force against his partner. However, another 20 felt that there were circumstances in which this might be acceptable, and four were **unsure**. There were no sex differences in the proportion of answers.

The reasons given were **self defence/protect children** (19), and to **protect partner from self-harm** (8).

Acceptability of the use of force by a woman on her partner

The 54 respondents who answered the question were evenly split on this issue, with 25 each answering yes and no. Four were again **unsure**. There were again no sex differences.

Self defence/protect children (24) was more commonly given for this answer, while **protect partner from self-harm** (7) showed little difference.

Chapter 11. Attitudes and beliefs about the clinic

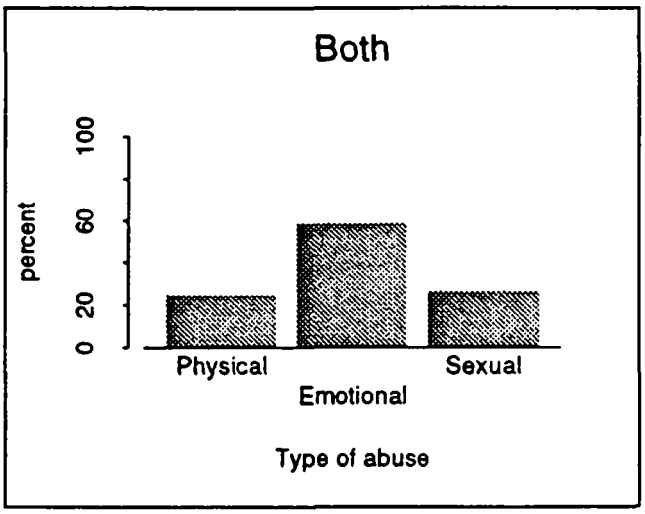
The next eleven questions dealt with the respondents' attitudes and beliefs about their own clinic, as well as their understanding of their clinic's recommendations for dealing with spouse abuse.

11.1 Proportion of clients involved in spouse abuse

Three questions asked for estimates of the proportion of clients entering the clinic who were involved in spouse abuse as **victims**, **perpetrators** and **both**. As respondents were able to indicate **no idea at all**, estimates were made by varying numbers, indicated for each estimate as (n=XX).

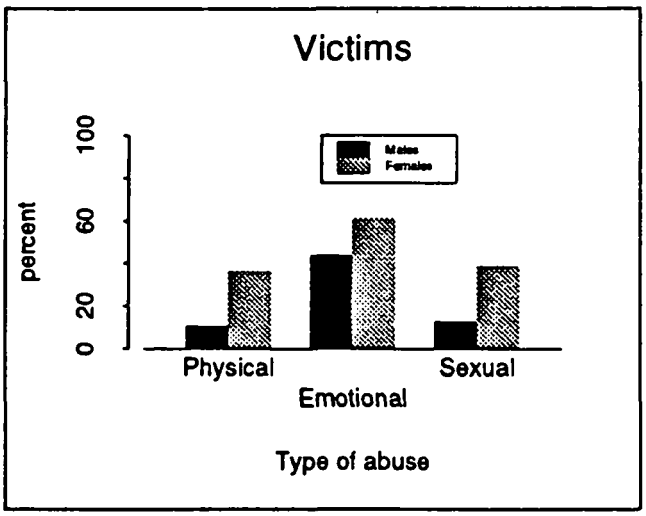
Both victims and perpetrators

Emotional abuse (n=35) was estimated to be about twice as common among clients entering the clinic as either **physical** (n=29) or **sexual** (n=25) abuse, with a mean of over half of clients in a relationship in which both partners inflicted emotional abuse. The estimates for clients were close to those discussed earlier for prevalence in the Australian population.

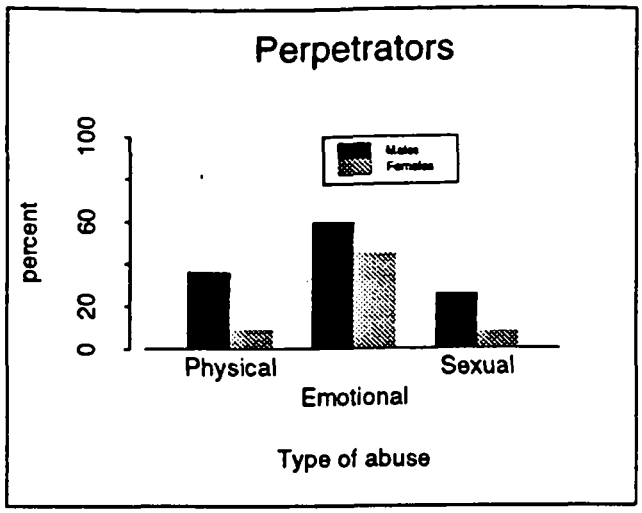


Victims

While the overall estimates for the three types of abuse remained about the same for clients entering the clinic who were only victims, it is obvious that **males** were thought to be victims of **physical** (male n=34, female n=38) and **sexual** (male n=31, female n=35) abuse much less frequently. The estimates for **emotional** (male n=42, female n=41) abuse were closer for the sexes, but males were still thought less likely to be victims. While the estimates for physical and sexual abuse were close to those discussed earlier for the Australian population, the estimates for emotional abuse were substantially higher for the clients.



Perpetrators



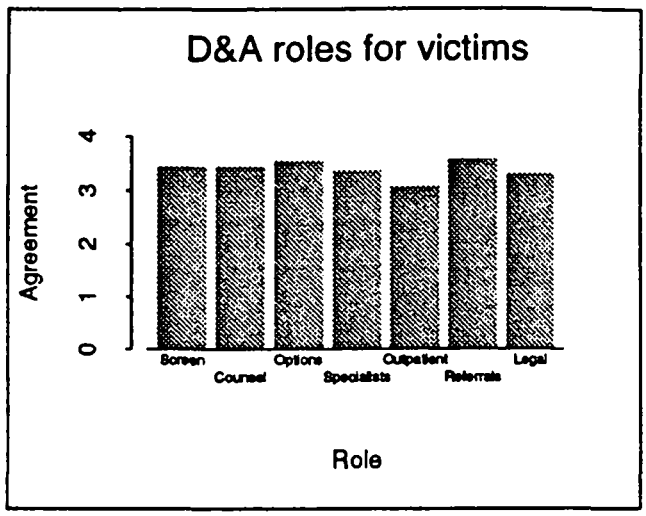
Again, the overall estimates of the proportion of clients entering the clinic who were **perpetrators** of the three types of abuse were very similar. It is obvious that the respondents did not perceive the three groups to be exclusive, as the total percentage of those clients involved in **emotional abuse** would be greater than 100%. In these estimates, the sex difference exhibited in the previous estimates was reversed, with males thought much more likely to be perpetrators of **physical** (male n=41, female n=31) and **sexual** (male n=34, female n=24) abuse, and somewhat more likely to be perpetrators of **emotional** (male n=42, female n=37) abuse. As in the case of victims, the estimates for physical and sexual abuse were close to those given for the Australian population, but the estimates for emotional abuse were substantially higher for clients.

11.2 Role of D&A Clinics in spouse abuse

Respondents were given two lists of seven statements of roles for D&A clinics in relation to spouse abuse, plus an **other** option which the respondent could nominate. The respondents were asked to indicate their agreement with each of these statements by selecting one of five categories of agreement, ranging from **strongly agree** to **strongly disagree**. The two lists referred to **victims** and **perpetrators** respectively, but otherwise referred to the same roles.

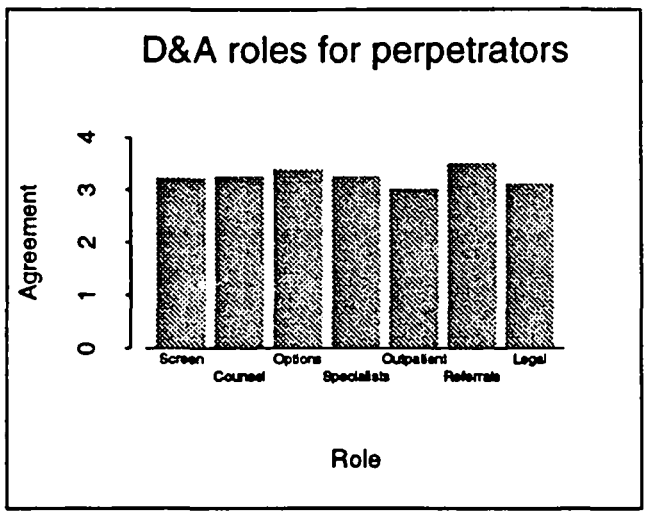
Victims

There was a high level of agreement with the roles listed, with **referrals to therapy** having the highest level of agreement, and the **discussion of all options** with victims. Referral to **legal** services, and the provision of **outpatient services dealing with spouse abuse issues** found less agreement. 52 to 54 respondents answered the individual items.



Perpetrators

There was almost as high a level of agreement with the roles listed for perpetrators as for victims, with **referrals to therapy** having the highest level of agreement, and the **discussion of all options** with perpetrators. Meeting less agreement were the statements that perpetrators should be referred to **legal** services, and that **outpatient services dealing with spouse abuse issues** should be provided. 50 to 53 respondents answered the individual items.



11.3 Recommendations of the clinic on spouse abuse

Respondents were asked whether their clinic recommended any actions for dealing with spouse abuse, and what those actions were. The questions were again separated into **victims** and **perpetrators**.

Victims

37 of the 53 respondents answering this question replied that such recommendations existed, with 29 of these stating that **counselling** was the recommended action. **Information about resources** (9) and **legal advice** (8) were the next two most common recommendations.

Perpetrators

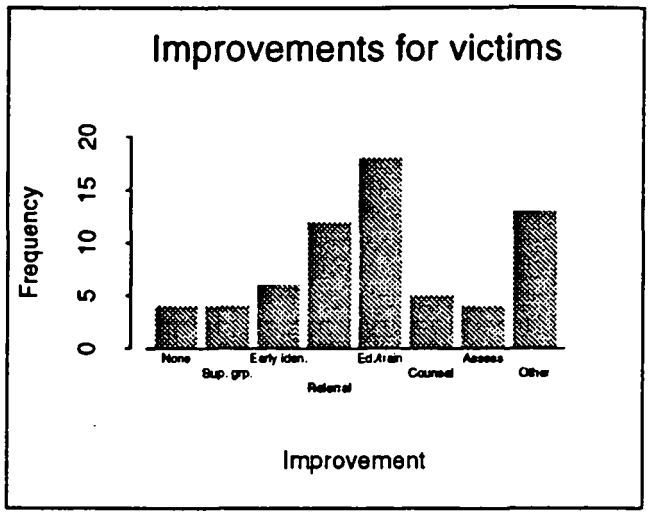
28 of the 53 respondents answering this question replied that such recommendations existed, with 22 of these stating that **counselling** was the recommended action. **Information about resources** (5) and **legal advice** (3) were again the next two most common recommendations, with **therapy** (3) as common as the latter.

11.4 Improvement in support within the clinic

Respondents were asked whether they felt that improvements could be made in the support given to those clients involved in spouse abuse. Suggested improvements relevant to **victims** and **perpetrators** were recorded separately.

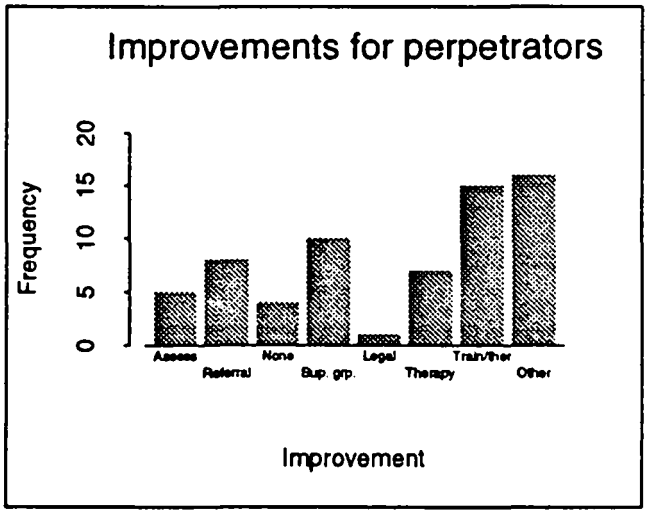
Victims

The most frequently mentioned improvement was **specialised education/training for staff**, with **referral** also common. **Support groups, assessment** and **none needed** were much less common.



Perpetrators

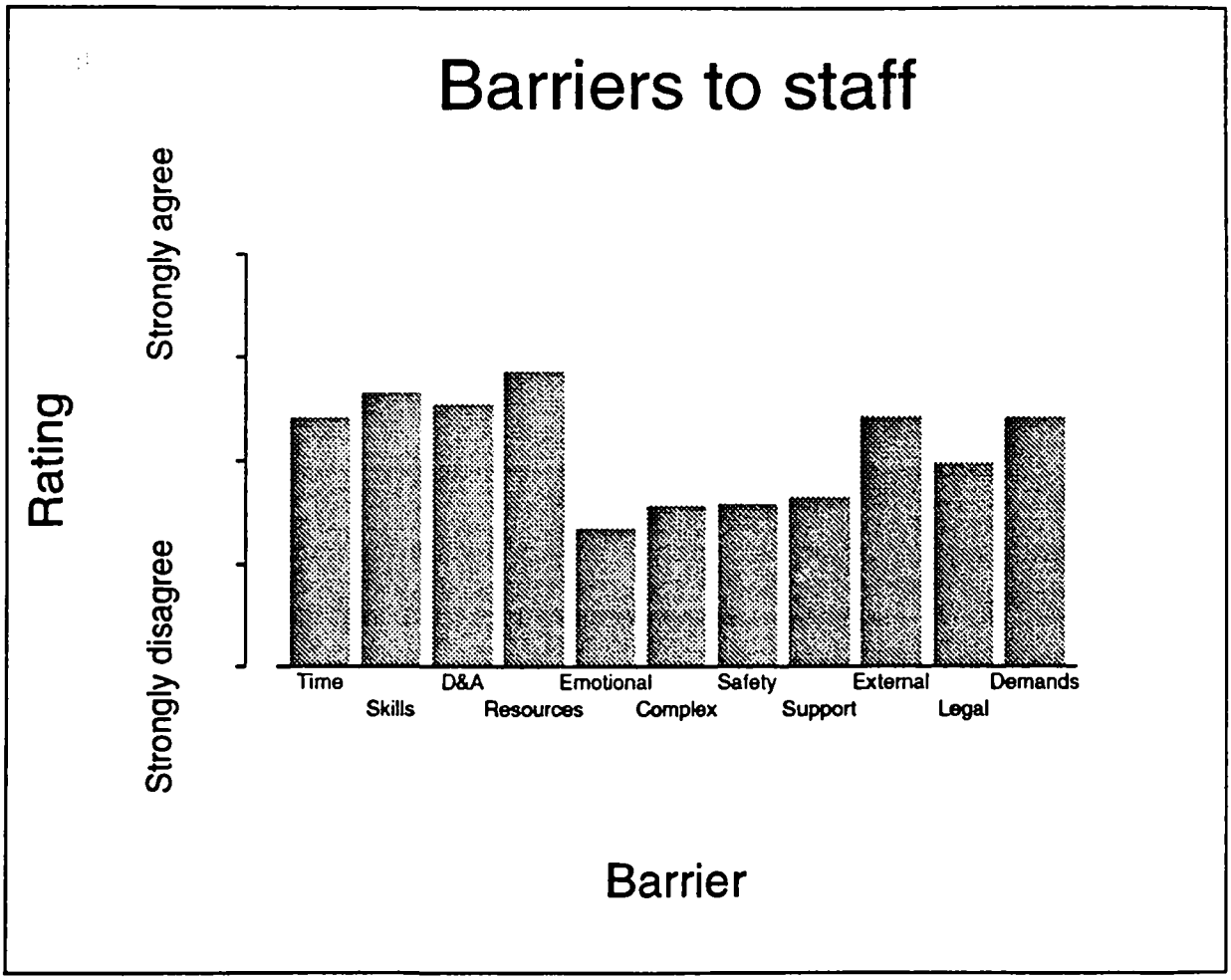
The most often mentioned improvement was **specialised counselling/therapy/training for staff**, with **special therapy/support groups** also mentioned often. **Legal advice** was the least often mentioned improvement, with **none needed** also uncommon.



11.5 Barriers to staff addressing spouse abuse

In this question, respondents were asked to indicate their agreement with each of a list of eleven statements, by marking one of five boxes labelled from **Strongly agree** to **Strongly disagree**. The respondent was also asked to rank each statement with which they had agreed (i.e., marked the first or second box) in order of importance beginning from 1. There was available an open category, labelled **other**, in which the respondent could indicate their agreement with up to three statements which were not included in those presented. No usable data was collected from this category.

Limited resources within the clinic and **lack of knowledge and skills** were rated as the most important barriers to staff addressing spouse abuse issues. **Lack of time, lack of external resources and support, extra demands with training** and the **main concern being drug and alcohol dependency** were also rated highly. **Issue too emotional** was rated as the least important.



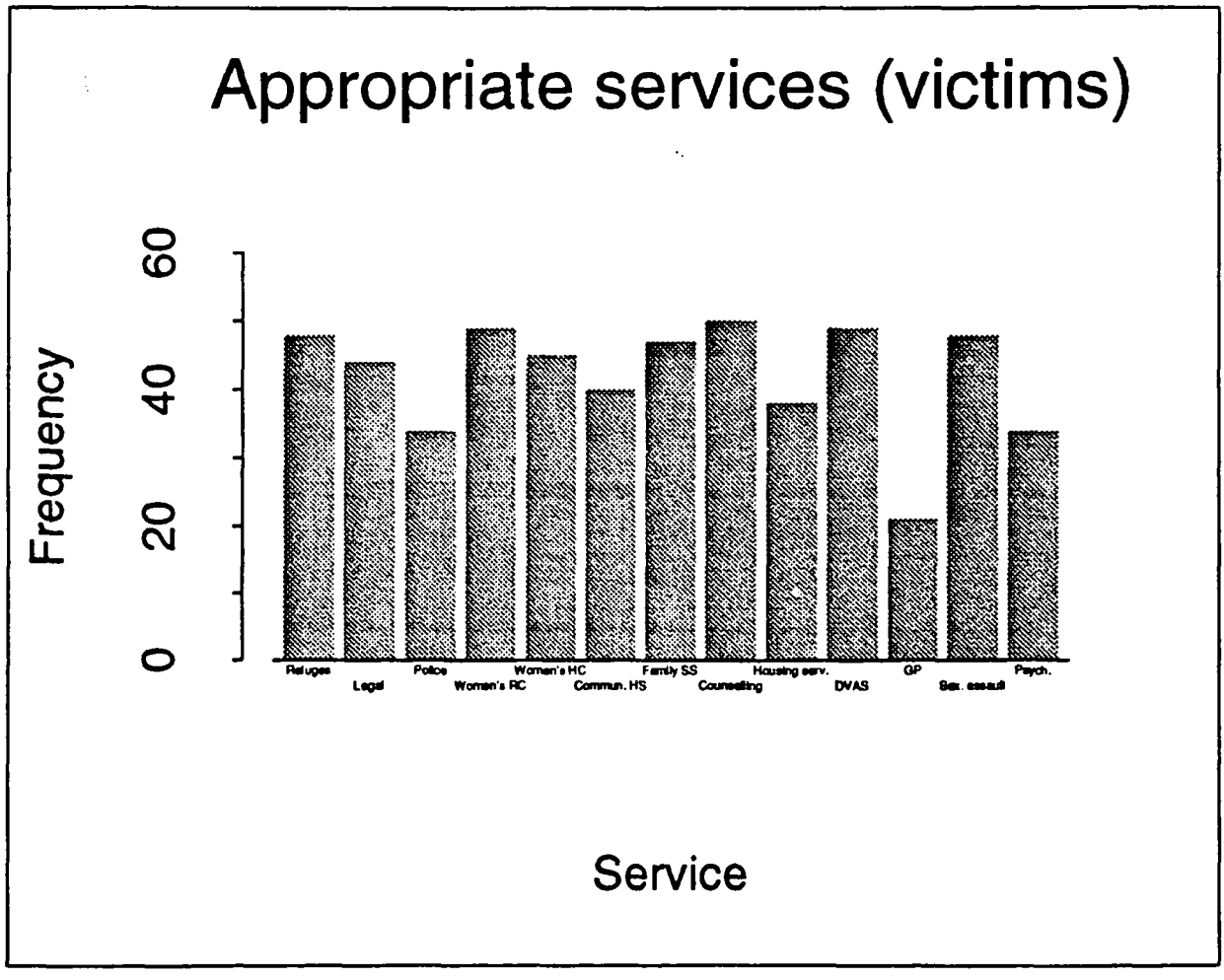
Time - Lack of time
Skills - Lack of knowledge/skills
D&A - Main concern is drug and alcohol
Resources - Limited resources
Emotional - Issue too emotional
Complex - Problem is too complex
Safety - Concern for staff safety
Support - Lack of admin. support
External - Lack of external resources
Legal - Poss. legal complications
Demands - Extra demands training/seminars

Chapter 12. Dealing with spouse abuse

The next thirty six questions dealt principally with the respondents' behaviour in dealing with clients involved in spouse abuse, although some questions were more hypothetical than others.

12.1 Services appropriate for the referral of victims

The number of respondents answering this question who felt that a service was appropriate for the referral of victims is illustrated below. Counselling services, Domestic Violence Advocacy Service, and specialist women's centres were thought appropriate for victims by the highest proportion of respondents, with ancillary, but related, services following. General practitioners were rated as least appropriate. The small number of responses in the "other" category precluded analysis.

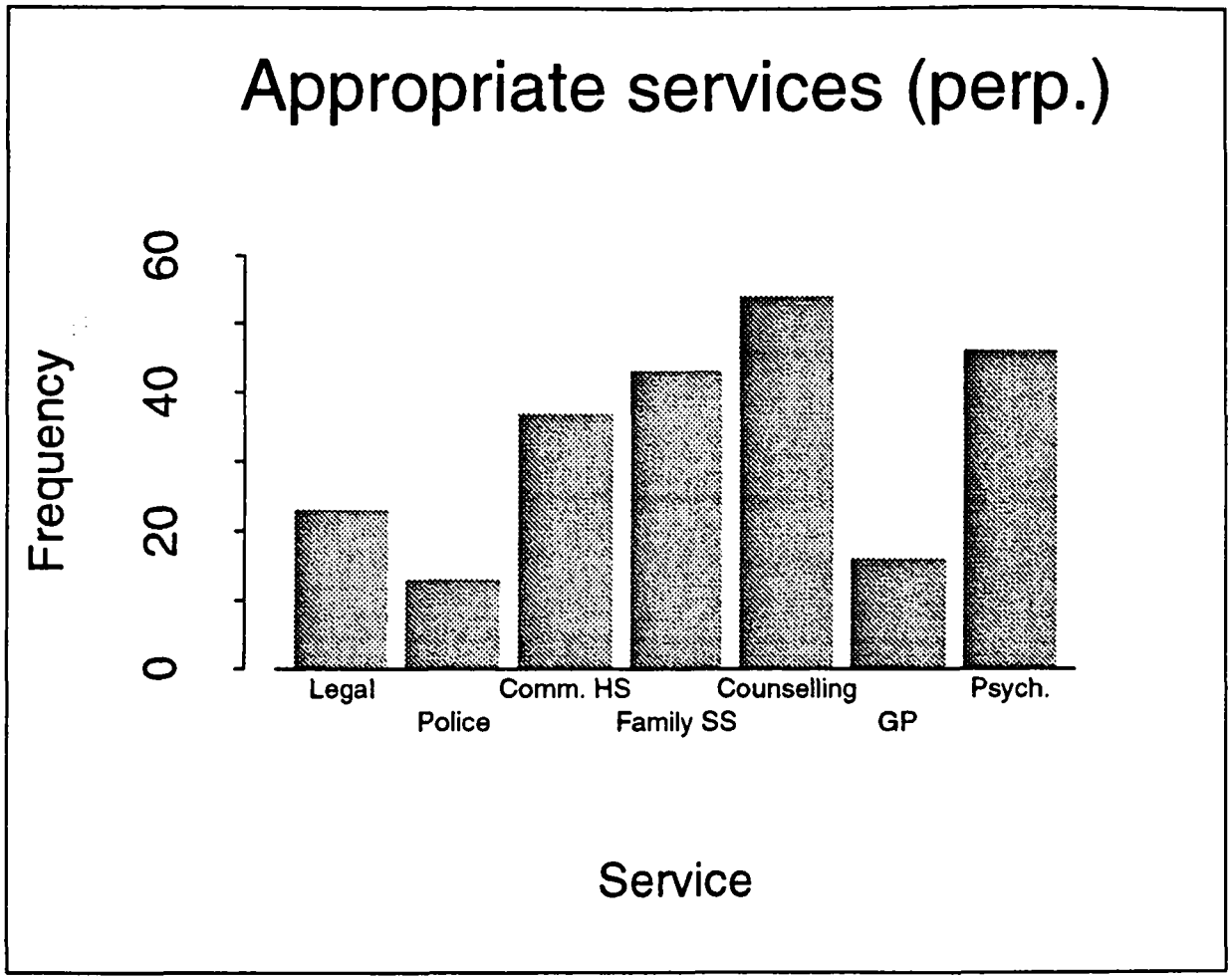


Refuges - Womens' refuges
Womens' RC - Womens' Resource Centres
Commun. HS - Community Health Services
Counselling - Counselling services/marriage/therapy
DVAS - Domestic Violence Advocacy Service
Sex. assault - Sexual assault centres

Legal - Legal services
Womens' HC - Womens' Health Centres
Family SS - Family Support Services
Housing serv. - Housing services
GP - General practitioners
Psych - Psychiatrists/psychologists

12.2 Services appropriate for the referral of perpetrators

A similar question in regard to the appropriateness of services for the referral of perpetrators found the replies shown below. Counselling services were again felt to be the most appropriate, with psychiatrists/ psychologists being felt much more appropriate for perpetrators, perhaps in the absence of specialist services. General practitioners were again thought less appropriate, although Police were thought the least appropriate in this context. The small number of responses in the "other" category precluded analysis.

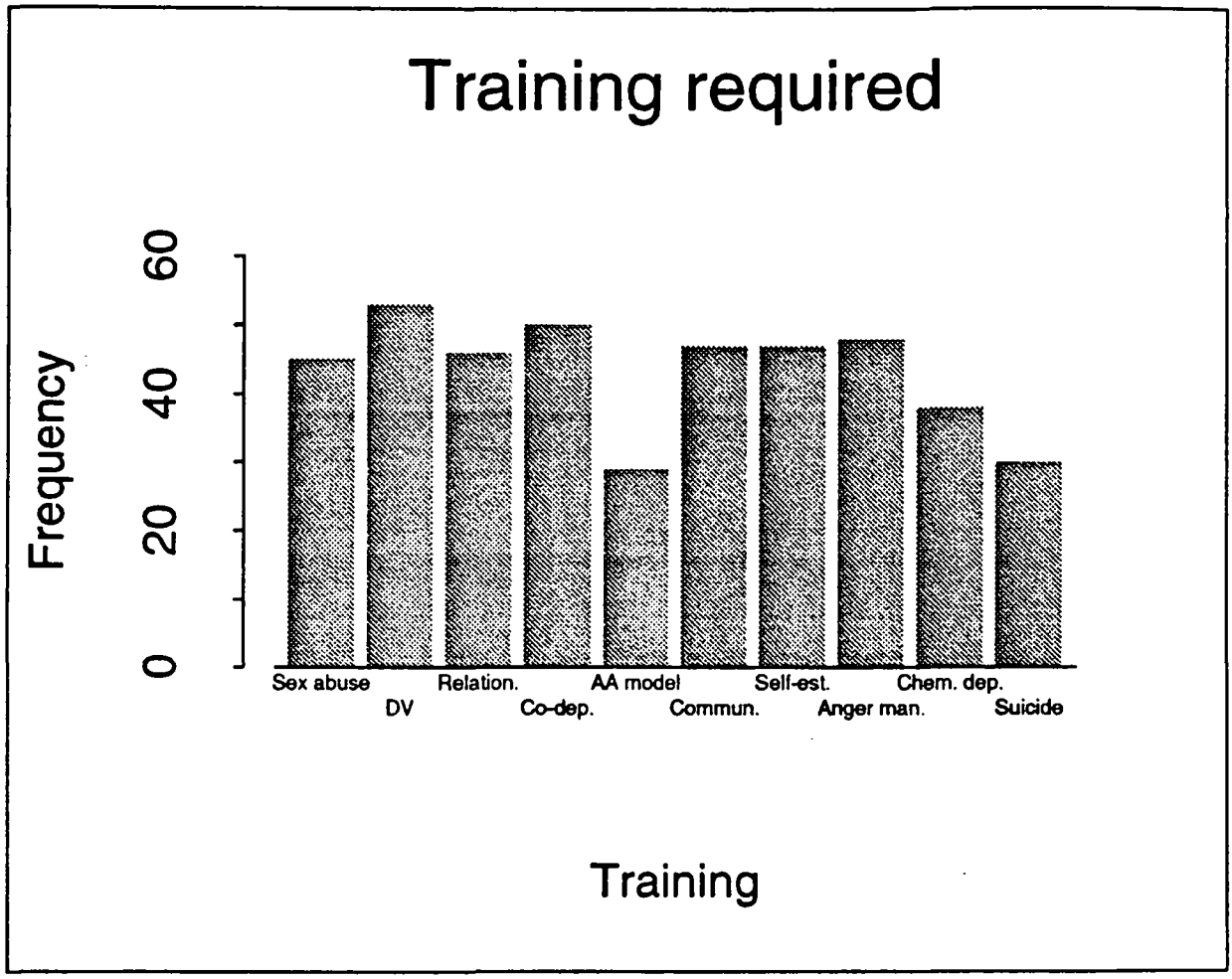


Legal - Legal services
Family SS - Family Support Services
GP - General practitioners

Comm.HS - Community Health Services
Counselling - Counselling services/marriage/therapy
Psych. - Psychiatrists/psychologists

12.3 Areas of training required for D&A staff

Ten areas of training were listed in this question, which asked the respondents to indicate which they thought were required to enable drug and alcohol clinic staff to deal effectively with victims and perpetrators of spouse abuse. Domestic violence was the area chosen by the largest proportion of respondents, while even the areas chosen by the lowest proportions were selected by over half of respondents.



Sex abuse - Sexual abuse
Relation. - Relationship and intimacy
AA model - Alcoholics Anonymous Model
Self-est. - Self esteem/assertiveness
Chem. dep. - Chemical dependency

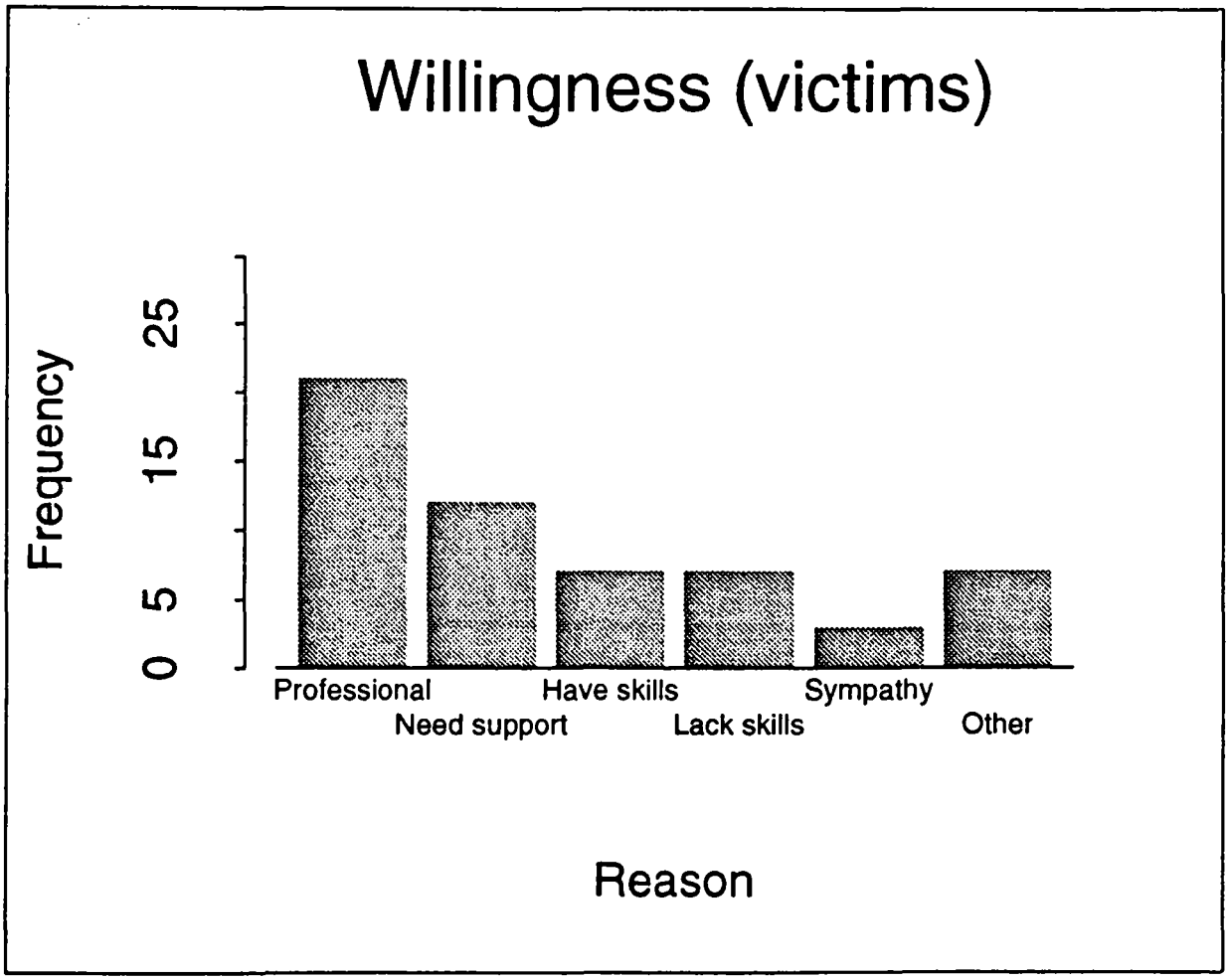
DV - Domestic violence/spouse abuse
Co-dep. - Co-dependency
Commun. - Communications
Anger man. - Anger management

12.4 Working with DV clients

Six questions sought information about how the respondents felt about working with clients who were involved in domestic violence. For both **victims** and **perpetrators**, the respondents were asked to indicate their **willingness to work with** such clients, the **satisfaction** they gained from working with them, and the **positive and negative aspects** of such work. As well as seeking the relative degree of these factors, respondents were also asked to give reasons for their answers.

Expressed willingness to work with victims

Almost 90% of respondents answering this question were either **very willing** or **quite willing** to work with victims on spouse abuse issues. The reason cited by the largest number of respondents was **professional**, with **support for victims** also being a commonly cited reason. The **lack of knowledge** reason was given by those who were less willing.



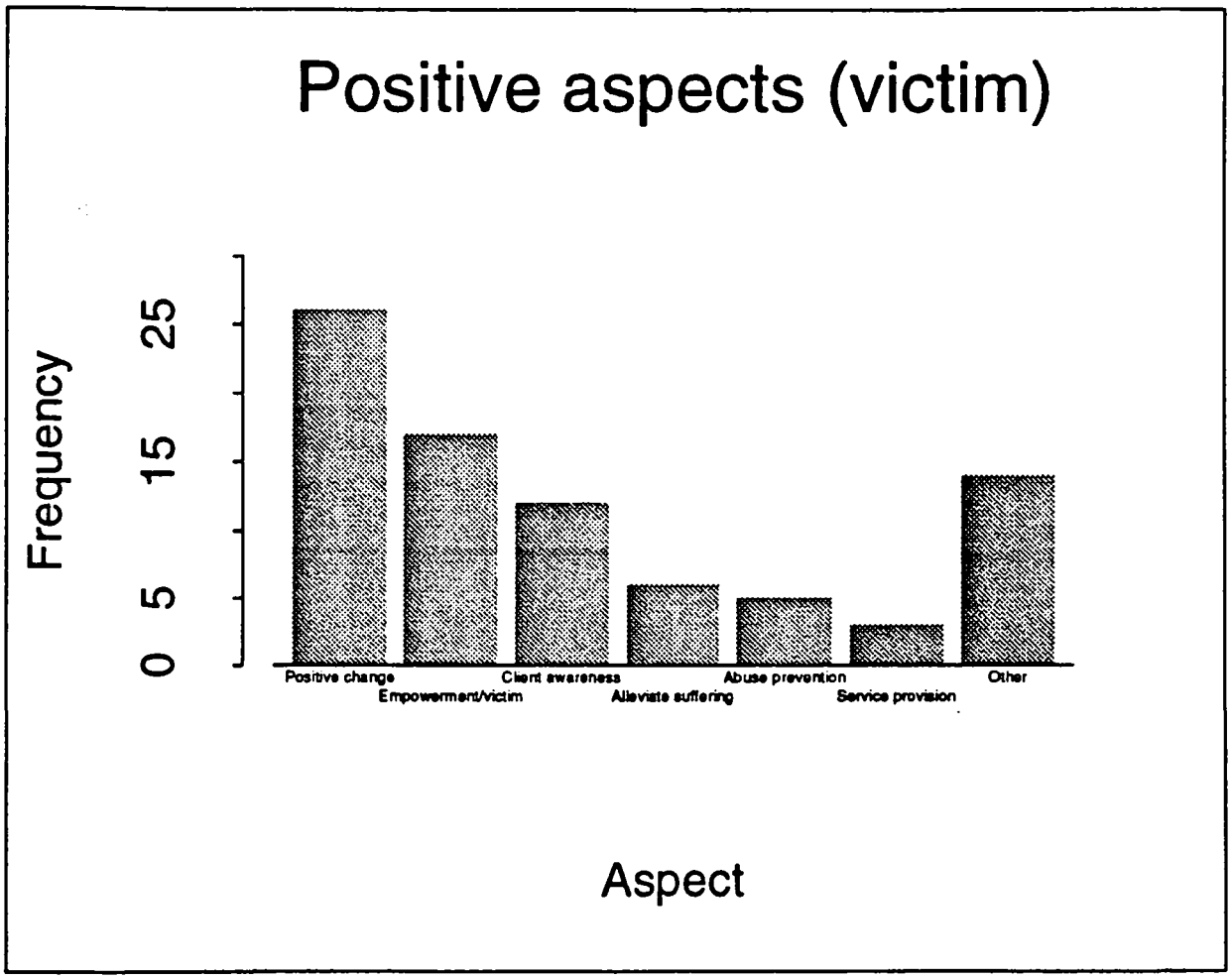
Professional - Part of professional responsibility
Have skills - Have the experience/knowledge/skills
Sympathy - Sympathy/empathy for victim
Need support - Victims need support and counselling
Lack skills - Lack sufficient experience, knowledge and skills

Reported satisfaction in working with victims

One quarter of the respondents who answered this question reported that working with victims was **very satisfying**, while another third reported that it was **quite satisfying**. Only 7% found it **quite dissatisfying**.

Positive aspects of working with victims

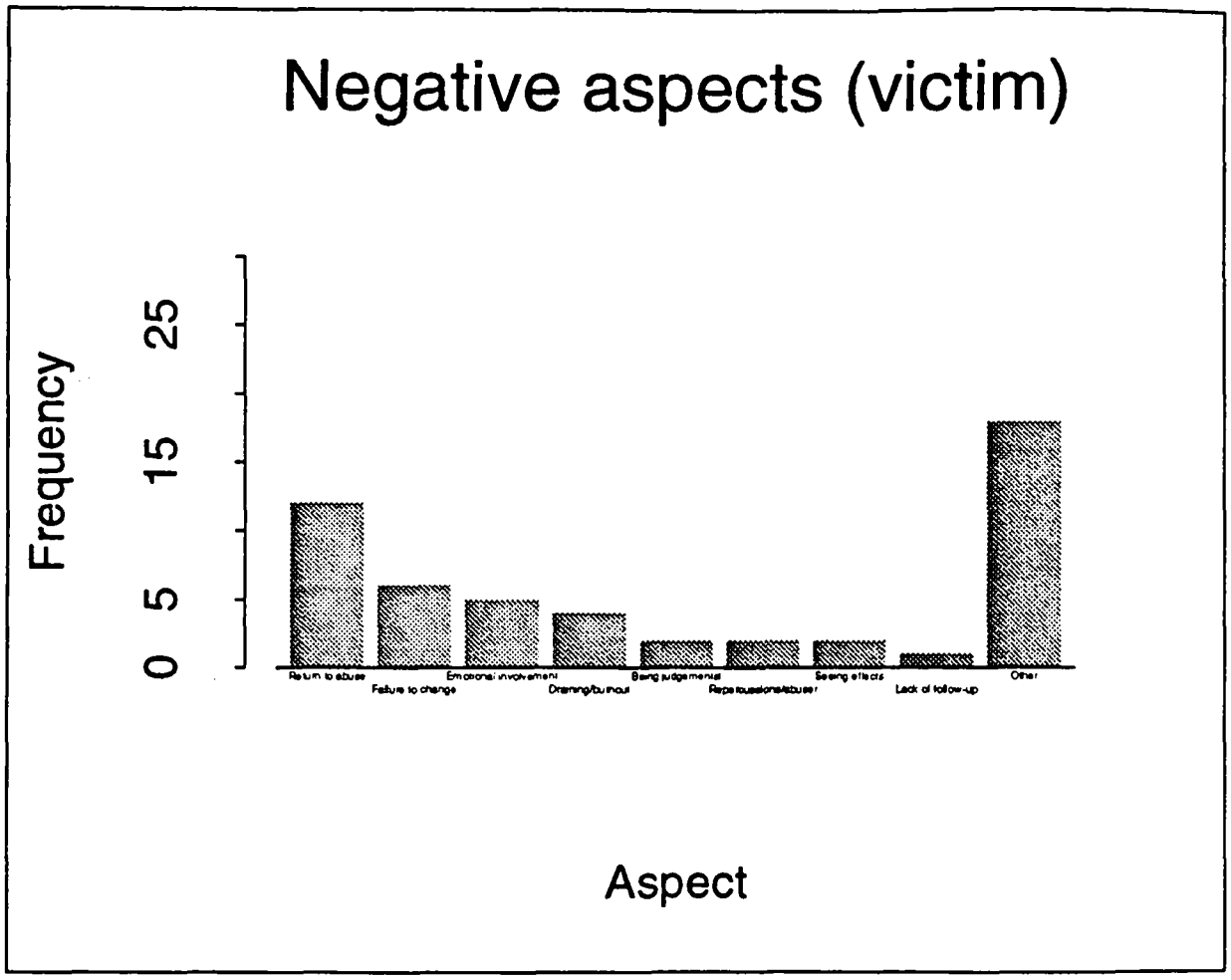
The two most commonly mentioned positive aspects were **Reward of witnessing positive changes in the client** and **Empowerment for the victim**.



Positive change - Reward of witnessing positive changes in the client
Empowerment/victim - Empowerment for the victim
Client awareness - To make the client aware of their rights/alternatives
Alleviate suffering - Alleviate unnecessary suffering
Abuse prevention - Keeping client out of an abusive environment
Service provision - Providing a service which is not offered elsewhere

Negative aspects of working with victims

Seeing the victim return to the abusive situation/unwillingness to change was the most often cited negative aspect of working with victims. The majority of reasons cited were connected with lack of change or recidivism. There were many more reasons given by only one or two respondents in this question, which have been included in the **other** category in the illustration.

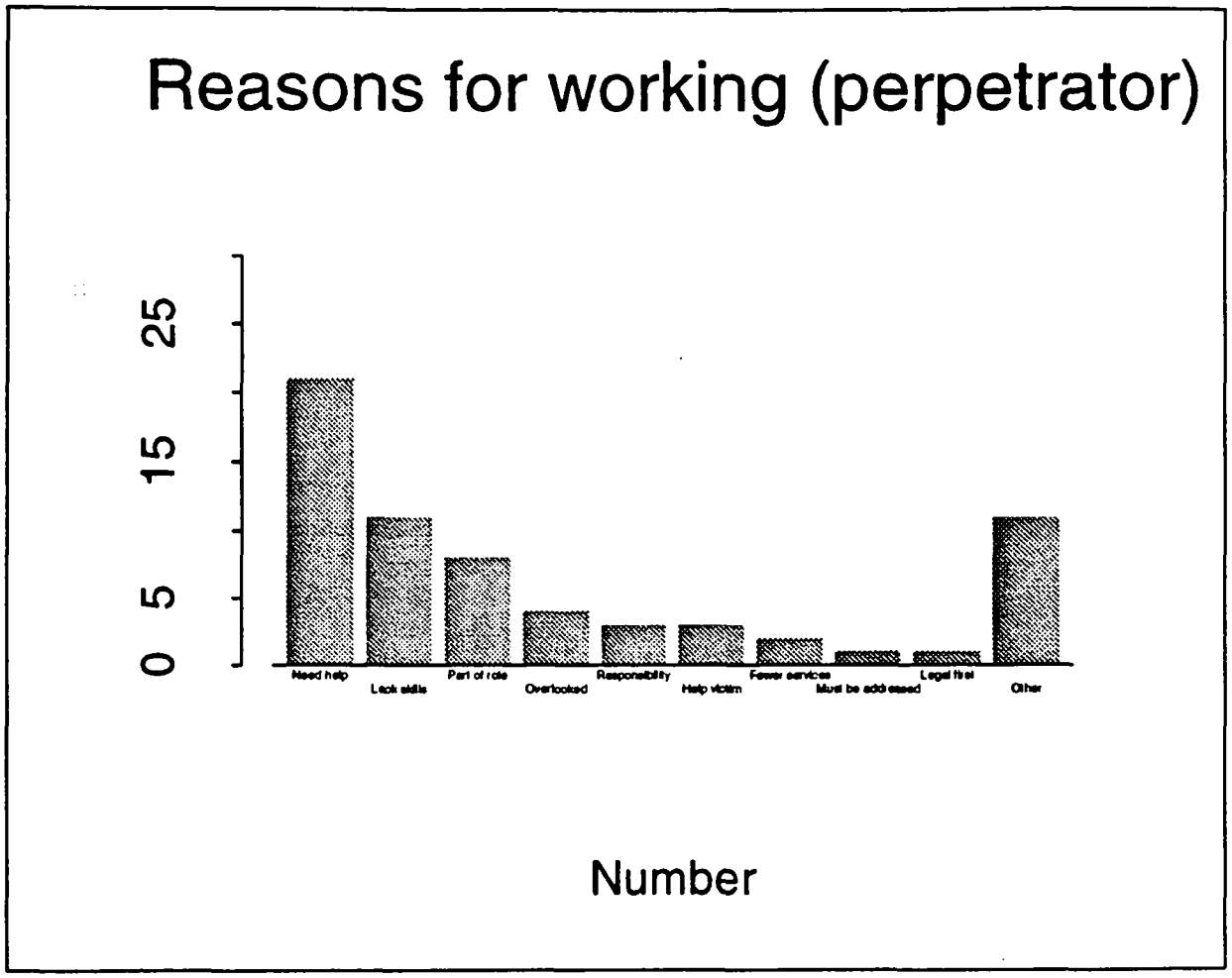


Return to abuse - Seeing the victim return to the abusive situation/unwillingness to change
Failure to change - Unable to resolve their situation/impart positive change
Emotional involvement - Becoming emotionally involved
Draining/burnout - Too draining/staff burnout/unable to give as much as is required
Being judgemental - Being judgemental/one sided/difficult to assess
Repercussions/abuser - Repercussions by abusive spouse
Seeing effects - Seeing psychological effects on the victim

Expressed willingness to work with perpetrators

Just over one quarter of respondents answering this question were **very willing** to work with perpetrators, and a further 40% were **quite willing**. Just under 9% were **quite unwilling**, and one respondent answered **very unwilling**.

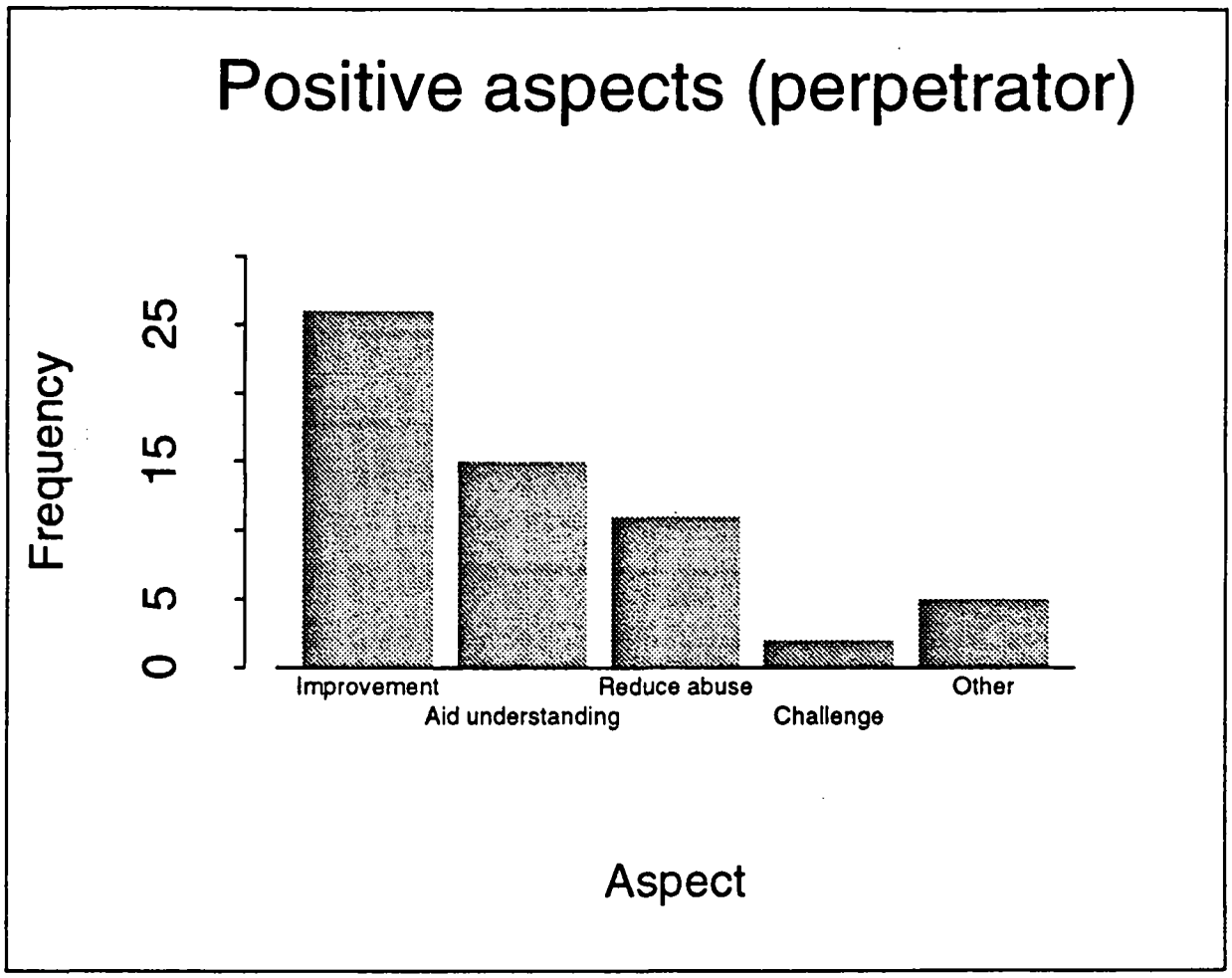
The most common reason given for the expressed willingness was **perpetrators need help to change their behavior**, with the second most often mentioned reason was **have insufficient skills/knowledge**, indicating unwillingness to work with perpetrators.



Need help - Perpetrators need help to change their behaviour
Lack skills - Have insufficient skills and knowledge
Part of role - Have skills and knowledge/part of role
Overlooked - Empathy lies with victim/too judgemental
Responsibility - Any client who asks for help should get it/they are victims as well
Help victim - Helping/addressing the issue may help victims
Fewer services - Fewer services available for perpetrator
Must be addressed - Big problem in the community/domestic violence must be addressed
Legal first - Judicial system should deal with perpetrators first

Positive aspects of working with perpetrators

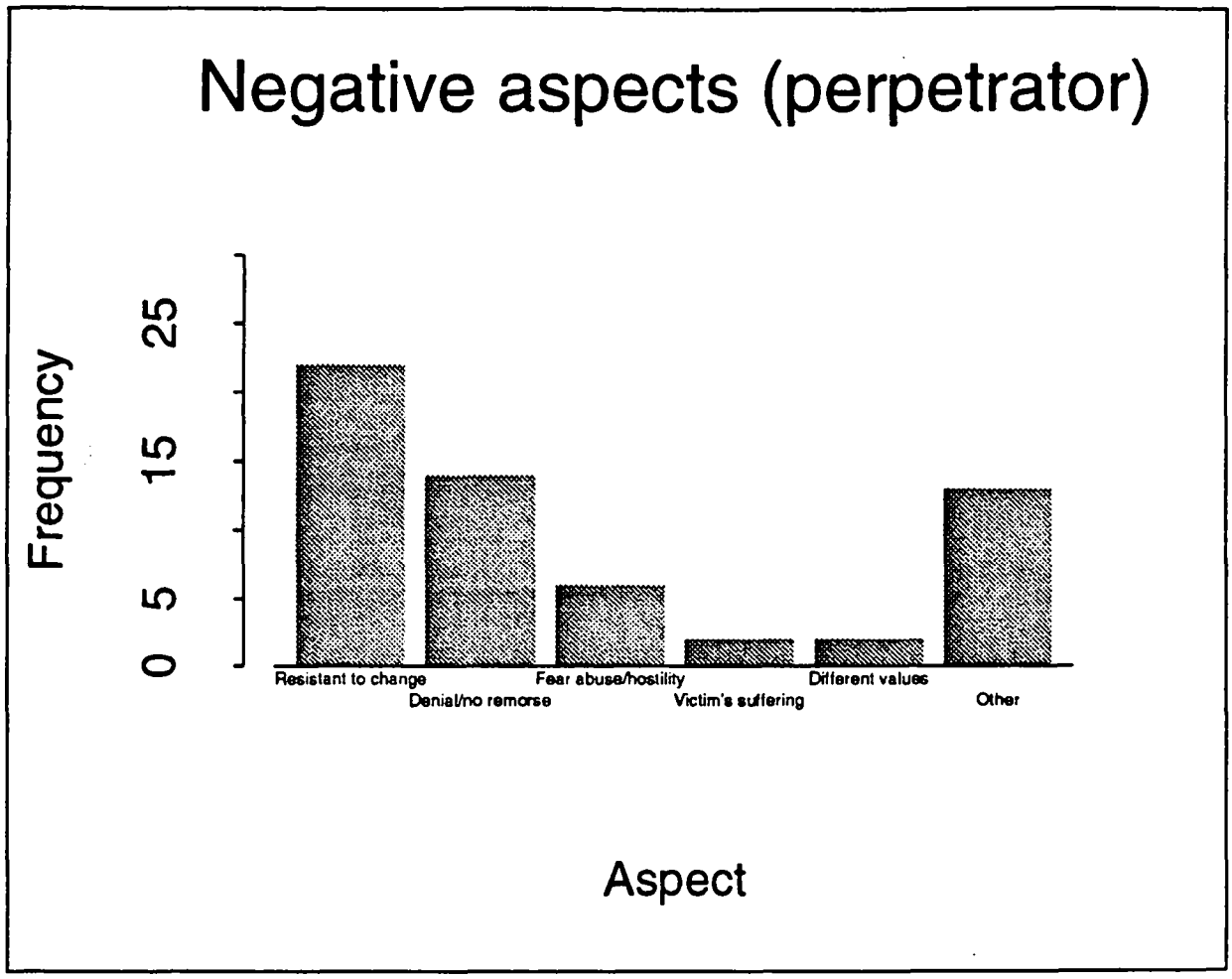
The most commonly cited positive aspect of working with perpetrators was **seeing/initiating improvement/positive change**. **Stopping/lessening abuse** was common, reflecting more a concern with the victim.



Improvement - Seeing/initiating improvement/positive change in client
Aid understanding - Help perpetrator to understand his/her behaviour
Reduce abuse - Chance of stopping/lessening the abuse
Challenge - Addressing a difficult issue/challenge

Negative aspects of working with perpetrators

The negative aspect most commonly given was **resistance to change**, with the similar **denial/no remorse** second. Again, some responses such as **knowledge of pain and suffering of the victims**, related to the abused partner.



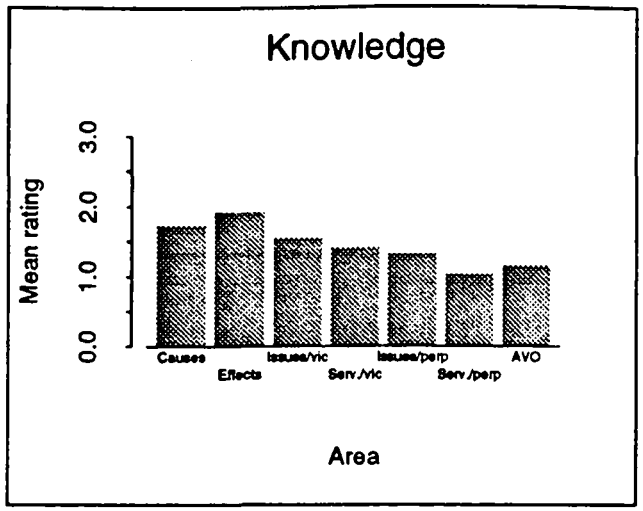
Denial/no remorse - Dealing with those who are in denial or show no remorse
Fear abuse/hostility - Worker fears abuse/aggression/hostility from perpetrator
Victim's suffering - Knowledge of the pain and suffering of victims
Different values - Difficulty in working with people with different value systems

12.5 Self-reported knowledge, confidence and effectiveness

Respondents were asked to indicate their knowledge in seven areas of domestic violence, and their confidence and effectiveness in nine activities related to domestic violence. Answers were chosen from four categories for each item, which ranged from **Very** (knowledgeable, confident, effective) to **Not at all**.

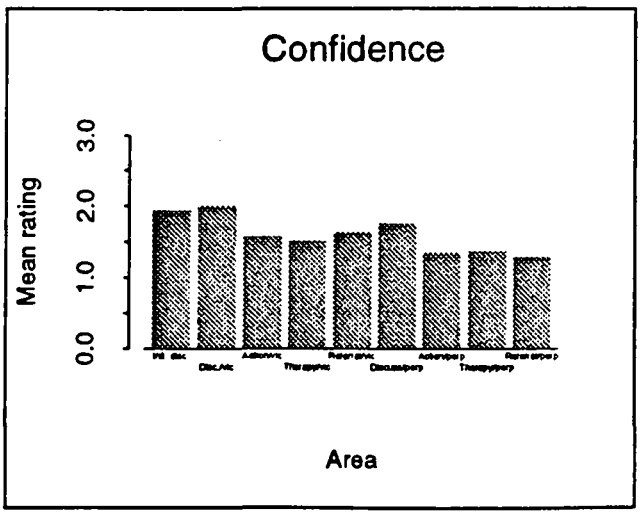
Knowledge

Respondents reported the highest degree of knowledge about the **effects** of spouse abuse, followed by the **causes**. In general, they reported less knowledge about issues connected with **perpetrators** than with those connected with **victims**.



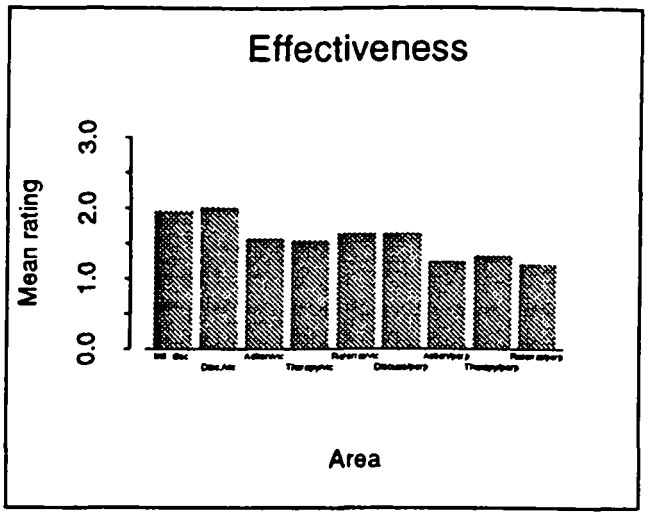
Confidence

Respondents reported the most confidence in **discussing experiences with victims of spouse abuse**, followed by **initiating discussion on spouse abuse with clients**. Again, they tended to report less confidence in areas connected with **perpetrators** than with those connected with **victims**.



Effectiveness

Respondents reported that they were most effective in **discussing experiences with victims of spouse abuse**, followed by **initiating discussion on spouse abuse with clients**. Again, they tended to report less effectiveness in areas connected with **perpetrators** compared to those connected with **victims**.



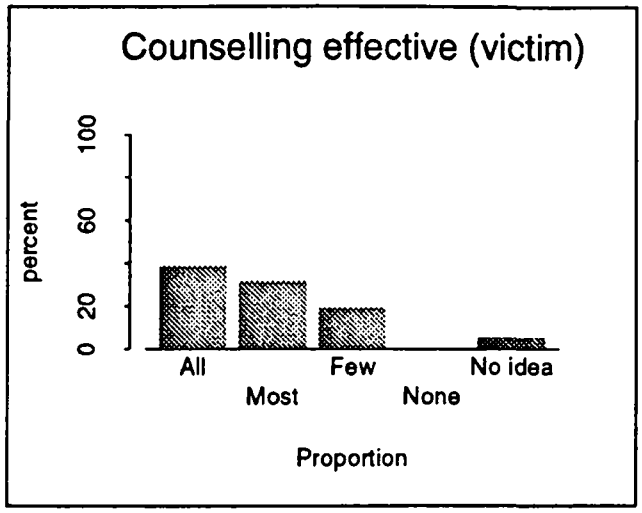
12.6 Beliefs about the usefulness of counselling

Four questions asked respondents to indicate their beliefs about the usefulness of counselling for both victims and perpetrators of spouse abuse. Two asked whether counselling was **worthwhile**, and the other two asked for an estimate of the proportion of victims and perpetrators respectively that would benefit from counselling. The proportions ranged from **all** to **none** with an additional category of **no idea at all**.

Victims

Over 90% of respondents who answered this question did so in the affirmative, with only 2 respondents **unsure**. None indicated that counselling was **not worthwhile**.

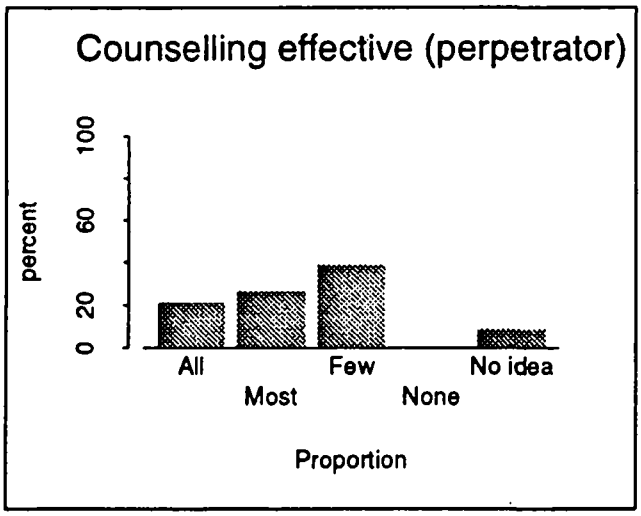
Just under 40% of respondents answering the next question felt that **all victims** would benefit from counselling, and more than 30% felt that **most victims** would benefit. Just under 20% indicated that **some victims** would benefit from counselling, and there were none who felt that **no victims** would benefit.



Perpetrators

Well over 80% of respondents who answered this question replied that it was **worthwhile** to counsel perpetrators, with only 4 respondents **unsure**. Only 1 indicated that counselling was **not worthwhile**.

20% of respondents answering the next question felt that **all perpetrators** would benefit from counselling, and over one quarter felt that **most perpetrators** would benefit. Almost 40% indicated that **some perpetrators** would benefit from counselling, and there were none who felt that **no perpetrators** would benefit.

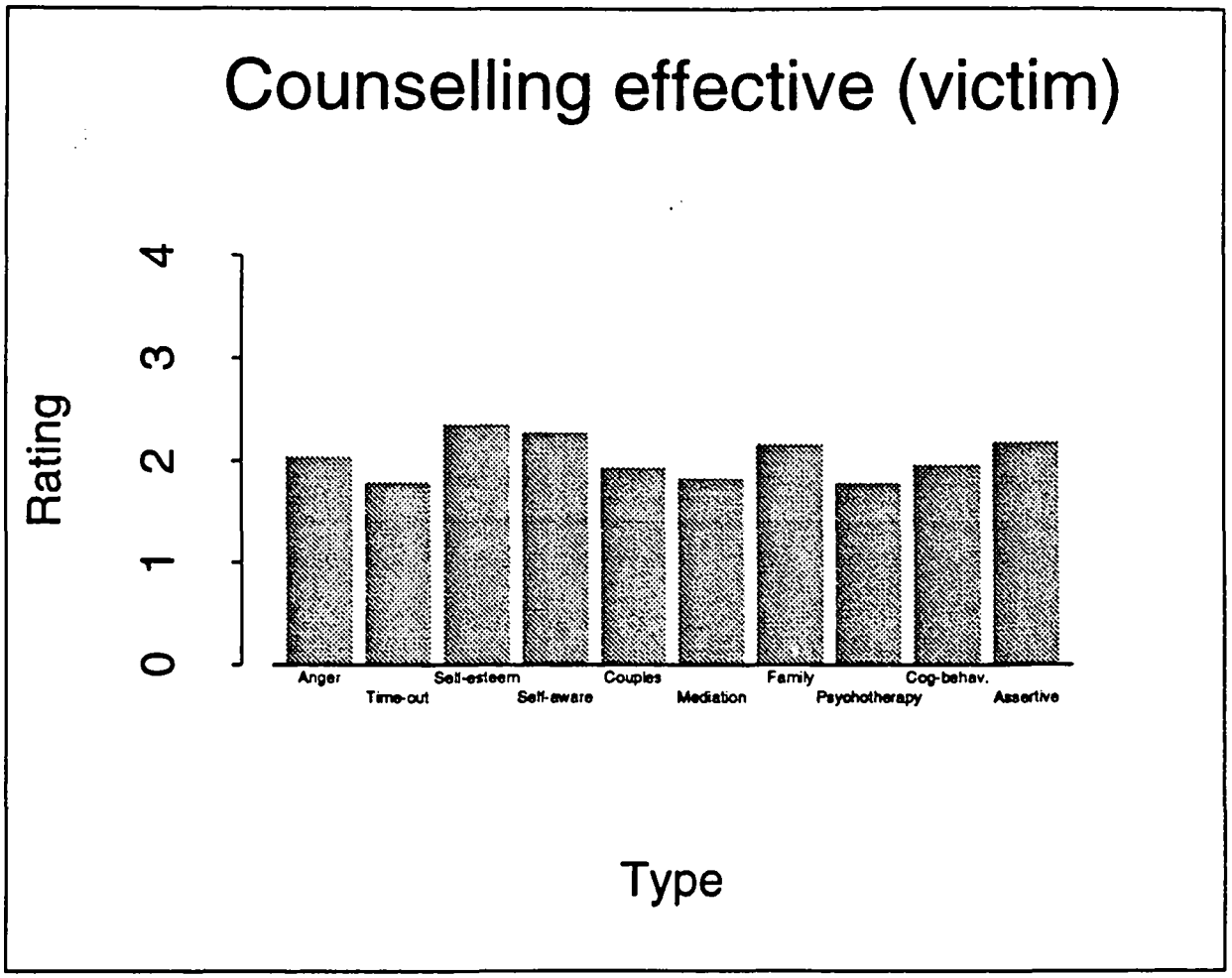


12.7 Effectiveness of types of counselling

Two questions of ten parts each sought the respondent's opinion of the effectiveness of different types of counselling for **most** victims and perpetrators of spouse abuse respectively. Respondents were asked to mark one of four categories ranging from **Very effective** to **Not at all effective**, or a fifth category labelled **Don't know**.

Victims

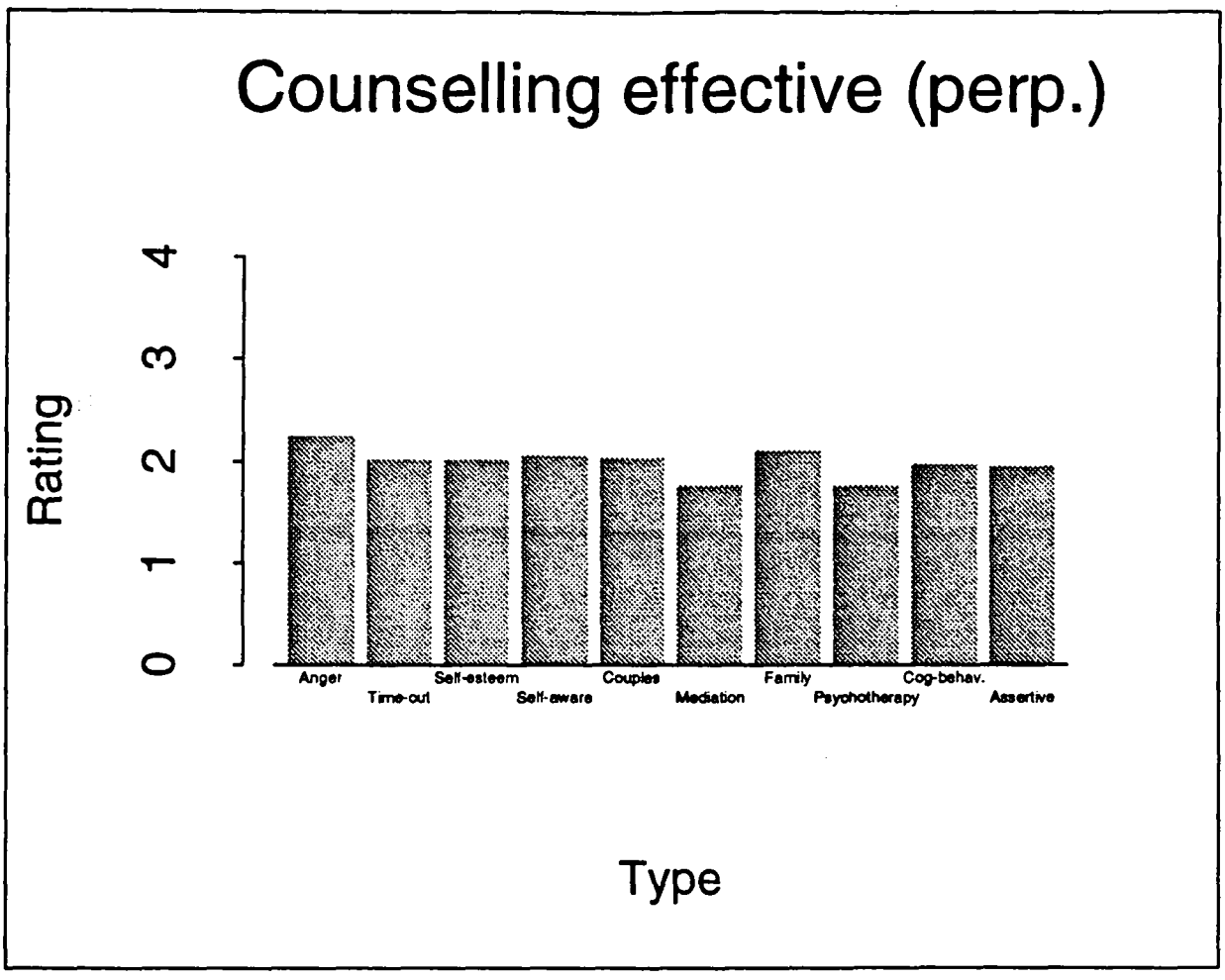
Self-esteem and **self-awareness** classes were felt to be the most effective types of counselling for the victims of spouse abuse, while **time-out** and **psychotherapy** were judged as least effective. There was not a great deal of difference in mean ratings between the types of therapy judged most effective and those judged least effective.



Anger - Anger management
Self esteem - Self esteem classes
Couples - Couples counselling
Cog-behav. - Cognitive behavioural therapy
Time-out - Time-out strategies
Self-aware - Self-awareness classes
Family - Family therapy
Assertive - Assertiveness training

Perpetrators

Anger management and **family therapy** were felt to be the most effective types of counselling for perpetrators of spouse abuse. **Mediation** and **psychotherapy** were judged to be the least effective. Again, there were not large differences in the mean ratings of effectiveness for different therapies.

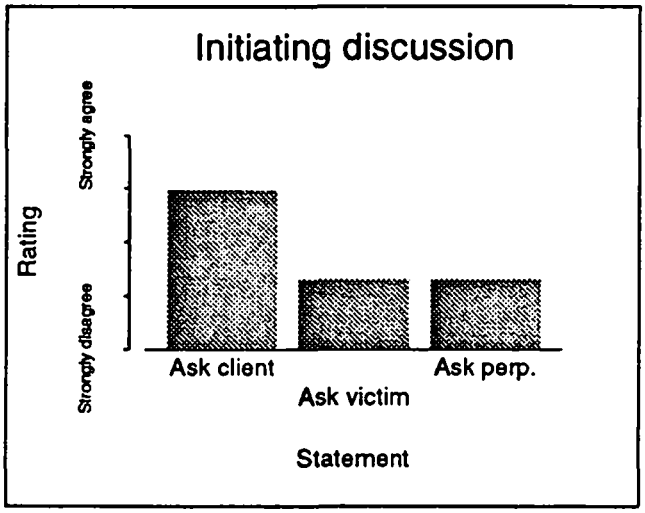


Anger - Anger management
Self esteem - Self esteem classes
Couples - Couples counselling
Cog-behav. - Cognitive behavioural therapy
Time-out - Time-out strategies
Self-aware - Self-awareness classes
Family - Family therapy
Assertive - Assertiveness training

12.8 Attitudes about working with DV clients

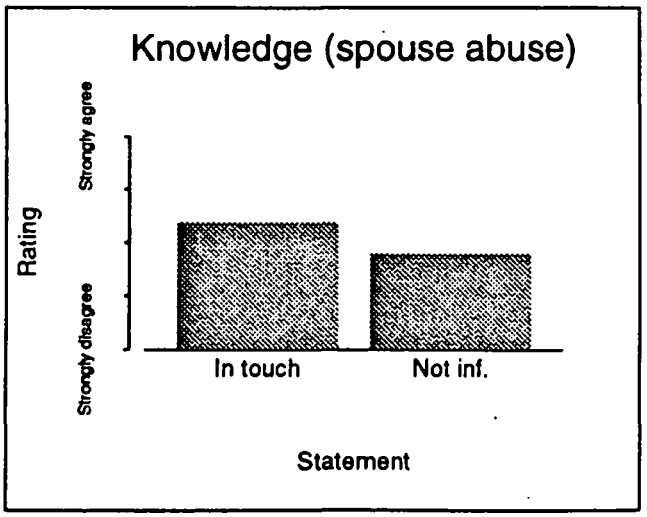
A question which included 35 statements about working with clients who were involved in spouse abuse asked respondents to indicate their level of agreement with each statement. Five response categories (**Strongly agree, Agree, Neither agree nor disagree, Disagree** and **Strongly Disagree**) scored from 1 to 5 respectively, were available. The statements related to a variety of aspects of such work, such as willingness ("I don't want to work with **victims** of spouse abuse"), client reactions ("**Clients** would resent being asked about spouse abuse") and outcomes ("I believe that counselling **victims** is effective"). These responses will be discussed in related groups.

Initiation of discussion about spouse abuse



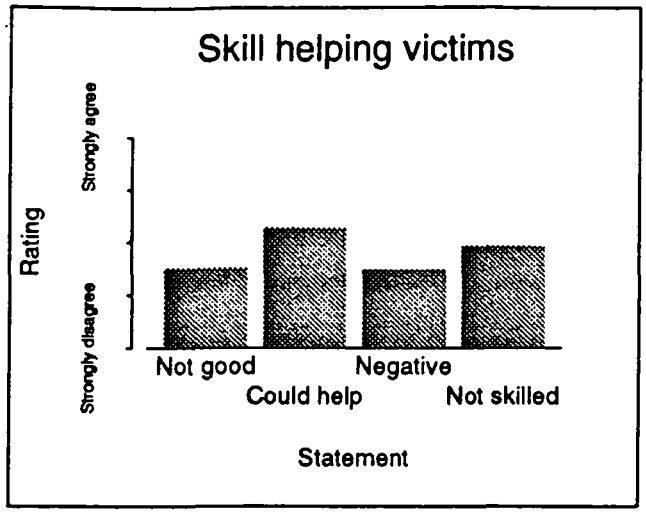
The average score for the statement "I feel that I have a responsibility to ask **clients** whether they are experiencing spouse abuse" was almost exactly equal to the **Agree** level (2.04). The statements "It's not my place to be asking clients whether they are **victims** of spouse abuse" and "It's not my place to be asking clients whether they are **perpetrators** of spouse abuse" both had an average score of just less disagreement than the **Disagree** category (3.69). Overall, then, respondents tended to agree that discussion about spouse abuse should be initiated.

Knowledge about spouse abuse



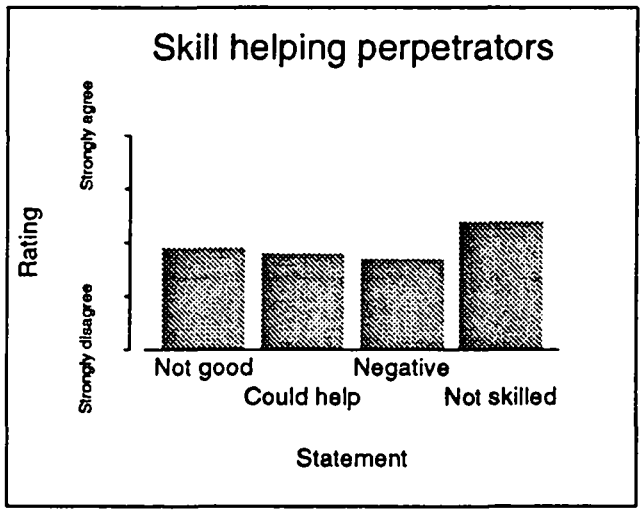
"I feel that I'm in touch with the issues of spouse abuse" received an average rating about halfway between **Agree** and **Neither agree nor disagree** (2.63), while "I'm not well informed about spouse abuse" had an average rating between **Neither agree nor disagree** and **Disagree** (3.22). Respondents showed very moderate agreement with statements indicating that they felt they were well informed about spouse abuse.

Skills in dealing with spouse abuse victims



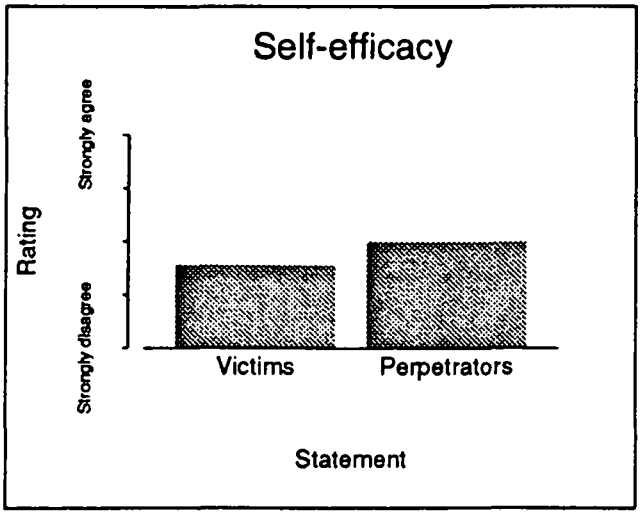
"I wouldn't be particularly good at helping victims of spouse abuse" had an average rating exactly halfway between **Neither agree nor disagree** and **Disagree** (3.5). "I feel that I can adequately assess and advise victims of spouse abuse" was rated between **Agree** and **Neither agree nor disagree** (2.72). "I feel quite negative about my ability to work with victims" was rated halfway between **Neither agree nor disagree** and **Disagree** (3.52). Finally, "I am not skilled in techniques for helping victims of spouse abuse" received an average rating almost equal to **Neither agree nor disagree** (3.07). Overall, respondents showed a modest positive assessment of their skills in dealing with **victims**.

Skills in dealing with spouse abuse perpetrators



"I wouldn't be particularly good at helping perpetrators of spouse abuse" had an average rating about equal to **Neither agree nor disagree** and **Disagree** (3.09). "I feel that I can adequately assess and advise perpetrators of spouse abuse" was rated below **Neither agree nor disagree** (3.2). "I feel quite negative about my ability to work with perpetrators" was again rated below **Neither agree nor disagree** (3.3). Finally, "I am not skilled in techniques for helping perpetrators of spouse abuse" received an average rating between **Agree** and **Neither agree nor disagree** (2.61). Overall, respondents were less positive about their skills in dealing with **perpetrators**.

Self-efficacy in dealing with spouse abuse

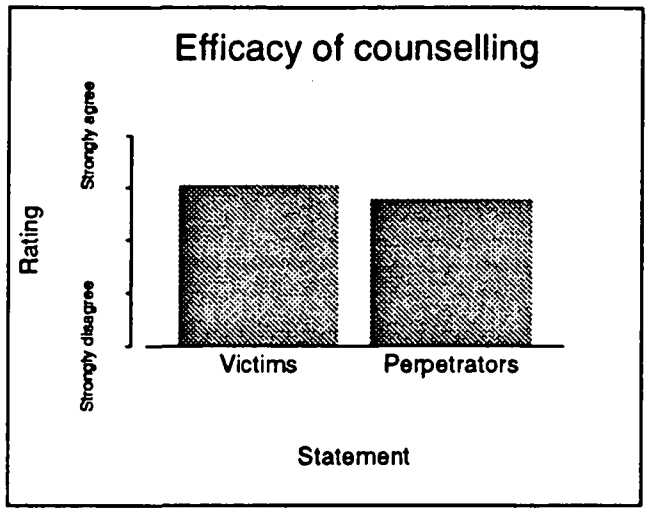


"I feel so powerless when I work with victims" was rated between **Neither agree nor disagree** and **Disagree** (3.44), while "I feel so powerless when I work with perpetrators" was rated at exactly **Neither**

agree nor disagree (3.0). In self-efficacy as well as skills, respondents were less confident with **perpetrators.**

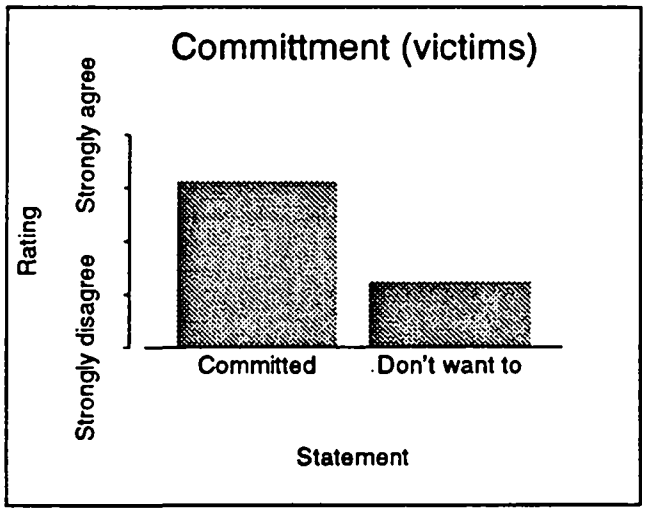
The efficacy of counselling in spouse abuse

"I believe that counselling **victims** is effective" received an average rating just above **Agree** (1.96). "I believe that counselling **perpetrators** is effective" received an average rating just below **Agree** (2.24). Respondents tended to be less confident about the efficacy of counselling **perpetrators.**



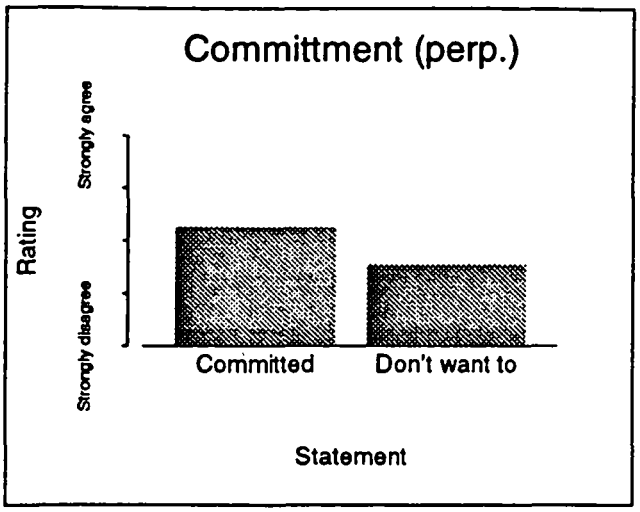
Expressed committment to working with victims

"I am committed to assisting **victims** of spouse abuse" was rated above **Agree** (1.89), the highest average agreement rating on this question. "I don't want to work with **victims** of spouse abuse" was rated close to **Disagree** (3.78), the highest average disagreement rating. Respondents showed a strong committment overall to working with **victims.**



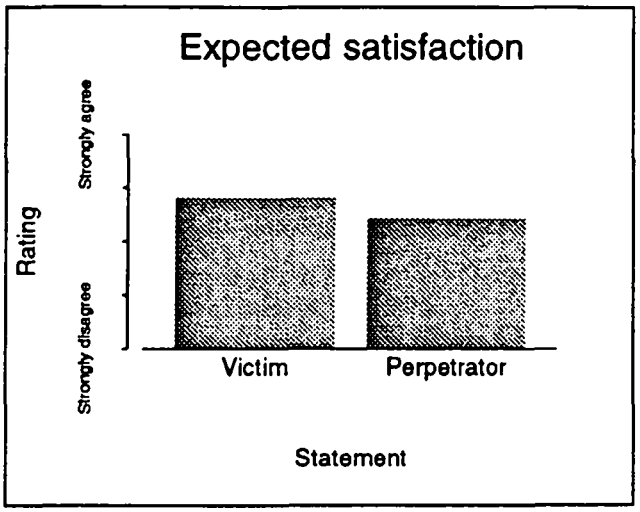
Expressed committment to working with perpetrators

"I am committed to assisting **perpetrators** of spouse abuse" was rated near **Neither agree nor disagree** (2.74). "I don't want to work with **perpetrators** of domestic abuse" was rated between **Neither agree nor disagree** and **Disagree** (3.44). The overall committment to working with **perpetrators** was substantially less than that with **victims**.



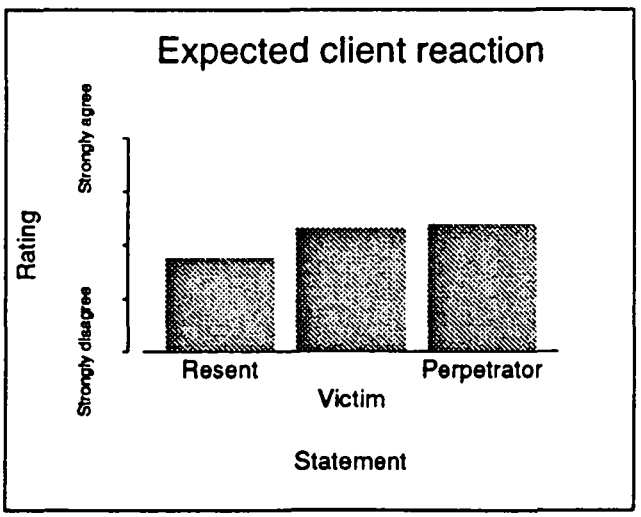
Perceived/expected satisfaction with working on spouse abuse

"It is/would be rewarding to work with **victims** of spouse abuse" received an average rating just less than the **Agree** category (2.19), while "It is/would be rewarding to work with **perpetrators** of spouse abuse" was rated between the **Agree** and **Neither agree nor disagree** categories (2.57). Respondents tended to perceive/expect slightly less reward for working with **perpetrators**.

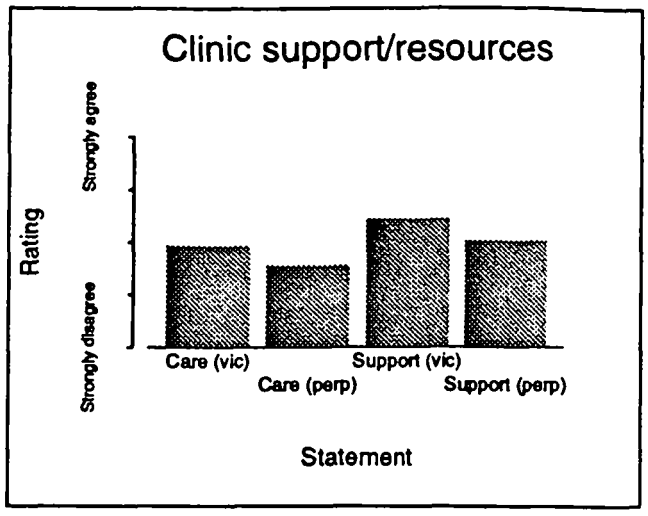


Expected reactions of clients to inquiry and intervention

"**Clients** would resent being asked about spouse abuse" was disagreed with just more than the **Neither agree nor disagree** category (3.24). "There could be a risk of court proceedings if I identify a **client** as a **victim**" was rated between the **Agree** and **Neither agree nor disagree** categories (2.69), as was "There could be a risk of court proceedings if I identify a **client** as a **perpetrator**" (2.61). While there was mild disagreement with client resentment for inquiry, there was some apprehension about retributive legal action for intervention.

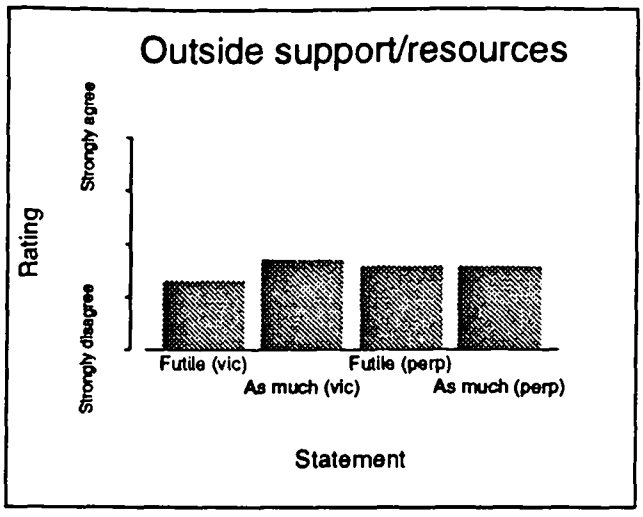


Resources and support within the clinic



"There are sufficient resources within the clinic to provide the care and support needed by victims" was rated almost equal to **Neither agree nor disagree** (3.07), while "There are sufficient resources within the clinic to provide the care and support needed by perpetrators" was rated well below **Neither agree nor disagree** (3.45). "I am well supported at my clinic when dealing with victims of spouse abuse" was rated between the **Agree** and **Neither agree nor disagree** categories (2.56), while "I am well supported at my clinic when dealing with perpetrators of spouse abuse" received a somewhat lower rating (2.98). Resources and support for **perpetrators** was seen as less available within the clinic.

Resources and support outside the clinic



"All of my efforts are futile when it comes to enlisting outside help for **victims**" was rated well below **Neither agree nor disagree** (3.69). "The number of agencies and services in this area enables me to do as much as I would like for **victims**" also received an average rating below **Neither agree nor disagree** (3.29). "All of my efforts are futile when it comes to enlisting outside help for **perpetrators**" was again rated well below **Neither agree nor disagree** (3.41). "The number of agencies and services in this area enables me to do as much as I would like for **perpetrators**" received almost the same average rating (3.43). There was a moderate inadequacy expressed about the resources and support available outside the clinic, which was slightly more apparent for **perpetrators**.

One statement, "I'm too busy dealing with drug and alcohol problems to spend time on anything else", was not obviously related to any of the previous groups. It received an average rating halfway between **Neither agree nor disagree** and **Disagree** (3.5).

12.9 Factor analysis of attitude statements

The attitude statements were subjected to principal components analysis with orthogonal rotation of the components to discover whether any underlying general attitudes might emerge. Nine factors emerged from the analysis, of which five had relatively straighforward interpretations. The factor analysis was rerun, retaining only the first five factors.

Self-efficacy/willingness to initiate

The first factor had a substantial contribution from fourteen of the responses, including those from statements such as "I don't want to work with victims/perpetrators...", "I feel so powerless when I work with victims/perpetrators", "It's not my place to be asking clients whether they are victims/perpetrators...", "I wouldn't be particularly good at helping...", "I feel quite negative about my ability...", "All my efforts are futile...enlisting outside help...". Numerically high scores on this factor indicated high perceived self-efficacy and willingness to initiate work on spouse abuse.

Diagnostic skills/support

The second factor had a substantial contribution from eight of the responses, including "I feel that I can adequately assess and advise...", "There are sufficient resources at the clinic...", "I am well supported at my clinic..." and "The...agencies and services...enable me to do as much as I would like...". Numerically low scores on this factor indicated high perceived diagnostic skills, knowledge and support.

Helping skills/knowledge

Four responses had a substantial contribution to this factor, including "I feel that I am in touch with the issues...", "I'm not well informed...", "I am not skilled in techniques for helping victims/perpetrators...". Numerically high scores indicated higher confidence in the respondent's helping skills and knowledge.

Committment to help perpetrators

The responses to three statements were important in this factor. The statements were: "It would be rewarding to work with perpetrators...", "I am committed to assisting perpetrators..." and "I believe that counselling perpetrators is effective". Numerically low scores indicated a higher committment to helping **perpetrators**.

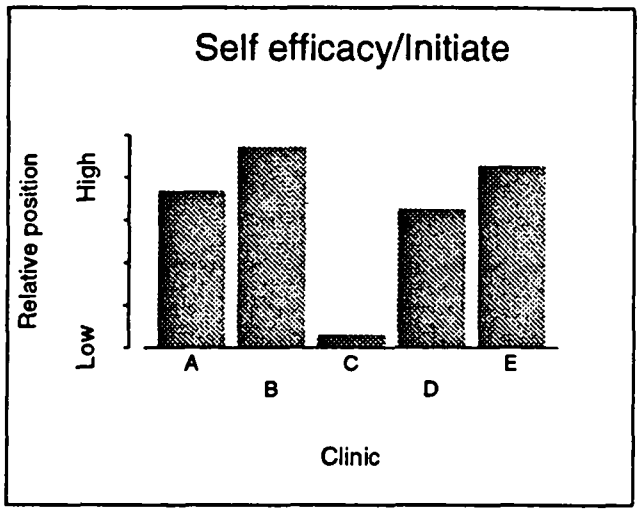
Committment to help victims

The greatest contribution to this factor was from the following; "I feel that I have a responsiblity to ask clients whether they are experiencing spouse abuse", "I am committed to assisting victims..." and "It is/would be rewarding to work with victims...". Numerically low scores indicated a high committment to helping **victims**.

12.10 Comparison of clinics on attitude scores

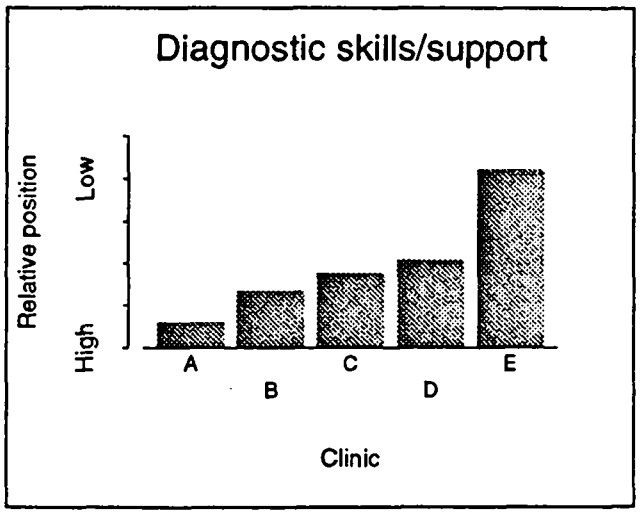
Self-efficacy/willingness to initiate

The most obvious difference on this factor is the relatively low mean score for the Clinic C. This is interpreted as a low perceived self-efficacy in dealing with spouse abuse, and a relative reluctance to initiate discussion of the issue with clients.



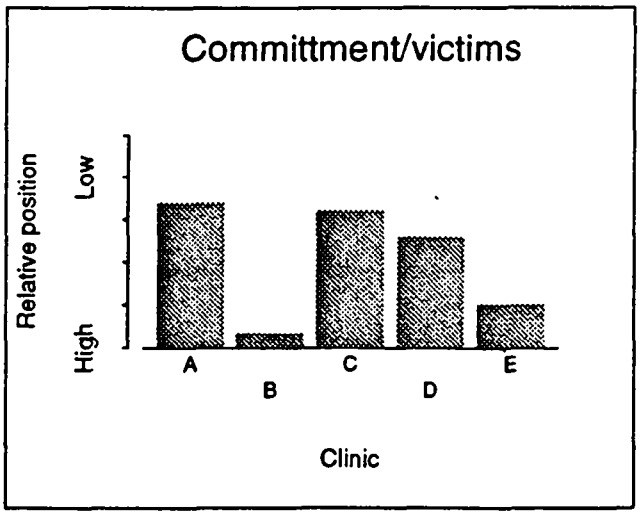
Diagnostic skills/knowledge/clinic support

Notable here is the high level of perceived diagnostic skills, knowledge and clinic support at the clinic A, and the low level of this perception at clinic E.



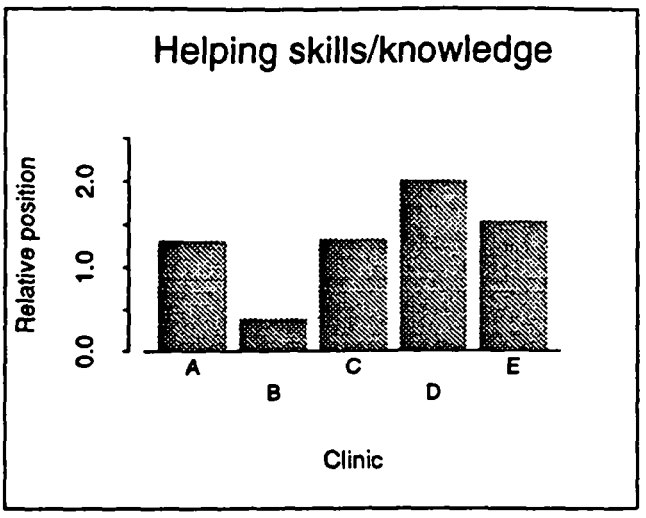
Committment to help victims

Here, clinics B and E had mean scores indicating that their expressed committment to help victims was relatively strong.



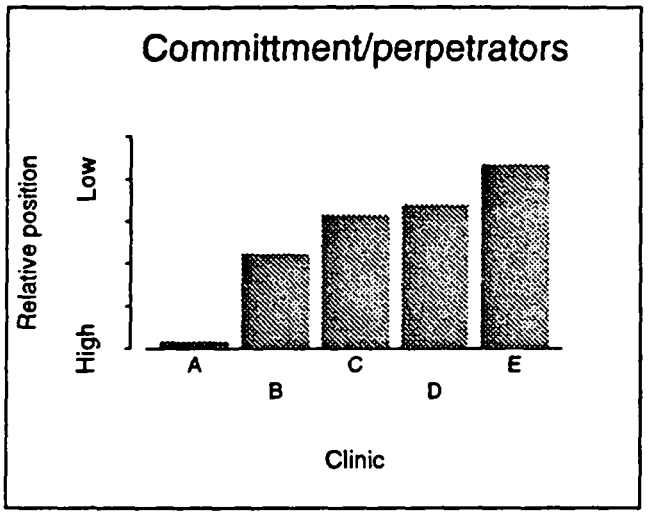
Helping skills/knowledge

Again, the mean score for clinic B indicated that there was a perception of good helping skills and adequate knowledge at that clinic.



Committment to help perpetrators

Clinic A stood out here with a high expressed committment to help perpetrators, compared to the other clinics.



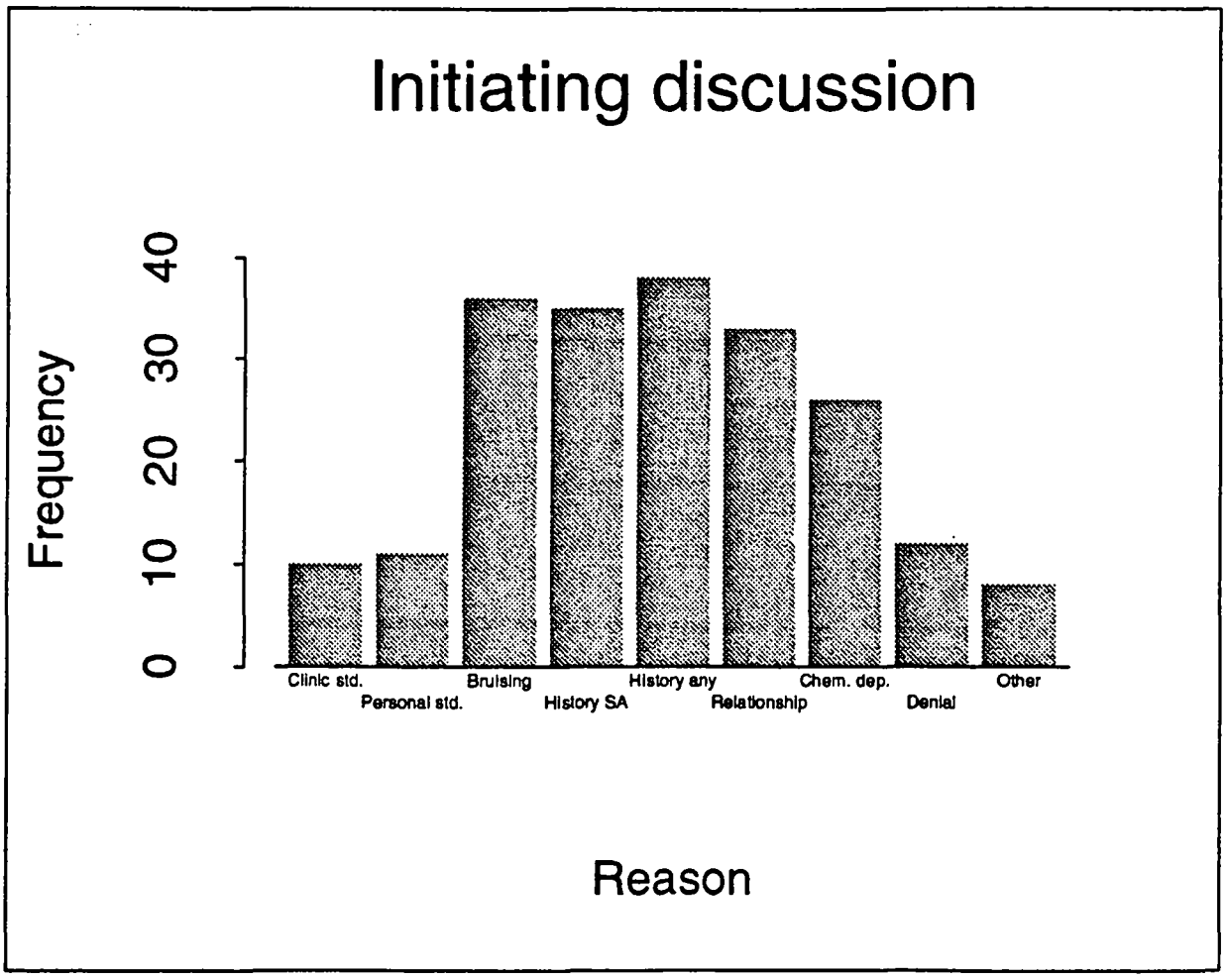
12.11 Detection procedures for spouse abuse

Nineteen questions dealt with the way in which the respondent discovered, and elicited and recorded information about, spouse abuse. The first eleven questions related to **victims**, while the latter eight related to **perpetrators**.

Victims

Initiation of discussion about spouse abuse: Respondents estimated that they initiated discussion of spouse abuse with just over one quarter (26.5%) of their clients. They estimated that just over one fifth (21.9%) of their clients initiated discussion of spouse abuse.

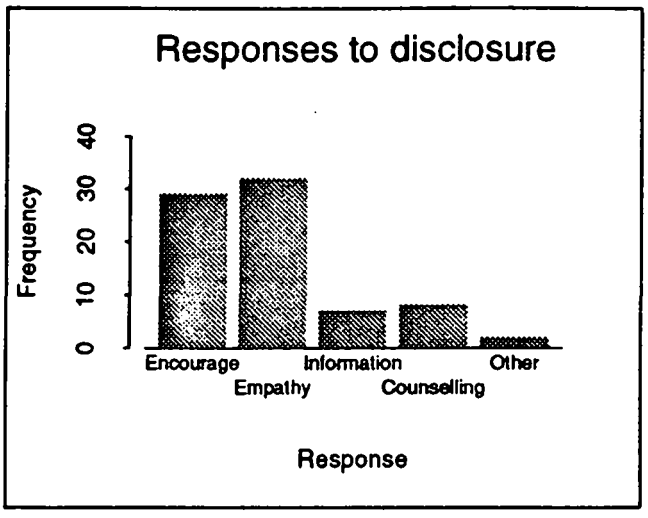
The most frequently cited reason for initiating discussion was a **history of any abuse** for the client, followed by **bruising and/or injuries**. About one fifth of the respondents answering the question included **denial of spouse abuse prior to being asked**.



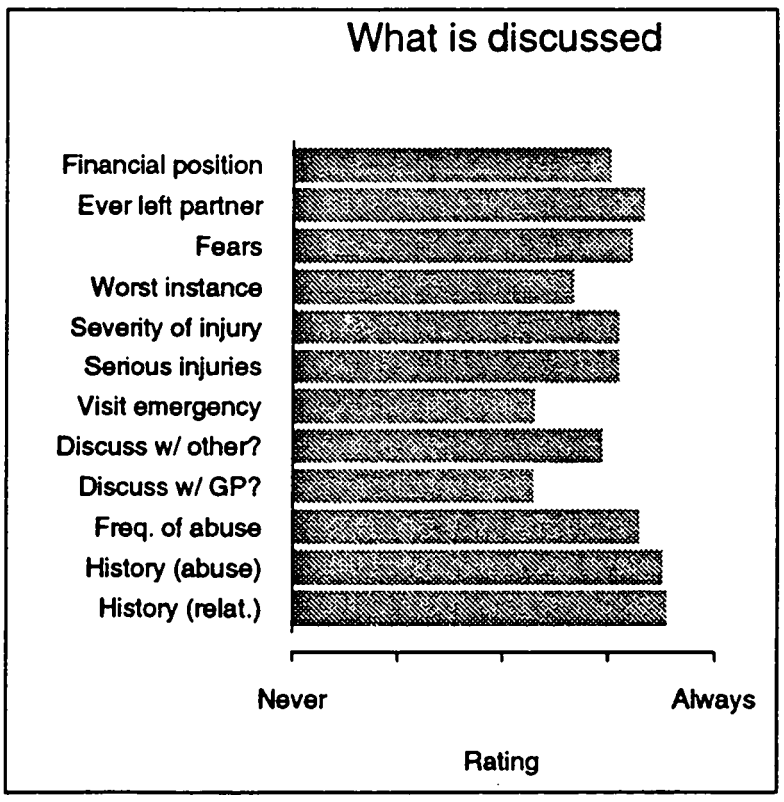
Clinic std. - Standard question in clinic's assessment
Pers. std. - Standard question in [respondent's] assessment
History SA - Client has a history of spouse abuse
Chem. dep. - Client's partner is chemically dependent

Contact with victims: 87% of the 52 respondents answering this question had come into contact with a client who was a victim of spouse abuse.

Responses to disclosure of spouse abuse: Respondents were asked to list up to five of their responses to the disclosure of spouse abuse. The most common response to disclosure by the 39 respondents was to **give empathy/support**, followed closely by **encouraging further disclosure**. Less frequent were **give information/resource material** and **counselling or referral**. Respondents were also asked to indicate the extent of encouragement they gave to continue discussion on five categories ranging from **Strongly encourage** to **Strongly discourage**. Almost half of respondents answering the question indicated that they **Strongly encouraged** further discussion, with almost 40% **Encouraging**. No respondents indicated that they **Discouraged** further discussion.



Questions asked in response to disclosure: Eighteen different queries were listed which might be asked in the discussion of spouse abuse. Respondents were asked to indicate the frequency with which they asked for such information by selecting one of five categories ranging from **Always** to **Never**. **History of the relationship** and **Possibility of counselling** were rated as the most frequent queries, while **Whether abuse discussed with GP** and **Number of visits to emergency department** were rated as the least frequent.

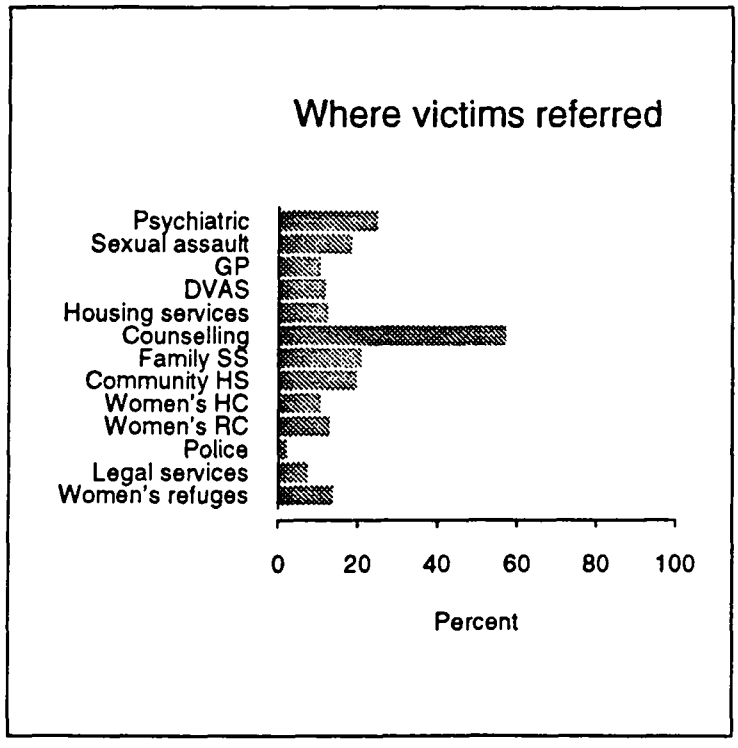


Twenty four of the 49 respondents completing these items indicated that they addressed issues with victims which were not on the previous list. By far the most common of these was **History of previous relationship**.

Recording of details of assessment: Just under half (44%) of the 49 respondents answering this question indicated that they recorded details of their assessment of victims. About half of these recorded details in their **intake assessment**, while over 80% recorded details in their **progress notes**. Only one respondent indicated that details were recorded elsewhere, and this was not specified.

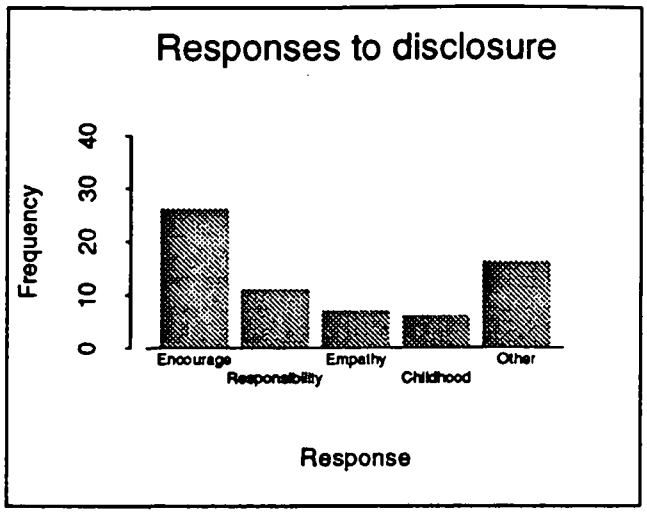
Discussion of the victim's situation with other staff: All but one of the 50 respondents answering this question replied in the affirmative. Two thirds of these discussed the situation in **case conferences**, under half in **informal discussions**, and under one third did so during **clinical supervision**. 40% indicated that discussion took place in situation other than those listed, of which **at handover of shift** was the most common, with a few instances of **team/staff meetings**.

Referral of victims: Respondents were asked to estimate the percentage of victims they referred to each of a list of thirteen agencies or services. The most common referral service for victims was **Counselling**, with **psychiatrist/psychologist** referrals half as frequent. **Police** and **Legal services** were the least common referrals. Only three respondents out of the 37 giving estimates replied that they did not refer victims.

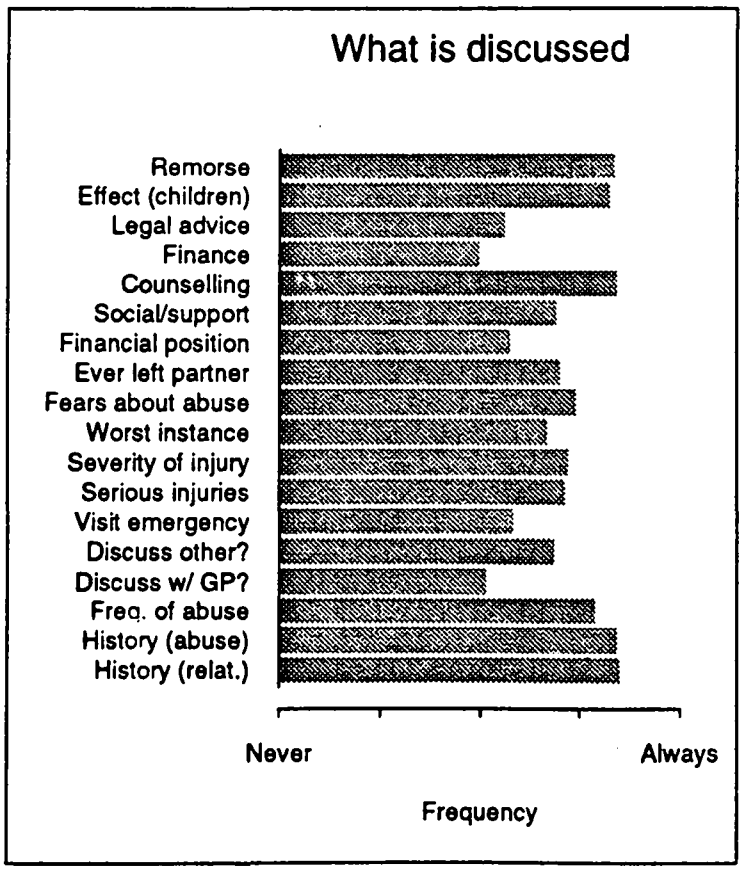


Perpetrators

About three quarters of the 53 respondents who answered this question had come into contact with a client who was a **perpetrator** of spouse abuse.



Responses to disclosure of spouse abuse: Respondents were asked to list up to five of their responses to the disclosure of spouse abuse. The most common response to disclosure by the 38 respondents was to **elicit facts/encourage discussion**, followed by **encourage responsibility for change**. Less frequent were **empathy** and **asking about childhood**. Respondents were also asked to indicate the extent of encouragement they gave to continue discussion on five categories ranging from **Strongly encourage** to **Strongly discourage**. Almost half of the 43 respondents answering the question indicated that they **Strongly encouraged** further discussion, with under one third **Encouraging**. Three selected **Neither encourage nor discourage**, and one respondent indicated that they **Strongly discouraged** further discussion.



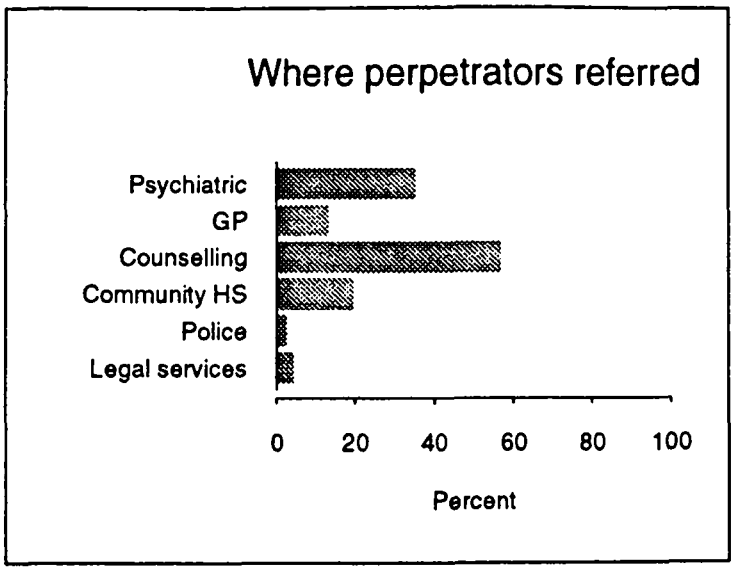
Questions asked in response to disclosure: Eighteen different queries were listed which might be asked in the discussion of spouse abuse. Respondents were asked to indicate the frequency with which they asked for such information by selecting one of five categories ranging from **Always** to **Never**. 41 respondents completed this section. **History of the relationship, history of the abuse** and **possibility of counselling** were rated as the most frequent queries, while **Requirement for finance** and **Discussion with GP** were rated as the least frequent. **Number of times partner visited emergency department** was also infrequent, consistent with the ratings for victims. Nineteen respondents reported discussing issues which were not listed, with **childhood history** and **Drug/alcohol**

history/consumption accounting for almost all such responses.

Recording of details of assessment: Over half of the 42 respondents who answered this question indicated that they recorded details of their assessment of perpetrators. Practically all of these recorded details in both **intake assessments** and **progress notes**.

Discussion of the perpetrator's situation with other staff: All of the 41 respondents answering this question replied in the affirmative. Just under three quarters of these discussed the situation in **case conferences**, under half in **informal discussions**, and just over one quarter did so during **clinical supervision**. Over one third indicated that discussion took place in situation other than those listed, of which **at handover of shift** was the most common, with about half as many instances of **team/staff meetings**.

Referral of perpetrators: Respondents were asked to estimate the percentage of perpetrators they referred to each of a list of thirteen agencies or services. The most common referral service mentioned by the 32 respondents who gave at least one estimate for perpetrators was **Counselling**, with **psychiatrist/psychologist** referrals just more than half as frequent. **Police** and **Legal services**, as for victims, were the least common referrals. Only three respondents replied that they did not refer perpetrators.



Support for spouse abuse work within the clinic

Respondents were asked to indicate which forms of support were available within their clinic from a list of five, with a sixth option for others not listed. Of the 53 respondents answering this question, 20 indicated that **supervision** was available, 29 that **case conferences** were held, 39 that **other staff** were available for support, 12 that **counselling services for staff** were available, and 17 that **in-service training** was available. Only one respondent indicated that another form of support was available, and this was not specified.

Satisfaction with support: Of 49 respondents who gave a rating of satisfaction with staff support on one of five categories ranging from **Very satisfied** to **Very dissatisfied**, 4 were **Very satisfied**, 17 each were **Satisfied** and **Neither satisfied nor dissatisfied**, 6 were **Quite dissatisfied**, and 5 **Very dissatisfied**.

Suggestions for improvement: Twenty nine respondents felt that there were **improvements or additions** which might be made to staff support at their clinic, with three answering **don't know** to this question. **Training and education** was mentioned 31 times in descriptions of such improvements or additions, with **debriefing sessions** mentioned 9 times.

Information available: Respondents were asked to indicate whether one or more of eleven types of information were available in their clinic. **Community health services, Psychiatrists/psychologists** and **Women's refuges** were marked as the most frequently available, while **legal proceedings** and **legal advice centres** were the least available.

Chapter 13. DV prototypes

13.1 The development of prototypes of victims, perpetrators and couples

Three questions asked the respondents to indicate what proportion of victims before the commencement of abuse, victims after the commencement of abuse and perpetrators could be characterised by fourteen statements, such as "Have a psychiatric illness". To condense these statements into constructs relevant to individuals, the responses to these questions were subjected to a principal components analysis with varimax rotation, resulting in three factors for each type of victim, and four factors for perpetrators. These factors were interpreted as indicating beliefs about prototypical victims and perpetrators. The victim prototypes obtained were quite similar both before and after the abuse had commenced, indicating that such prototypes represent dispositional characteristics in the minds of the respondents, and are not principally effects of abuse. All further discussion of victim prototypes refers to those after the commencement of the abuse.

Interpretation of the prototypes

The prototypes have been descriptively labelled to indicate the overall interpretation of the combined characteristics. That is, the prototype (factor) which was dominated by the item "Have a psychiatric illness" has been labelled "Mad", while the prototype dominated by items indicating violent and impulsive behaviour has been labelled "Bad". The prototype principally affected by items indicating guilt, shame and fear has been labelled "Sad". The first rotated factor for perpetrators was quite distinct from the victim factors, and has been labelled "Trapped", to indicate the combination of anger, low self-esteem, uncontrolled temper and anxiety which might accompany unsatisfactory social adjustment.

Three of the prototype labels are common to both victims and perpetrators. The "Sad" victim is characterised by anxiety and low self-esteem as well as the guilt/shame/fear of loss of control and remorse that are common characteristics of the "Sad" perpetrator. "Bad" victims and perpetrators alike are characterised by enjoyment of abuse, drug abuse and impulse disorder. Finally, "Mad" victims and perpetrators have in common a strong attribution of their condition to psychiatric illness.

Construction of prototype couples

Correlations between the victim and perpetrator prototype scores suggested that there were also prototypes of couples. The observed relationships were sufficiently strong to consider two prototypical couples, labelled "Sad victim/Trapped perpetrator" ($r=0.41$, $p<.001$), and "Bad victim/Bad perpetrator" ($r=0.34$, $p=.001$). Scores for the prototypical couples were calculated by simply summing the scores of the two individual prototypes. These scores were only used to assess relationships with subject measures.

Projected usefulness of the prototypes

The prototypes are an attempt to construct meaningful composite images of those involved in domestic violence, and to ascertain the extent to which these images affect the other beliefs and behaviours of those who may encounter such individuals in their profession. Thus, if a professional has a strong prototype of, say, the "Mad" perpetrator, this may influence the way in which they deal with perpetrators of domestic violence that they encounter.

Characteristics of the prototype scores

As low scores indicated stronger agreement with the characteristics chosen, and the coefficients for the factor scores were largely positive, numerically low factor scores indicate strong prototypes.

13.2 The relationship between prototypes and subject measures

The first relationships examined were between the prototype scores and subject measures. It was initially necessary to determine whether prototypes were determined by characteristics of the respondents before assessing the extent to which they were associated with other attitude and behaviour scores. Age, educational attainment and number of years in the drug and alcohol field were suitable measures to use in regression models for predicting the prototype scores. The categorical measures (sex, country of birth, marital status, course attendance and clinic) were tested individually.

Age

No associations of prototype scores with age emerged.

Sex

There were no significant differences on prototype scores between males and females.

Country of birth

Country of birth was dichotomised to **Australia** and **Other countries**. There were no significant differences between these two categories on any of the prototype scores.

Marital status

Prototype scores were compared between those respondents who were **single**, and those who were currently, or had been, in a formalised relationship. There were no significant differences.

University

The scores of respondents who reported having completed a university course were compared with those who had not. No differences were found.

Drug and alcohol experience

The length of time that the respondents had been in the drug and alcohol field was directly related to the strength of the "Trapped" perpetrator and the "Sad victim/Trapped perpetrator" couple. This indicates that the strength of these prototypes tend to diminish with amount of

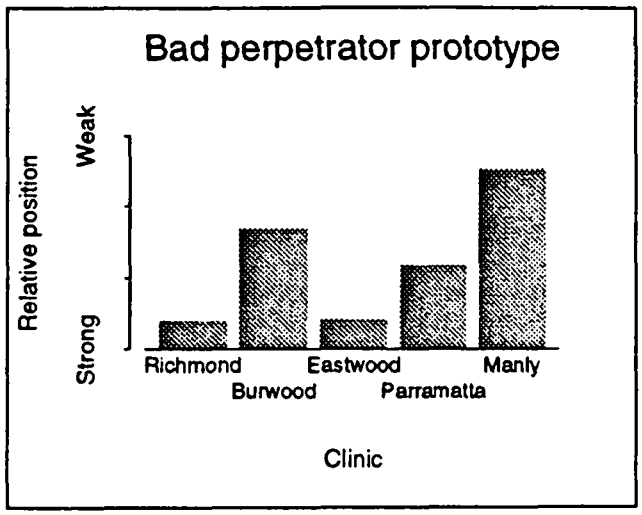
experience in the drug and alcohol field.

Attendance at courses

Respondents who had attended one or more courses apart from their formal education were compared with those who had not. No differences were found.

Clinic

The mean scores for clinics were compared against the overall mean, to determine whether any of the clinics differed significantly. The mean score for the "Bad" perpetrator by respondents at clinic E was significantly higher, indicating a significantly weaker prototype.



13.3 Prototypes and estimates of spouse abuse

Two sets of three questions sought estimates from the respondents of the percentages of individuals who were involved in three classifications of spouse abuse (physical, emotional and sexual). The first set concerned the **Australian population**, and the second set concerned **clients entering the clinic**. The first question in each set asked for estimates of the percentage of clients who were in a relationship where **both partners (Mutual violence)** inflicted the specified abuse, the second referred to clients who were **victims**, and the third referred to clients who were **perpetrators**.

Mutual violence

The estimated percentage of **Australians** who were in a relationship in which **both** partners inflicted **physical** abuse on each other tended to be higher in those respondents with a strong "Bad" victim prototype (F=6.87, p=.014). There were no relationships between prototype scores and **emotional** abuse estimates. The estimates for **sexual** abuse were directly related to the strength of the prototypes of "Sad" and "Trapped" perpetrators, and inversely related to the strength of the "Bad" perpetrator prototype, in that order (F=9.99, p=.0002). That is, those with stronger "Sad" or "Trapped" perpetrator prototypes tended to give higher estimates, and those with "Bad" perpetrator prototypes tended to give lower.

The percentage of **clients** who were in a relationship in which **both** partners inflicted **emotional** abuse was estimated to be higher by those respondents who had a strong "Trapped" perpetrator prototype (F=5.32, p=.028). There were no associations of prototype scores with estimates of **physical** or **sexual** abuse.

Victims

Separate estimates were sought for **males** and **females** on this question.

Males: The percentage of **male Australians** estimated to be victims of **physical** abuse tended to be higher if the respondent had a strong "Bad" victim prototype (F=13.49, p=.0009). The corresponding estimate for **emotional** abuse tended to be higher for those with a strong "Trapped" perpetrator prototype (F=8.68, p=.006). Estimates for **sexual** abuse tended to be higher in those with a strong "Trapped" perpetrator prototype (F=6.28, p=.018).

The percentage of **male clients** who were victims of **physical** abuse was estimated to be higher by those respondents with a strong "Bad" victim prototype (F=5.12, p=.031). The estimates of **male clients** who were victims of **emotional** abuse were larger for those respondents with strong "Trapped" perpetrator prototypes (F=6.43, p=.015). There were no associations between prototype scores and the estimates for **sexual** abuse of male clients.

Females: Estimates of the percentage of **female Australians** who were victims of **physical** abuse tended to be higher in those with strong "Sad" victim prototypes, and lower in those

with strong "Trapped" perpetrator prototypes (F=4.96, p=.013). There were no relationships of prototype scores with estimates of **emotional** or **sexual** abuse.

The percentage of **female clients** who were victims of **physical** abuse was estimated to be higher by those respondents with a strong "Bad" victim prototype (F=5.66, p=.02). The estimates of **female clients** who were victims of **emotional** abuse were larger for those respondents with strong "Trapped" perpetrator prototypes (F=8.42, p=.006). The estimates for **sexual** abuse of **female clients** were lower for those respondents with a strong "Mad" perpetrator prototype (F=4.89, p=.034).

Perpetrators

Separate estimates were again sought for **males** and **females** on this question.

Males: There were no relationships of prototype scores to estimates of **male Australians** inflicting **physical, emotional** or **sexual** abuse.

The percentage of **male clients** who were perpetrators of **sexual** abuse was estimated to be lower by those respondents with a strong "Mad" perpetrator prototype (F=4.42, p=.044). There were no other associations of prototypes with **male** perpetrator estimates.

Females: Estimates of the percentage of **female Australians** inflicting **physical** abuse tended to be higher in those with strong "Bad" victim prototypes (F=11.18, p=.002). Estimates for both **emotional** (F=9.74, p=.004) and **sexual** (F=9.2, p=.005) abuse tended to be higher in those with strong "Trapped" perpetrator prototypes.

The percentage of **female clients** who were perpetrators of **emotional** abuse was estimated to be higher by those respondents with a strong "Trapped" perpetrator prototype (F=5.28, p=.028). No associations of prototypes with estimates of **physical** or **sexual** abuse were found.

13.4 Prototypes and the provision of services for clients

Two questions asked staff to indicate their agreement with the provision of seven domestic violence related services to clients. The first question related to victims of spouse abuse, and the second to perpetrators. For each of the fourteen answers, regression models were computed, using the scores for prototype individuals and those for prototype couples as possible predictors. For the first seven answers, the prototypes of the three types of victims after the commencement of abuse were used, while for the second seven answers, the four scores of the prototype perpetrators were used.

Victims

The seven types of roles that might be suitable for D&A clinics are discussed separately.

Screen to identify victims: Agreement with providing **routine screening** was inversely related to the extent to which victims were characterised as "Bad", and directly related to the extent to which they were classified as "Sad" ($F=8.83$, $p=.0005$). That is, respondents appeared to be more reluctant to agree with the provision of routine screening to the extent that they had a strong "Bad victim" prototype, and more willing to agree to the extent that they had a strong "Sad victim" prototype.

Counselling within the clinic: Agreement with providing **counselling within the clinic** was inversely related to the strength of the "Bad" victim prototype ($F=4.38$, $p=.041$). Respondents were less willing to see this service as suitable for a D&A clinic to the extent that they had a strong "Bad" victim prototype.

Discuss all options with victims: Agreement with **discussing all options with victims** was also inversely related to the strength of the "Bad" victim prototype ($F=6.56$, $p=.013$). Respondents were less willing to see this service as suitable for a D&A clinic to the extent that they had a strong "Bad" victim prototype.

Call in specialists for victims: Agreement with **calling in specialists** was not significantly related to any of the prototype scores.

Outpatient service: There were no associations of prototype scores with the level of agreement to provision of **outpatient services for victims**.

Provide referrals to other agencies: Agreement with **providing referrals** was again inversely related to the strength of the "Bad" victim prototype ($F=5.98$, $p=.018$). Respondents were less willing to see this service as suitable for a D&A clinic to the extent that they had a strong "Bad" victim prototype.

Provide referrals to legal services: There were no associations of prototype scores with the level of agreement to provide **referrals to legal services**.

Perpetrators

The seven types of roles that might be suitable for D&A clinics are again discussed separately.

Screen to identify perpetrators: Agreement with providing **routine screening** was inversely related to the extent to which perpetrators were characterised as "Bad" ($F=4.60$, $p=.037$). That is, respondents tended to be more reluctant to agree with the provision of routine screening to the extent that they had a strong "Bad" perpetrator prototype.

Counselling within the clinic: Agreement with providing **counselling within the clinic** was again inversely related to the strength of the "Bad perpetrator" prototype, and directly related to the strength of the "Trapped" perpetrator prototype ($F=5.13$, $p=.009$). Respondents tended to be less willing to see this service as suitable for a D&A clinic to the extent that they had a strong "Bad perpetrator" prototype, and more agreeable to the provision of such a service to the extent that they had a strong "Trapped" perpetrator couple prototype.

Discuss all options with perpetrators: Agreement with **discussing all options with perpetrators** was also inversely related to the strength of the "Bad perpetrator" prototype ($F=12.67$, $p=.0008$). Respondents tended to be less willing to see this service as suitable for a D&A clinic to the extent that they had a strong "Bad perpetrator" prototype.

Call in specialists for perpetrators: Agreement with **calling in specialists** showed no significant relationship to any of the prototype scores.

Outpatient service: There were no associations of prototype scores with the level of agreement to provision of **outpatient services for victims**.

Provide referrals to other agencies: Agreement with **providing referrals** was again inversely related to the strength of the "Bad perpetrator" prototype ($F=20.11$, $p=.0000$). Respondents tended to be less willing to see this service as suitable for a D&A clinic to the extent that they had a strong "Bad perpetrator" prototype.

Provide referrals to legal services: Agreement to provide **referrals to legal services** for perpetrators was not related to any prototype scores.

13.5 Prototypes and barriers to the provision of services

The associations between prototypes and indicated barriers to the provision of services were more complex, but formed two groups, one related to the "Bad" prototypes, and one to the "Sad" and "Trapped" prototypes.

Agreement that **Lack of knowledge/skills** (F=4.4, p=.041), **Lack of external resources/support** (F=7.03, p=.002) and **Extra demands with training/seminars** (F=6.55, p=.014) were barriers to addressing spouse abuse issues was most strongly associated with the "Sad" victim prototype score, with an additional contribution on the second barrier from the "Sad" perpetrator prototype score. These relationships were direct; stronger prototypes were related to higher agreement that the barrier was present.

In contrast, the **Issue too emotional** (F=11.73, p=.001), **Concern for staff safety** (F=10.47, p=.002) and **Possible legal complications** (F=7.79, p=.008) barriers were associated with the "Bad" victim prototype. The **Problem too complex** (F=4.90, p=.032) and **Lack of support from clinic administration** (F=9.35, p=.004) were associated with the "Bad" perpetrator prototype. These relationships were also direct, the strength of the prototype tended to predict the extent to which respondents agreed that the barrier was present.

It appears that staff with a strong "Sad" or "Sad/Trapped" prototype cite barriers relating to training and support, while staff having one or more strong "Bad" prototypes tend to cite barriers relating to difficulties or danger with the involvement. If the **Lack of support from clinic admin** is interpreted as failure to back up staff involvement in domestic violence, this becomes consistent with the general picture.

13.6 Prototypes and willingness to work with spouse abuse and satisfaction

There were no effects of prototypes on expressed willingness to work with either victims or perpetrators. However, both the "Bad" and "Sad" victim prototypes were associated with increased satisfaction in working with victims (F=5.59, p=.006). The presence of a strong "Mad" perpetrator prototype was associated with increased satisfaction in working with perpetrators (F=6.91, p=.011).

13.7 Prototypes and reported knowledge, confidence and effectiveness

The relationship between prototype scores and the respondents' self-reported knowledge, confidence and effectiveness in dealing with spouse abuse issues was examined. The seven areas of knowledge, nine areas of confidence, and nine of effectiveness were combined into three scores, each one the mean of all scores recorded for each area. All prototype scores were available for entry into the regression models for each score.

Knowledge

The strength of the "Bad" perpetrator prototype score was directly related to the respondents' estimate of their knowledge ($F=5.39$, $p=.024$). That is, respondents with a stronger "Bad" perpetrator prototype tended to have a higher estimate of their overall knowledge.

Confidence

There were no significant relationships of prototype scores to the estimates of respondent's confidence.

Effectiveness

There were no significant relationships of prototype scores to the estimates of respondent's effectiveness.

13.8 Prototypes and the efficacy of counselling

Two questions were asked about the respondents' estimates of the efficacy of counselling **victims** and **perpetrators** in terms of the proportion of each for whom counselling would be effective. There were no associations between prototype scores and the estimates.

13.9 Prototypes and attitude factors

The first five factors derived from the analysis of the responses to the 35 attitude statements had reasonably straightforward and unambiguous interpretations in terms of general attitudes toward working with those clients who were involved in domestic violence. Regression models were calculated for each of these factors, allowing any of the prototype scores to enter the equation in a stepwise method.

Efficacy/willingness to initiate

For the first attitude factor, two prototype scores entered the regression equation, the "Bad" victim and "Bad" perpetrator couple. These two had a highly significant ($F=30.09$, $p<.0001$) association with scores on this factor. The presence of a strong prototype predicted a reduced efficacy/willingness to initiate score, which is consistent with the earlier association observed between this prototype and a reduced agreement with the provision of a number of services.

Diagnostic skills/clinic support

For the second attitude factor, the "Bad perpetrator" prototype was the only one to enter the equation. There was a smaller, but still significant ($F=10.05$, $p=.002$) association with the respondent's estimation of their diagnostic skills and support at their clinic. In this case, a strong prototype was associated with more positive estimations of skills and support.

Well-informed/skilled in techniques

The third attitude factor was significantly associated with the "Sad perpetrator" prototype ($F=4.56$, $p=.036$), stronger prototype scores being associated with increased reported information and ability to help.

Committment to perpetrators

There were no signficant associations between prototype scores and scores on this attitude factor.

Committment to victims

Two of the prototype scores were associated with the **committment to victims** attitude factor scores. The first, and most important was the presence of a strong "Sad victim" prototype, which was associated with a stronger committment to victims. The second was the presence of a strong "Bad perpetrator" prototype, which was associated with a reduced committment to victims ($F=8.61$, $p=.0004$). This may at first appear counterintuitive, until the high correlations used to define prototype couples are considered. The "Sad" victim scores were most highly correlated with the "Trapped" perpetrator scores, indicating that there may be a strong discrimination by some of the respondents between types of couples. If such discrimination is between those for whom the spouse abuse is deemed to be caused by external factors (e.g. poverty, lack of social status and achievement) and those for whom spouse abuse is due to personality factors (e.g. aggresiveness, impulsiveness), it is possible that the "Bad perpetrator" best exemplifies this distinction.

Chapter 14. Discussion - Staff attitudes and behaviours

14.1 Respondent information

Demographic information

The sample contained a proportion of females which, while larger than the Australian average, was comparable to that of staff in drug and alcohol clinics. Non-Christian religious affiliations were underrepresented in the respondent sample. This probably representing selection by the clinics, 3 of which were connected with Christian religious institutions.

Clinic information

The clinics chosen for the study represent a cross-section of community types in the Sydney area, and are not concentrated in any given area. The proportions of the different positions of the respondents are comparable to those in drug and alcohol clinics in the Sydney area. Respondents had a wide range of experience in their present position, and in the drug and alcohol field.

Educational information

Respondents were generally better educated than the general population, most having completed a university course. The professional qualifications reported were unexceptional for staff in drug and alcohol clinics. Spouse abuse was not reported to be a part of the formal courses by most respondents.

14.2 Concepts of spouse abuse

Images and understanding

While the content of most of the images given was appropriate, the understanding of spouse abuse was most frequently stated as the abuse itself, rather than in terms of interpersonal relationships, or social interpretations of such behaviour.

14.3 Beliefs on prevalence of spouse abuse

Estimates of prevalence in Australia

Accuracy of estimates: Estimates of the prevalence of domestic violence vary widely, and the proportion of this which may be classified as spouse abuse makes it even more difficult to provide a basis for comparison. Estimates of the proportion of relationships in which physical violence occurs range from under 10% to almost 50%. Two surveys which provide estimates of physical violence in societies similar to Australia report that under 20% of married couples engage in such violence in the USA (Strauss and Gelles, 1986) and Canada (Kennedy and Dutton, 1989). This would indicate that the estimates given for physical violence tended to be somewhat high.

It is generally agreed that non-physical coercive behaviour (e.g. shouting, emotional manipulation) is more common than physical coercion. Therefore, the relative magnitudes of estimates for physical and emotional abuse are reasonable. The problem of defining and ascertaining the prevalence of sexual abuse makes any discussion of the accuracy of such estimates futile.

Sex differences: Females were generally estimated as more likely to suffer, and less likely to perpetrate, all types of abuse, with the possible exception of emotional abuse. This is broadly consistent with similar estimates in the literature.

Chronological pattern: The majority of respondents felt that spouse abuse increases over time, which is consistent with the educational literature.

Prevalence in different socioeconomic groups

Most of the respondents felt that there were no differences in the prevalence of spouse abuse between different socioeconomic groups. Of the minority that did, most felt that lower socioeconomic groups had a higher prevalence. From estimates in the literature, this appears to be the case for physical abuse, but less certain for the other forms of abuse.

Prevalence in different ethnic groups

In the case of differences in prevalence between ethnic groups, there was greater agreement that these were present. It is again difficult to ascertain to what extent the stated differences actually exist.

14.4 Beliefs about the antecedents and effects of spouse abuse

Victim behaviour

While there was some support for the notion that victims unconsciously contributed to abuse, the respondents generally rejected the notion of conscious provocation by victims. Similarly, there was very little agreement with the ideas that victims enjoy any aspect of abuse.

Relative responsibility

Responsibility for spouse abuse was assigned almost entirely to the perpetrator. This is consistent with the rejection of the idea that victims provoke abuse, but the almost complete absence of shared responsibility appeared to be even stronger than in the previous set of questions.

Factors important in the occurrence of spouse abuse

Alcohol/drugs was felt to be the most important factor of those listed on the questionnaire in the occurrence of spouse abuse. This is consistent with the conclusions of Lehman and Krupp (1983). **Social attitudes**, which on the questionnaire were entirely concerned with male/female relationships, were considered the next most important. **Psychological problems** were chosen as the next most important factor, followed by **family dysfunction**. **Social conditions**, which were characterised as principally unemployment/ welfare on the questionnaire, were felt to be the least important. This is consistent with the limited acceptance that spouse abuse was more prevalent in lower socioeconomic groups.

Family history

The effects of **suffering** and **witnessing** abuse as a child on the probability of an individual becoming a **victim** or **perpetrator** of spouse abuse were reported to be very similar by the respondents.

Perpetrators: Suffering abuse was almost unanimously thought to increase the probability that an individual would later become a perpetrator of spouse abuse. Of those respondents who gave an estimate, only two felt that suffering abuse did not change the probability of becoming a perpetrator. Witnessing abuse appeared to be considered almost as important, although three respondents felt that it would reduce the probability of becoming a perpetrator.

Victims: Suffering and witnessing abuse were again felt to increase the probability of an individual becoming a victim of spouse abuse. The proportions of respondents selecting the various options were almost the same as those for perpetrators. It is clear that the respondents felt that domestic violence involving children was an important factor in the development of spouse abuse in later life.

- The low rating of **family dysfunction** as such in the previous section, as opposed to witnessing and suffering abuse, seems to indicate that respondents may not have assumed that this category could include domestic violence involving children.

14.5 Beliefs about victims and perpetrators

Victims

The profiles of victims before and after the commencement of abuse were quite similar, with the major difference being an overall increase in the estimated proportions. **Low self-esteem, anxiety** and **guilt/shame** were the most important both before and after, with **very angry** joining these factors in the profile after the commencement of abuse.

All respondents felt that victims found it difficult to leave an abusive relationship. The reasons given for this fell principally into two categories, ignorance (of services/support/rights) and fear/shame (of reprisal/family disintegration). If the number of respondents citing these reasons may be taken as a measure, these two broad categories are thought to be about equally common. The significance of these reasons may be underlined by the fact that all respondents felt that spouse abuse had damaging psychological effects on the victim, with most viewing these as long-term.

There was, as expected, a strong gender differentiation, with victims believed to be female. This was especially evident in the responses to appropriate referral services, where the second most frequently selected service was **Womens' Resource Centres**.

Counselling was felt to be effective for a greater proportion of victims than perpetrators, and the most effective types of counselling were felt to involve **self-esteem** and **self-awareness**.

Perpetrators

The profile of perpetrators had many similarities to those of victims, with **low self-esteem** thought to be a characteristic of many perpetrators. However, **very angry, uncontrollable temper, emotionally disturbed, have an impulse disorder** and **enjoy the abuse** were thought to be characteristics of relatively greater proportions of perpetrators.

The reasons given for perpetrators not leaving an abusive relationship were dominated by power and control. The overall conception of an abusive relationship among the respondents appears to be one in which the perpetrator is principally concerned with maintaining control of the relationship.

As with victims, there was a gender differentiation, with perpetrators assumed to be male. When answering a direct question about female perpetrators, responses would acknowledge that female perpetrators were common, although a minority. However, in questions which did not directly mention female perpetrators, the pattern of responding indicated that the prototypical perpetrator was male.

Counselling was felt to be effective for a smaller proportion of perpetrators than victims, and the most effective types of counselling were thought to be **anger management** and **family therapy**. The emphasis for perpetrators seems to be on controlling unacceptable behaviour, rather than the personal development endorsed for victims. However, the differences between the relative effectiveness of different types of counselling were small.

Dealing with spouse abuse

There was unanimity among the respondents in the opinion that spouse abuse should be viewed as a legal matter, principally because of the violence concerned. Counselling was the most frequently mentioned alternative. It is notable that **early (school) education** was mentioned fairly often, supporting the previous interpretation that experiences in childhood are felt to be important determinants of spouse abuse. It is interesting that in the question asking the most effective way of dealing with spouse abuse, counselling/therapy methods were more common than legal, despite the fact that all respondents felt that spouse abuse should be viewed as a legal matter.

Acceptability of force on a partner

While the reasons given for legitimising the use of force on a partner were similar for both sexes, there was a somewhat larger proportion of respondents that felt it was legitimate for a woman to use force, than for a man.

14.6 Attitudes and beliefs about the clinic

Estimates of spouse abuse among clients

The estimates were close to those made by respondents for the Australian population, with the exception of slightly higher estimates for emotional abuse. All client estimates differed by less than 10% from the Australian estimates, with the largest differences occurring in the most common categories (e.g. emotional abuse). There is an obvious inconsistency in the rating of alcohol/drugs as an important factor in the occurrence of spouse abuse, and the lack of increased estimates of physical abuse among clients of drug and alcohol clinics. The estimates for physical abuse, however, were broadly consistent with those derived from the Conflict Tactics Scale. These estimates found approximately 14% of clients being **victims**, and another 13% **perpetrators**. These estimates did not show a striking difference in prevalence between the sexes, except in **mutual violence**, where the proportion of females ivolved (27%) was about half again that of males (18%).

Appropriate roles for D&A clinics

Overall, there was a high level of agreement with all of the roles suggested for clinics, with a slightly higher level of agreement for roles involving victims. The somewhat higher agreement with **counselling** and **referral for therapy** were consistent with the reported recommendations of the clinics, mainly **counselling**. This was again reinforced when compared with the suggested improvements, most of which were concerned with **staff training**.

Barriers to addressing spouse abuse

While the respondents agreed most strongly with the statement that **clinic resources** were the most important barrier to addressing spouse abuse, **lack of knowledge and skills** was second, reinforcing the interpretation that clinic staff are generally willing to address spouse abuse, but feel uncertain about their qualifications to deal with it. This is consistent with the large number of respondents indicating that all ten of the suggested areas of training were required to deal effectively with spouse abuse.

14.7 Dealing with spouse abuse

Referral for counselling was the most frequently mentioned service which was felt to be appropriate for both victims and perpetrators. This is consistent with the previous preferences for counselling as an appropriate method of dealing with spouse abuse.

Victims

By far the majority of respondents expressed a willingness to work with victims, and attributed this willingness in the main to **professional responsibility**. Over half felt that this work would be **satisfying**, and the rewards of working with victims were mainly concerned with satisfaction in seeing positive changes in the victim's condition. The negative aspects of working with victims similarly stressed the disappointment of failing to generate such positive changes.

Counselling was by far the most frequent referral reported for victims, with a number of other services occurring about one third as often.

Perpetrators

Respondents tended to express less willingness to work with perpetrators, with a small number stating some degree of unwillingness. Interestingly, the reason of **professional responsibility** was much less often mentioned, perhaps indicating the notion that professional responsibilities do not extend to the perpetrator. The most common reason, that perpetrators **need help**, may indicate that committment to help perpetrators tends to be more individually based. The positive and negative aspects of working with perpetrators were quite similar to those expressed for victims; seeing positive changes in the client were rewarding, and failing to see change was the most common negative aspect.

Counselling was also the most frequently reported referral for perpetrators, although psychiatric assessment tended to be somewhat more frequent than for victims. Perpetrators were in general considered more difficult and less rewarding to work with than victims.

14.8 Attitudes toward working with spouse abuse

The attitude factors indicated that there were considerable differences between the clinics in their overall attitudes toward working with clients involved in spouse abuse. On the **self-efficacy/willingness to initiate** factor, clinic C stood out as expressing low self efficacy and/or a reluctance to initiate discussion on spouse abuse with clients.

Clinic A had the highest perceived level of **diagnostic skills/knowledge/clinic support**, as indexed by scores on that factor, while the mean score of clinic E indicated a less optimistic perception of these areas.

In contrast, clinic A had the worst score, and clinics B and E the best, on **committment to help victims**.

There was a clear differentiation of **diagnostic skills** and **helping skills** shown in the scores for the latter, as three of the clinics (A, C and D) had mean scores which indicate that their perceived level of **helping skills/knowledge** was relatively better.

A very interesting relationship emerged between **committment to help victims** and **committment to help perpetrators**, with clinic A, which had a score indicating the least committment to victims, having a score indicating the highest committment to perpetrators. On the other hand, clinic E, which apparently had a high committment to victims, had the lowest committment to perpetrators. Clinic B showed a less dramatic change in the same direction.

14.9 Prototypes

The following table summarises the associations of prototype scores with broad aspects of the attitudes and behaviour of the respondents.

TABLE 1 - Prototypes and the attitudes and behaviours of respondents.

	"Sad" victim	"Bad" victim	"Mad" victim	"Trapped" perp.	"Sad" perp.	"Bad" perp.	"Mad" perp.
Inflicting physical		++					
Inflicting emotional				+++			
Inflicting sexual	+			++		-	
Suffering physical	+	++		-			
Suffering emotional				++			
Suffering sexual							--
Services for victims	+	----					
Services for perp.				+		----	
Lack skills/support	+						
Too emotional/staff safety/legal		+					
Problem too complex/lack admin. support						+	
Satisfaction in working/victims	+	+					
Satisfaction in working/perp.							+
Reported knowledge						+	
Efficacy/willing to initiate		-				-	
Diagnostic skills/ clinic support						+	
Informed/skilled in helping					+		
Committment to victims	+					-	

"Bad" prototypes

A number of associations in the table appear consistent. The "Bad" victim prototype is strongly associated with both inflicting and suffering physical violence. As some of these associations come from the **mutual violence** couples, where both inflict abuse, these associations are not necessarily contradictory. Both the "Bad" victim and the "Bad" perpetrator prototypes are associated with reported barriers involving staff well-being, and reluctance to initiating discussion of, intervention in, and providing additional services for, spouse abuse. It is of interest that the influence of the "Bad" victim prototype appears stronger than the "Bad" perpetrator prototype overall, and that self-reported diagnostic skills (as contrasted with helping skills) and knowledge tend to be greater in respondents holding strong "Bad" prototypes.

"Sad" prototypes

The "Sad" victim is associated with suffering physical abuse, but not to the extent of the "Bad" victim. The association with inflicting sexual abuse does not necessarily mean that the victim inflicts such abuse, but that they are likely to be in a relationship where such abuse occurs. This prototype is associated with increases in the willingness to provide services, satisfaction in working with victims and committment to victims. The "Sad" perpetrator is associated with reports of increased knowledge/skill in helping (as contrasted with diagnostic skill) from respondents.

"Mad" prototypes

The "Mad" victim prototype does not appear to affect the attitudes or behaviour of the respondents to any extent, and that of the "Mad" perpetrator only in a reduced estimate of sexual abuse, and increased satisfaction in working with perpetrators.

The "Trapped" perpetrator

This prototype is strongly associated with both inflicting and suffering emotional abuse, and to a lesser extent, sexual abuse. There is even a negative relationship with suffering physical abuse. It is the only perpetrator prototype associated with increased willingness to provide services for perpetrators. There is some evidence that the strength of this prototype tends to diminish with increasing experience in the drug and alcohol field.

Core prototype attributes

The core attributes of two of the prototypes are clear. The "Bad" prototypes share violent behaviour, alcohol/drug abuse and impulsiveness. The "Sad" prototypes share the low self-esteem, anxiety and guilt/shame/fear characteristics. It appears that the "Mad" prototypes, while reasonably well-defined, are not associated with many differences in the attitudes and behaviours surveyed. It is possible that the principal underlying attributional constructs in the respondents' typing of victims and perpetrators divide reactive personality traits (low self-esteem, anxiety, guilt/shame/fear) from active ones (aggression, impulsiveness). Thus the first group may be seen as victims of the situation, responsive to change, whereas the second group are perceived to be resistant to change, and potentially dangerous to the well-being of others.

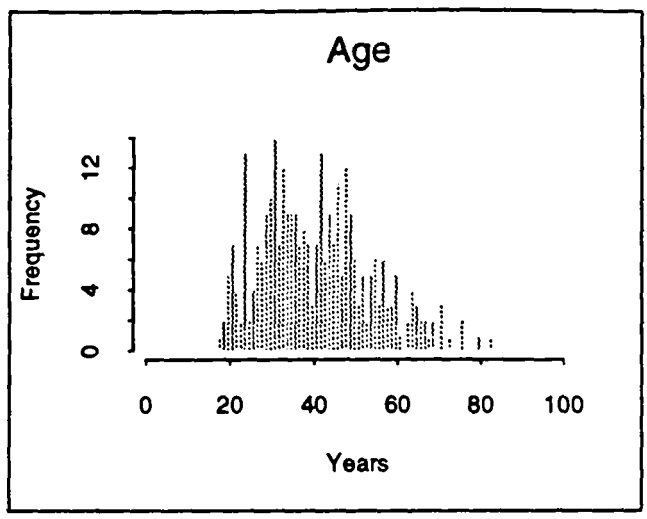
15. Detection of spouse abuse in clients

15.1 Sample validation

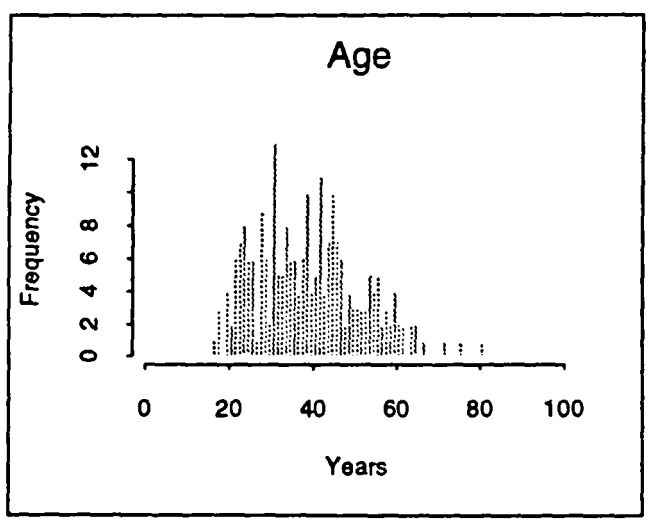
There were 312 cases available for the analysis in the initial sample, and 237 in the follow-up.

Age

Initial sample: The distribution of clients' ages for the initial sample is illustrated at the right. The mean age was just under 40 years, and ages ranged from 18 to 82.



Follow-up sample: The distribution of clients' ages for the follow-up sample is illustrated at the right. The mean age was just over 38 years, and ages ranged from 9 to 80. The distributions of age are quite similar for both samples.

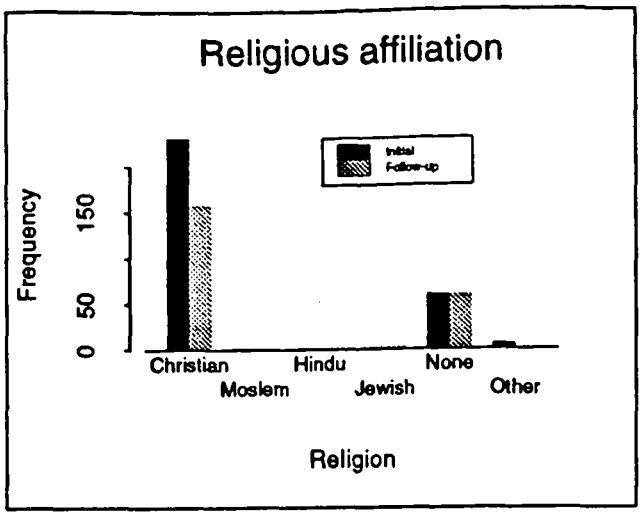


Sex

The initial sample was 65.7% male, while the follow-up sample was 67.1% male, almost the same percentage.

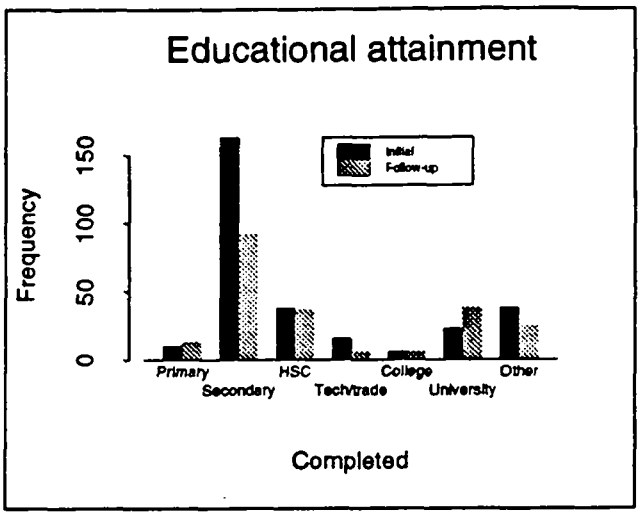
Religious affiliation

Most clients gave their religious affiliation as either Christian or None. The distributions of religious affiliation are quite similar for both samples.



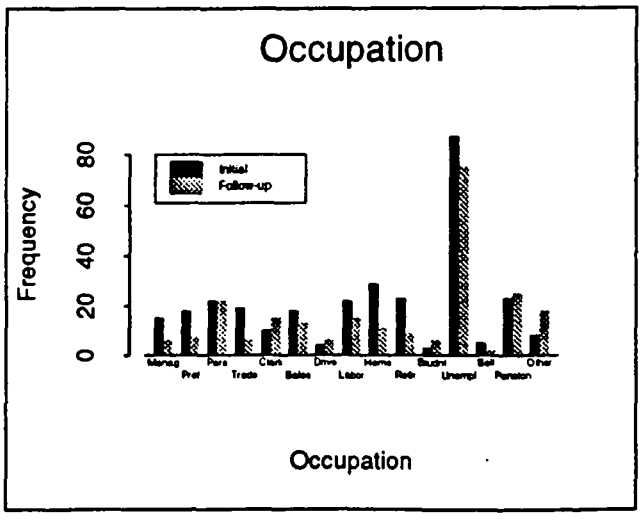
Educational attainment

The educational attainment of clients entering the clinic is illustrated at the right. There were minor differences in the proportions of clients completing various levels of education, but overall, differences between the two samples were minor.



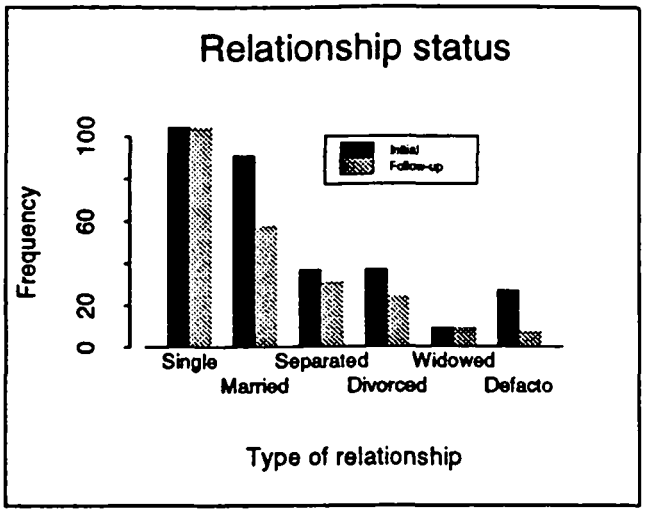
Occupation

Occupations were divided into fifteen categories, with the largest number of clients in the **unemployed** category in both samples.



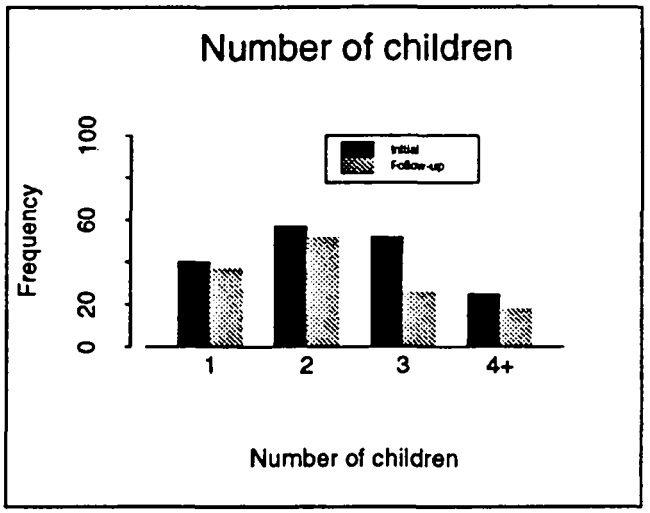
Relationship status

The most striking difference between the relationship status of the clients in the two samples was the increased proportion of those **never married** in the follow-up sample (Test of binomial proportions, p=0.024). This was consistent with the higher proportion of clients currently in an intimate relationship in the initial sample (50%), compared to the proportion in the follow-up sample (42%), although this difference was not significant.



Children

Over half of the initial sample (56%) had children, with almost the same proportion (55%) having children in the follow-up sample. Despite the apparent difference in the proportion of clients with 3 or more children, there was no significant difference between the samples.



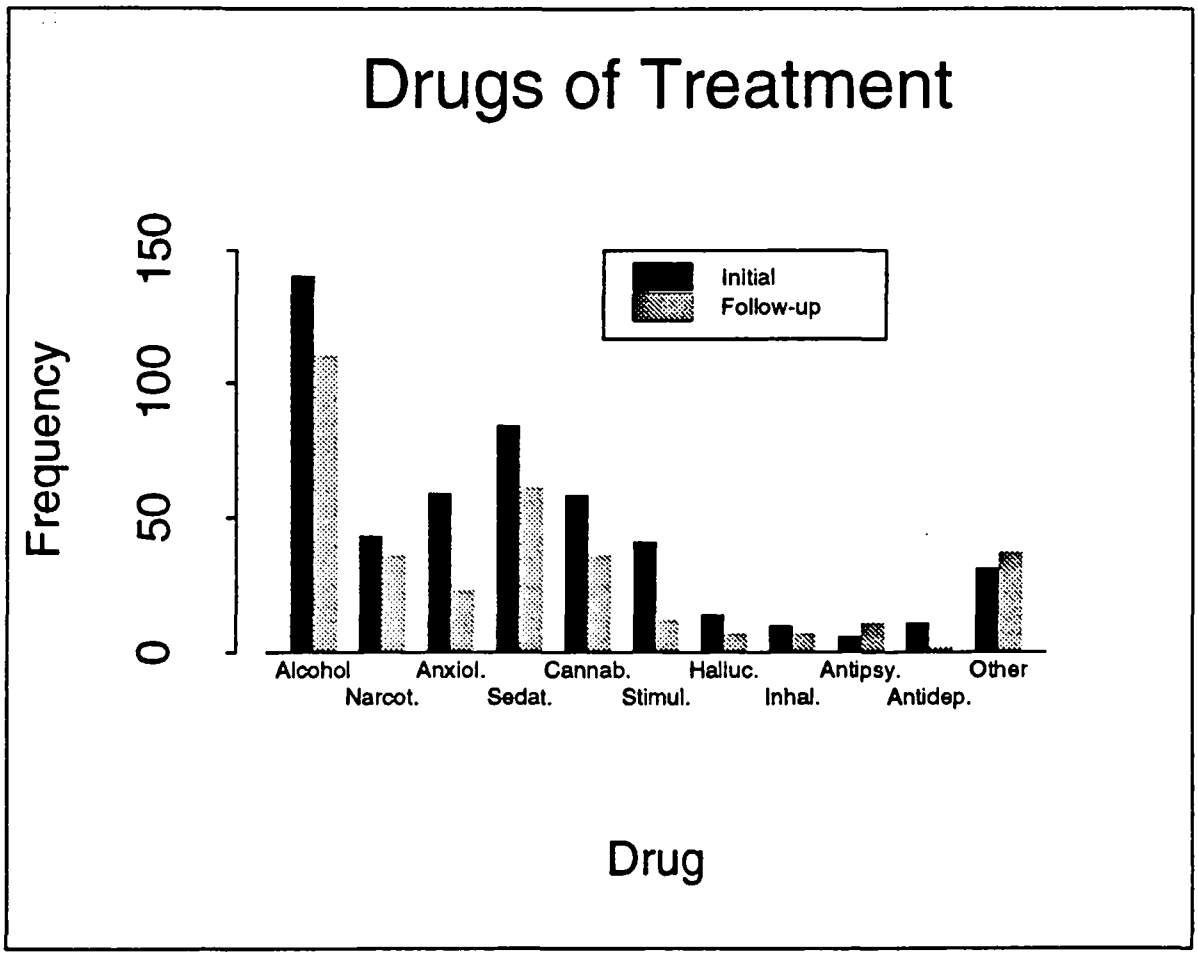
15.2 Client encounters

Drugs taken in the past 24 hours

Clients were asked which of 10 specified types of drugs they had taken in the past 24 hours, with an additional miscellaneous category for drugs not listed. **Alcohol** was the most commonly used drug, with **sedatives** and **anxiolytics** following, but reported much less frequently.

Drugs of treatment

The primary drugs of treatment were recorded for the same 10 specified types as above. Again, alcohol was the most common drug recorded, with **sedatives, anxiolytics** and **cannabis** less frequently reported but also common.



History of psychiatric illness

Almost one third (30%) of the 292 clients for which this information was available in the initial sample had a history of psychiatric illness. Just over one third (35%) of the 198 clients for which this information was available in the follow-up sample had such a history.

Description of childhood

Almost 40% of 293 clients answering this question in the initial sample reported an **unhappy** childhood, with another 33% reporting a **happy** childhood. The remainder, just under 28%, **not stating** either way. 42% of 225 clients in the follow-up sample reported an **unhappy** childhood, 31% reported a **happy** one, and the remaining 16% did not state either way.

History of abuse

Almost exactly one third (33%) of the 301 clients answering this question reported that they had suffered some sort of abuse. Another 23% stated that they had suffered no abuse, with the remainder not stating whether abuse had occurred. 33% in the follow-up sample also reported some sort of abuse, with 16% denying any, and the remaining 51% not stating either.

Abuse suffered in childhood

Three specific categories of abuse were listed, **sexual**, **emotional** and **physical**. A fourth **other** category was also available, but only 6 clients of 147 (initial) and 6 of 94 (follow-up) answering this question selected this category.

Sexual: 40 (27%) of the clients answering this question reported that they had suffered sexual abuse at some time during their childhood in the initial sample. 27 clients (29%) of the follow-up sample reported sexual abuse.

Emotional: 52 (35%) of the clients answering this question in the initial sample reported that they had suffered emotional abuse at some time during their childhood. 34 clients (36%) of the follow-up sample reported emotional abuse.

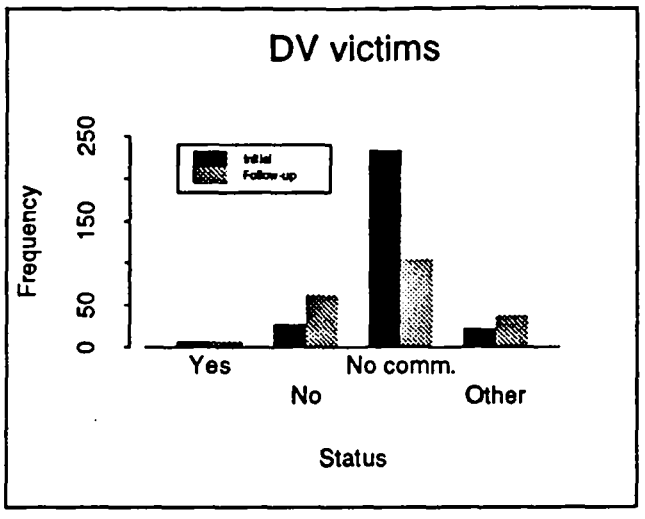
Physical: 48 (33%) of the clients answering this question reported that they had suffered physical abuse at some time during their childhood in the initial sample. 39 clients (41%) of the follow-up sample reported physical abuse.

Legal history

134 (44%) of the 302 clients answering this question reported a legal history in the initial sample. 129 (43%) reported no legal history, and 39 (13%) did not state their legal history. 101 (43%) of the 235 clients in the follow-up sample for which this information was available had a legal history, 106 (45%) had none, and 28 (12%) had not stated this information.

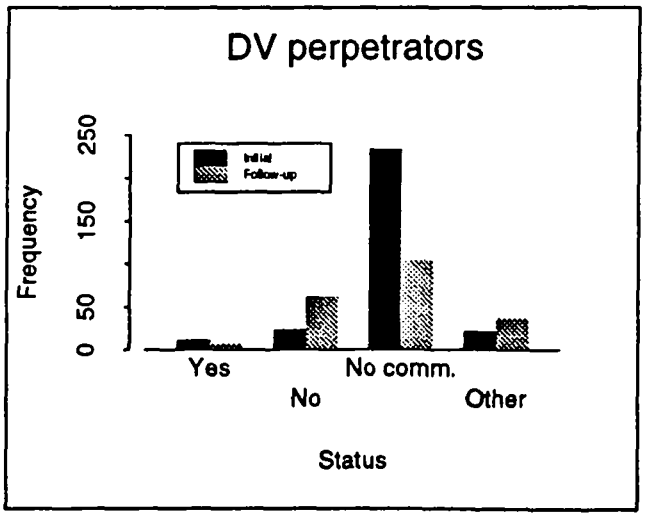
Current domestic violence status

The domestic violence status was obtained from the medical records for the period of admission studied. 289 records from the initial sample, and 184 from the follow-up, were available. Whether the client was a victim or a perpetrator of domestic violence was recorded separately.



Victims: 7 (2%) of the clients for whom data was available in the initial sample had been recorded on their medical records as a victim of domestic violence. 7 (3%) of the clients with available data in the follow-up sample had been recorded as victims on their medical records.

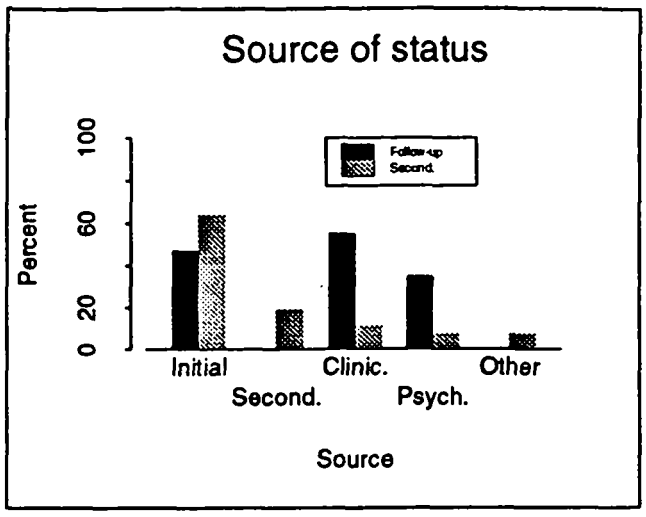
Perpetrators: 11 (4%) of the clients in the initial sample had been recorded as being perpetrators of domestic violence. 13 (6%) of the clients in the follow-up were recorded as being perpetrators.



Source of domestic violence status

In the initial sample, there were 55 cases for which the source of domestic violence could be recorded. In the follow-up, 105 cases were available for analysis.

While the most common source of domestic violence status was the **clinical notes** in the initial sample, in the follow-up the most common source was the **initial assessment**, a significant increase over the initial sample (Test of proportions, $p<.001$). The tendency was for the domestic violence status to be recorded earlier in the clinical encounter.



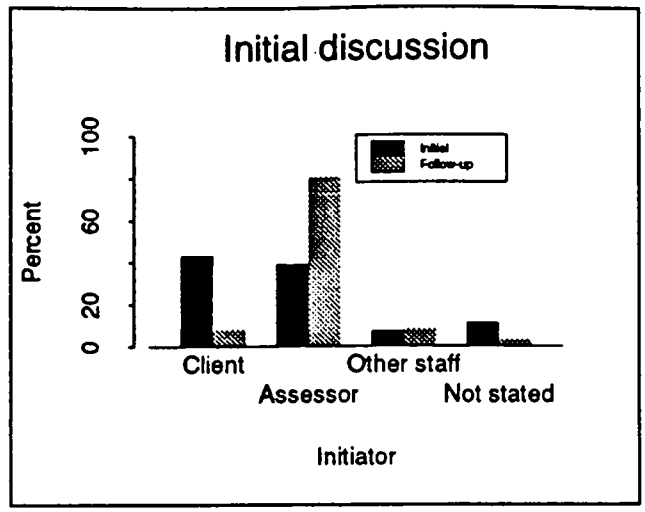
This was confirmed by the average length of time after admission that spouse abuse was first recorded in the client's medical notes. In the initial sample, the average length of time was 5.6 days, while in the follow-up sample, the average was 1.4 days ($t=4.6$, $p<.001$).

15.3 Action taken in the clinic with regard to physical abuse

The final five questions were concerned with how the abuse was disclosed/discovered, and what actions were taken with regard to this.

Initiation of discussion

There were 46 cases for which data was available for this question in the initial sample, and 59 in the follow-up. While discussion was initiated about equally often by the client and the assessor in the initial sample, the assessor was much more likely to initiate such discussions in the follow-up sample (Test of proportions, $p<.001$).



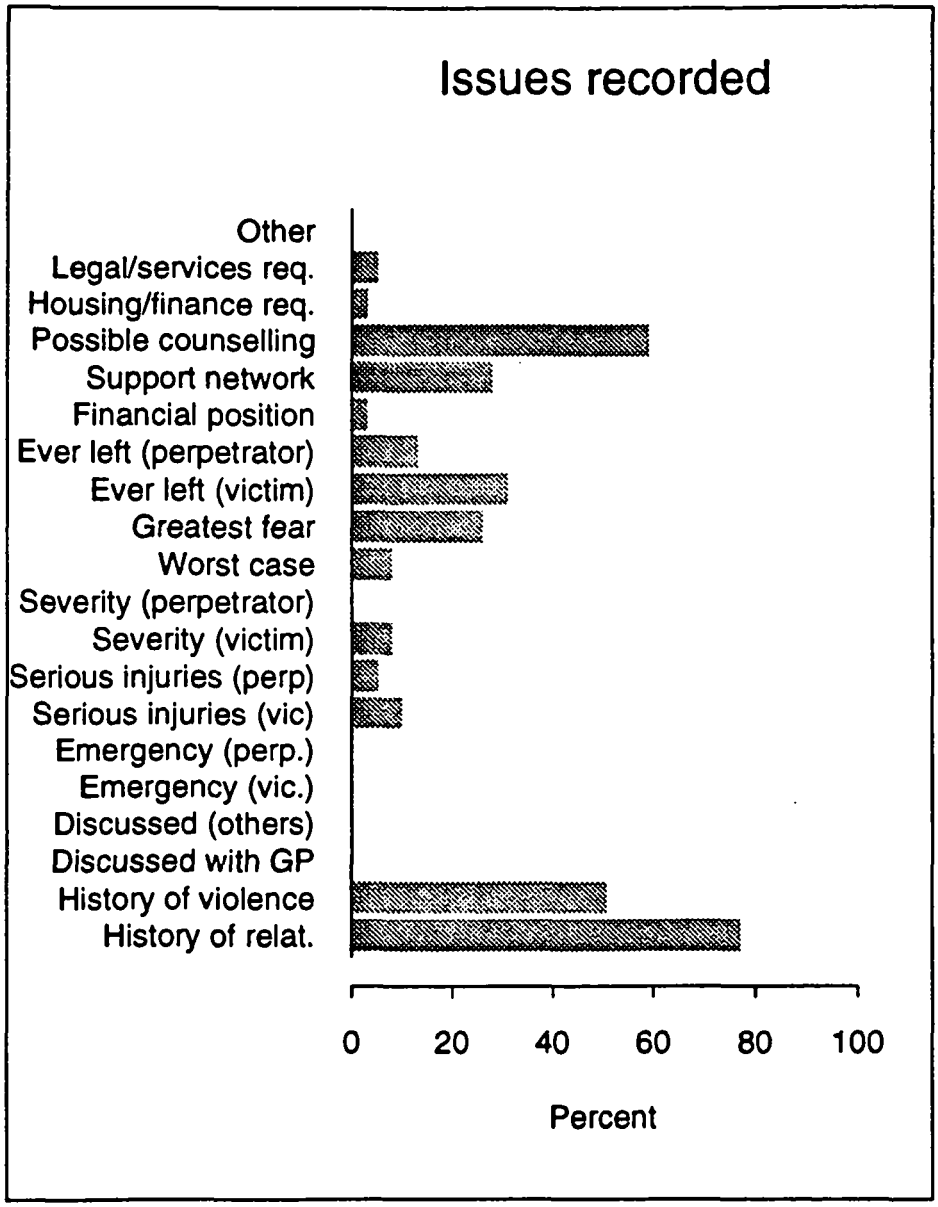
Client presenting with bruising and/or injury

No clients involved in domestic violence were identified by the presence of bruising or injury in either of the samples.

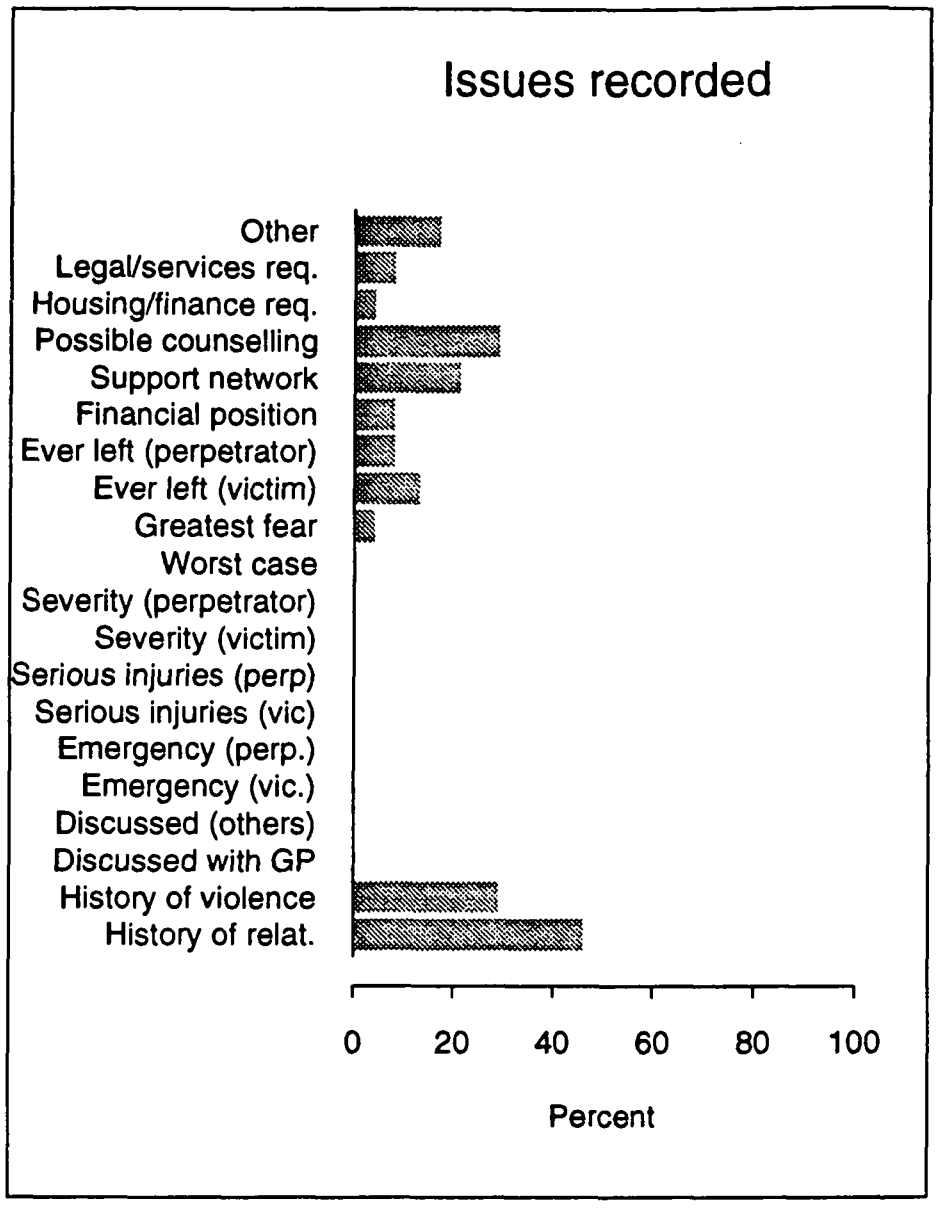
Issues recorded in relation to physical abuse

Nineteen specific issues were listed on the questionnaire which related to physical abuse. 39 cases were available for analysis in the initial sample, while 26 were available in the follow-up sample.

Issues discussed (initial sample): Issues discussed were typically history of the relationship and violence, and the possibility of counselling. Explicit details of injury were rarely discussed.



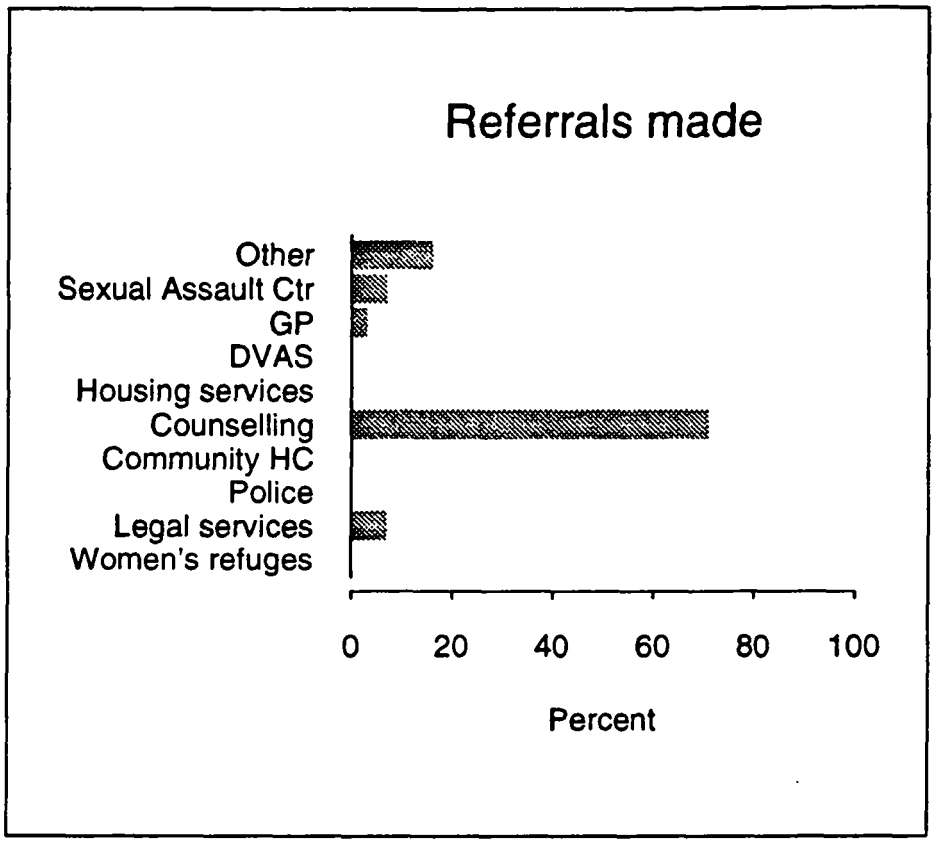
Issues discussed (follow-up): The history of the relationship and the violence were again common, as was the possibility of counselling. However, the proportion of clients with whom these issues were discussed was lower in the follow-up sample.



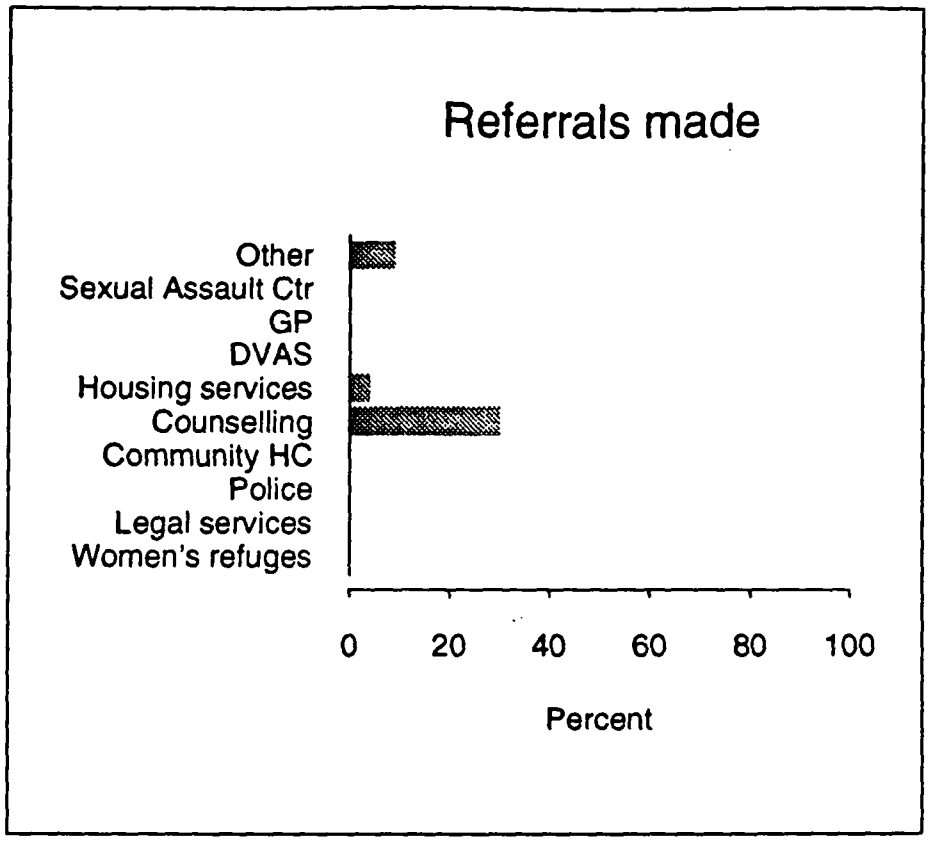
Referrals made in relation to physical abuse

Nine specific types of referral were listed on the questionnaire, with a non-specific **other** category. There were 31 cases available for analysis in the initial sample, and 23 in the follow-up sample.

Referrals made (initial sample): Counselling was the most frequent type of referral in the initial sample. The number of referrals to counselling was greater than all other referrals combined.



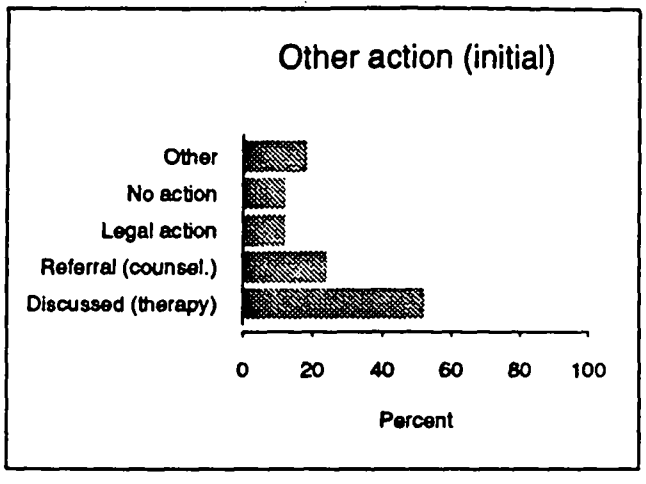
Referrals made (follow-up): Counselling was still the most common type of referral, although there were proportionately fewer referrals in the follow-up sample.



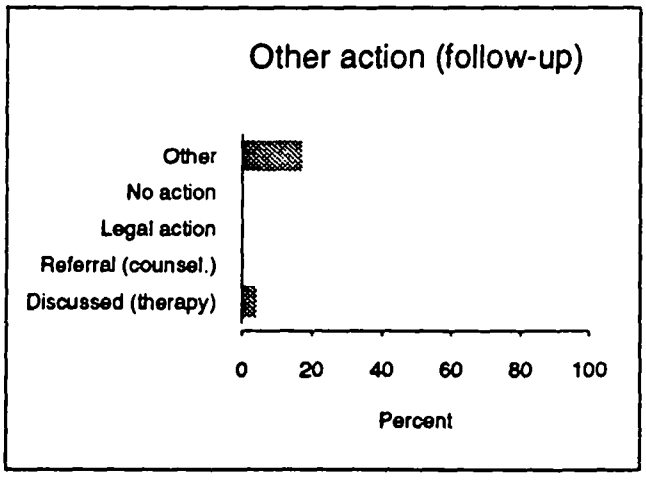
Other action taken by staff in relation to physical abuse

The final question sought information about other action taken by staff. Four categories of action were defined; **Discussion at therapy/counselling at clinic, referral to counselling/aftercare, legal action** and **client signed out/no action.** There was also a non-specific **other** category.

Initial: Discussion at therapy/counselling was the most common action taken in the initial sample, accounting for just over half (52%) of the 33 cases for which there were responses which could be analysed. **Referral to counselling/aftercare** was the next most common.



Follow-up: Discussion was much less common in the follow-up sample, accounting for only one of the 23 cases available for analysis. The **other** category was the one most commonly recorded. The overall rate of other staff action was much lower in the follow-up.



15.4 Characteristics of those involved in DV

The characteristics of clients which were identified as being involved in domestic violence have been compared both to the overall sample, and between the initial and follow-up samples. Victims and perpetrators are discussed separately.

Victims

Seven victims were identified in both the initial and follow-up samples.

Clinic: The majority of the victims in the initial sample (4) were identified at clinic B, with two at clinic A and 1 at clinic C. In the follow-up sample, the majority (4) were identified at clinic A, with one each at clinics B, D and E.

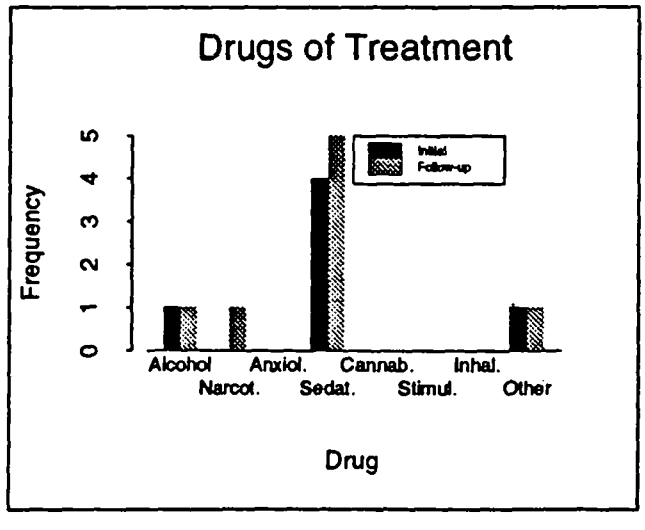
Age: The mean age of clients identified as victims was 41 years in the initial sample, with only a slight increase to 42 years in the follow-up sample.

Sex: All seven victims in the initial sample were female. In the follow-up sample, four victims were male, and the remaining three were female.

Education: The most common educational attainment in both samples was **secondary** (4), with only one **university** graduate in each sample.

Relationship status: In the initial sample, almost all of the victims identified (6) were **married**, all currently in an intimate relationship. None were married in the follow-up sample, with most either **separated** or **divorced**. Five were currently in an intimate relationship.

Children: In both samples, six out of seven clients who were identified as victims had children. This was higher than the average of just over half for both of the entire samples, and the number of children was also greater.



Chemical dependency: The most common primary drug of treament for those clients identified as victims in the

initial sample was **sedatives** (4). This was also true of the follow-up, where five such clients were admitted for treatment for sedative use. **Alcohol** was a primary drug of treatment for one client in each sample.

Psychiatric illness: There were two clients identified as victims who had a history of psychiatric illness recorded in both the initial and follow-up samples.

Description of childhood: While only three of the clients identified as victims in the initial sample reported an **unhappy** childhood, six of those in the follow-up sample did so. However, for three clients in the initial sample, the description of childhood was **not stated**.

History of abuse: While only three clients in the initial sample reported suffering abuse in childhood, all seven in the follow-up sample did so. Again, however, for three of the clients in the initial sample, their history of abuse was **not stated**.

Forms of abuse suffered in childhood: Only one client in the follow-up sample reported an **other** type of abuse in childhood.

While there were no clients identified as victims in the initial sample who reported sexual abuse in childhood, four of the clients so identified in the follow-up sample reported such abuse.

Three clients in each sample reported emotional abuse during childhood.

Three clients in the initial sample, and four in the follow-up sample, reported physical abuse during childhood.

Legal history: Five of the seven clients in the initial sample, and all seven of those in the follow-up sample, reported a legal history. When the two samples were combined, clients identified as victims were significantly more likely to report a legal history (Test of proportions - p=.0063).

Perpetrators

Eleven clients were identified as perpetrators of domestic violence in the initial sample, while thirteen were identified in the follow-up sample. They were compared as follows.

Clinic: Four perpetrators in each sample were identified at clinic A. Three were identified at clinic B in the initial sample, and five in the follow-up. Clinic D reported three in the initial sample, and none in the follow-up, while clinic E reported only one in the initial sample, but four in the follow-up.

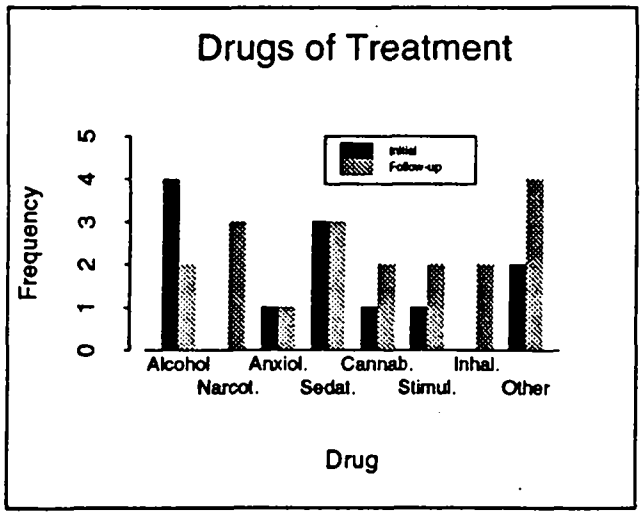
Age: The mean age of clients identified as perpetrators was 33 years in both the initial and follow-up samples. As perpetrators tended to be male, this was compared to the breakdown of age by sex to determine if this might be due to selection. In the initial sample, the average age of males was under three years less than that of females, and in the follow-up sample, the average age of males was greater.

Sex: The majority of clients identified as perpetrators were male, with eight out of eleven in the initial sample, and eleven out of thirteen in the follow-up.

Education: As with victims, the most common educational attainment in both samples was **secondary** (4), with only one **university** graduate and one who had attended, but not completed, in the follow-up sample.

Relationship status: The perpetrators were fairly evenly spread among the **never married, married, separated** and ***de facto*** categories in both samples. Approximately seven out of ten perpetrators were currently in an intimate relationship in both samples.

Children: Just over 60% of perpetrators had children in both samples. This was only slightly higher than the average of just over half for both of the entire samples, and not significantly different. The number of children of perpetrators was slightly greater in the initial sample.



Chemical dependency: Alcohol was as common as **sedatives** as the most common primary drug of treament for those clients identified as perpetrators. Perpetrators apparently used a wider variety of drugs than did victims.

Psychiatric illness: Three perpetrators had a history of psychiatric illness recorded in the initial sample, and two in the follow-up sample.

Description of childhood: While seven of the clients identified as perpetrators in the initial sample reported an **unhappy** childhood, only three of those in the follow-up sample did so. However, for five clients in the follow-up sample, the description of childhood was **not stated.**

History of abuse: Seven perpetrators in the initial sample reported suffering abuse in childhood, while only three in the follow-up sample did so. Again, however, for seven of the clients in the initial sample, their history of abuse was **not stated.**

Forms of abuse suffered in childhood: One perpetrator in each sample reported sexual abuse in childhood.

Six perpetrators in this initial sample reported emotional abuse during childhood, while only two in the follow-up sample did so. However, the majority of perpetrators did not disclose childhood abuse.

Three clients in the initial sample, and only one in the follow-up sample, reported physical abuse during childhood.

Legal history: Most perpetrators in the initial sample (9), and the follow-up sample (11), reported a legal history. This was a significantly higher proportion than all clients when both the initial and follow-up samples were combined (Test of proportions - p=.0005).

15.5 Discussion of detection of spouse abuse in clients

Detection of spouse abuse

While there were differences in the numbers of victims and perpetrators identified at each clinic, the small numbers demand caution in the interpretation of these results. Despite a numerical increase in the percentage of clients identified as victims and perpetrators in the follow-up, there were no statistically significant differences. Information concerning spouse abuse was, however, recorded earlier in the clinical encounter, and discussion of spouse abuse was more often initiated by the staff.

The percentage of clients identified as victims was less than one-fifth of the estimated prevalence for all drug and alcohol clients, as measured by the Conflict Tactics Scale in our study. For perpetrators, the percentage identified was just under one third of the corresponding estimate. The relative percentages are somewhat counterintuitive given the current attitudes expressed about victims and perpetrators. All indications are that victims are treated more sympathetically, and are rarely attributed responsibility for spouse abuse. It is unclear as to why perpetrators should apparently be more willing to disclose their involvement.

Association of subject measures with identification

Victims: The most obvious association was with **legal history**. Victims were more likely to report a legal history than clients overall. Neither the history of abuse in childhood, nor the reported happiness of their childhood were associated with detection as a victim. Similarly, a reported diagnosis of psychiatric illness was not associated with detection.

Perpetrators: Identification of a client as a perpetrator of spouse abuse was also associated with reported legal history. The association was even stronger than that observed with victims. Perpetrators appeared to be younger than victims, although the small numbers detected were not sufficient to establish statistical significance.

Action taken in cases of spouse abuse

As noted in other sections of this report, counselling is the most commonly suggested, and most frequently pursued, action taken in response to disclosure of spouse abuse. This was the case here, both in action taken in the clinic, and in referrals.

Chapter 16: Prevalence of domestic violence in drug and alcohol centres and client characteristics.

16.1. Introduction

The association between alcohol and domestic violence has been well established, however, few studies have provided estimates of the prevalence of perpetrators and victims amongst the clients of drug and alcohol rehabilitation clinics. These settings have also been relatively ignored as a setting to intervene for domestic violence.

For intervention to be successful we need to have a better understanding of the psychological and psychiatric profiles of these clients. Studies in the drug and alcohol setting have been few and far between. Additionally of those studies conducted, methodological problems including the lack of standardised assessment for alcohol and/or drug abuse and inadequate description/detail of the study population limit any definitive conclusions. Apart from addressing methodological problems of previous studies, a novel aspect of this research was to examine the extent of violence perpetrated by females against their male partners.

This chapter provides an overview of the methodology used to assess clients of drug and alcohol centres; the following chapters present the research findings.

16.2 Procedure

Client assessment

Client interviews commenced in the five drug and alcohol clinics following the completion of the staff educational component of the project. All clients of the 5 participating drug and alcohol clinics were asked by the clinic contact person(s) to participate in the project after they had spent a minimum of seven days at the clinic. Clients suffering from brain damage or psychosis were excluded. The interviews spanned a nine month period (from September 1994 until May 1995).

The designated contact person at each clinic initially approached clients to introduce the research project and to encourage participation. A preliminary date and time was made for the client to be interviewed.

Client interview procedures for each clinic were developed to take into consideration differences in clinical and administrative factors. A sample protocol is reproduced in Appendix 7, (Volume 2). Interviews were conducted either in the client's room or in a private office by trained research staff. The components of the interview and the topics to be covered were explained prior to its commencement. Clients were then required to read the client information sheet and to sign the consent form for participation in the study.

PART 2: Client Profile

Research staff reinforced that participation was voluntary and that they were free to discontinue the interview at any time.

Clients who agreed to participate were administered the structured interview (Appendix 8, Volume 2), which was the first component of the client assessment. The duration of the interview generally ranged between one and three hours. Following completion of the interview, research staff went through a safety checklist procedure (see Appendix 1, Volume 2) to determine any negative consequences of the interview. If concerns about the safety of the person or their partner were raised, the principal investigators and staff contact persons were notified. Where necessary and where consent was obtained from the client, interviewers informed staff of clients who became distressed by issues raised during the interview. Additionally, resources and a list of support services were provided to clients identified as a victim or perpetrator of abuse.

The second component of the client assessment was the self-completion questionnaire (Appendix 9, Volume 2). Clients were asked to complete this in their own time over the following week. In most cases, the self-completion questionnaire was returned to the interviewer; others returned the self-completion section to the clinic contact person in a sealed envelope. Clients who did not return the questionnaire during their stay at the clinic were contacted through the phone and asked to complete and return the questionnaire. For some clients the follow-up procedure required the mailing of another questionnaire together with a reply paid envelope for its return.

During the period of the study a total of 380 patients were admitted to the five clinics. Of these, 68 clients were ineligible due to psychiatric or medical problems or because they left within the first seven days of their admission. Of the remaining 312 clients, 49 refused to participate in the project. The final number of clients who participated was 263 (84.3%). Of those clients who agreed to be interviewed, 185 completed the self-report questionnaires; this comprised 70.3% of those interviewed and 59.3% of the eligible client population.

Description of client interview and self-completion questionnaire

Client interview

The semi-structured client interview was developed by the investigators and piloted with 25 clients of D and A centres not involved in the project. The interview examined biographical and demographic factors and provided a detailed assessment of drug and alcohol abuse, both current and past. The client's medical, psychiatric and legal history was obtained. A family history, including demographic information, as well as exposure to drug and alcohol abuse, psychiatric illness and violence in the family of origin, was obtained. The client's current and past relationships were examined and a detailed description of physical and verbal abuse if present, and its relationship to drug and alcohol use, was assessed.

Embedded within the interview were standardised assessment measures relating to:

1. Childhood and adolescent sexual abuse

(i) Sexual abuse scales (Finkelhor. 1987)

The questionnaire used was based on that developed by Finkelhor. It comprises two sections relating to any sexual experiences before the age of 13 and sexual experiences which were forced and/or were with a person at least 5 years older at the time. The six questions within each scale are graded from 'kissing in a sexual way' to 'having sexual intercourse'. They also ask who the perpetrator was, the age of the respondent at the time and the duration of the abuse.

2. Childhood and adolescent psychological and physical abuse

(i) Psychological and Physical Child Maltreatment Scales (Briere & Runtz. 1988)

The psychological maltreatment scales (PSY) and the physical maltreatment scales (PHY) are 7 item and 5 item scales respectively, which are scored separately for parental behaviours. They apply to abuse occurring before the fourteenth year. The PSY applies to parental behaviour which is primarily verbal and the PHY to parental behaviour which involves threatened or real physical pain. They score the behaviour of each parent on a frequency basis.

3. Relationship conflict and violence

(i) Conflict Tactics Scales (CTS; (Straus. 1979)

These scales are designed to measure the use of Reasoning (rational discussion and argument), Verbal Aggression (verbal and non-verbal acts which symbolically hurt the other) and Violence (the use of physical force to resolve the conflict) within a relationship. The Violence scale can be further subdivided into Minor Violence (eg. pushing, slapping) and Severe Violence (eg. kicking, beating, threatened or actual use of a weapon). Although the CTS has been used for many years and is an accepted measure, a criticism has been that it does not consider violence used in self-defence. To overcome this problem, the relevant questions in the CTS were complemented by the same questions modified by adding 'in self defence'. Scores were obtained in the recommended fashion, the scaling being based on frequency of each behaviour.

(ii) Psychological Partner Maltreatment Scale

This scale was developed by modifying the Psychological Child Maltreatment Scale **(Briere and Runtz, 1990)** mentioned above. It used the same questions but modified the

wording to make it apply to partners rather than parents. It was scored in a similar fashion to the Child scale.

4. Hazardous and harmful drinking

(i) Alcohol Use Disorders Identification Test (AUDIT; (Saunders, Aasland, Babor, De La Feunte, & Grant. 1993)

AUDIT is a ten item questionnaire to enable the identification of persons with harmful and hazardous alcohol consumption. It covers three principal domains: 1. consumption of alcohol; 2. dependence syndromes; and 3. alcohol related problems. A cut-off score of 8 is used to define hazardous drinking whilst a cut-off score of 13 is used to define harmful drinking patterns.

Self-completion questionnaire for clients

The self-completion questionnaire examined specific and general psychopathology and personality structure using standardised scales. The following scales were included:

1. General psychopathology

(i) SCL-90 (Derogatis, Rickels, & Rock. 1976)

This is a 90 item self-report symptom inventory, oriented toward the measurement of psychopathology in medical and psychiatric patients. Each item is rated on a 5 point scale of distress, from 'not at all' to 'extremely'. It is scored on 9 primary symptom dimensions; Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, Psychoticism. The Global Severity Index (GSI), a score of general psychopathological severity was also used..

(ii) SRQ-20 (Beusenberg & Orley. 1994)

This scale was developed by WHO as a screening instrument for mental health disorders. It consists of 20 questions, answered 'Yes' or 'No', dealing with symptoms and problems likely to be present in those people suffering from neurotic disorders. A cut-off point of 7/8 has generally been used to indicate the presence of a case.

2) Depression

(i) Beck Depression Inventory (BDI; (Beck, Ward, Mendelson, Mock, & Erbaugh. 1961)

This scale provides a quantitative assessment of the intensity of depression. It consists of 21 questions which measure the behavioural manifestations of depression in a valid and reliable fashion. A score of more than 13 signifies a mild depression, more than 21 a moderate depression and more than 30 a severe depression.

3) Anxiety

(i) State-Trait Anxiety Inventory (Spielberger, Jacobs, Russel, & Crane. 1983)

Only the Trait component of this measure was used. It consists of 20 questions which assess the level of anxiety as a relatively stable personality trait, on a 4 point scale from 'almost always' to 'almost never'.

4) Anger

(i) State-Trait Anger Scale (Spielberger, Jacobs, Russel, & Crane. 1983)

Both components of this scale were used. They each consist of 15 questions, the 'State' questions assessing anger as an emotional state which varies in intensity and the 'Trait" questions assessing anger as a relatively stable personality trait ie. how frequently a respondent feels state-anger over time. Scoring is based on 4 point scales; 'almost always' to 'almost never' for Trait and 'not at all' to 'very much so' for State.

5) Personality

(i) NEO PI-R (Costa & McCrae. 1991)

The Revised NEO Personality Inventory consists of 240 items on a 5-point scale. It is a concise measure of the 5 major dimensions of adult personality and some of the more important traits which define each dimension. The 5 dimensions are: Neuroticism which includes anxiety, anger hostility, depression, self-consciousness, impulsiveness and vulnerability; Extroversion which includes warmth, gregariousness, assertiveness, activity, excitement-seeking and positive emotions; Openness which includes fantasy, aesthetics, feelings, ideas and values; Agreeableness which includes trust, straightforwardness, altruism, compliance, modesty and tender-mindedness; Conscientiousness which includes competence, order, dutifulness, achievement striving, self-discipline and deliberation.

6) Relationship satisfaction

(i) Dyadic Adjustment Scale (DAS; (Spanier. 1976)

This scale provides a measure of the quality of marital and similar dyadic relationships. Its 32 questions have been divided into four subscales which measure: dyadic satisfaction (includes questions measuring level of happiness and the level of conflict experienced in the relationship); dyadic consensus (includes questions measuring agreement on common goals, decision making, recreation; dyadic cohesion (quality of interaction, working and engaging in outside interests together and enjoyment of interactions; and affectional expression (sexual relationship and demonstration of affection). The dyadic adjustment score is the sum of the four subscales.

7) Spouse abuse

(i) Index of Spouse Abuse (ISA;(Hudson & Mcintosh. 1981))

The Index of Spouse Abuse is intended to be used in clinical settings to evaluate change in the degree or severity of both physical (ISA-P) and non physical (ISA-NP) abuse as perceived by female respondents; although in the current study the questionnaire items were modified so that they were relevant to both sexes. It is a 30-item scale comprising the two subscale to measure physical and non-physical abuse; each item represents a behaviour or partner interaction considered to be abusive. A cut-off score of 10 for the ISA-P and 25 for the ISA-NP is recommended.

Chapter 17. Psycho-demographic profile of clients

Demographic information

Age and gender

Sixty-six percent of the 232 clients were male. The mean age was 38 and ranged between 18 and 69.

Country of birth

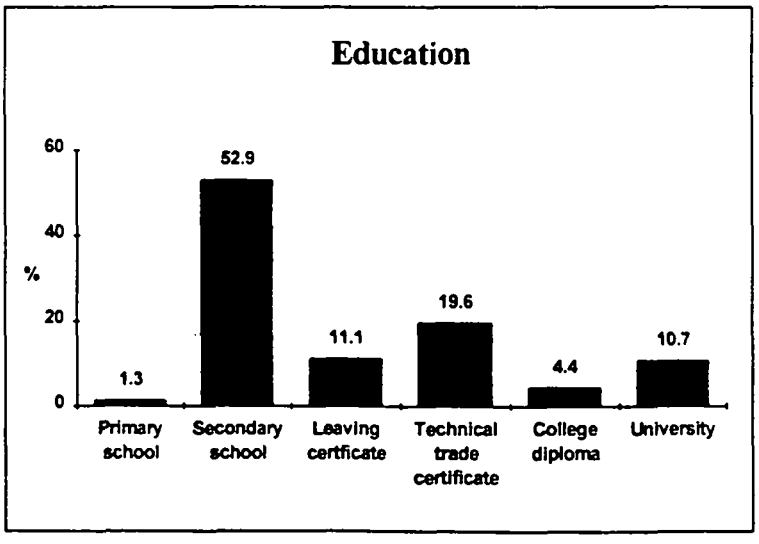
The majority of clients were born in Australia (81.4%). Others were born in England (9.3%), New Zealand (3.5%) and a smaller number in non-English speaking countries (5.3%). English was the language spoken at home for 97% of clients.

Religion

Fifty-four percent of 226 clients reported their religion as Christian, 40% reported no religion at all, while the remaining 6% reported a religion falling within the 'Other' category.

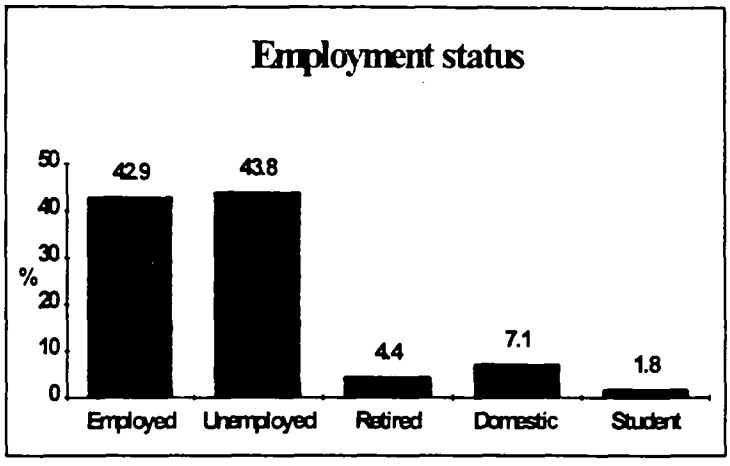
Education

Over half of 225 clients had undertaken some high school and an additional 11% had completed their leaving certificate (HSC). A further 20% of clients had received a technical or trade certificate, 11% had a university degree and an additional 4.4% had a college diploma.



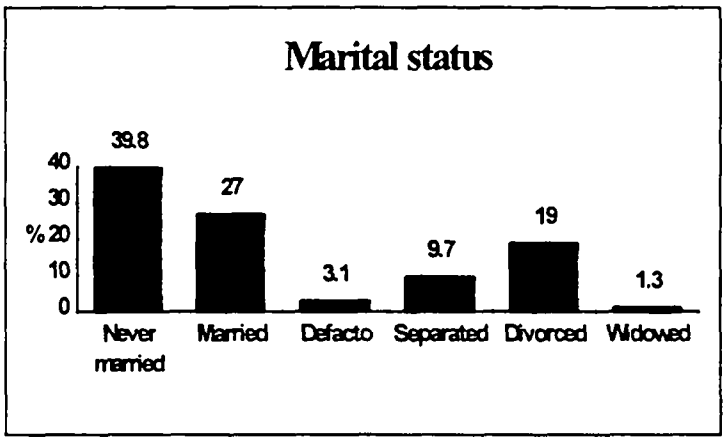
Employment status

43% of 226 clients were employed, 44% were unemployed, and the remainder were retired, involved in house duties, or studying. Of those currently employed, 53% were employed in white collar jobs. Over half the clients received some type of welfare benefit (52%).



Marital status

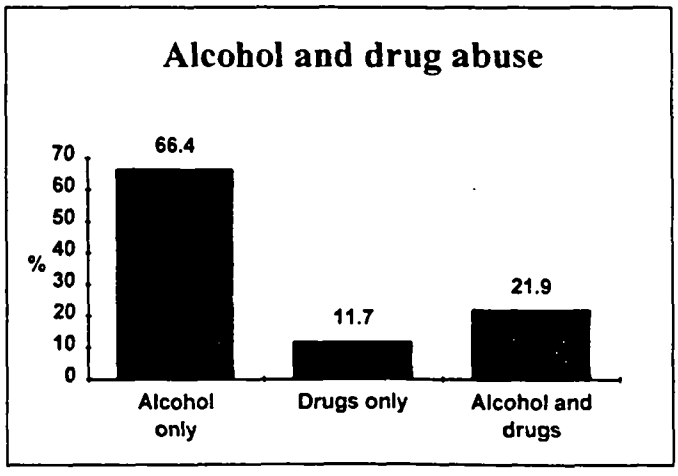
Approximately, 30% of 226 clients were either married or in a defacto relationship. Twenty-nine percent were either separated or divorced, while 40% percent had never married. Close to sixty percent of clients had children with the majority (88%) having fewer than four.



Alcohol and drug abuse

Information was obtained on the whether the client abused alcohol and/or drugs. Alcohol abuse was defined by a score of 13 or more on AUDIT. Drug abuse was defined as using either marijuana, heroin, methadone, cocaine, stimulants, or hallucinogens on more than 1-2 days per week.

One hundred and forty-eight of 223 (66.4%) clients abused alcohol only, twenty-six (11.7%) abused only drugs while 49 (21.9%) abused both alcohol and drugs. Of the 148 male clients 95 (64.2%) abused alcohol only, 17 (11.5%) abused drugs only and 36 (24%) abused both. Of 75 female clients 53 (70.7%) abused only alcohol, 9 (12%) abused drugs only and 13 (17.3%) abused both.



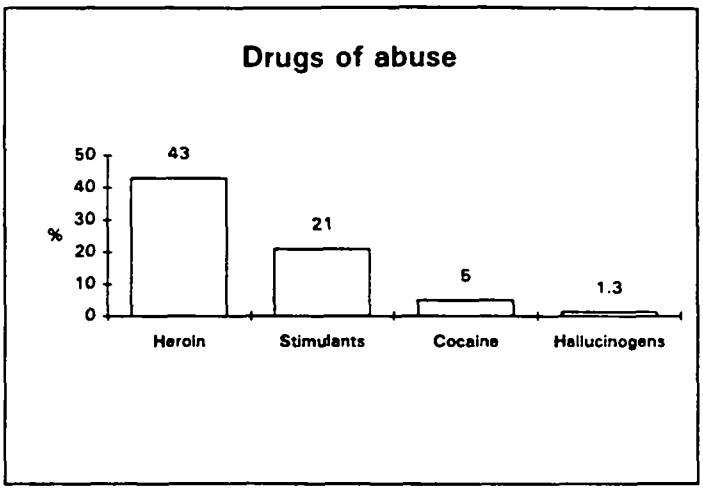
Alcohol abuse

Clients were asked to detail their alcohol consumption for a typical week during the last year. Of the 190 clients who responded to this question and who abused alcohol, the mean number of standard drinks consumed in a week was 146. Males on average consumed 162.8 drinks and females 113.2 standard drinks in a typical week.

The mean age of onset of drinking for those who abused alcohol was reported to be 15.5 years; 14.8 for males and 16.9 for females. The mean age for drinking regularly for those who abused alcohol was 20 years; 18.5 for males and 23.7 for females. Mean scores on AUDIT for the alcohol abusing group was 27.9; 27.9 for males and 27.9 for females.

Drug abuse

Of the 75 clients who abused one or more drugs, 56 used marijuana (75%), with the majority using on a daily basis (79%); thirty-two clients used heroin or methadone (43%) with the majority (75%) using it on a daily basis and 16 (21%) abused stimulants with the majority (69%) using on a daily basis. Only four (5%) abused cocaine (and on a daily basis) and only one client (1.3%) abused hallucinogens and this was nearly every day.



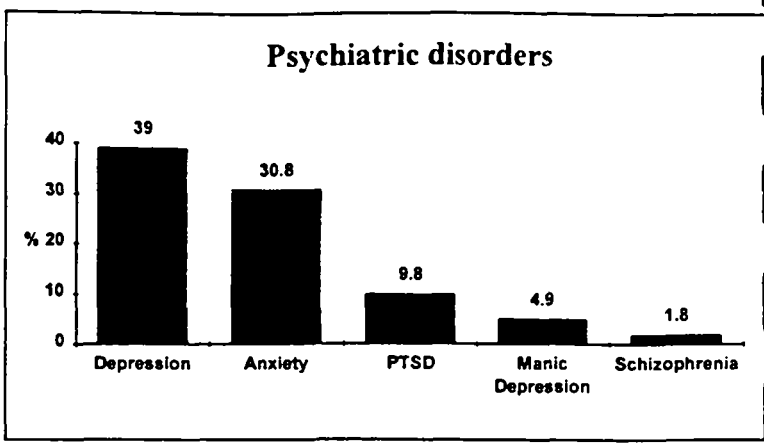
Psychiatric and medical disorders

Information was obtained on whether clients had ever been diagnosed as having a psychiatric or medical illness and whether they were currently receiving treatment for the disorder.

Psychiatric disorders

Nearly half (44%) of 196 clients had at some time received a diagnosis of a psychiatric disorder and 26.5% of those with a diagnosis were currently being treated for the disorder. 64 of the male clients (42.7%) had a psychiatric diagnosis compared with 38 of the female clients (50%).

The most common psychiatric disorder was depression, followed by anxiety and post-traumatic stress disorder. Very few clients were diagnosed as having a psychotic disorder; only 4.9% and 1.8% of clients had ever received a diagnosis of manic-depressive illness and schizophrenia respectively.



A large proportion of clients had seriously thought about suicide (57.5%) and of those, 66% had actually attempted suicide. 82 (56.2%) of male clients and 45 (59.2%) of female clients had seriously thought about suicide. 59.7% of these males and 77.7% of these females had attempted suicide.

Medical conditions

64% of all clients had suffered from a medical condition and 51% of those with a condition were currently receiving treatment for it.

96 of the male clients (64%) had a medical diagnosis compared with 52 (68%) of female clients. The most common medical conditions were liver disease (32.7%), vitamin deficiency (28.1%), hypertension (15%), ulcers (14.7%), peripheral neuritis (5.8%), heart disease (4.9%) and epilepsy (2.2%).

Psychological variables

A number of psychological variables were assessed using standardised measurement. These included measures of: 1. neurotic disorder (SRQ) 2. marital satisfaction (Dyadic Adjustment scale), 3. anger (Spielberger trait and state anger scales, hostility subscale of the SCL-90), 4. anxiety (Spielberger trait anxiety scale, anxiety subscale of the SCL-90), 5. depression (BDI and depression subscale of the SCL-90), 6. Specific psychopathology (SCL 90) and 7. personality (NEO- PI).

SRQ: Mean scores were 11.7 and 13.0 for males and females. These scores are well above the cutoff point of 7/8 and are indicative of neurosis.

Dyadic Adjustment

The dyadic adjustment scale provided scores on four dimensions; dyadic consensus, dyadic satisfaction, dyadic cohesion, affectional expression as well as a global measure of dyadic adjustment. Table 1 presents the mean scores for the overall index and each subscale for the study population together with normative data.

The mean dyadic adjustment score of 83.5 was somewhat below the mean reported for the comparison group comprising married and divorced individuals combined; it was more similar to the mean score for the divorced subgroup. Mean dyadic consensus and dyadic satisfaction scores were well below the mean score for the comparison group; these scores were nearly identical to the mean score for the divorced subgroup.

In contrast the mean affectional expression score for clients was similar to the comparison group and mean scores on the dyadic cohesion scale of 12.59 were somewhat higher than the comparison group sharing more similarities to the married comparison group.

Table 1. Comparison of client scores on the Dyadic Adjustment Scale with norms

	D & A clients (N=115)		Married comparison group (N=218)		Divorced comparison group (N=94)		Total Married & Divorced comparison group (N=312)	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Dyadic Adjustment Scale	83.5	23.4	114.8	17.8	70.7	23.8	101.5	28.3
Dyadic Consensus Subscale	41.0	12.6	57.9	8.5	41.1	11.1	52.8	12.1
Dyadic Satisfaction Subscale	22.7	5.8	40.5	7.2	22.2	10.3	35.0	11.8
Dyadic Cohesion Subscale	12.6	5.8	13.4	4.2	8.0	4.9	11.8	5.1
Affectional Expression subscale	7.3	3.4	9.0	2.3	5.1	2.8	7.8	3.0

Anger

As can be seen from Table 2, the mean scores on trait anger for male and female clients were almost double the scores for the comparison male and female groups. Mean score on state anger was also considerably higher for the clients groups compared with the comparison groups. The hostility subscale of the SCL-90 provided an additional measure of 'anger'. There were no differences between the client and comparison group on this scale.

Anxiety

Mean scores on the trait anxiety scale for males and females were much higher than the mean scores for comparison males and females (Table 2). Our second measure of anxiety came from the SCL-90. The mean score for clients was higher than the mean score for the comparison group (Table 2).

Table 2. Comparison of client scores on the Spielberger State/trait anger scale and the Spielberger trait anxiety scale with norms for working males and females.

	Male clients		Female clients		Scores for Working males comparison		Scores for Working females comparison	
	Mean, (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N
State anger	24.0 (10.1)	85	23.7 (8.9)	43	14.3 (?)	*	13.7 (*)	*
Trait anger	35.0 (9.0)	87	35.4 (9.8)	45	18.5 (?)	*	18.5 (?)	*
Trait anxiety	52.5 (12.8)	88	57.4 (10.2)	44	34.9 (9.2)	1,387	34.8 (9.2)	451

* Not stated

Depression

Mean scores on the BDI were 16.19 and 16.55 for males and females respectively indicative of mild to moderate depression. The depression subscale of the SCL-90 produced different results to the BDI. The mean score for male clients of 1.82 was similar to the comparison group of 1.87. However, mean score for females of 2.39 was higher.

SCL-90

The SCL-90 comprises nine subscales; somatisation, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism and also provided a measure of severity of psychopathology called the GSI. Scores for depression, anxiety and hostility have been reported above.

Mean score on the GSI and the Somatisation, Obssessive Compulsive, Interpersonal Sensitivity, Paranoid Ideation and Psychoticism subscales were all higher for the client group than the symptomatic comparison group (Table 3).

Table 3. Comaprison of client scores on the SCL-90 with comparison norms

	D & A clients (N=128)		Symptomatic volunteers (N=209)	
	Mean	SD	Mean	SD
Global Severity Index (GSI)	1.56	.78	1.3	.59
Somatisation subscale	1.29	.84	.9	.64
Obssessive Compulsive subscale	1.79	.88	1.58	.83
Interpersonal Sensitivity subscale	1.78	.93	1.49	.85
Hostility subscale	1.25	.95	1.27	.92
Phobic anxiety subscale	.92	.92	.7	.67
Anxiety subscale	1.65	.9	1.49	.78
Depression subscale	2.02	.93	1.87	.84
Paranoid ideation subscale	1.62	.86	1.16	.87
Psychoticism subscale	1.34	.85	.82	.64

NEO Personality Inventory

The NEO comprised 5 domain subscales; neuroticism, extraversion, openness, agreeableness, and conscientiousness. Mean scores on the Agreeableness and Conscientiousness scales were significantly lower for male and female clients than the corresponding comparison groups. Clients had higher mean scores on the Neuroticism domain subscale than the comparison group. Mean score on the Extraversion scale was lower for female clients than females in the comparison group. There were no diferences on the mean score for Openness for clients and the comparison group (Table 4).

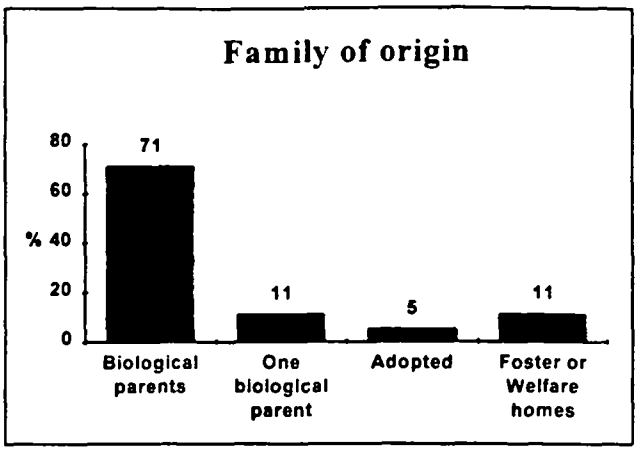
Table 4. Comparison of client scores on the NEO-PI with comparison norms

	Male clients			Female clients			Comparison males (N=500)		Comparison females (N=500)	
	Mean	SD	N	Mean	SD	N	Mean	SD	Mean	SD
Agreeableness domain	107.4	10.9	82	106.1	8.6	41	123.3	25.1	129.9	21.2
Conscientiousness domain	107.4	13.1	83	105.4	9.2	42	133.4	21.6	134.5	18.8
Extraversion domain	103.6	12.7	81	103.4	8.7	39	106.0	22.6	112.8	18.7
Neuroticism domain	101.3	13.9	78	103.8	9.4	36	70.0	20.4	73.7	24.0
Openness domain	106.6	10.6	81	105.1	29.3	41	104.3	18.5	106.7	18.4

Family history

Family of origin

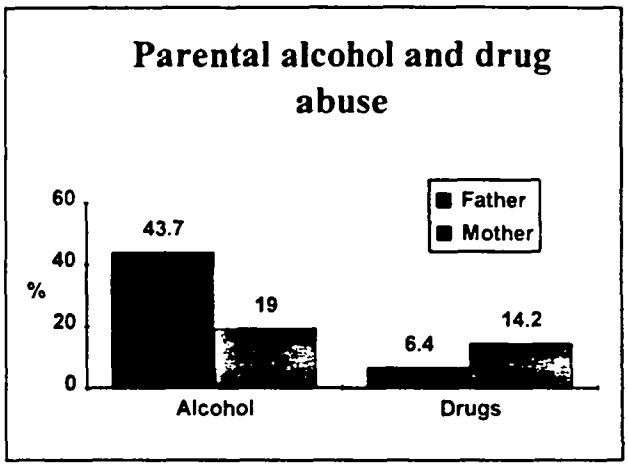
Details were obtained from clients on whether they had been raised by biological or adoptive parents. 161 (71%) grew up with both biological parents, 11% grew up with one biological parent, 5% of clients were adopted or lived with stepparents and 11% grew up in foster/welfare homes.



Alcohol and drug abuse

Parents

On the basis of information obtained from clients, 50.7% of 221 clients had parent(s) (biological and adoptive combined) who abused alcohol;19% of 211 mothers abused alcohol compared with 44% of 206 fathers. 18.2% of 225 clients had parent(s) (biological and adoptive combined) who abused drugs; 14.2% of 212 mothers abused drugs compared with 6.4% of 203 fathers.



Siblings

34.7% of 190 clients had siblings with a history of drug abuse and 18.7% of 187 clients had siblings with a history of alcohol abuse.

Psychiatric illness

12% of 209 mothers were reported to have a history of psychiatric illness (n=209) compared with only 6.1% of 198 fathers.

Chapter 18. Childhood history of violence

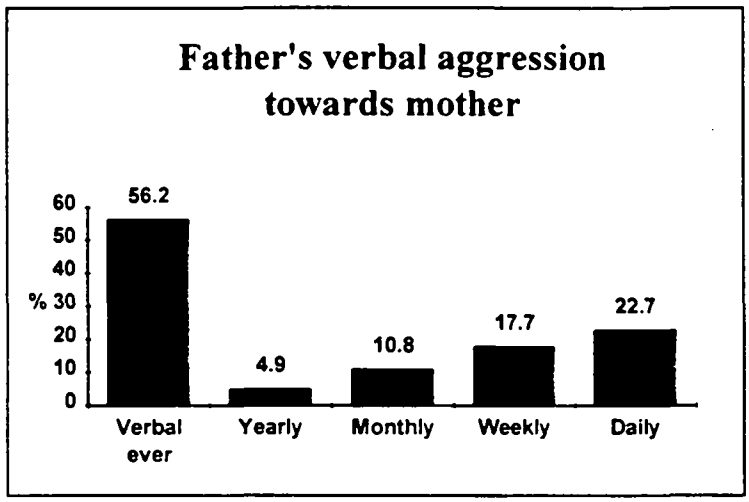
Clients were asked whether parents were verbally or physically aggressive towards each other or towards the client. Verbal aggression was defined as ever shouting/screaming, threatening/intimidating, humiliating/demeaning or swearing/cursing. Physical aggression included actions such as hitting and throwing things around.

Verbal aggression between parents

Father towards mother

114 of 203 fathers (56.2%) were reported by clients to have been verbally aggressive 'ever' towards the mother.

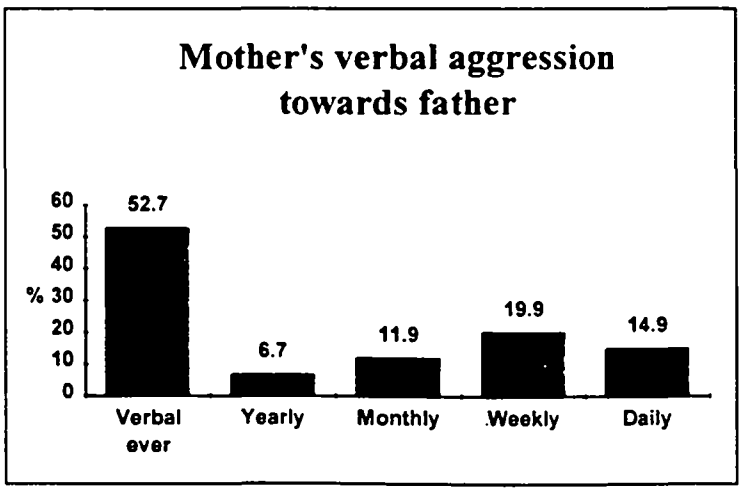
Forty-six of 203 fathers, (22.7%) were reported to be verbally aggressive daily, 36 (17.7%) were verbally aggressive weekly, 22 (10.8%) monthly and 10 (4.9%) yearly.



Mother towards father

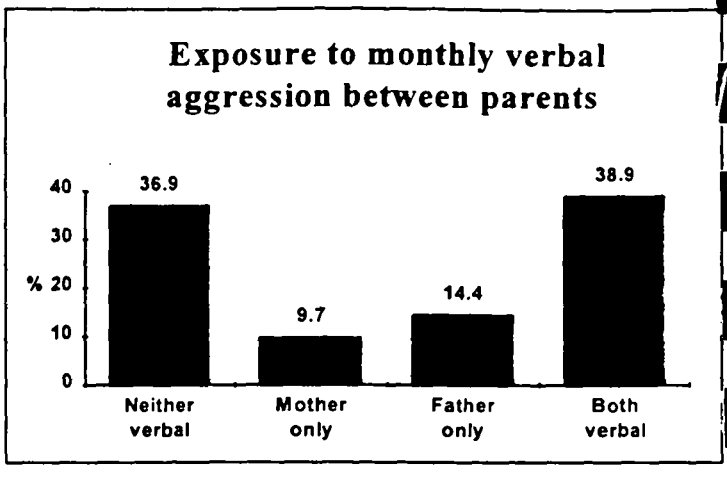
106 of 201 mothers (52.7%) were reported by clients to have been verbally aggressive ever towards the father.

Twenty-nine of 201 (14.4%) mothers were reported to be verbally aggressive daily, 40 (19.9%) were reported to be verbally aggressive weekly, 24 (11.9%) were reported to be verbally aggressive monthly and 13 (6.5%) yearly.



One or both parents verbally aggressive

Analyses of clients exposed to verbal aggression were conducted using the criteria of verbal aggression occurring on at least a monthly basis. 123 clients of 195 clients (63.1%) reported that one or both parents were verbally aggressive towards one another. 19 clients (9.7%) reported that their mother was verbally aggressive compared with 22 clients (14.4) who reported that their father was verbally aggressive. A further 76 (38.9%) were verbally aggressive towards each other.

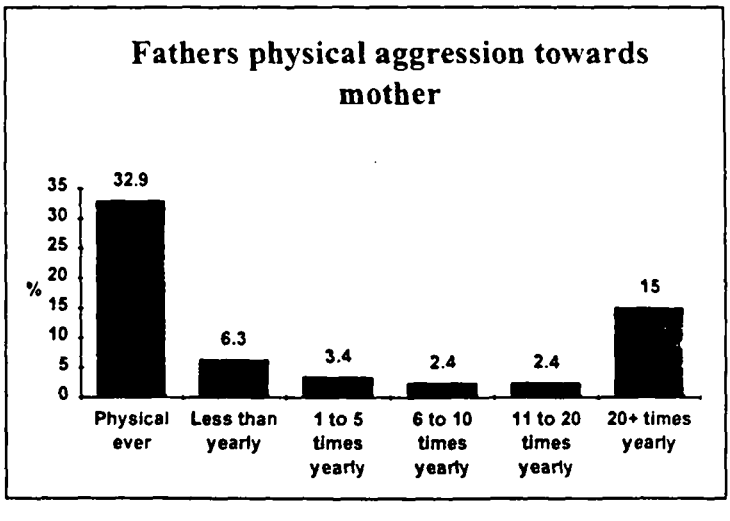


Physical aggression between parents

79 of 201 clients (39.3%) reported that one or both parents were physically aggressive ever towards one another.

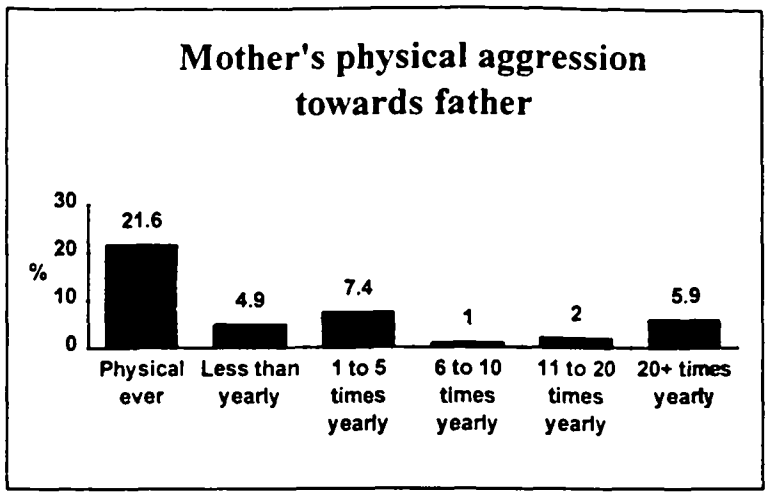
Father physical aggression towards mother

68 fathers of 207 (32.9%) were reported to have been physically aggressive ever against the mother. Of the 68 fathers who were physically aggressive towards the mother, 21.3% were aggressive less than once per year, 11.5% were aggressive between one and five times a year, 8.2% were aggressive between 6-10 times a year, 8.2% between 11-20 times and 15% were physically aggressive more than 20 times a year.



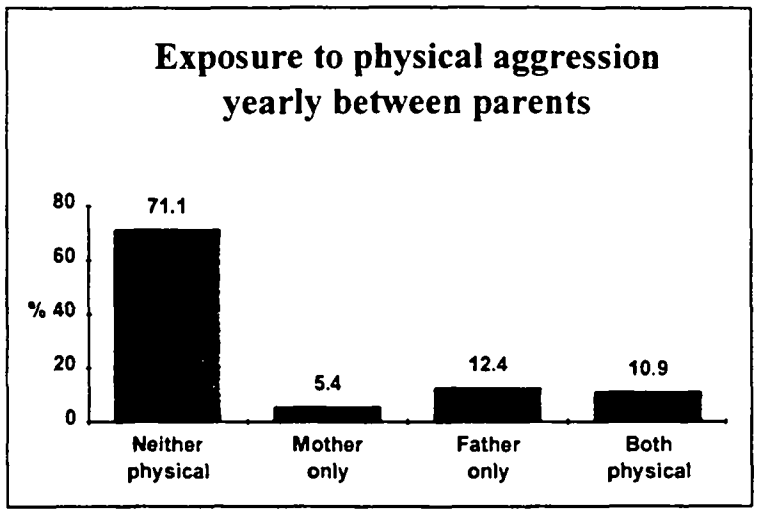
Mother physical aggression towards father

44 mothers of 204 (21.6%) were reported to have been physically aggressive ever against the father. Of the 43 mothers who were physically aggressive against the father, 23.3% were aggressive less than once per year, 34.9% were aggressive 1-5 times per year, 4.7% were aggressive 6 to 10 times per year, 9.3% were aggressive 11-20 times per year and 27.9% were aggressive more than 20 times per year.



Exposure to physical aggression between parents

Analyses of clients exposed to physical aggression were conducted using the criteria of physical aggression occurring on at least a yearly basis. 58 of 201 clients (28.9%) reported that one or both parents were physically aggressive towards one another. Eleven clients (5.4%) reported that their mother was physically aggressive compared with 25 clients (12.4%) who reported that their father was physically aggressive. A further 22 parents (10.9%) were physically aggressive towards each other.



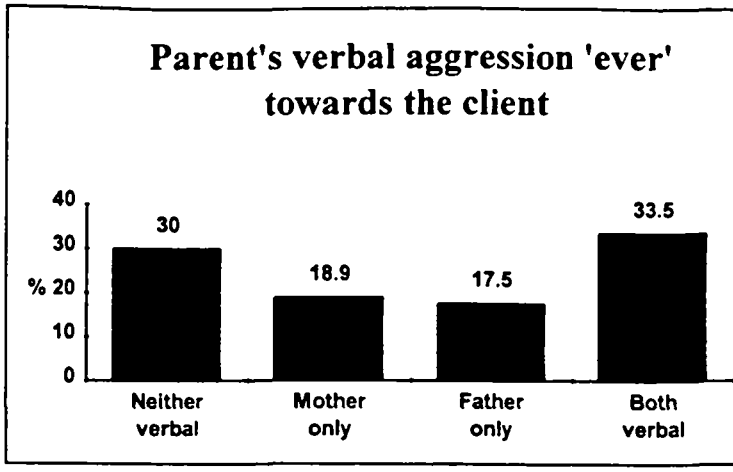
Parental alcohol use and physical aggession

49 of 67 (73.1%) clients reported that their father had usually been drinking alcohol prior to being physically aggressive towards the mother. 18 of 40 (45%) clients reported that their mother had usually been drinking alcohol when physically aggressive towards the father.

Verbal aggression of parents towards the client

144 of 206 clients (70%) reported that one or both parents were verbally aggressive towards them.

39 clients (18.9%) reported that their mother was verbally aggressive towards them compared with 36 clients (17.5%) who reported that their father was verbally aggressive. A further 69 (33.5%) reported both parents to be verbally aggressive towards them.

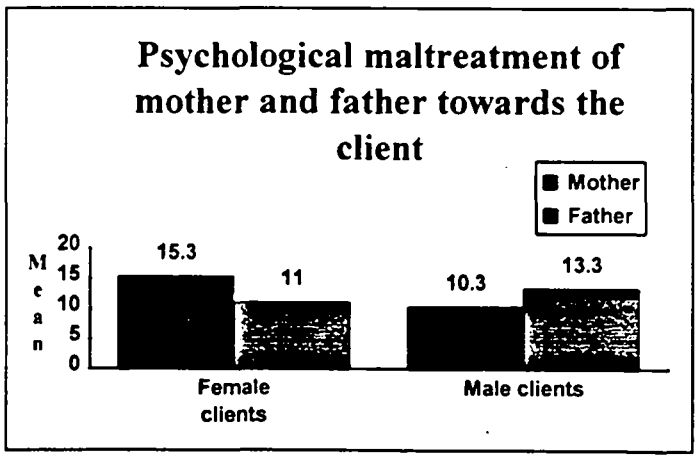


99 of the male clients (72.8%) reported that one or both parents were verbally aggressive towards them. 24 clients (17.6%) reported that their mother was verbally aggressive towards them compared with 25 clients (18.4%) who reported that their father was verbally aggressive. A further 50 (36.8%) reported both parents to be verbally aggressive towards them.

45 of the female clients (64.3%) reported that one or both parents were verbally aggressive towards them. 15 clients (21.4%) reported that their mother was verbally aggressive towards them compared with 11 clients (15.7%) who reported that their father was verbally aggressive. A further 19 (27.1%) reported both parents to be verbally aggressive towards them.

Psychological maltreatment

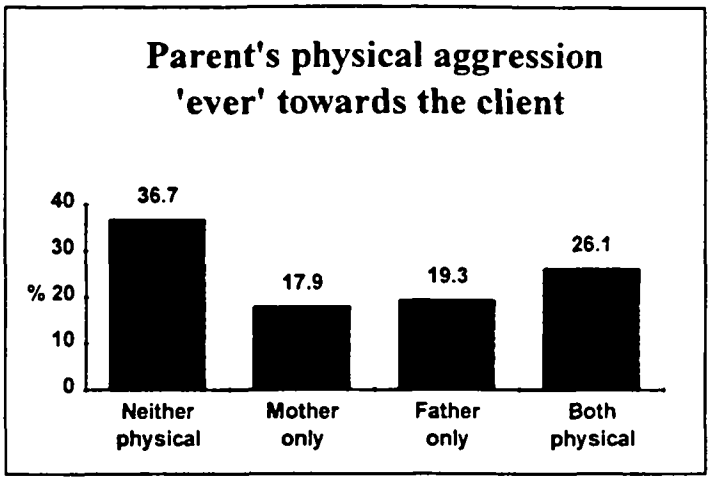
Mean scores on the psychological maltreatment scale for mothers towards the client were 11.97. This was lower than the comparison mean for controls (mean = 14.60). The mean score for mother's psychological maltreatment for males and females was 10.32 and 15.31 respectively.



Mean scores on the psychological maltreatment scale for fathers towards the client were 12.49. This was higher than the comparison mean for controls (mean = 11.22). The mean score for father's psychological maltreatment for males and females was 13.29 and 11.0 respectively.

Physical aggression of parents towards the client

131 of 207 clients (63.3%) reported that one or both parents were physically aggressive towards them; 37 (17.9%) had mothers who were physically aggressive compared with 40 (19.3%) fathers. An additional 54 (26.1%) clients experienced physical aggression from both parents.

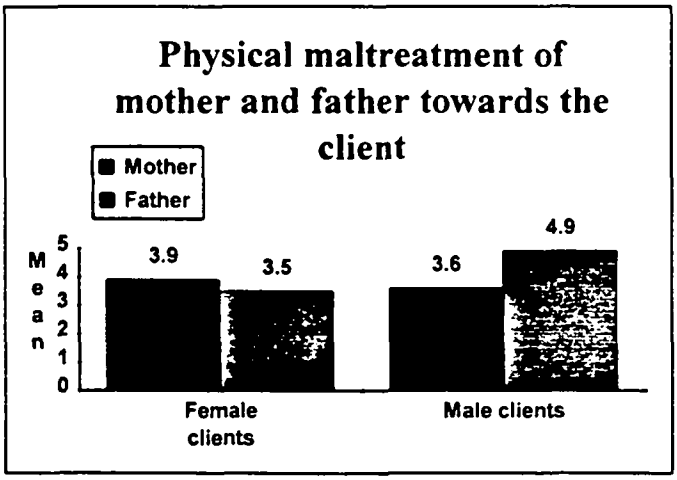


96 male clients (69.1%) reported that one or both parents were physically aggressive towards them; 23 (16.6%) had mothers who were physically aggressive compared with 30 (21.6%) fathers. An additional 43 (30.9%) clients experienced physical aggression from both parents.

35 female clients (51.5%) reported that one or both parents were physically aggressive towards them; 14 (20.6%) had mothers who were physically aggressive compared with 10 (14.7%) fathers. An additional 11 (16.2%) clients experienced physical aggression from both parents.

Physical maltreatment

Mean scores on the physical maltreatment scale for mothers toward the client was 3.72. This was higher than the comparison mean for controls (mean = 2.67). The mean score for mother's physical maltreatment for males and females was 3.62 and 3.9 respectively.



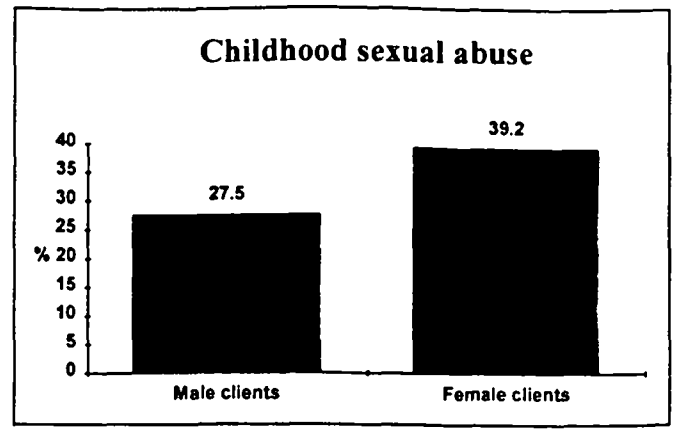
Mean scores on the physical maltreatment scale for fathers towards the client were 4.4. This was higher than the comparison mean for controls (mean = 2.02). The mean score for father's physical maltreatment for males and females was 4.86 and 3.49 respectively.

Parental alcohol use and physical aggression towards the client

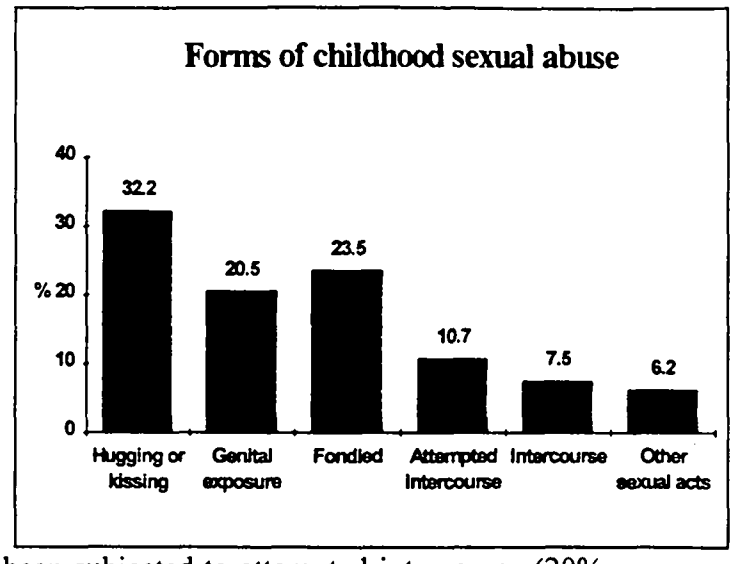
36 of 101 (35.6%) clients reported that their father had usually been drinking alcohol prior to being physically aggressive towards the client. 10 of 113 (8.8%) clients reported that their mother had usually been drinking alcohol when physically aggressive towards the client.

Childhood sexual abuse

Childhood sexual abuse was defined as being kissed or hugged in a sexual way through to sexual intercourse prior to the age of 13. Seventy of 232 (31.4%) clients reported that they were subjected to sexual abuse. 29 (39.2%) of the female clients had been abused compared with 41 (27.5%) of the male clients.



Forms of childhood sexual abuse



Of those who had been abused 32.2% had been hugged or kissed in a sexual way (13.7% by immediate family member; 82.3% by other relatives or persons known to the family; 3.9% by strangers), 20.5% had been exposed to others genitals (11.9% by immediate family member; 78.6% by other relatives or persons known to the family; 9.5% by strangers), 23.5% had been fondled in a sexual way, (16.7% by immediate family member; 75% by other relatives or persons known to the family; 8.3% by strangers), 10.7% had been subjected to attempted intercourse (20% by immediate family member; 80% by other relatives or persons known to the family) and for 7.5% sexual intercourse had occurred (21.4% by immediate family member; 71.4% by other relatives or persons known to the family; 7.1% by strangers). A further 6.2% had experienced other sexual acts (10% by immediate family member; 70% by other relatives or persons known to the family; 20% by strangers).

Chapter 19. Violence amongst the client population

Any problems in the relationship

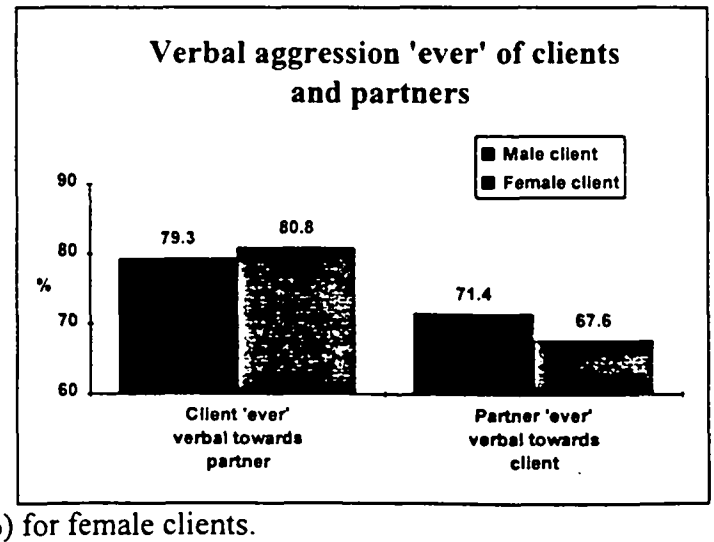
Clients were asked early during the interview whether there were any problems in their relationship. Of the 189 clients who answered this question, only a small proportion acknowledged any form of abuse as being a problem; 6.3% reported physical abuse, 3.7% reported emotional abuse, 1.1% reported sexual abuse and 1.1% reported financial abuse.

Psychological/verbal aggression between client and partner

Verbal aggression was assessed using four methods. The first was the question "have you ever been verbally aggressive towards your partner " and "has your partner ever been verbally aggressive towards you". The second measure was the ISA, the third method was the verbal aggression subscale of the CTS and the fourth method was the psychological abuse scale for parents modified for the client and partner for which there are no norms. This section reports the findings from the first three measures.

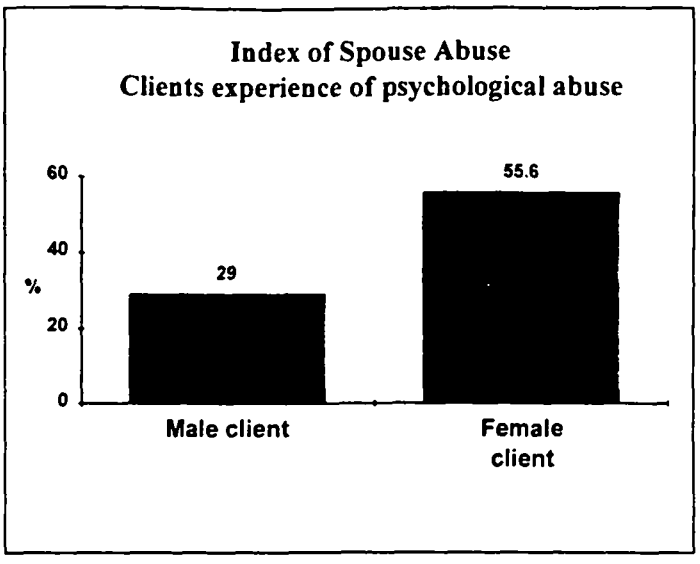
Item on verbal aggression

In response to the question "have you ever been verbally aggressive towards your partner?" 170 of 213 clients (79.8%) answered yes. This corresponded to 111 of 140 (79.3%) for male clients and 59 of 73 (80.8%) for female clients.



In response to the question has your partner ever been verbally aggressive towards you? 150 of 214 clients (70.1%) replied yes. This corresponded to 100 of 140 (71.4%) for male clients and 50 of 74 (67.6%) for female clients.

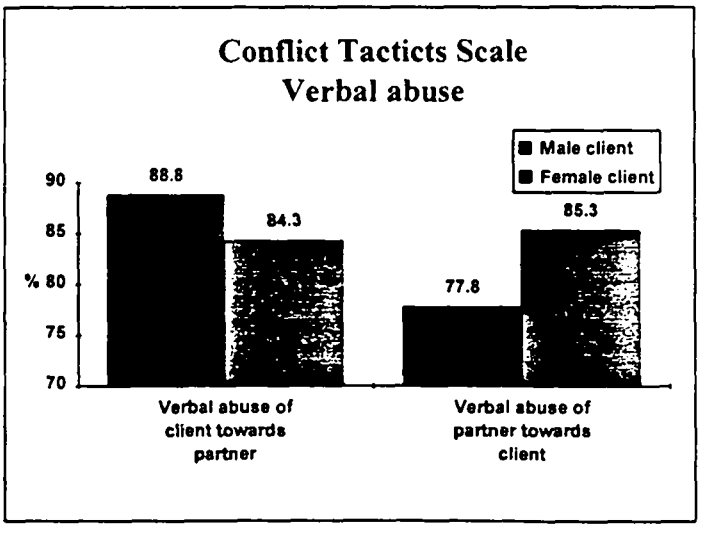
Index of Spouse Abuse



Using the ISA the mean level of non-physical abuse experienced by male and female clients was 22.76. For the males it was 19.01 and for females it was 29.59.

24 of 82 (29%) male clients scored above the cut-off point of 25 indicative of experiencing non-physical abuse while 25 of 45 (55.6%) female clients scored above the cut-off point of 25. The mean scores for males and females who scored above the cut off point were 44.57 (SD=13.12) and 50.52 (SD=18.95) respectively.

Conflict Tactics Scale



Using the verbal aggression subscale of the CTS, 87.3 % of 204 clients reported that they were verbally aggressive towards their partner in the last year. 80.3% of partners were reported to be verbally aggressive towards the client during the last year.

There were few differences between gender. 88.8% of 134 male clients reported that they verbally abused their partner and 77.8% of the male clients reported that their partner verbally abused them. This compared with 84.3% of 70 female clients reporting that they verbally abused their partner and 85.3% of the female clients reporting that their partner had verbally abused them.

The prevalence of verbal aggression amongst male and female clients towards their partner were compared to norms based on a US national probability sample {1979}. 67.2 % of 134 male clients had a verbal aggression score above the 50th percentile, 24.6% had a score above the 75th percentile and 14.9% scored above the 95th percentile. 64.4% of their partners had a verbal aggression score above the 50th percentile, 38.5% had a score above the 75th percentile and 11.9% scored above the 95th percentile,

71 % of 69 female clients had a verbal aggression score above the 50th percentile, 55.1% had a score above the 75th percentile and 21.7% had a score above the 95th percentile. 67.2 % of their partners had a verbal aggression score above the 50th percentile and 55.2% had a score above the 75th percentile and 23.9% scored above the 95th percentile..

Summary and comparison of different methods for assessing verbal aggression.

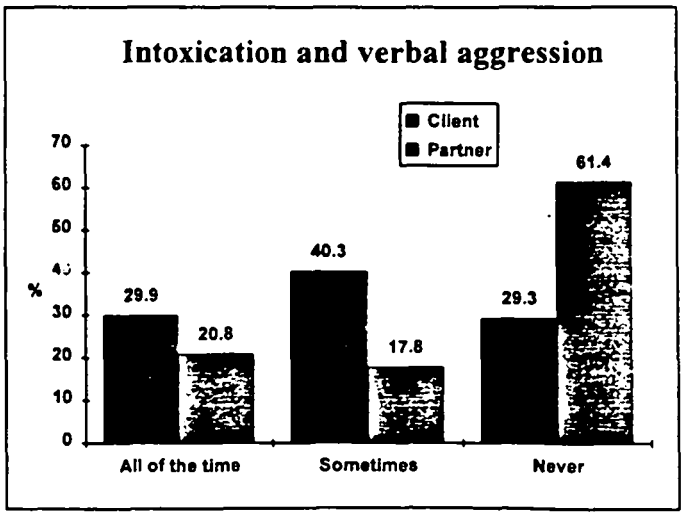
Client verbal aggression against partner: The verbal aggression question and the CTS produced similar results, although higher rates were achieved for males with the CTS. For the verbal aggression question 111 of 140 males (79.3%) and 59 of 73 female clients (80.8%) reported that they abused their partner. This compared with 88.8% of 134 male clients and 84.3% of 70 females for the CTS. The ISA does not provide an index of verbal abuse for clients.

Partner verbal aggression against client: The CTS produced the highest rates of the client being verbally abused by their partner with the corresponding figures of 77.8% and 85.3% for males and females respectively. Using the single aggression question 71.4% for males and 67.6% of the females acknowledged that they had been verbally abused ever. The CTS rates were higher than the verbal aggression question despite the fact that the CTS was restricted to the last 12 months as opposed to 'ever'.

The ISA produced the lowest rates with only 29% and 55.6% of males and females respectively reporting that they had been abused in the last 12 months. This may reflect the more strict definition of 'victim' used to develop the ISA scale. For example, if the 75% percentile is used to identify victims from the CTS scale more equivalent rates of non-physical abuse are identified for both males and females (38.5% vs 55.6% respectively).

Verbal aggression and alcohol abuse

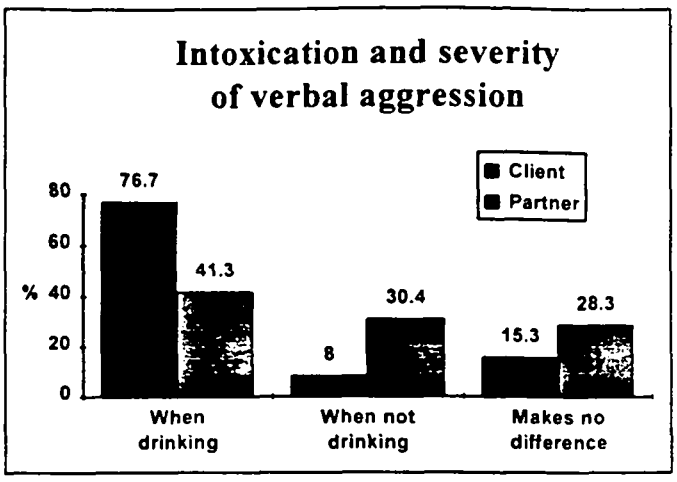
Clients were asked whether they were usually verbally aggressive against their partner when they had been drinking and clients were also asked whether their partner was usually verbally aggressive towards them when their partner had been drinking.



43 of 144 clients (29.9%) reported that they were verbally aggressive all of the time when drinking, 58 (40.3%) reported that they were sometimes verbally aggressive towards their partner when they had been drinking and 43 (29.3%) reported that they were never

verbally aggressive towards their partner when they had been drinking.

21 of 101 clients (20.8%) reported that their partner had been drinking all of the time when they were verbally aggressive towards the client, 18 (17.8%) reported that their partner was sometimes verbally aggressive towards the client when they had been drinking and 62 (61.4%) reported that their partner was never verbally aggressive towards the client when they had been drinking.



105 of 137 clients (76.7%) reported that the verbal aggression was worse when they had been drinking. 11 (8%) reported that the verbal aggression was worse when they had not been drinking and 21 (15.3%) reported that it made no difference.

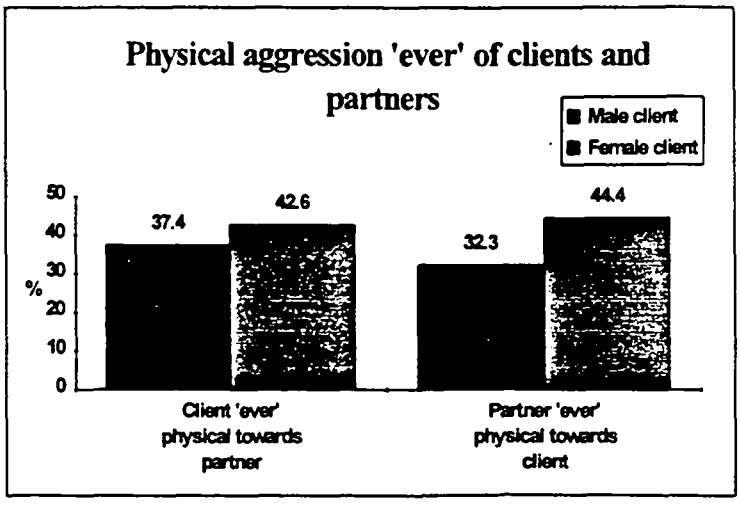
38 of 92 clients (41.3%) reported that the verbal aggression of their partner was worse when the partner had been drinking. 28 (30.4%) reported that the verbal aggression was worse when the partner had not been drinking and 26 (28.3%) reported that it made no difference.

Physical aggression between client and partner

Physical aggression was assessed using three methods. The first method asked whether the client had been physically aggressive towards their partner in the last year and whether their partner been physically aggressive towards them in the last year. The second method was the physical abuse scale of the ISA and the third was the physical aggression subscale of the CTS. This section reports the findings for each method.

Item on physical aggression

In response to the question whether the client had been physically aggressive to their partner 69 of 177 (39%) clients answered yes. This corresponded to 46 of 123 (37.4%) for male clients and 23 of 54 (42.6%) for female clients.



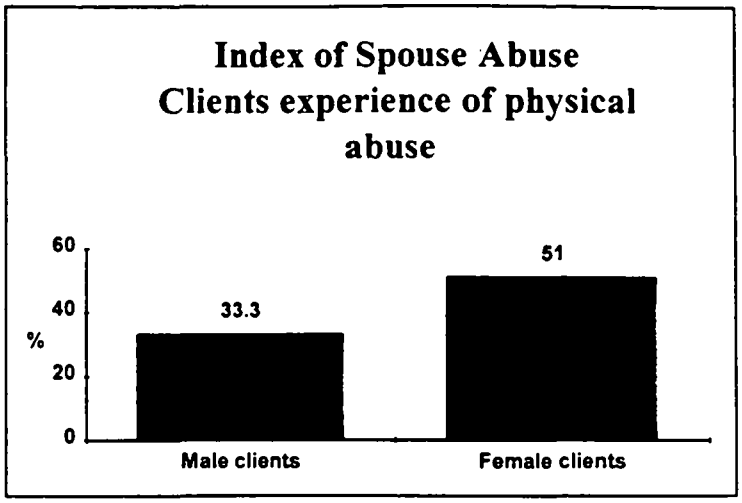
In response to the question "has your partner ever been physical aggressive towards you?" 70 of 193 clients (36.3%) replied yes. This corresponded to 42 of 130 (32.3%) for male clients and 28 of 63 (44.4%) for female clients.

Index of Spouse Abuse

Using the physical abuse scale of the ISA the mean level of physical abuse experienced by clients was 12.38. For males it was 9.77 and for females it was 17.28.

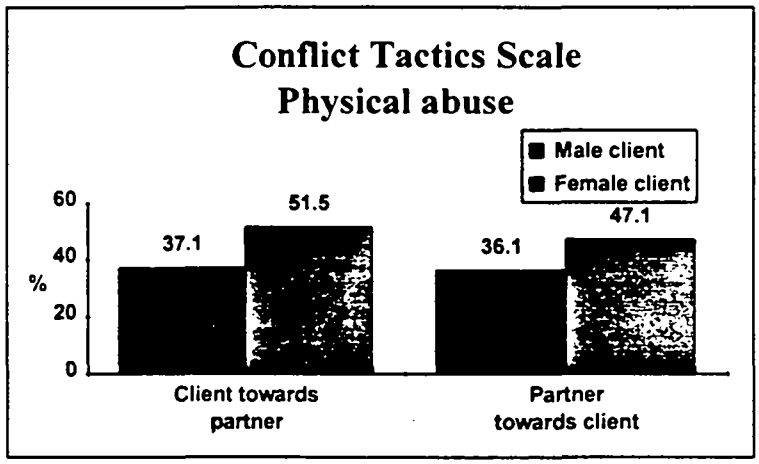
27 of 81 (33.3%) male clients scored above the cut-off point of 10 indicative of experiencing physical abuse while 22 of 43 (51%) female clients scored above the cut-off point of 10.

The mean scores for males and females above the cut-off point were 27.36 (SD=13.78) and 35.48 (SD=14.7) respectively.



Conflict Tactics scale

Using the CTS, 42% of 200 clients reported that they were physically aggressive towards their partner in the last year. 37.1% of 132 male clients reported that they physically abused their partner and 51.5% of 68 female clients reported that they physically abused their partner.



39.8% of 200 clients reported that their partner was physically aggressive towards them during the last year. 36.1% of 132 male clients claimed that their partner physically abused them and 47.1% of 68 female clients claimed that their partner physically abused them.

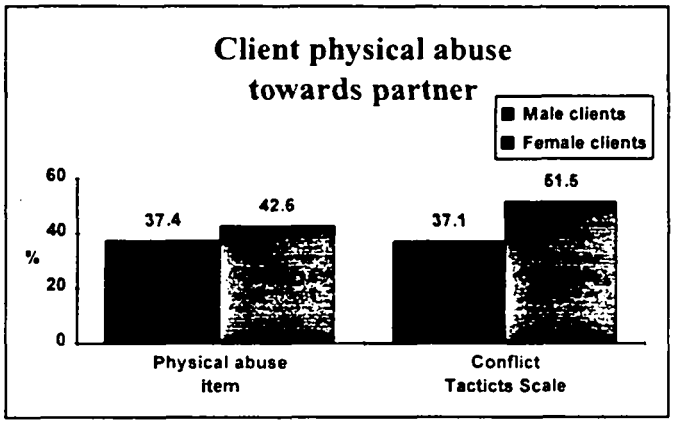
Summary and comparison of different methods for assessing physical aggression.

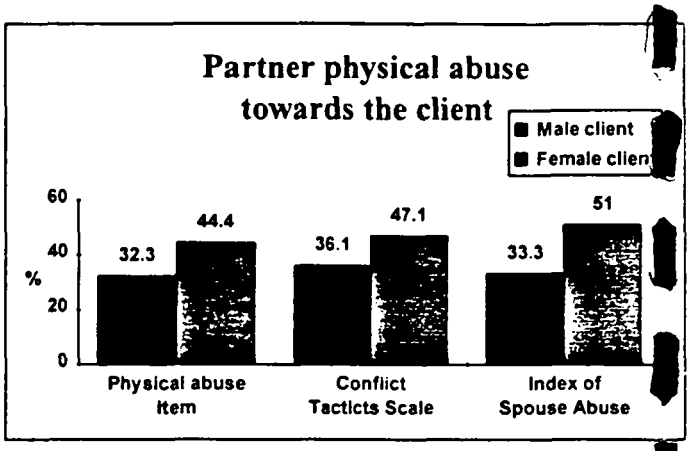
Client physical aggression towards partner: The physical aggression question and the CTS produced similar results, although higher rates of physical aggression were observed with the CTS for female clients. For the abuse question 37.4% male and 42.6% of female clients reported that they physically abused their partner. This compared with 37.1% of male and 51.5% of female clients for the CTS. The ISA does not provide an index of physical abuse for clients.

Partner physical aggression towards client: Rates of physical aggression for the partner towards the client were very similar. CTS rates for the client being abused by their partner were 36.1% and 47.1% for males and females respectively. Using the

single physical aggression question 32.3% of males and 44.4 % of females reported that they that they had been physically abused 'ever'. The ISA produced rates of physical abuse of 33.3% and 51% for males and female clients respectively.

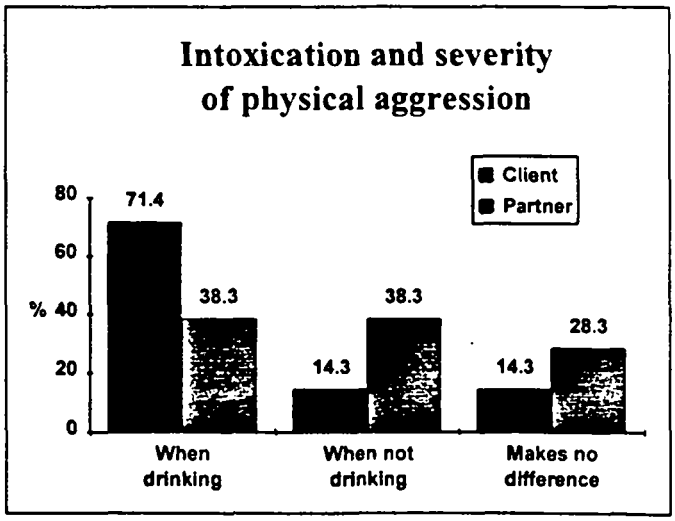
Rates based on CTS and the ISA were higher than the physical aggression question for partner aggression against the client despite the fact that these scales were restricted to the last 12 months as opposed to 'ever'.





Physical aggression and alcohol use

While the mean number of times the client reported that they were physically aggressive towards their partner in the last year was 5.99 (SD=8.51), the mean number of times that they were under the influence of alcohol was reported to be 4.63 (SD=8.0). While the mean number of times the client reported that their partner was physically aggressive towards them in the last year was 10.51 (SD=22.6), the mean number of times that they were under the influence of alcohol at the time was reported to be 7.77 (SD=23.8).



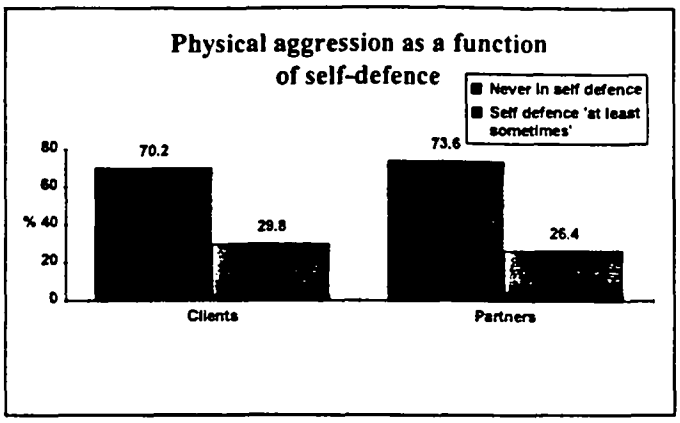
25 of 35 clients (71.4%) reported that the physical aggression was worse when they had been drinking. 5 (14.3%) reported that the physical aggression was worse when they had not been drinking and 5 (14.3%) reported that it made no difference.

23 of 60 clients (38.3%) reported that the physical aggression was worse when the partner had been drinking. 20 (33.3%) reported that the physical aggression was worse when the partner had not been drinking and 17 (28.3%) reported that it made no difference.

Detailed data on physical violence from the Conflict Tactics Scale

Overall violence index for clients and their partners

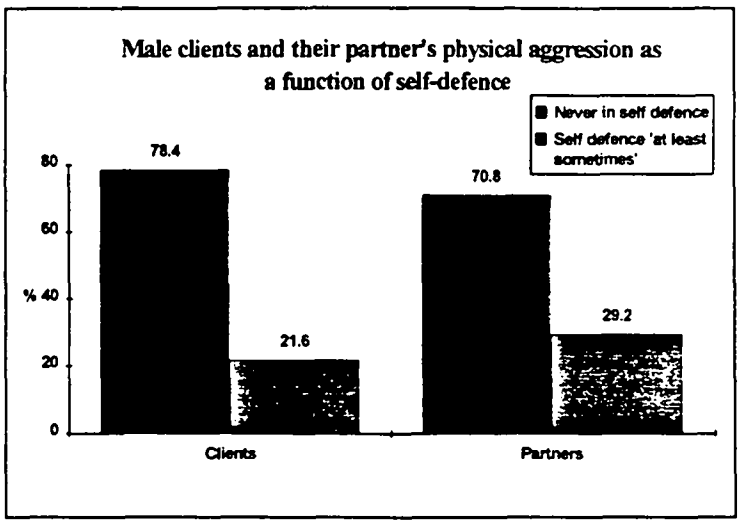
42% of 200 clients reported that they were physically aggressive towards their partner in the last year, and 70.2% of those who were violent claimed that this was never in self-defence.



39.8% of clients reported that there partner was physically aggressive towards the client during the last year and 73.6% of these clients reported that their partner was not defending themselves.

Male clients and their partners

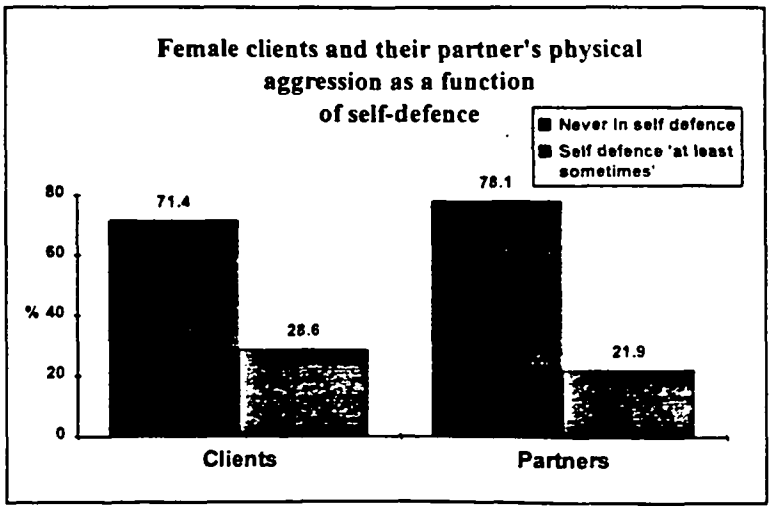
37.1% of 132 male clients reported that they physically abused their partner and 78.4% reported that this was never in self-defence. 36.1% of male clients reported that their partner physically abused them and 70.8% of those that were abused reported that this was never in self-defence.



The prevalence of physical aggression amongst male clients against their partner were compared to norms based on the US national probability sample {1979}. 37.1 % of male clients had a physical aggression score above the 75th percentile and 12.9% scored above the 95th percentile. 36.1% of their partners had a physical aggression score above the 75th percentile and 18.8% scored above the 95th percentile.

Female clients and their partners

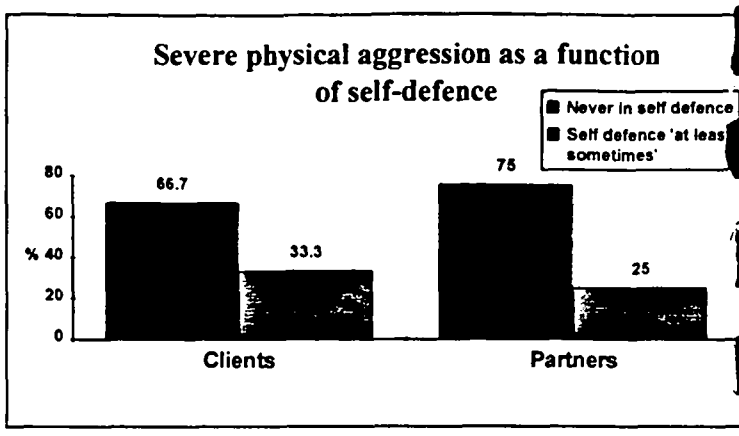
51.5% of 68 female clients reported that they physically abused their partner and 71.4% of those that were aggressive reported that this was never in self-defence. 47.1% of female clients claimed that their partner physically abused them and that 78.1% of these aggressive partners were never defending themselves. 52.2% female



clients had a physical aggression score above the 75th percentile and 23.9% had a score above the 95th percentile. 47.8 % of their partners had a physical aggression score above the 75th percentile and 28.4% scored above the 95th percentile {1979}.

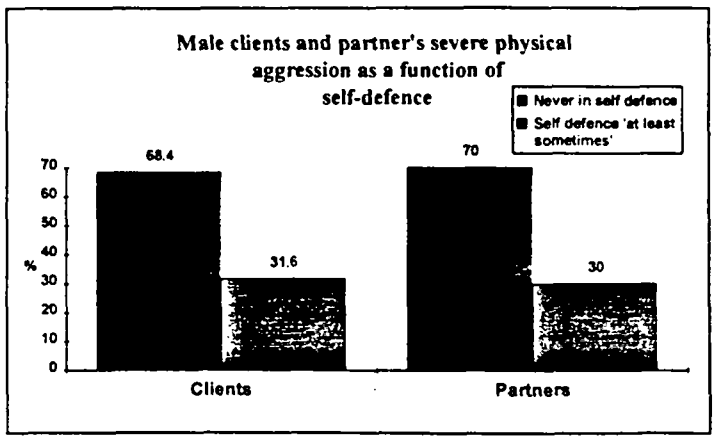
Severe violence index for clients and their partners

19.4% of the 201 clients reported that they used severe violence against their partner during the last year and 66.7% of those who were violent claimed that this was never in self-defence. 24% of clients reported that their partners were severely physically aggressive towards the client and that for 75% of violent partners the aggression was never in self-defence.



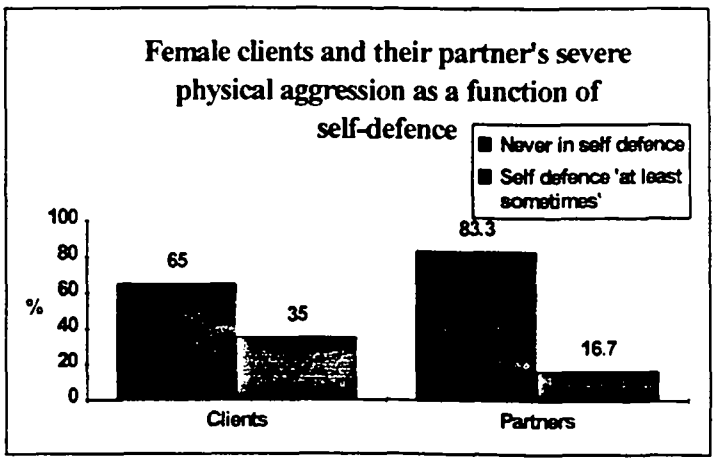
Male clients and their partners

14.3% of 132 male clients reported that they severely physically abused their partner and 68.4% reported that this was never in self-defence. 22.6 % of male clients claimed that their partner severely physically abused them and that for 70% of aggressive partners the aggression was never in self-defence.



Female clients and their partners

29.4% of female clients reported that they severely physically abused their partner and 65% of those that were aggressive reported that this was never in self-defence. 26.5% of female clients claimed that their partner severely physically abused them and that for 83.3% of partners the aggression was never in self-defence.



Remorse about the violence

Clients were asked whether they or their partner experienced remorse on a typical occasion when physical aggression had been initiated. 44 clients of 58 (75.9%) reported that they had felt remorse after being physically violent towards their partner. 22 of 38 (57.9%) clients reported that their partner experienced remorse when they were physically aggressive towards the client.

Violence in previous relationships

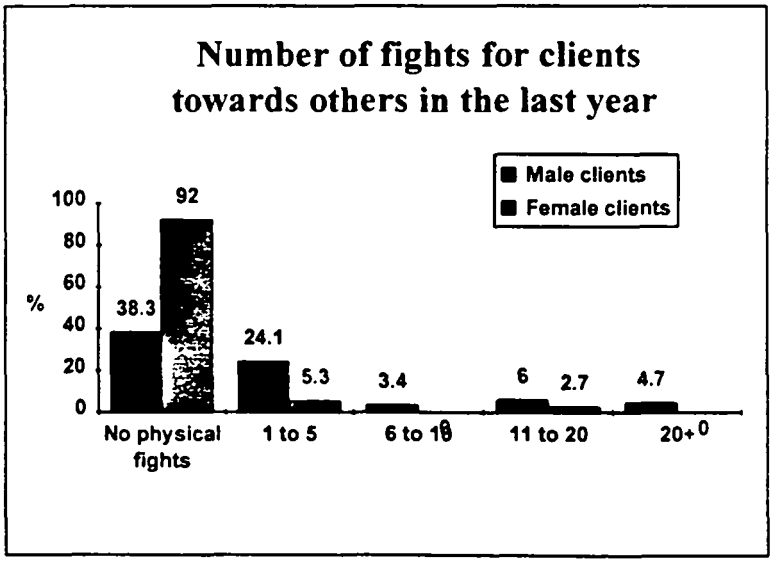
57 of 223 (25.6%) clients reported that they had been physically aggressive towards a partner in a previous relationship. 72 of 223 (32.3%) clients reported that a partner in a previous relationship had been physically aggressive towards them. 37 of 204 partners (18.1%) were reported to have been aggressive in a previous relationship.

General violence

63 clients of 224 (21.8%) reported that they had been violent in the last year to someone other than their partner. Of 149 males, 57 (38.3%) had been violent compared with 6 of 75 females (8%).

Of 224 clients, 17.8% had been in 1 or 5 fights, 2.2% had been in 6 to 10 physical fights, 4.9% had been in 11 to 20 fights and 3.1% had been in more than twenty fights.

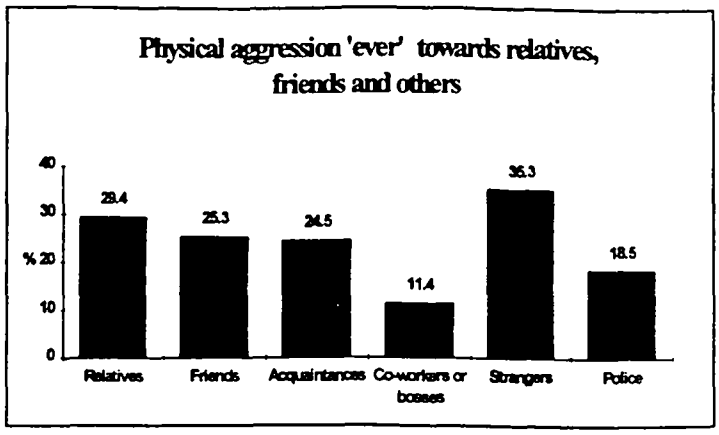
For males, 24.1% had been in 1 or 5 fights, 3.4% had been in 6 to 10 physical fights, 6% had been in 11 to 20 fights and 4.7% had been in more than twenty fights. 38.3% of males had not been in a fight excluding partners.



For females, 5.3% had been in 1 or 5 fights, 2.7% had been in 11 to 20 fights, with the remainder (92%) not being involved in any physical fights excluding partners.

65 of 221 (29.4%) clients reported that they had been physically aggressive towards relatives, 55 of 217 (25.3%) towards friends, 54 of 220 (24.5%) towards acquaintances, 25 of 219 (11.4%) towards co-workers or bosses, 77 of 218 (35.3%) towards strangers and 40 of 216 (18.5%) towards police.

Clients were asked whether there was a period in their life when they had been more physical fights than the last year. 103 of 218 (47.2%) clients said there had been such a period. 87 of 147 male (59.2%) clients compared with 16 of 71 female (22.5%) clients said that there had been a time when they were in more physical fights.



Of those who had been more violent, 24.3% had been more violent during childhood (up to age 12), 37.9% during adolescence (13-17), 36.9% during young adulthood (18 to 25) and 19.4% in adult life (26+). For males who had been violent 21 of 87 (24.1%) had been more violent during childhood, 37.9% during adolescence, 41.4% during early adulthood and 17.2% during adult life. For females, who had been violent 4 of 16 (25%) had been more violent during childhood, 37.5% during adolescence, 12.5% during early adulthood and 31.3% during adult life.

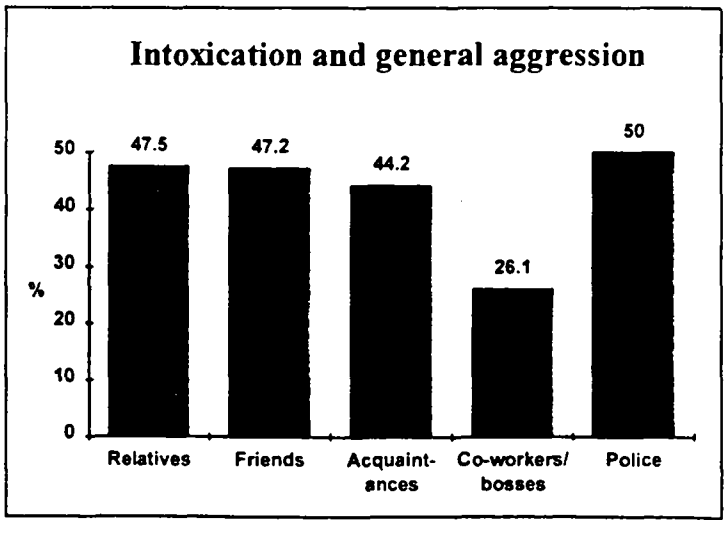
Legal consequences of violence

52 of 218 clients (23.9%) had been arrested for their physically aggressive behaviour and 11 of 196 (5.6%) had been sent to gaol for their violent behaviour.

General violence and alcohol aggression

Over half the clients reported that they were under the influence of alcohol when aggressive with relatives, friends, acquaintances, strangers or police.

29 of 61 clients who were aggressive with relatives (47.5%) were under the influence of alcohol all of the time or most of the time. The remainder (52.5%) were some of the time, rarely or none of the time aggressive with relatives while under the influence of alcohol.



25 of 53 clients who were aggressive with friends (47.2%) were under the influence of alcohol all of the time or most of the time. The remainder (52.8%) were some of the time, rarely or none of the time aggressive with relatives while under the influence of alcohol.

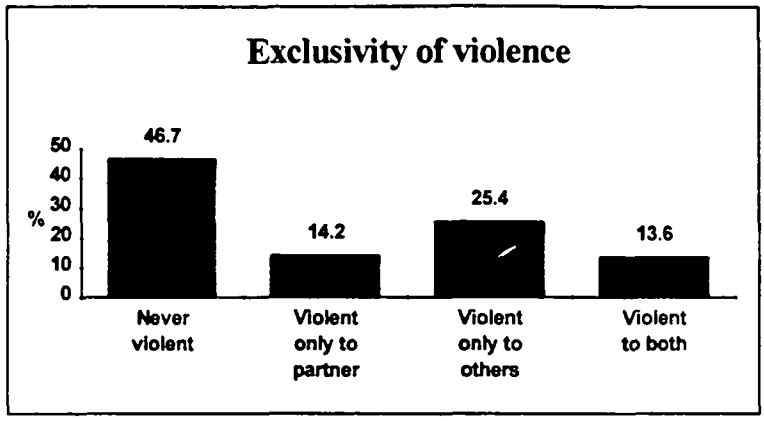
23 of 52 clients who were aggressive with acquaintances (44.2%) were under the influence of alcohol all of the time or most of the time. The remainder (55.8%) were

some of the time, rarely or none of the time aggressive with relatives while under the influence of alcohol.

6 of 23 clients who were aggressive with co-workers or bosses (26.1%) were under the influence of alcohol all of the time or most of the time. The remainder (73.9%) were some of the time, rarely or none of the time aggressive with relatives while under the influence of alcohol.

19 of 38 clients who were aggressive with police (50%) were under the influence of alcohol all of the time or most of the time. The remainder (50%) were some of the time, rarely or none of the time aggressive with relatives while under the influence of alcohol.

Relationship of general physical aggression to spouse abuse.



79 of 169 clients (46.7%) reported that they were not physically violent towards their spouse or to other people in the last year; 23 (13.6%) reported that they were violent to other people but not their spouse; 43 (25.4%) reported that they were violent towards their spouse but not other people and 24 (14.2%) were violent to both their spouse and other people (χ^2=3.55, p=.059). Therefore of the 67 spouse abusers, 64.2% were not violent towards anyone else compared with 35.8% who were violent to other people in the last year.

Classification of partner abuse

The data from the physical aggression subscale of the CTS was used to classify clients into a perpetrator group, a victim group and a mutual violence group. Two methods were used.

Method 1

The criteria used for the first method was as follows:

1. Clients who were physically aggressive but their partners were not (Perpetrator group)

2. Clients who were not physically aggressive but were the recipients of aggression by their partners (Victim group)

3. Clients who were aggressive towards and experienced aggression from their partners (Mutual violence group).

Method 2

The second method took into account whether physical aggression was in self-defence. The criteria for classifying perpetrators, victims and the mixed group was:.

1. Clients who were physically aggressive but their partners were not (Perpetrator group)

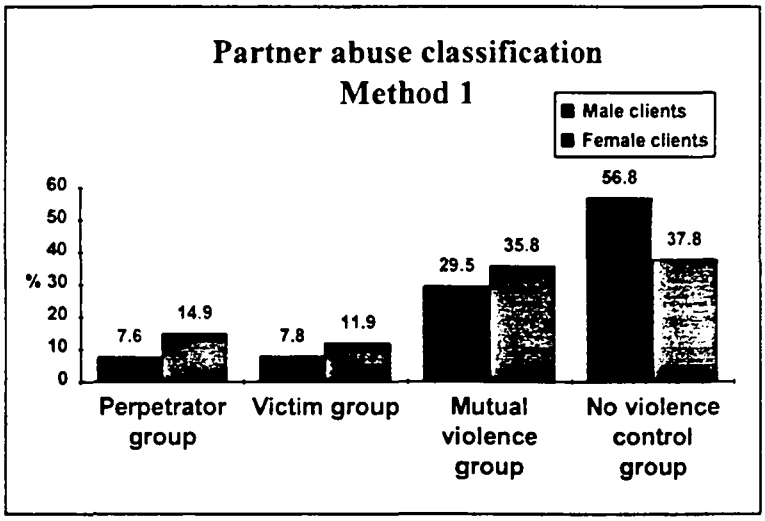
2. Clients who were physically aggressive and who had partners who were physically aggressive but only in self-defence (Perpetrator group).

3. Clients who were physically aggressive but only because they defended themselves against their partner's aggression (Victim group).

4. Clients who were not physically aggressive but were the recipients of aggression by their partners (Victim group)

5. Clients and partners who were both physically aggressive towards each other but the overall level of aggression of each could not be accounted for by self-defence (Mutual violence group)

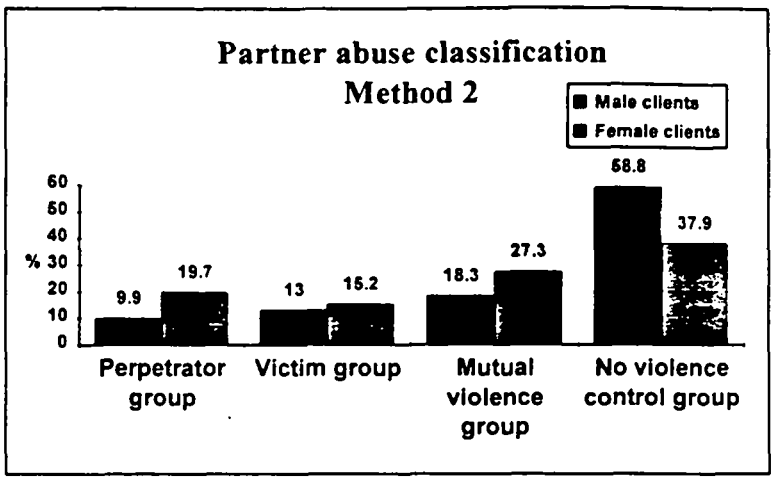
Using the **first method**, 20 clients of 199 (10.1%) were identified to be perpetrators, 16 (8%) were identified to be victims and 63 (31.7%) were identified to be in the mutual violence group. 100 clients (50.3%) were neither victims or perpetrators. Therefore, the overall prevalence rate of partner abuse using the first method was 41.7%.



Of the 132 male clients, 10 (7.6%) were classified as perpetrators, 8 (7.8%) as victims and 39 (29.5%) as mutually violent. 75 male clients (56.8%) were neither victims or perpetrators. Of the 67 female clients 10 (14.9%) were perpetrators, 8 (11.9%) were victims and 24 (35.8%) as mutually violent. 25 (37.8%) were neither perpetrators or victims.

Using the **second method,** 26 clients of 197 (13.2%) were classified as perpetrators, 27 (13.7%) as victims and 42 (21.3%) as mutually violent. 102 clients (51.8%) were neither victims or perpetrators. Therefore, the overall prevalence rate of partner abuse using the second method was 34.5%.

Of the 131 male clients 13 (9.9%) were classified as perpetrators, 17 (13%) as victims and 24 (18.3%) as mutually violent. 17 male clients (58.8%) were neither victims or perpetrators. Of the 66 female clients 13 (19.7%) were classified as perpetrators, 10 (15.2%) as victims and 18 (27.3%) as mutually violent. 25 (37.9%) were neither perpetrators or victims.

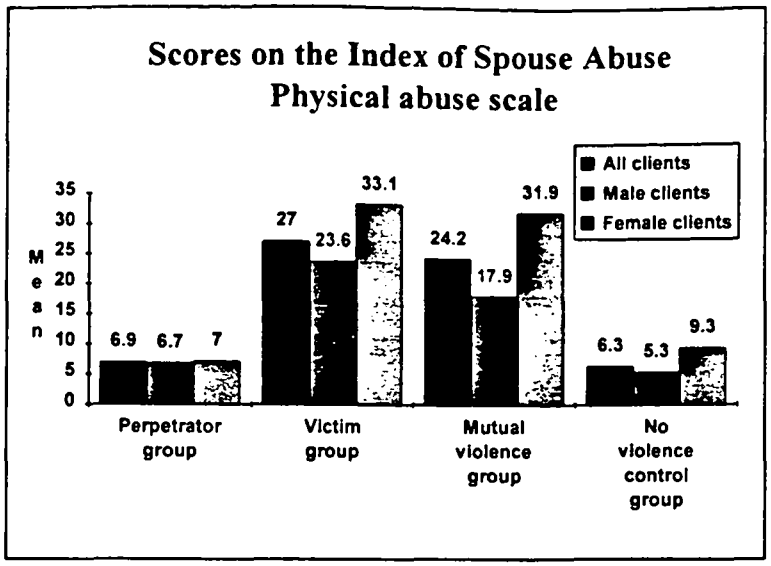


The second classification system taking into account self-defence was used for all analyses examining characteristics of clients who were perpetrators, victims or involved in relationships where there was mutual violence. Each of these groups were compared with a control group of clients who were not violent towards their partner. For all comparisons, males or females in each of the perpetrator and victim groups were compared with male and female control clients respectively.

Relationship of classification to other measures of physical violence

The physical abuse measure derived from the index of spouse abuse was used to validate the classifications of 'victim', 'perpetrator' and 'mutual violence' groups derived from the CTS. It was hypothesised that perpetrators would not differ significantly from controls on the physical abuse scales, whereas 'victims' and the 'mutual' violence groups would have significantly higher scores for partners physical abuse towards them than controls.

As expected, there were no significant differences between perpetrators and controls on the index of spouse physical abuse indicating that the level of physical abuse experienced by perpetrators from their partners did not differ from controls. However, significant differences were evident for the victim group (26.99 vs 6.25, p=.000) and the mutual violence group (24.21 vs 6.25, p=.000).



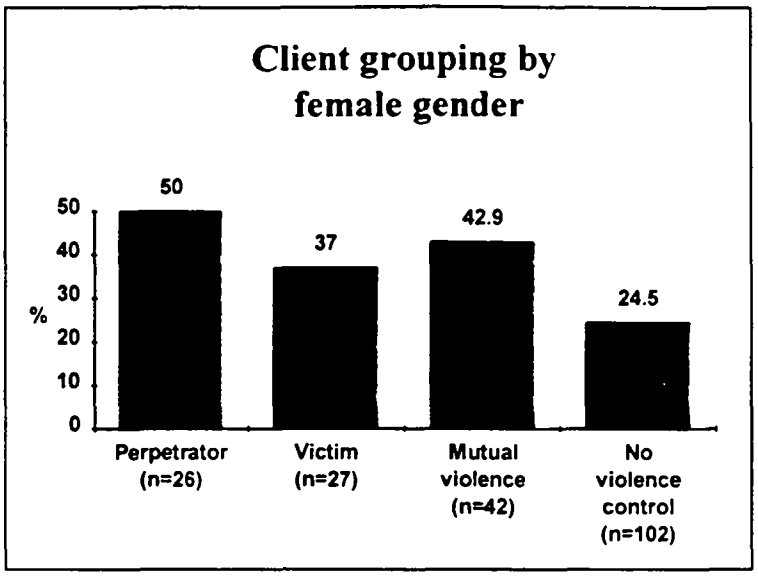
The comparisons for male victims and male controls (23.62 vs 5.28, p=.009) and female victims and female controls (33.12 vs 9.29, p=.007) were significant. The comparisons for male mutual violence group and male controls (17.85 vs 5.28, p=.013) and female mutual violence group and female controls (31.85 vs 9.29, p=.008) were significant.

Chapter 20. Demographics, psychiatric and family history: relationship with spouse abuse

Demographic information

Gender

There were significantly more females in the perpetrator group (χ^2=6.4, p=.01) and mutual violence group (χ^2 = 4.8, p=.03) than the control group. Although not significant, a greater proportion of females were in the victim group than the non violent control group.

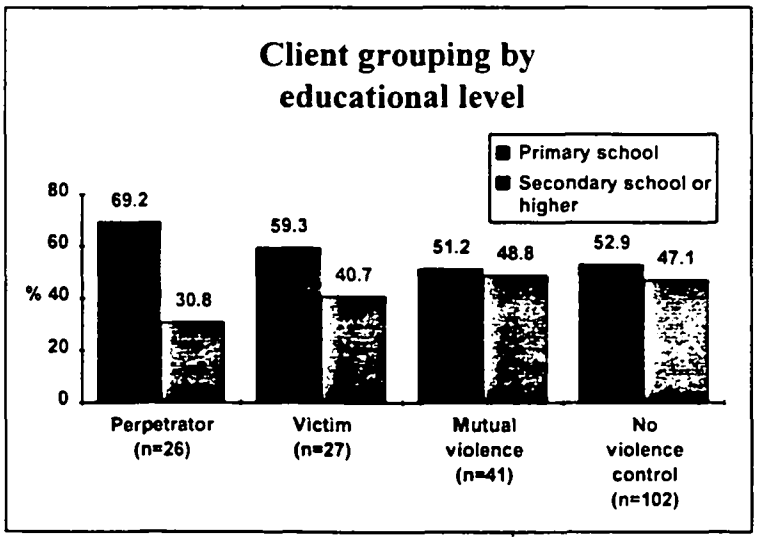


Age

The mean age of 33.3 (SD=7.1) for female perpetrators was significantly lower than the mean age for female controls (42.2, SD = 11.8, p=.02).

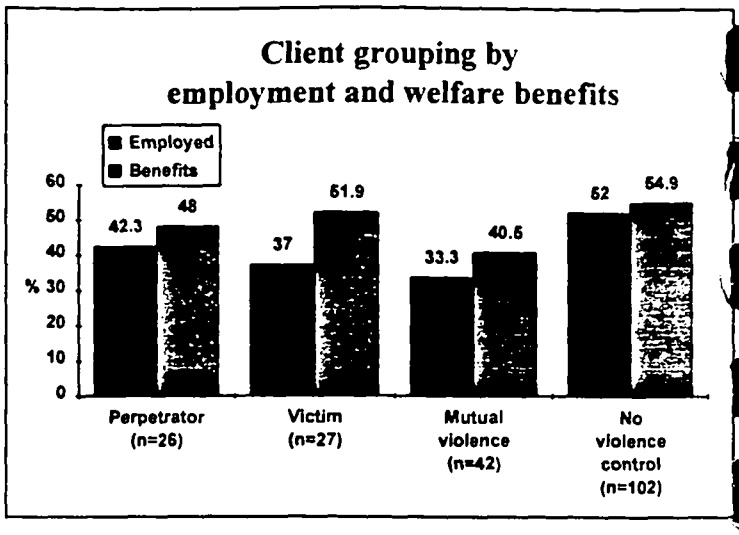
Education

A significantly smaller proportion of the male perpetrator group had completed secondary school, trade certificate, college or university education compared with the male control group (χ^2=4.15, p=.04). Only 10% of female victims had completed secondary school or a higher level of education compared with 52% of the control group (Fishers exact test p=.03).



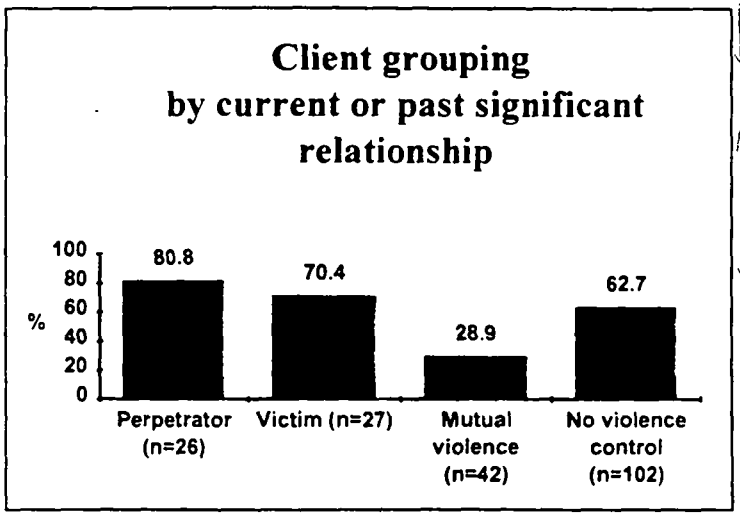
Employment status and welfare benefits

A smaller proportion of clients in the mutual violence group were employed compared with controls (χ^2=4.1, p=.04) and significantly more females in the mutual violence group (72.2%) than female controls (36%) received welfare benefits (χ^2=5.49, p=.02).



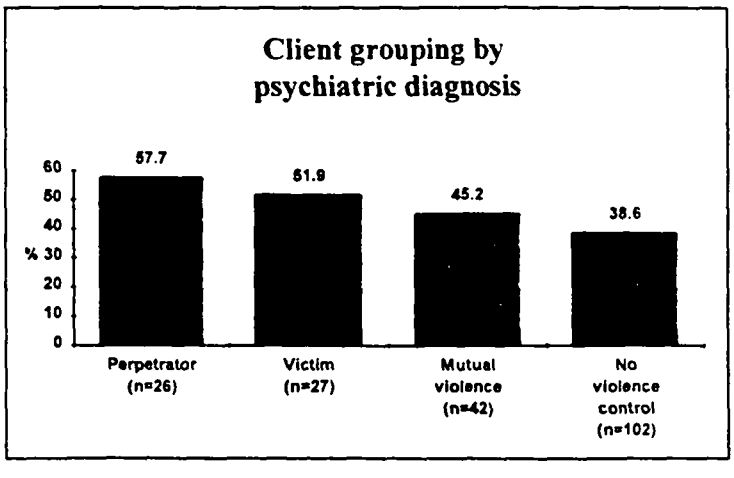
Marital status and relationship status.

No significant findings were found for marital status and client grouping. However, 92.3% of female perpetrators were either currently in a relationship or had been in a significant relationship lasting more than 12 months compared with 60% of controls (Fishers exact test, p=.04)



Psychiatric diagnosis

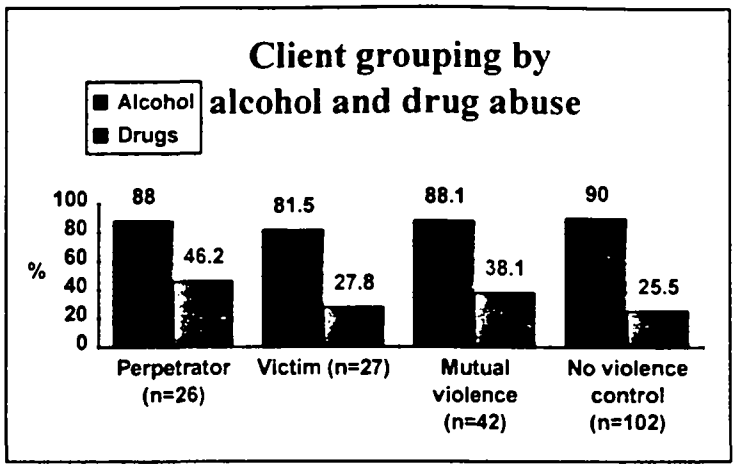
Proportions of males and females in each of the client groups who had ever received 1. a psychiatric diagnosis or 2. a medical diagnosis were compared with the appropriate control. The only significant finding was that male perpetrators were significantly more likely to have received a psychiatric diagnosis than male controls (69.2% vs 36.4%, χ^2 = 4.96, p=.02).



Chronic alcohol and drug abuse

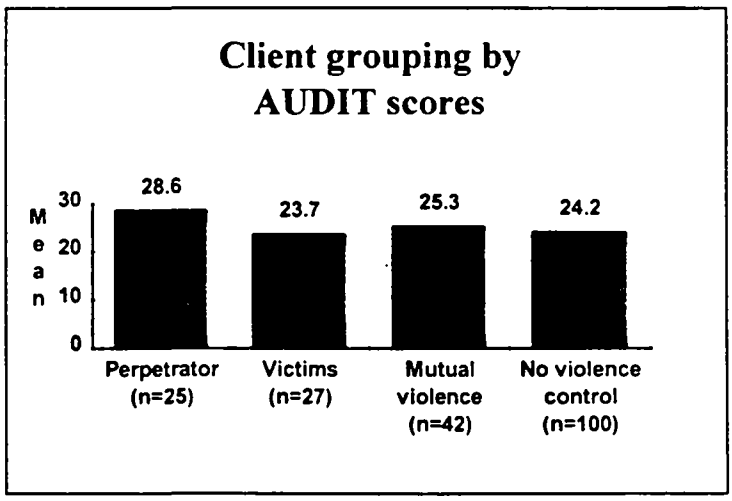
Males and females in each client group (perpetrators, victims and mutual violence group) were compared with the no violence control group to examine: 1. the proportions of clients who abused both alcohol and drugs, 2. the proportion of clients who abused alcohol with or without drugs and 3. the proportion of clients who abused drugs with or without alcohol.

There were no significant differences between client groups. However, 14 of the 26 perpetrators (46.2%) abused drugs compared with 25.5% of controls (p=.03); 7 of 13 female perpetrators (53.8%) abused drugs compared with only 4 of 25 female controls (16%; p=.02).



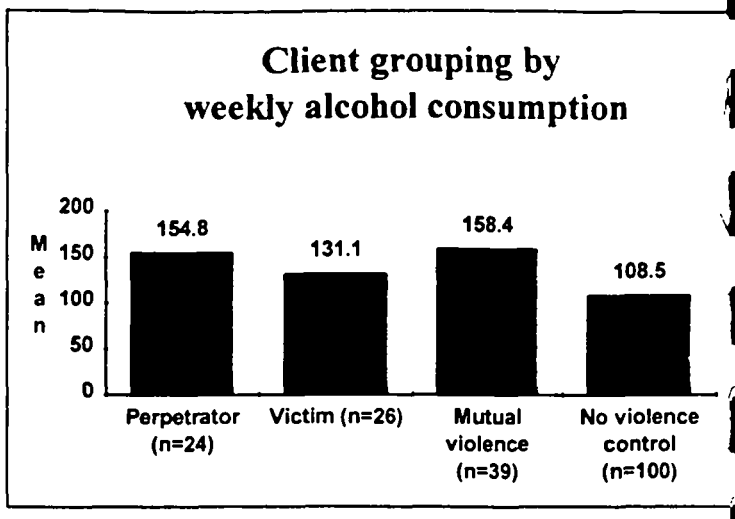
AUDIT

Mean AUDIT score for the client groups was compared with the control. Perpetrators had significantly higher scores on AUDIT when compared with controls (28.56 vs 24.18, p=.05). While mean AUDIT score was significantly higher for male perpetrators thanmale controls (30.15 vs 24.06, p=.036), there was no significant difference between female perpetrators and female controls (26.8 vs 24.5, p=.54). There were no significant differences on AUDIT for the victims compared with controls or for the mutual violence group compared with controls.



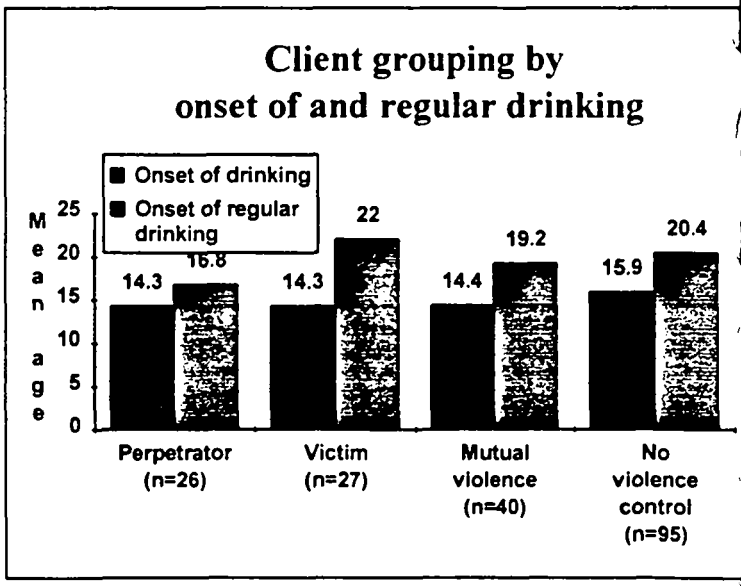
Quantity of alcohol consumed in a typical week

There were no signficiant differences in the quantity of alcohol consumed (standard drinks) for the perpetrator group compared with controls, however, male perpetrators drank significantly more alcohol in a typical week than male controls (202.8 vs 112.6, p=.04). The comparison between the victim group and control was not significant. The mutual violence group consumed significantly more alcohol than the control group (158.44 vs 108.5, p=.045). This effect was significant for males (192.63 vs 112.55, p=.02) but not for the female mutual violence group compared with controls.



Onset of drinking and regular drinking

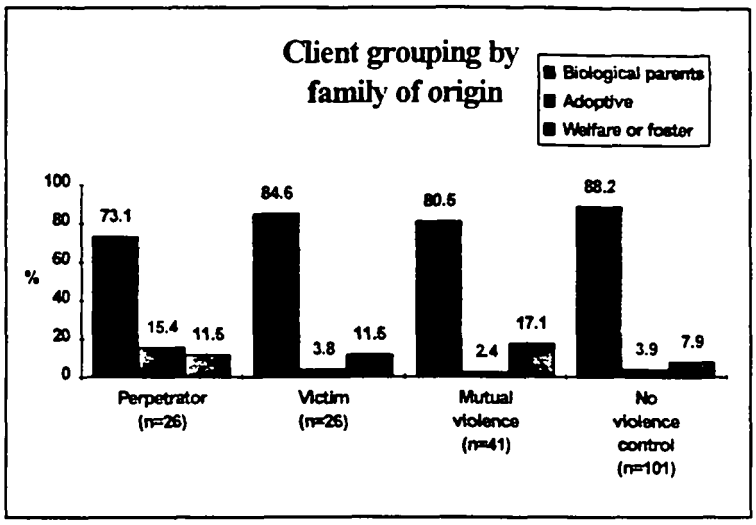
Mean onset of drinking and onset of drinking regularily was examined for the three client group compared with the control. Mean onset of drinking was not significantly different for perpetrators compared with the control group (14.35 vs 15.85, p=.22), however, mean onset of regular drinking was (16.84 vs 20.42, p= .02). Mean onset of regular drinking was significantly lower for male perpetrators compared with male controls (16.9 vs 24.14, p=.003) and for female perpetrators compared with female controls (16.76 vs 25.32, p=.002).



There were no significant differences for onset of drinking and regular drinking for the victim group compared with controls or for the mutual violence group compared with controls.

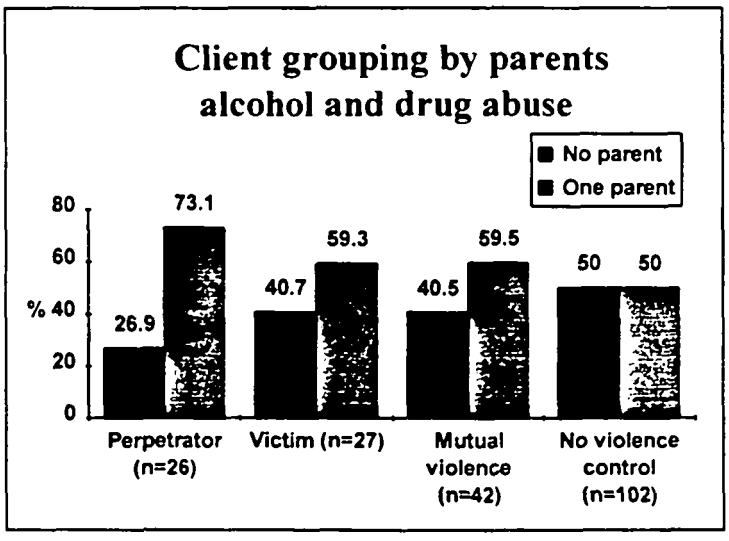
Family history

Family of origin



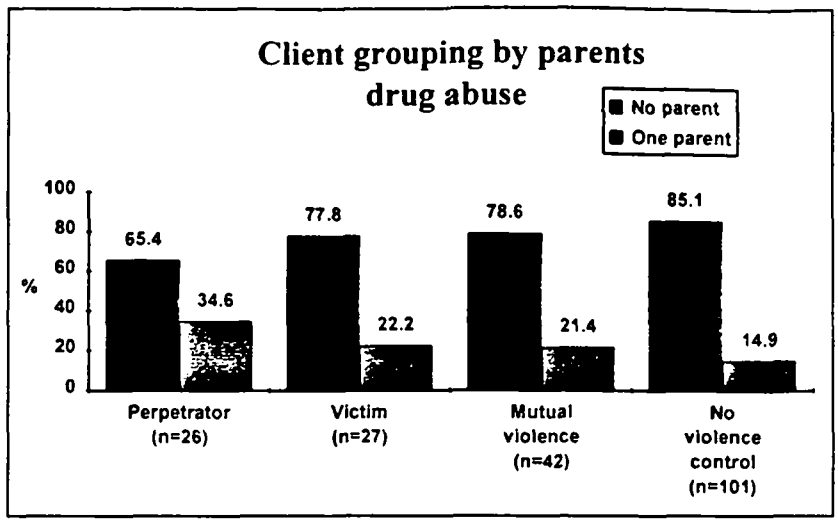
There were no significant differences between the perpetrator, victim, mutual violence group and the non-violent control group on whether they had been raised by biological parents, adoptive parents or welfare/foster homes. Although not significant, 15.4% of the perpetrator group had been raised by adoptive parents compared with 5% of the control group. Interestingly, in the mutual violence group, 17.2% were from welfare/foster homes compared with only 9.9% of the control group. The gender breakdown for this comparison shows that 21.7% of the male mutual violence group came from welfare homes compared with only 7.9% of the male controls.

Alcohol and drug abuse



A significantly larger proportion of perpetrators reported that at least one parent abused alcohol or drugs compared with clients in the no-violent control group (73% vs 50%; $\chi 2 = 4.45$, p=.03). While this effect was not significant for male perpetrators compared with male controls (61.5% vs 49.4%, the effect for female perpetrators compared with female controls was significant (84.6% vs 52%; Fishers exact test, p=.05).

The relative importance of drug and alcohol problems of parents was examined. Parent alcohol use was not significantly associated with the three client groups compared with the non-violent control group. 50% clients in the control group reported that at least one parent abused alcohol compared with 61.5%, 55.6% and 50% of clients in the perpetrator, victim and mutual violence groups respectively.

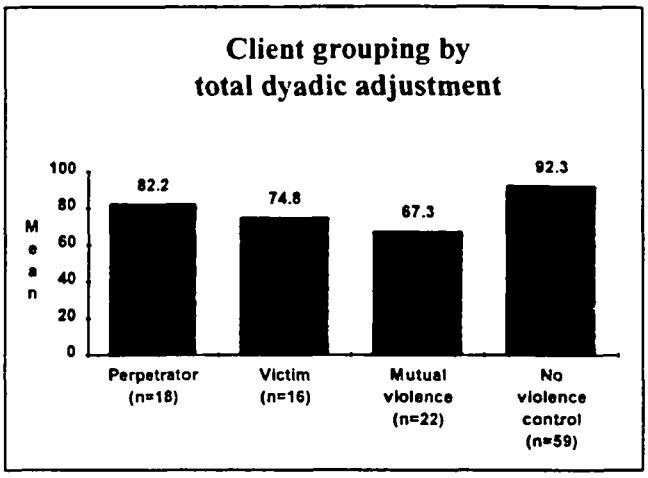


14.9% of clients in the control group had at least one parent who abused drugs compared with 34.6%, 22.2% and 21.4% of clients in the perpetrator, victim and mutual violence groups respectively. The comparison between perpetrators and controls was significant (Fishers exact test; p=.03). An analysis of the data by gender demonstrated a significant effect for females only. A larger proportion of female perpetrators were likely to have at least one parent who abused drugs compared with female controls (38.5% vs 8%, Fishers exact test, p=.03).

Chapter 21. Psychological profile: relationship with spouse abuse

Males and females in each client grouping (perpetrators, victims and mutual violence group) were compared with the no violence control group on each of the psychological measures.

Dyadic Adjustment scale



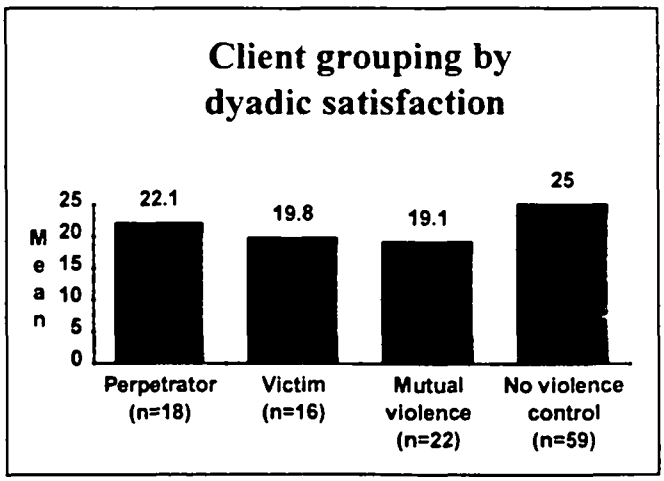
Total Dyadic Adjustment

Compared with controls, scores on the dyadic adjustment scale were significantly lower for perpetrators (p=.03), victims (p=.03) and the mutual violence group (p=.00).

Male clients in the mutual violence group had significantly lower scores on the dyadic adjustment scale (71.17 vs 94.29, p=.001). Female clients in the mutual group compared with female controls had significantly lower scores on the dyadic adjustment scale (84.67 vs 62.6, p=.04)

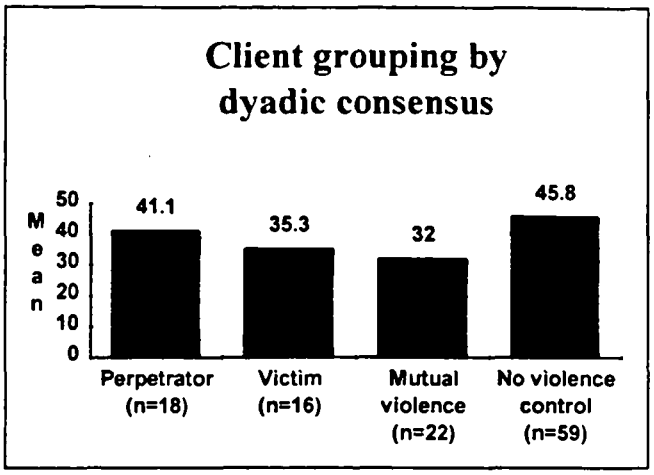
Dyadic Satisfaction

Compared with controls, scores on the dyadic satisfaction scale were significantly lower for the perpetrator (p= .044), victim (p= .001) and mutual violence (p=.00) groups.



Dyadic Consensus

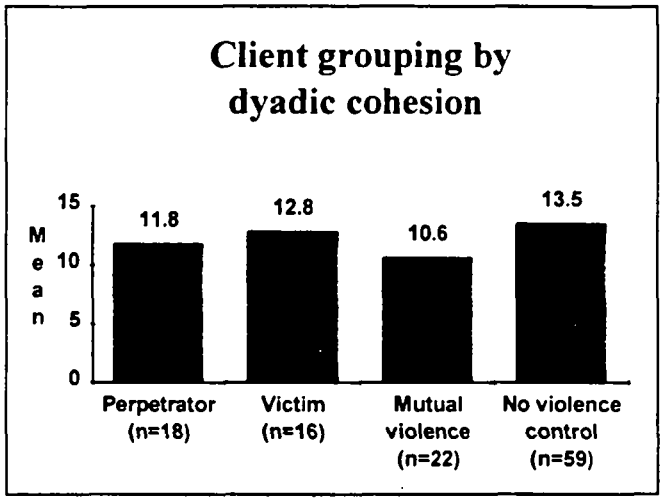
Compared with controls, scores on the dyadic consensus scale were significantly lower for clients in the victim (p=.003) and the mutual violence (p=.00) groups but not for the perpetrator group.



Compared with the appropriate gender control group, dyadic consensus scores were significantly lower for males (34.67 vs 46.53, p=.001) and females (28.9 vs 42.9, p=.007) in the mutual violence group .

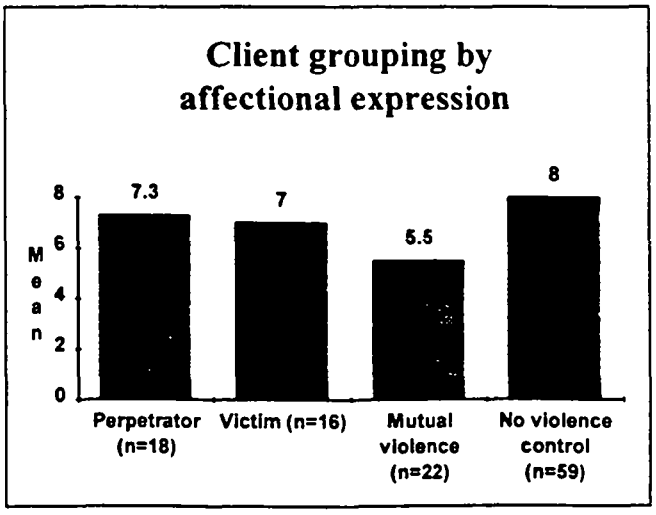
Dyadic cohesion

The mutual violence group was the only group that had significantly lower scores than controls on the dyadic cohesion scale (p=.05).



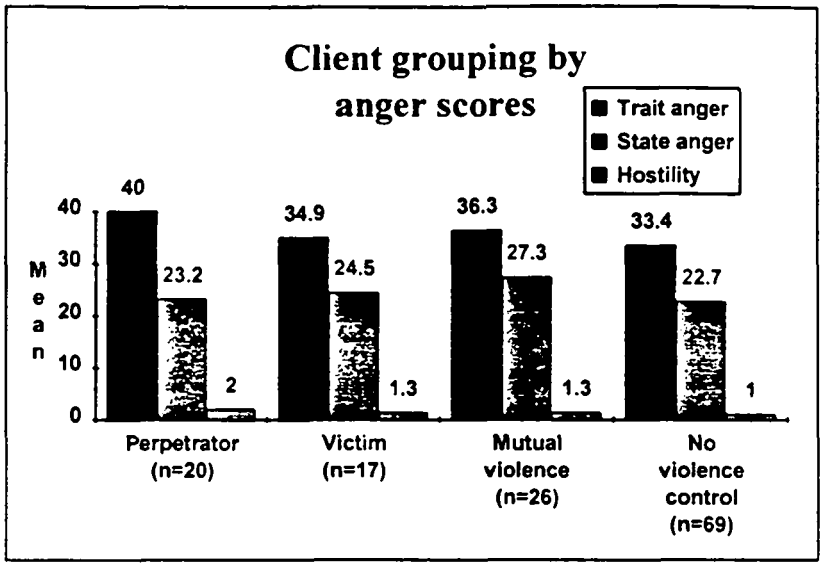
Affectional expression scale

The mutual violence group was the only group that had significantly lower scores than controls on the dyadic affectional scale. Males in the mutual violence group had significantly lower scores on this scale than controls (5.9 vs 8.3, p=.04).



Anger

Perpetrators had significantly higher scores than controls on the trait anger scale (p=.05) and on the hostility subscale of the SCL90 (p=.00). Mean score for male perpetrators was significantly higher than male controls for trait anger (p=.01) and nearly significant at .05 for the hostility sub scale (p=.07). Mean scores on the hostility subscale were significantly higher for female perpetrators compared with female controls (1.96 vs .96, p=.008).

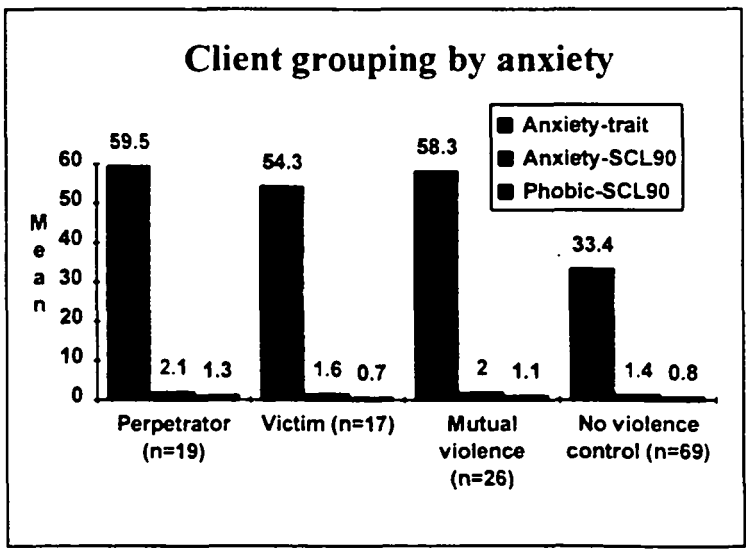


Interestingly, while there were no significant differences between the mutual violence group and controls on trait anger scores, clients in the mutual violence group had higher mean scores than controls for state anger (p=.03).

While there were no significant differences on state anger for male clients in the mutual violence group compared with controls, female clients in the mutual violence group had significantly higher mean state anger score compared with female controls (28.1 vs 21.5, p=.04).

Anxiety

Perpetrators had significantly higher scores than controls on the trait anxiety scale (p=.009), the anxiety subscale of the SCL90 (p=.005) and on the phobic subscale of the SCL90 (p=.03).



Male perpetrators had significantly higher mean scores than male controls on trait anxiety scale (61.0 vs 50.67, p=.04) and the anxiety subscale of the SCL90 (2.06 vs 1.37, p=.05).

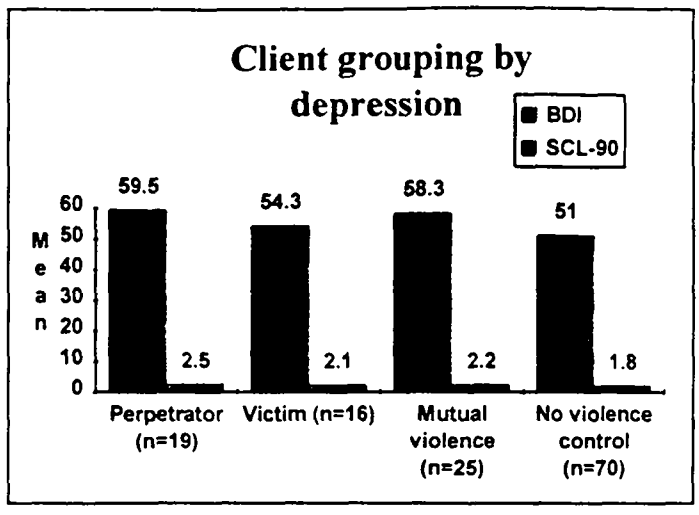
Trait anxiety was significantly higher

for female victims than female controls (64.33 vs 52.31, p=.004).

The mutually violent group had significantly higher mean scores than controls on trait anxiety (p=.012) and the anxiety subscale of the SCL90 (p=.005).

Depression

There were no significant differences between perpetrators and controls on the BDI, however, the depression subscale of the SCL90 was significantly higher for perpetrators compared with controls (2.52 vs 1.77, p=.002). While there were no significant differences on the depression subscale of the SCL90 for male perpetrators, female perpetrators had a significantly higher mean score on this scale than female controls (2.74 vs 2.01, p=.036).



Female victims had significantly higher depression scores on the SCL90 compared with female controls (2.67 vs 2.01, p=.05).

Clients in the mutual violence group had significantly higher depression scores than controls on the SCL90 (2.23 vs 1.77, p=.03).

SRQ

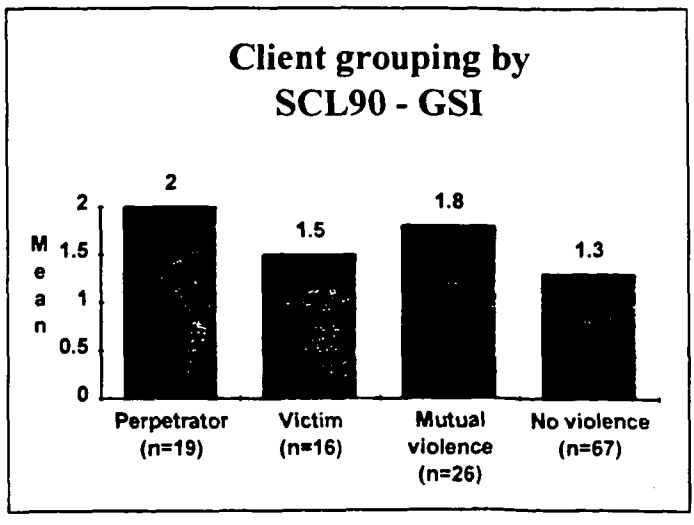
Perpetrators had significantly higher scores on this scale than controls (14.84 vs 11.23, p= .023).

Symptom Checklist-90

GSI

The global severity index was significantly higher for perpetrators compared with controls (1.9 vs 1.33, p= .001) and significantly higher for female perpetrators compared with female controls (2.09 vs 1.4, p=.018).

Mean score on this scale was significantly higher for clients in the mutual violence group than controls (p=.007). Mean score

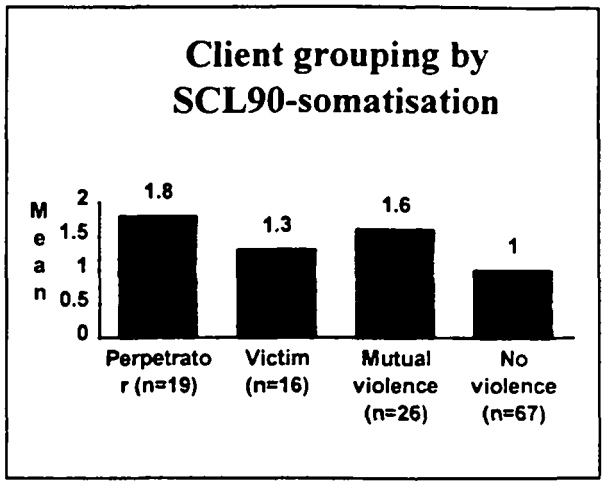


on this scale was nearly significantly higher for male clients in the mutual violence group compared with controls (1.74 vs 1.31, p=.057).

Somatisation

Mean score on the somatisation index was significantly higher for perpetrators compared with controls (p=.000) and for female perpetrators compared with female controls (2.06 vs 1.08, p=.004).

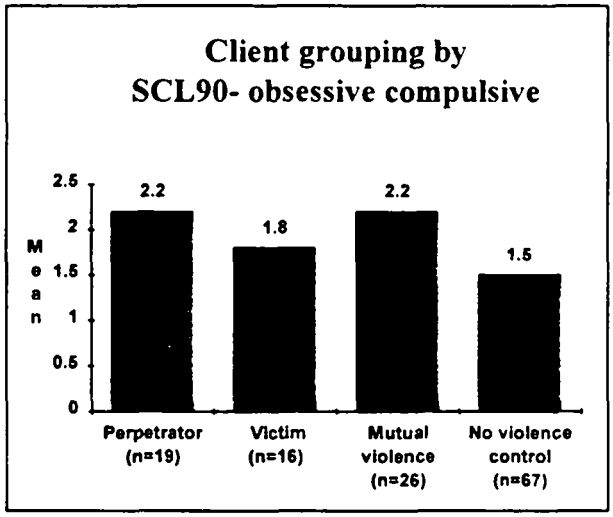
Mean scores on the somatisation index was significantly higher for clients in the mutual violence group compared with controls (p=.004) and for male clients in the mutual violence group compared with male controls (1.48 vs 1.01, p=.03).



Obsessive compulsive

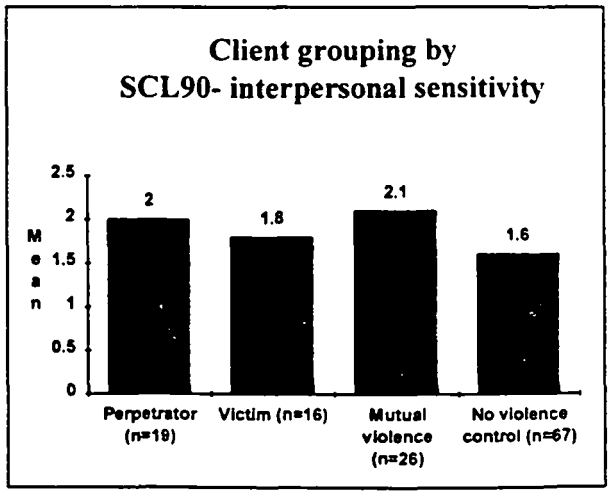
Mean scores on the obsessive compulsive subscale were significantly higher for perpetrators than controls (p=.002) and for female perpetrators compared with female controls (2.46 vs 1.49, p=.004).

Mean scores on the obsessive compulsive subscale were significantly higher for the mutual violence group than controls (p=.001), for males in the mutual violence group (2.14 vs 1.5, p=.016) and females (2.23 vs 1.49, p=.05) compared with male controls.



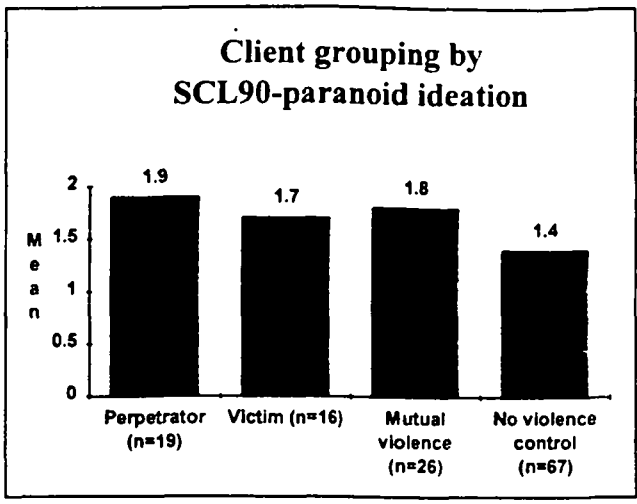
Interpersonal sensitivity

Mean scores on this subscale were significantly higher for perpetrators (p=.05) and the mutual violence group (p=.03) compared with controls.



Paranoid ideation

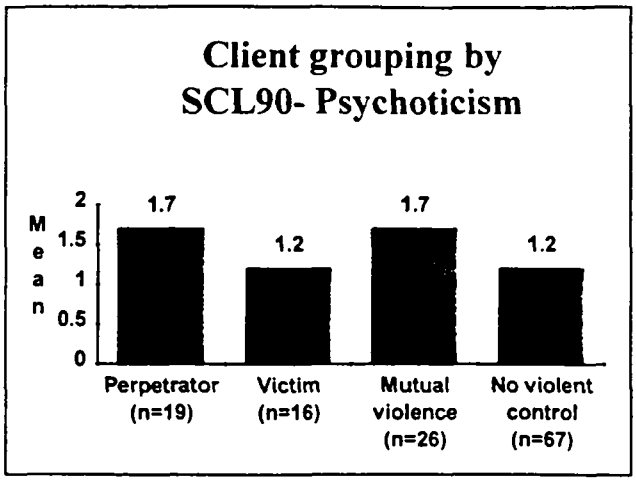
There were no significant differences on this subscale for perpetrators or victims. However, clients in the mutual violence group had a higher mean score compared with controls (p=.05). Females in the mutual violence group had significantly higher scores on this scale than female controls (2.08 vs 1.45, p= .04).



Psychoticism

Mean scores on the psychoticism subscale were significantly higher for perpetrators than controls (p=.02) and were nearly significantly higher at .05 for male perpetrators compared with male controls (1.73 vs 1.12, p=.06).

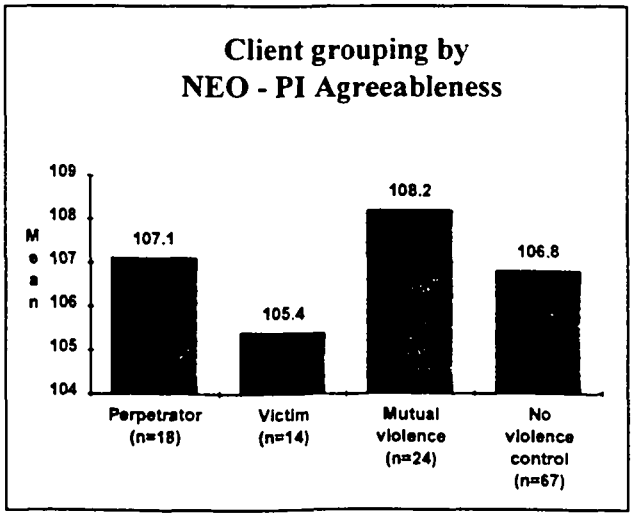
Mean scores on this scale were significantly higher for clients in the mutual violence group than controls (p=.01) and significantly higher for male clients in the mutual violence group compared with male controls (1.67 vs 1.12, p=.032).



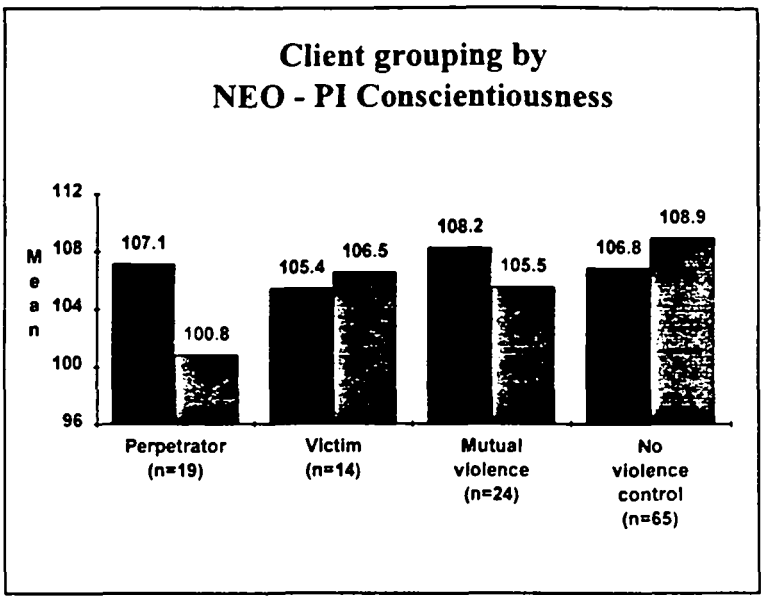
NEO Personality Inventory

Agreeableness

There were no significant differences on this scale between any of the client groups and controls. However, the mean score on the modesty subscale was significantly lower for male perpetrators than controls (14.53 vs 16.12, p=.045).



Conscientiousness

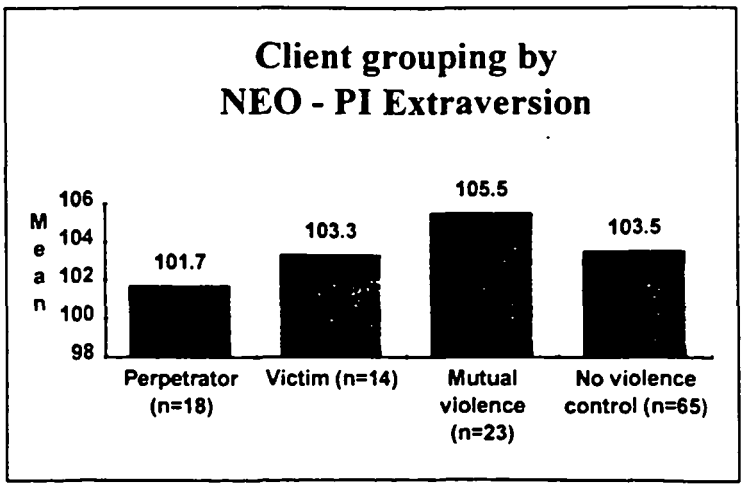


Perpetrators had significantly lower scores on this scale than controls (p=.004). Compared with controls, perpetrators had significantly lower scores for the competence (16.5 vs 18.2, p=.013), dutiful (16.3 vs 18.8, p= .01), achievement 14.5 vs 17.4, p=.00) and deliberation (17.6 vs 19.4, p=.009) subscales.

Male perpetrators had significantly lower scores on this scale than male controls (100.87 vs 109.86, p= .036). Compared with male controls, male perpetrators had significantly lower scores for the competence (16.12 vs 18.54, p=.02), dutiful (15.25 vs 18.84, p= .008) and achievement (14.75 vs 17.52, p=.021) subscales and a significantly higher score for the order subscale (20.75 vs 18.15, p=.02). There was no significant difference between female perpetrators and controls for the conscientiousness scale, however, the achievement subscale was significantly lower for female perpetrators compared with female controls (14.36 vs 16.88, p=.029).

Mean score on the conscientiousness scale and its subscales did not differ significantly between clients in the victim group and control group. Although male clients in the mutual violence group did not differ significantly from controls on the conscientiousness scale, they had significantly lower scores on the competence subscale compared to male controls (16.67 vs 18.55, p= .031).

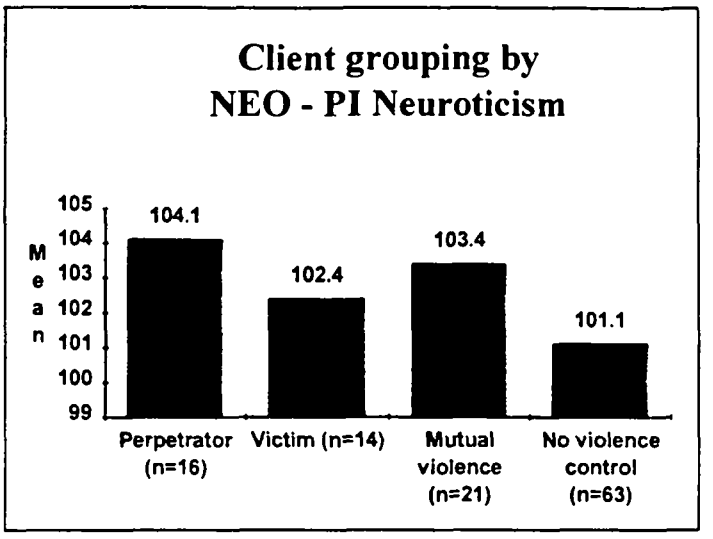
Extraversion



There were no significant differences on this scale for victims or clients in the mutual violence group. However male perpetrators had significantly lower mean score compared with male controls (15.75 vs 18.0, p=.038).

Neuroticism

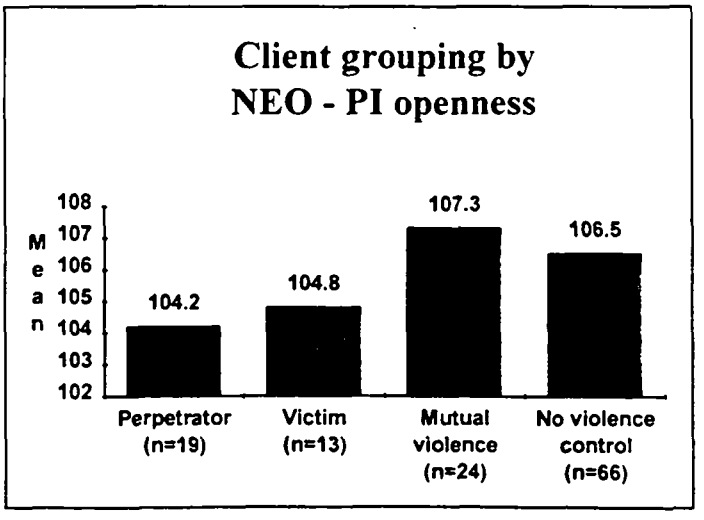
There were no significant differences on this scale between perpetrators and controls. However, the depression subscale was significantly higher for perpetrators compared with controls (19.9 vs 16.9, p=.008) and the mean score on the vulnerability scale was significantly higher for male perpetrators compared with controls (14.9 vs 17.37, p=.02).



Victims did not differ significantly from controls on the neuroticism scale, however, compared with controls, the mean score on the vulnerability subscale was significantly higher for victims (18.8 vs 17.1, p=.04) and male victims (19.56 vs 17.37, p=.03) than controls. Female victims compared with controls had significantly higher scores on the depression subscale (20.6 vs 18.0, p=.04) and interestingly, a significantly lower mean score on the impulsivity scale than controls (13.6 vs 16.7, p=.03).

Openness

There were no significant differences on this scale between perpetrators and controls. However, the fantasy subscale was significantly lower for perpetrators than controls (15.6 vs 16.9, p=.019).



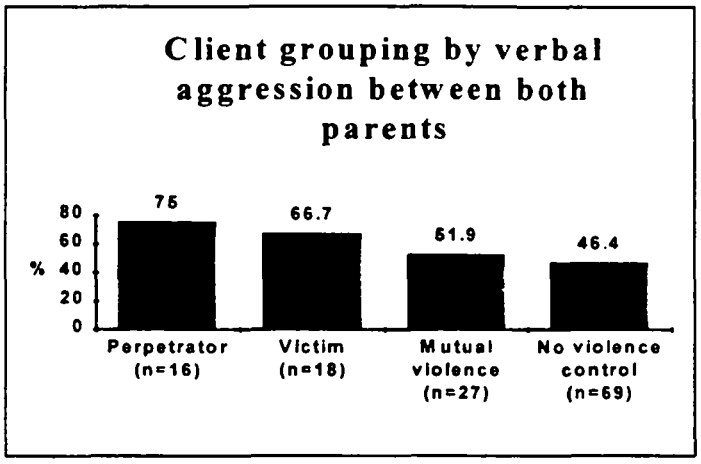
Chapter 22. Childhood abuse: relationship with spouse abuse.

Verbal aggression between parents

Both verbal

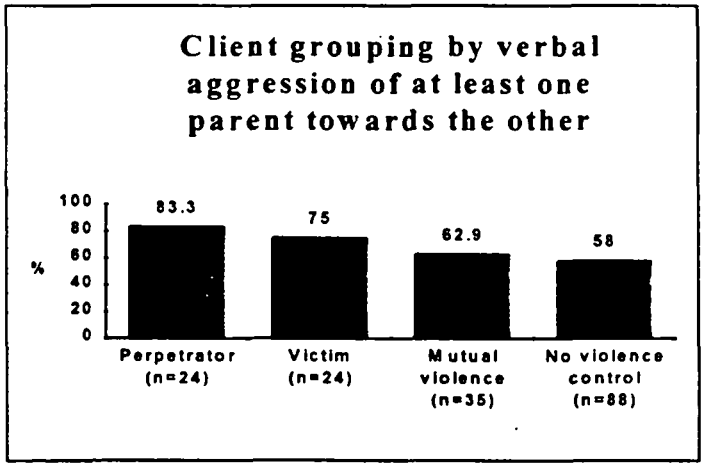
Each client group was compared with the control group to determine differences in the proportions of clients who reported that both parents were verbally aggressive towards each other compared with those that were never verbally aggressive towards each other. Verbal aggression was defined as occuring at least monthly.

46.4% of clients in the control group reported that both parents were verbally aggressive towards each other compared with 75%, 66.7% and 51.9% in the perpetrator, victim and mutual violence groups respectively. The comparison between perpetrators and the control group was significant (χ^2 =4.26, p=.04).



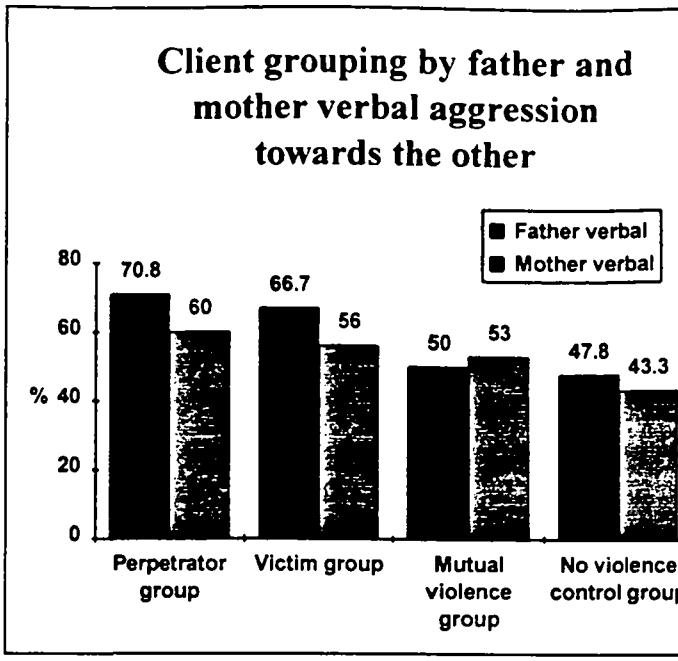
One verbal

Clients who had at least one parent who was verbally aggressive towards the other were compared with clients who had parents who were never verbally aggressive (the above definition of verbal aggression was used). 58% of clients in the control group reported that at least one parent was verbally aggressive towards the other compared with 83.3%, 75% and 62.9% in the perpetrator, victim and mutual violence groups respectively. The comparison between perpetrators and the control group was significant (χ^2=5.23, p=.02). Additionally, a significantly larger number of female victims (100%) than female controls (61.9%) experienced at least one parent being verbally aggressive towards the other. (χ^2 = 4.2, p=.04).



Father verbal towards mother

Analyses were undertaken to compare the effects of father verbal aggression towards the mother and vice versa. 47.8% of 92 clients in the control group reported that their father was verbally aggressive towards their mother compared with 70.8% of 24 perpetrators, 66.7 of 24 victims and 50% of 26 mutually violent clients. The comparison between perpetrators and the controls was significant ($\chi^2 = 4.0$, p=.04).

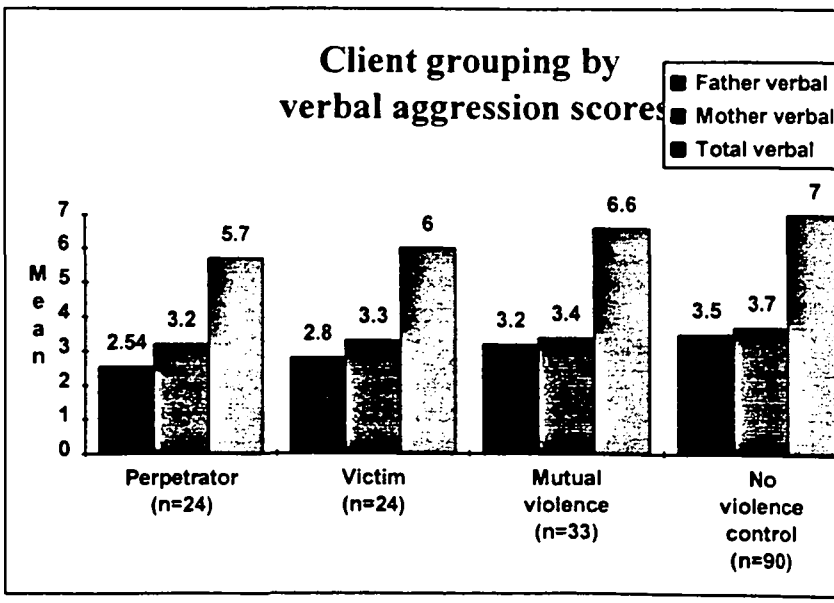


Mother verbal towards the father

43.3% of 90 clients in the control group reported that their mother was verbally aggressive towards their father compared with 60% of 25 perpetrators, 56% of 25 victims and 53% of 34 mutually violent clients. The only significant finding was that a significantly larger proportion of females in the mutual violent group reported that their mother was verbally aggressive towards their father ($\chi^2 = 3.88$, p=.05).

Frequency of verbal aggression

Clients were asked not only whether their father or mother was verbally aggressive towards each other but the frequency of the verbal aggression. The categories were no verbal aggression, daily verbal, weekly verbal and monthly or more verbal. (note this does not exclude either parent from being verbal).



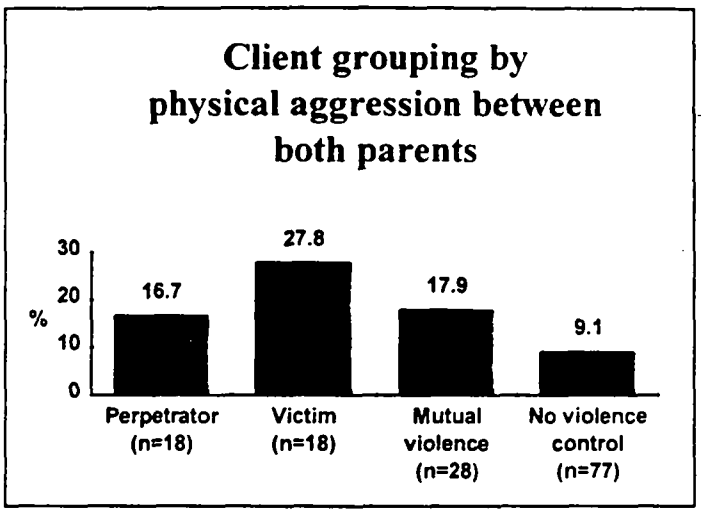
The mean score for father verbal aggression towards the mother was significantly higher for the perpetrator group than for the no violent control group (3.5 vs 2.5; p=.03). Although mean scores on father verbal aggression towards the mother did not differ between the victim and control group, the mean score for father verbal aggression towards the mother was significantly higher for the **female** victim group than the control group (3.3 vs 1.9; p=.05). There were no significant differences between the mutual violence group and the control group for

father verbal aggression towards the mother. Also, mothers verbal aggression towards the father did not differ between each of the client groups compared with the control.

Fathers verbal aggression towards the mother and mothers verbal aggression towards the father were summed to create a new variable (parental verbal aggression) indicative of level of exposure to verbal aggression between parents. The only significant finding was that perpetrators had a higher mean score for parental aggression than controls (7.0 vs 5.6, p=.04). However, given that this finding can be explained by fathers verbal aggression towards the mother alone and that the parental verbal aggression score did not differ between the victim and the control, it is possible that unidirectional verbal aggression is a more important variable for understanding factors associated with victims and perpetrators.

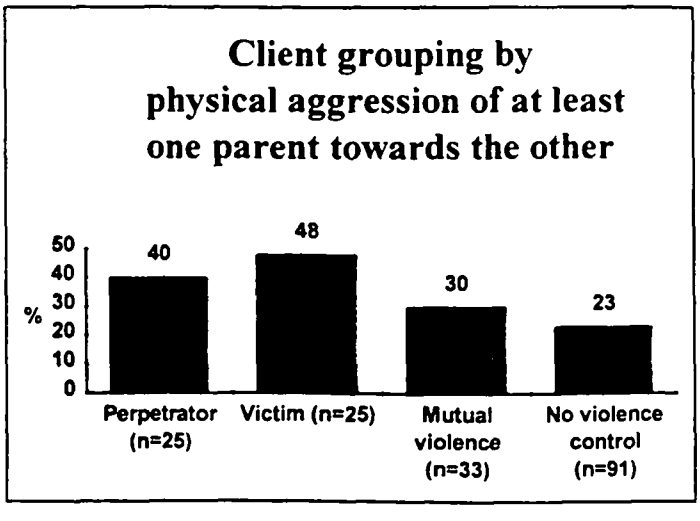
Physical aggression between parents

Both physical



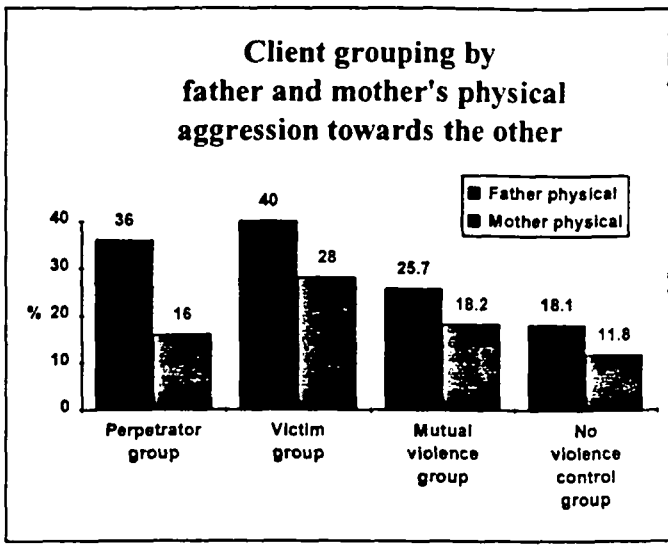
Clients with parents who were both physically aggressive towards each other were compared with clients who had parents who were not. Physical aggression was defined as aggression ocurring at least once per year. 9.1 % of clients in the control group reported that both parents were physically aggressive towards each other compared with 16.7%, 41.7% and 17.9% in the perpetrator, victim and mutual violence groups respectively. The comparison between victims and the control group was significant (Fishers exact test, p=.05).

One physical



Clients who had at least one parent who was physically aggressive towards the other at least once per year were compared with clients who had parents who were not physically aggressive. 23% of clients in the control group reported that at least one parent was physically aggressive towards the other compared with 40%, 48% and 30% in the perpetrator, victim and mutual violence groups respectively. The comparison between victims and the control group was significant (χ^2 = 5.98, p=.01). Although not significant, a higher proportion of female victims compared with female controls had at least one parent who was physically aggressive towards the other (55.6% vs 19%, Fishers exact test, p=.06) .

Father physical agression towards the mother



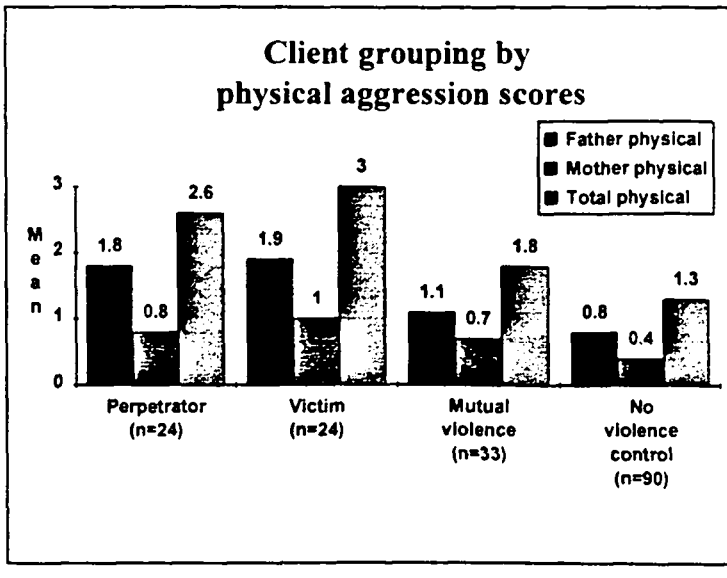
Analyses were undertaken to examine the effects of father's physical aggression towards the mother and vice versa. 18.1% of 94 clients in the control group reported that their father was physically aggressive towards their mother compared with 36% of 25 perpetrators, 40% of 25 victims and 25.7% of 35 mutually violent clients. The comparisons between perpetrators and the controls was significant ($\chi^2 = 3.71$, p=.05). Other significant differences were for the comparison between the victims and controls ($\chi^2 = 5.41$, p=.02) and female victims and female controls (55.6% vs 17.4%, $\chi^2 = 4.66$, p=.03).

Mother physical aggression towards the father

11.8% of clients in the control group reported that their mother was physically aggressive towards their father compared with 16% of perpetrators, 28% of victims and 18.2% of the mutually violent clients. The comparison between victims and controls was significant for both males and female victims combined (Fishers exact test, p=.05) and for male victims compared with male controls (37.5% vs 14.1%, Fishers exact test, p=.04)

Frequency of physical aggression

Clients were also asked how frequent was the physical aggression of their father and mother towards each other. The categories were no physical aggression, less than once a year, between 1-5 times a year, between 6-10, 11-20, and more than 20 times per year.



The mean score for father physical aggression towards the mother was nearly significantly higher for the perpetrator group than for the no violent control group (1.79 vs .83; p =.07). Mean score on fathers physical aggression towards the mother was significantly higher for the victim group compared with the control group (1.9 vs .83, P=.04) and for the female victim group than the control group (2.88 vs .95; p=.04), however there were no signifcant differences between male victims and male controls. There were no

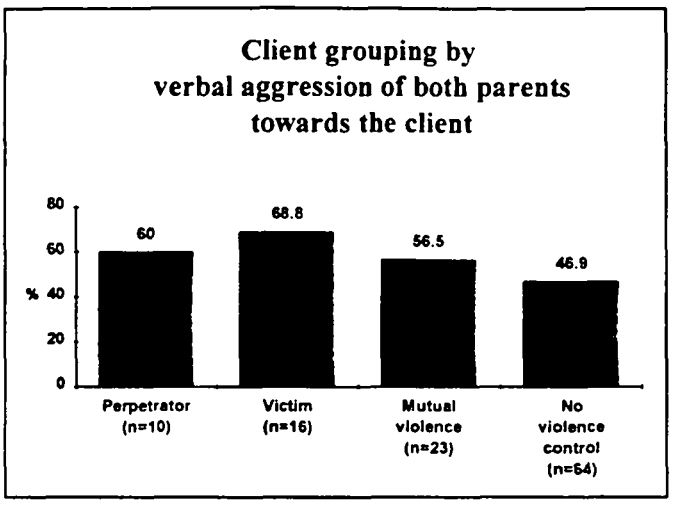
significant differences between the mutual violence group and the control for father's physical aggression against the mother. Also, mothers physical aggression towards the father did not differ between each of the client groups compared with the control group.

Father's physical aggression towards the mother and mother's physical aggression towards the father were summed to create a new variable (parental physical aggression) indicative of level of exposure to physical aggression between parents. The only significant finding was that victims had a higher mean score for parental physical aggression than controls (3.0 vs 1.3, p=.04).

Parental verbal aggression towards the client

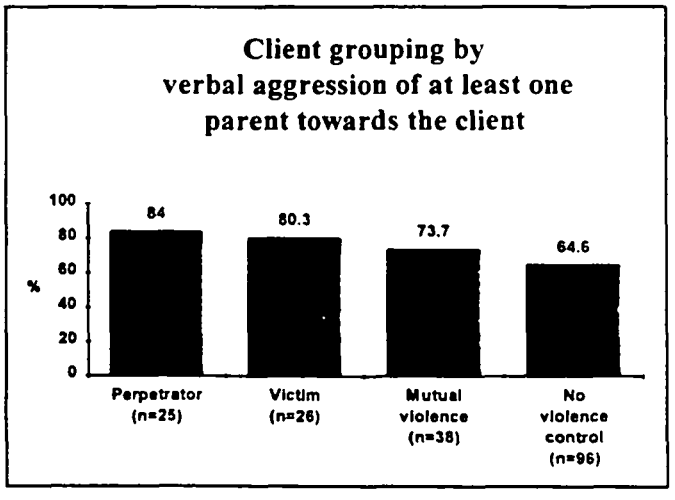
Both verbal towards the client

Clients with parents who were both verbally aggressive towards the client were compared with clients with parents who were not verbally aggressive towards them. Verbal aggression was defined as occuring ever. 46.9% of clients in the control group reported that both parents were verbally aggressive towards the client compared with 60%, 68.8% and 56.5% in the perpetrator, victim and mutual violence groups respectively. There were no significant differences between each of the client groupings and the controls.



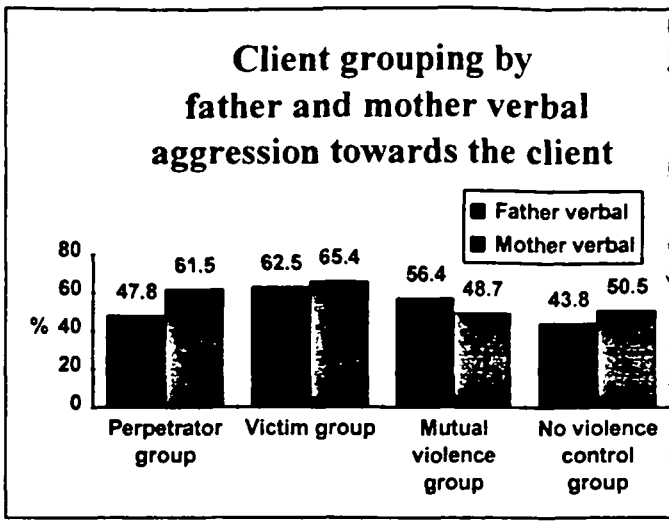
One verbal towards the client

Clients who had at least one parent who was verbally aggressive towards them were compared with clients who had parents who were never verbally aggressive towards them. 64.6% of clients in the control group reported that at least one parent was verbally aggressive towards the other compared with 84%, 80.3% and 73.7% in the perpetrator, victim and mutual violence groups respectively. While the comparison between the perpetrator and control group was not significant, the comparison between the female perpetrators and female controls was significant (84.6% vs 50%, Fishers exact test, p=.04).



Father verbal towards the client

Analyses were undertaken to examine the effects of father and mother verbal aggression against the client. 43.8% of 96 clients in the control group reported that their father was verbally aggressive towards them compared with 47.8% of 23 perpetrators, 62.5% of 24 victims and 56.4% of 39 mutually violent clients. None of the comparisons between the client groups and the control group were significant .

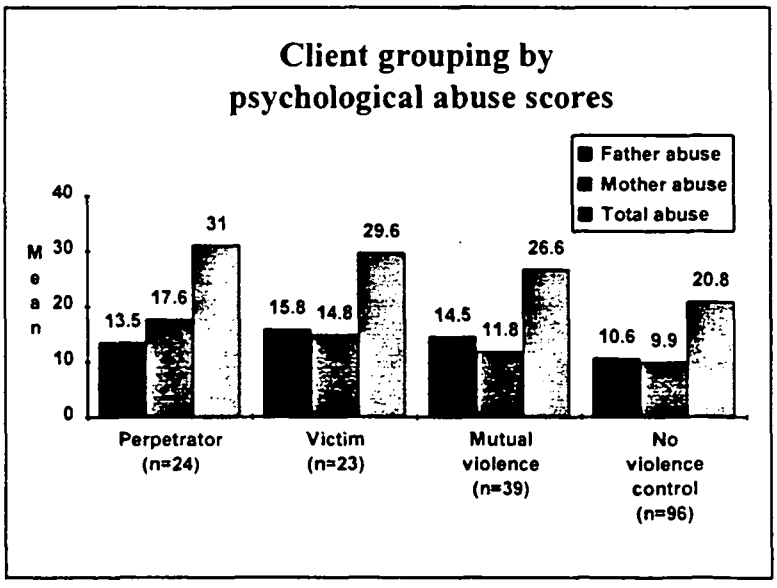


Mother verbal towards the client

50.5% of 99 clients in the control group reported that their mother was verbally aggressive to them compared with 61.5% of 26 perpetrators, 65.4% of 26 victims and 48.7% of 39 mutually violent clients. There were no significant comparisons between any of the client groups and the control group.

Severity of psychological abuse

Severity of psychological abuse by the mother and/or father towards the client was assessed using the psychological maltreatment scale for parents. Mean scores for father psychological abuse towards the client did not differ significantly between any of the client groups and the control group. However, the mean score for mother psychological abuse towards the client was significantly higher for perpetrators than controls (17.57 vs 9.8; p=.03) and for female perpetrators than female controls (23.53 vs 11.08; p=.05). Mother's psychological abuse towards the client was significantly higher for the victim group than the control group at .06 (14.8 vs 9.9).

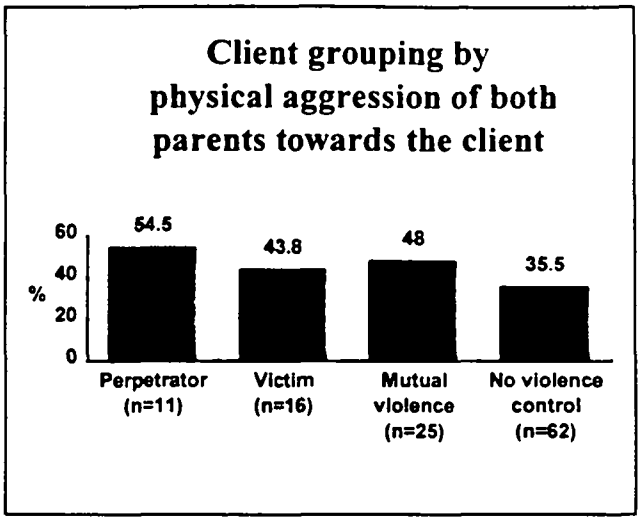


Father's and mother's psychological abuse towards the client were summed to create a new variable (parental psychological abuse) indicative of level of psychological abuse from parents. The only significant finding was that perpetrators had a higher mean score for parental psychological abuse than controls (30.58 vs 20.7, p=.04). Again unidirectional psychological abuse from the mother towards the client can explain this effect.

Parental physical aggression towards the client

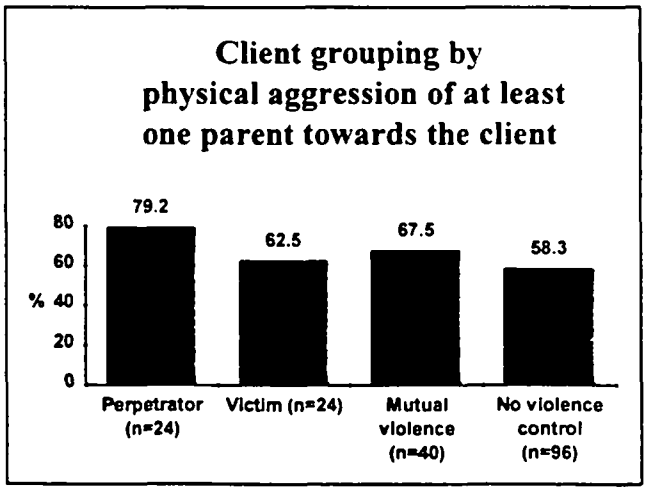
Both physical towards the client

Clients with parents who were both physically aggressive towards them were compared with clients whose parents were not physically aggressive towards them. Physical aggression was defined as occuring 'ever'. 35.5% of clients in the control group reported that both parents were physically aggressive towards the client compared with 54.5%, 43.8% and 48% in the perpetrator, victim and mutual violence groups respectively. There were no significant differences between each of the client groups and the control group.



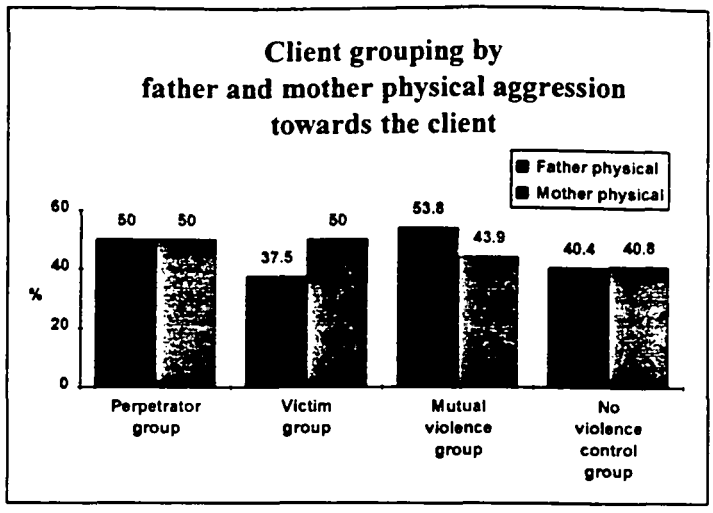
One physical towards the client

Clients who had at least one parent who was physically aggressive towards them were compared with clients who had parents who were never physically aggressive. 58.3% of clients in the control group reported that at least one parent was physically aggressive towards the other compared with 79.2%, 62.5% and 67.5% in the perpetrator, victim and mutual violence groups respectively. The comparison between the perpetrator and control group was close to significant ($\chi^2 = 3.55$, p=.06).



Father physical towards client

Analyses were undertaken to examine the effects of father and mother physical aggressive towards the client. 40.4% of 94 clients in the control group reported that their father was physically agressive towards them compared with 50% of 24 perpetrators, 37.5% of 24 victims and 53.8% of 39 mutually violent clients. None of the comparisons between each of the client groupings and the control were significant .

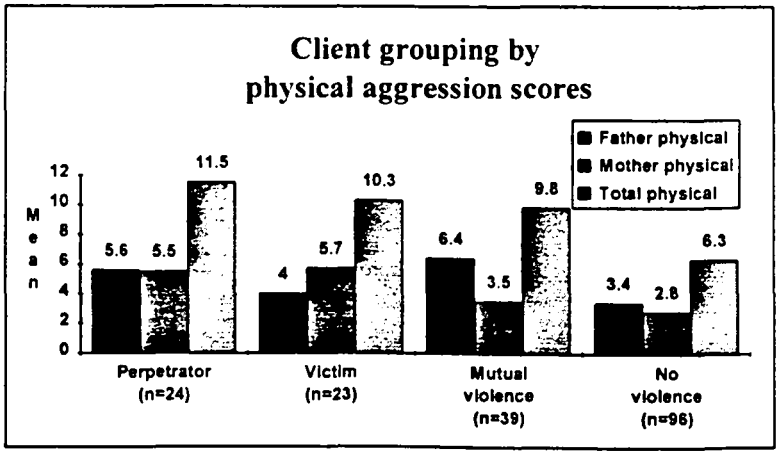


Mother physical towards the client

40.8% of 98 clients in the control group reported that their mother was physically aggressive to them compared with 50% of 26 perpetrators, 50% of 13 victims and 43.9% of 41 mutually violent clients. There were no significant comparisons between any of the client groups and the control group.

Severity of physical abuse towards the client

Severity of physical abuse by the mother and father towards the client was assessed using the physical maltreatment scale for parents. Mean score for fathers physical abuse towards the client was significantly higher for male perpetrators than male controls (8.17 vs 3.82; p=.02). Mean scores for mother's physical abuse towards the client was significantly higher for victims than controls (5.65 vs 2.83, p=.05) and for male victims compared with male controls (6.4 vs 3.1, p=.024).

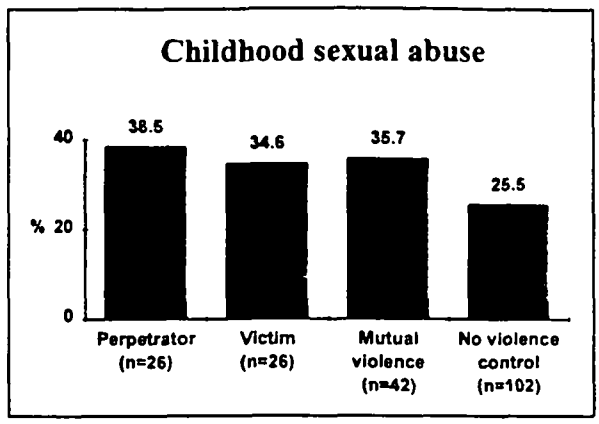


Father and mother physical abuse towards the client were summed to create a new variable (parental physical abuse score) indicative of level of physical abuse from parents. Mean scores on parental physical abuse score compared with controls was significantly higher for the group of perpetrators (11.54 vs 6.27, p=.01) and male

perpetrators (13.25 vs 6.99, p=.03). It seems that unidirectional abuse is better able to explain the relationship between parental abuse and becoming a victim or perpetrator.

Childhood sexual abuse

Clients who had been abused sexually before the age of 13 years were compared with those who had not experienced sexual abuse for each of the 3 client groupings compared with the control group. There were no significant differences for these comparisons.



Chapter 23. Summary and discussion

23.1 Client profile

Psychodemographic factors

The majority of the clients of the five clinics were male, born in Australia and with a mean age of 38. Most were either married or living in a defacto relationship. Almost half had achieved tertiary qualifications, however only 40% were employed.

As expected, the majority of clients were chronic alcohol abusers and only 12% abused drugs alone. In the latter case, whilst many had used marijuana recreationally, the reason for admission was opiate abuse.

Clients demonstrated a high level of psychopathology, characterised by depression and anxiety, a history of suicidal ideation and attempted suicide as well as higher scores on Somatisation, Obsessive Compulsive, Interpersonal Sensitivity, Paranoid Ideation and Psychoticism subscales of the SCL90. The personality assessment (NEO-PI) suggested that male and female clients were significantly less conscientious and agreeable than the normal population. Additionally, female clients were less extroverted. Other, psychological tests showed that the clients were usually anxious, mildly to moderately depressed and scored highly on the anger scale; mean scores on the anger scale were almost twice as high as the normative sample.

The high level of psychopathology of clients, is possibly related to their drug and alcohol abuse but just as likely to be related to an unstable childhood characterised by dysfunction in their family of origin. There was a high incidence of verbal and physical aggression both between parents and directed towards the clients by parents. Exposure to parental drug and alcohol abuse was also high. Clients came from families in which the father (73%) rather than the mother (45%) was more likely to have been consuming alcohol prior to being physically aggressive. Similarly, when the aggression was directed at the client, fathers (36%) more than mothers (9%) were likely to have been the offending parent. Findings of physical aggression in the family of origin and higher rates of parental alcohol and drug abuse are similar to that reported in other studies of alcoholic populations (Gondolf & Foster. 1991; Haver. 1987; Miller, Downs, & Gondoli. 1989; Miller, Downs, & Testa. 1993; Ireland & Widom. 1994).

Intimate relationships during adulthood were characterised by low levels of satisfaction, and high levels of conflict. Overall, levels of affectional expression were similar to a normative comparison group comprising married and divorced people however, interestingly, cohesion in the relationship was high and similar to happily married individuals. This last finding could be explained by the fact that not only had the clients committed themselves to their relationship but also the commitment was reinforced by the 'traumatic bonding' described by Dutton. (1995). Additionally, these

findings may indicate an unsatisfactory relationship characterised by high levels of emotional dependency.

Verbal aggression amongst clients

Verbal aggression was assessed using a single verbal aggression question and the verbal subscale of the CTS. Overall verbal aggression by the client towards the partner was high ranging between 79.3% and 88.8% with the CTS producing the highest rates (88.8%). Differences in verbal aggression between gender were minimal. It is of interest that the single verbal aggression question detected almost as much verbal aggression as the formal questionnaire.

Verbal aggression by partners towards the client was also reported to be high ranging between 67.6 and 85.3 using the single aggression question and the CTS. As was the case with aggression by the client, the CTS produced the highest rates of verbal aggression compared with the single verbal aggression question. In contrast, the ISA which was also used produced the lowest rates of verbal aggression towards the client (29% & 55.6% for males and females, respectively). This may be because the clinical cut-off score was established using women from shelters and community services who are likely to have had a history of battering.

Association with alcohol: Alcohol may have been associated with verbal aggression of the partner in 70% of cases. In contrast, approximately 60% of clients reported that their partners were never abusive towards them when drinking. This could however be explained by the fact that the clients may have been intoxicated much of the time. Clients reported that alcohol made both verbal (77%) aggression worse. A small proportion stated that it made no difference.

Physical aggression amongst clients

Physical aggression of the client towards the partner was assessed using the CTS, and a single physical aggression question. Rates of physical aggression by clients towards partners were high and ranged between 37.4 and 51.5. Interestingly, female clients were found to be more physically abusive than males and the difference between gender was higher using the CTS. When comparing partner physical aggression towards the client with these scales, as well as the ISA, between 33% and 51% reported being abused. Rates were similar across scales and female clients reported higher rates of being abused.

A high proportion of clients reported that they were physically aggressive in a previous relationship and an even higher proportion had experienced physical aggression in a previous relationship. This is consistent with the view that physical aggression is a function of perpetrator and victim characteristics rather than the relationship alone.

Association with alcohol: Clients reported that during the previous year, they had on average been physically aggressive towards their partner on 6 occasions. They had been intoxicated on approximately 75% of those occasions. Those clients who were subjected to physical aggression from their partners in the previous year, reported that their partner had been drinking 75% of the time. As for verbal aggression, clients reported that alcohol made physical (71%) aggression worse. A small proportion stated that it made no difference.

General aggression

Overall, general violence was high amongst clients (21.8%), particularly males. Close to 40% of male clients had been violent in the previous year towards someone other than their partner compared with 8% of female clients. Approximately one-third of clients who had abused their partners had also been physically aggressive towards other people in the last year.

Interestingly, a large proportion of clients reported that they were always under the influence of alcohol when aggressive with friends, relatives, acquaintances, coworkers/bosses, and police and ranged between 26% for bosses and 47.5% for friends.

Detailed examination of physical aggression

Detailed examination of physical aggression using the modified CTS (using self-defence criteria) produced interesting findings. Of those male and female clients reporting that they were physically aggressive towards their partner the majority admitted that this was not in self-defence. Surprisingly female clients as well as male clients admitted to this. When severe violence was examined a higher proportion of female clients (29.4%) than male clients (14.3%) reported having been violent, and this finding remained despite taking into account reported self-defence. This finding is contrary to the popular belief that males are predominantly the perpetrators of spouse abuse and women the victims.

We developed a classification system that categorised clients into one of four groups; perpetrator, victim, mutual violence and no violence control groups and compared prevalence rates in each category using the original CTS scale and the modified CTS scale incorporating self-defence criteria. Using the original CTS, perpetrators were those clients that were exclusively violent towards partners, victims were never violent but had a partner who was violent, the mutual group included those clients who were violent towards each other and the no violence controls were those clients and partners who were never violent towards each other. Using the modified CTS, we made use of scores on self-defence questions to determine the four groups. For example, a client who was violent would not be classified as a perpetrator if their violence was always in self-defence, but would be classified as a victim.

Using the first method (original CTS), 10.1% of clients were classified as perpetrators, 8% were identified to be victims, 31.7% were classified in the mutual violence group. Using the second method (modified CTS) 13.2%, 13.7% and 21.3% were classified into the perpetrator, victim and mutual violence groups respectively. As can be seen from this data, when self-defence was taken into account, the number of clients in the mutual violence group decreased; 6 were classified as perpetrators and 11 as victims. There were no major gender differences in this re-classification.

By including self-defence criteria to classify clients as victims and perpetrators of abuse we have addressed one of the limitations of the CTS. Moreover, our classification system that incorporates mutual violence provides the opportunity to examine a group of clients whose characteristics may differ substantially from those clients who are victims or perpetrators. Without such discrimination, it is likely that both victims and perpetrators would be misclassified. A clear example of the benefits of such a classification system is evident from a hypothetical example of a woman in a mutually violent relationship, who is assessed using the ISA and found to be a victim.

23.2 Profile of perpetrators

Demographic profile

As discussed above there were significantly more females in the perpetrator group than the no violent control group. Female perpetrators tended to be younger than female controls, and they were much more likely to be in a current relationship or to have had a significant relationship lasting more than 12 months. Male perpetrators were less likely than male controls to have completed secondary school.

Alcohol and drug abuse

The finding that perpetrators are commonly found amongst clients of drug and alcohol clinics is consistent with the literature. Using the CTS to define all those who were physically aggressive as perpetrators, we found an overall prevalence rate of 42% for physical aggression; this was 37% of male clients and 52% of female clients. Although there are no comparable studies for female perpetrators, rates of 37% for males were consistent with rates of 40% found by Gondolf & Foster (1991) but lower than the prevalence rate of 68% reported by Powers (1983). When the CTS was used to classify clients into the perpetrator, victim, mutual violence and non violent controls using self defence criteria, the prevalence of perpetrators was 13.2%; 9.9% of male and 19.7% of female clients. There is no other study to which these results can be compared.

The perpetrator client group was no more likely than non-violent controls to abuse alcohol but interestingly, they were more likely to abuse drugs than controls. This

effect was highly significant for female perpetrators (54%) compared with female controls (16%). The severity of alcohol abuse, however, was significantly higher for perpetrators. The age of onset of drinking regularly was significantly lower for perpetrators compared with controls. These characteristics are commonly seen in type II alcoholics described by Cloninger et al (1981) and others (Babor et al, 1992).

Family history

The results of our study indicate that perpetrators were more likely to be raised by families in which there was significant dysfunction. Interestingly, 15.4% of the perpetrator group had been raised by adoptive parents compared with 5% of the control group, however, this finding was not significant. Perpetrators were more likely to report that one or more parents abused alcohol or drugs. However, it was parental drug use that was significantly related to being classified as a perpetrator; close to 35% of perpetrators had at least one parent who abused drugs compared with 15% of no violent controls. This effect was more evident for female perpetrators than male perpetrators.

It is well documented in the literature that perpetrators are significantly more likely to come from families in which there was physical aggression between parents and towards them (Hotaling & Sugarman. 1986; Hillier & Foddy. 1993). Our findings are consistent with the literature. Perpetrators were significantly more likely to have been exposed to fathers who were physically aggressive towards the mothers (36%) than the control group (18%) and the physical aggression shown was significantly more frequent. Exposure to summated physical aggression of parents was not significantly different for perpetrators compared with controls indicating that the fathers physical violence towards the mother was the critical factor. The experience of physical aggression from one parent was also significantly higher amongst perpetrators (79.2%) than controls (58.3%) with male perpetrators being subjected to significantly more severe physical aggression from their fathers than male controls.

Whilst we have not been able to find any study reporting on the effect of verbal aggression during childhood in relation to spouse abuse, our study demonstrated that verbal aggression or psychological maltreatment was more prevalent amongst perpetrators than controls, both in terms of witnessing verbal aggression between parents and in terms of experiencing verbal aggression by parents. Specifically, during their childhood and adolescence, perpetrators were significantly more likely than controls to report verbal aggression between both parents (75% vs 46.4%) or by one parent towards the other (83.3 vs 58%) on at least a monthly basis. Although, the prevalence and frequency of verbal aggression was high for both the father and mother significant differences were only found between perpetrators and controls for fathers verbal aggression towards the mother.

Moreover, the perpetrator group was more likely to be subjected to verbal aggression towards them by either both parents (60%) or at least from one parent (84%), however these rates were not significantly different from the controls (46.9% and 64.6% respectively). While the severity of psychological abuse from the father towards the client was not significantly higher for perpetrators and controls, psychological abuse from the mother was significantly higher, particularly towards female clients.

As can be seen from the above findings perpetrators came from families in which there was a high level of verbal and physical aggression between the parents and directed towards them. For both male and female perpetrators fathers physical violence towards the mother was important and for male perpetrators severity of fathers physical aggression towards them were critical. It is highly likely that modelling of the father was a significant factor in the later development of abusive behaviour, particularly for male perpetrators. For female clients mothers psychological abuse towards the client may have been important.

Psychological factors

A novel aspect of our research was the examination of the quality of intimate relationships. Perpetrators demonstrated lower rates of dyadic adjustment compared with controls. Overall they were less satisfied with their relationship, however, they did not differ significantly from controls, in terms of dyadic consensus, cohesion and affectional expression. On one level these results are not surprising. The dynamics of an abusive relationship in which there is a power imbalance could express itself in less satisfaction with the relationship despite few disagreements as reflected by the consensus, cohesion, and affectional expression subscales.

We found that perpetrators level of anger was higher than the control group both for males and females. Anxiety was found to be higher than controls on all measures of anxiety. Depression as measured by the SCL90, was significantly higher for perpetrators compared with controls. Perpetrators had a higher overall level of psychopathology compared with controls (GSI, SRQ). They tended to somatise more, and be more obsessive compulsive than controls. They tended to have more feelings of personal inadequacy and inferiority as well as discomfort during personal interactions (interpersonal sensitivity). They also scored higher than controls on the psychoticism subscale of the SCL90 indicative of a withdrawn, isolated, schizoid lifestyle. The literature generally reports that perpetrators are often depressed (Hamberger & Hastings, 1986), but only one study mentions high levels of anxiety (Hamberger & Hastings. 1991). Some studies have found that perpetrators are more angry and hostile than non-violent controls (Maiuro et al, 1986, Tolman & Bennett. 1990) however, some negative findings have also been reported (Hastings & Hamberger, 1988). In the Hamburger and Hastings study (1988), anger was measured using the Novaco anger scale, which many argue is not a good measure.

A novel finding of our study was that perpetrators scored highly on the obsessive/compulsive subscale of the SCL-90. One other study may have alluded to this characteristic in the context of a dependent/compulsive personality typology of batterers (Hastings and Hamberger, 1988). This finding is of interest given that a major component of obsessive compulsive behaviour is the need to be in control. The need to control has been identified as an important aspect of an abusive relationship. This finding can not be attributed to the effects of or cravings for alcohol/drugs because these effects were observed in relation to a control group who also abused

drugs and/or alcohol. Further research is needed to delineate more clearly the relationship between OCD and perpetrator status.

Our personality assessment indicated that perpetrators were more argumentative, aggressive and defensive but more self-conscious than the client control group. They also tended to be less ambitious, less competent and poorer in self-discipline. They were impatient and impulsive, had difficulties in asserting themselves and were less friendly and sociable. Consistent with the above findings, they were often depressed and withdrawn, more moody and anxious and had difficulties expressing affection. Overall these findings are consistent with characteristic reported in the literature including low self-esteem, dependency on their partners, a fear of intimacy, feelings of inadequacy, a need to be in control, rigidity and resistance to change, poor impulse control, low frustration tolerance, low assertiveness and poor communication skills (Morley. 1994; Follingstad & Breiter. 1994).

A number of studies have postulated distinct personality typologies for batterers. These include the schizoid/borderline, anti-social/narcissistic and the dependent/compulsive type (Bland & Orn. 1986; Hotaling & Sugarman. 1986). A further personality type is associated with a severe level of general violence and the abuse of alcohol and drugs. Although we were not able to group perpetrators into specific typologies in our population because of small sample sizes, perpetrators displayed some of the personality characteristics described in these typologies. For example, schizoid borderline personality is consistent with results from the Psychoticism subscale of the SCL90 and the dependent/compulsive personality is consistent with the finding that perpetrators need to be in control, abuse drugs and alcohol and experience high levels of anxiety.

23.3 Profile of victims

Demographic factors

Both male and female clients had experienced physical victimisation by their partner. Although not significant, female clients were much more likely than controls to be victims of physical abuse. Female victims were significantly less likely to have completed a high school education. Approximately half the victims had histories of psychiatric illness which is to be expected, given the stress involved in being in an abusive relationship and is consistent with the findings of previous studies (Koss, Woodruff, & Koss. 1990; Mullen, Roman-Clarkson, Walton, & Herbison. 1988; Gleason. 1993).

Alcohol and drug abuse

Our study found that the prevalence of victims of physical aggression (using the original CTS that did not take into account self-defence) amongst our alcohol and drug abusing population was 40%. This was 36% of male clients and 47% of female clients. While there are no comparable prevalence studies for male victims, Bergman et al (1987) found a prevalence rate of 65% in a study of alcoholic women (Bishop & Patterson. 1992).

When the CTS and self defence criteria were used to classify clients as victims, prevalence rates were 13.7%; 13% of male and 15.2% of female clients. There is no other study to which these results can be compared.

When comparing the victim and control groups for their alcohol and drug use, the victim group was similar in the nature and severity of the substance abuse as well as age of onset of regular drinking.

Family history

There were no differences in the composition of the family of origin and also in the presence of parental alcohol or drug consumption for clients in the victim group compared with the control group. Overall, victims as a group generally appeared to be similar in this way/many respects to the non-violence control group.

The presence of parental physical aggression during childhood appears to have been a significant factor in the family history of victims. Victims were more likely than controls to witness both parents being physically aggressive towards each other. Moreover, this effect was significant for the mother and father. Female victims were significantly more likely than controls to have been exposed to physical aggression perpetrated by the father towards the mother; the frequency of aggression by the father was also significantly higher than controls. Interestingly male victims appear to have been exposed to physical aggression perpetrated by the mother towards the father. The model which the mother presented to the daughter could understandably have predisposed the daughter to becoming a victim in adult relationships.

In terms of the abuse directed towards the client, we found that the victim group was significantly more likely than the control group to have been subjected to physical maltreatment from the mother.

During their childhoods, significantly more female victims than controls were exposed to verbal aggression from at least one parent (100% vs 62%). Moreover, female victims were significantly more likely than controls to have been exposed to more frequent verbal aggression from the father towards the mother. In terms of verbal aggression directed towards the client, we found that the victim group was significantly more likely than the control group to have been subjected to psychological maltreatment from the mother.

Overall, the findings relating to the exposure to aggression between parents and the experience of aggression from parents suggest that the critical factors are the gender of the parent who is perpetrating the aggression whether it is towards the other parent or the client. That is, if the mother abuses the father or the male client, the male client is more likely to become a victim and vice versa. These findings reinforce the possibility that victims identify with the same sex parent as a model for the predisposition to becoming a victim in later relationships.

Psychological factors

Similar to perpetrators, victims demonstrated lower rates of dyadic adjustment compared with controls. However, in contrast to perpetrators they reported significantly lower consensus in the relationship. This is consistent with what would be expected in an abusive relationship in which decisions are dictated by the perpetrator. Although victims were less satisfied with their relationship than non-violent controls their reported levels of cohesion and affectional expression were similar to controls. As discussed above in relation to perpetrators, the element of traumatic bonding may have been influential.

For the victim group, the level of general psychopathology was found to be similar to that of the non-violence control group and contrasts markedly with that found for perpetrators. However scores were elevated on some scales. Specifically, female clients demonstrated significantly higher levels for depression and anxiety relative to the non-violent controls. Interestingly, the comparison between male and female clients combined on both these factors was not significantly different to controls. This finding suggests that male victims experienced less anxiety and depression in their abusive relationships and is consistent with reports in the literature that abuse has different consequences for males and females. The literature also supports our findings relating to higher levels of anxiety and depression in victims of abuse.

Overall, personality measures did not delineate any specific typology for victims compared with controls. The only findings were that victims tended to be self-effacing, quiet, deliberate and low in self confidence.

23.4 Profile of Mutual violence group

Demographic profile

Clients in the mutual violence group were significantly more likely than non-violent controls to be female and unemployed. Female clients in the mutual violence group were significantly more likely to be receiving welfare benefits than female controls.

Alcohol and drug use

In the study we found that 21.3% of clients engaged in mutual physical violence (using the CTS with self-defence criteria) with their partner; 18.3% of male and 27.3% of female clients. This prevalence rate is high, however, there are no other studies to which these results can be compared.

The only significant finding for alcohol and drug use of clients in the mutual violence group was that they were significantly more likely to consume larger amounts of alcohol than clients in the control group. This effect was highly significant for male clients in the mutual violence group (54%) compared with male non-violent controls (16%).

Family history

Clients in the mutual violent group were more likely than controls to be raised in welfare or foster homes (17% vs 10%), however this comparison was not statistically significant. Similar to victims and in contrast to perpetrators there were no differences in the presence of parental alcohol or drug problems for clients in the mutual violent group compared with the control group.

Overall, physical or verbal aggression between parents or from parents towards the client was not significantly different for the mutual violent group compared with controls. The only significant finding was that a larger proportion of females in the mutual violent group reported that their mother was verbally aggressive towards their father. These findings contrast markedly with the those for the perpetrator and victim groups. It should be stated, however, that although not significant, the mutual violence group compared with controls was characterised by mutual physical aggression between parents, the father being physically aggressive towards the mother and vice versa, higher levels of verbal aggression directed towards the client in particular from the father, more physical aggression from at least one parent, particularly the father and from both parents. It is possible that failure to find statistical differences between the mutual violence group and controls results from insufficient power to detect the effects; but it is apparent that the differences between groups are smaller than that seen for perpetrators and victims compared with controls. Further studies are needed to confirm our findings.

Clients in the mutual violence group demonstrated lower rates of total dyadic adjustment, dyadic satisfaction and consensus compared with controls. This was consistent with the findings for the perpetrator and victim groups. In contrast to the victim and perpetrator groups, clients in the mutual violence group scored had significantly lower scores than non violent controls for dyadic cohesion and affectional expression. The fact that the mutual violence group rated their relationship more negatively in all aspects measured could be due to the fact that these relationships are chronically unstable with the need for control not being a strong factor. Alternatively, it is possible that there is a continual power struggle between

both partners in the relationship, with neither person assuming absolute control in the relationship. In fact these relationships may be characterised by a balance in power and control and contrasts with abusive relationship in which the perpetrator has total control.

We found that clients in the mutual violence group experienced levels of anger similar to the control and victim groups. Women in this group did however manifest significantly higher levels of state anger, possibly related to their admission to the clinic. Their scores were found to be higher than controls on measures of anxiety and depression, similar to the victim and perpetrator groups. Clients in the mutual violence group also had a higher overall level of psychopathology compared with controls (GSI). Moreover their scores on the subscales of the SCL-90 mirrored those of the perpetrator group in all respects except the paranoid ideation subscale where scores were significantly higher than controls, particularly for female clients. Although perpetrators had higher mean scores for the paranoid ideation than the mutual violence group compared with controls, it is likely that the effect was not significant for perpetrators because of the smaller sample size.

Our personality assessment indicated that clients in the mutual violence group had few distinguishing characteristics and in this regard were similar to the victim group and quite different from the perpetrator group.

In conclusion, it appears that clients in the mutual violence group shared characteristics with both the victims and perpetrators. However they tended to consume more alcohol than the either victims or perpetrators. More often they had spent time in welfare/foster homes, which tend to be rigid and impersonal. Their domestic relationships were distinguished by a lack of cohesion probably reflecting a greater reliance on an autonomous lifestyle which could easily have developed during their stay in welfare/foster homes, and although not statistically significant, an overall greater level of violence in the family origin.

Chapter 24. Summary and Conclusions

24.1 Staff

Staff at the clinics surveyed generally expressed a high level of concern for those involved in spouse abuse, and a corresponding willingness to provide what help they could to such individuals. The contrasts in attitudes and behaviours thus represent differences within a group of relatively highly committed workers.

Both the drug and alcohol clinics and the workers surveyed were typical of those found in the Sydney metropolitan area.

Staff tended to overestimate the prevalence spouse abuse in the Australian population, if estimates obtained from surveys in the United States of America and Canada are valid for Australia. A number of results indicated that there was a strong tendency to characterise perpetrators of spouse abuse as male, and victims as female. While there are undoubtedly such differences in the proportions of sexes involved in these roles, the extent to which this was expressed in estimates of prevalence is greater than that found in actual studies of sex differences. Estimates of differences in the prevalence of spouse abuse in different socioeconomic groups tended to reflect what is known of such differences, but the estimates for different ethnic groups varied considerably from relevant estimates in the literature.

Respondents were generally more supportive of victims, and assigned the responsibility for spouse abuse almost solely to perpetrators. Not surprisingly, alcohol and drug use was felt to be the most important influence upon spouse abuse. Victims were characterised as having low self-esteem, anxiety and guilt/shame, while the most salient characteristics of perpetrators in addition to low self-esteem were very angry, emotionally disturbed and having an uncontrollable temper. The most effective treatments suggested agreed with these characteristics, with personal development therapies suggested for victims, and strategies to control unacceptable behaviour suggested for perpetrators. Legal intervention in spouse abuse was endorsed by all respondents, but counselling was most frequently mentioned as a preferred intervention in every question which dealt with this. It is of interest that there may be a polarisation of attitudes with respect to committment to victims and perpetrators. The mean factors scores for two clinics showed a strong inverse relationship between committment to victims and committment to perpetrators. In each case, the score for the weaker committment to one party was the lowest observed for any clinic, and in one case, the score for the stronger committment was the highest. We suggest that very high expressed committment to either victims or perpetrators is likely to be accompanied by a reduction in committment to the other party. This may have been expressed by the respondents themselves in two of the responses to negative aspects of working with victims, becoming emotionally involved and being judgemental/one sided.

Respondents' reports of actual experience with clients involved in spouse abuse were quite consistent with their expressed beliefs. Respondents were generally less confident about their skills with perpetrators, but about as likely to refer perpetrators, when compared with victims. Counselling was the most common referral.

Perhaps the most interesting finding to emerge from the staff survey was the appearance of interpretable prototypes of victims and perpetrators, and the association of these prototypes with a variety of attitudes and behaviours. Respondents who expressed "Bad" prototypes were more reluctant to become involved in changing behaviour, less agreeable to providing services, and more pessimistic about the efficacy of intervention. While it is not possible to determine how these prototypes were developed with the present data, ascertaining the contribution of cultural and educational influences, and actual experience with those involved in spouse abuse, would provide a much better understanding of how these prototypes mesh with reality, and how the clinical situation is affected by them.

24.2 Clients

We found a very high prevalence of both victims and perpetrators of domestic violence amongst clients of the clinics. Additionally, a large proportion of clients were in mutually violent relationships. The relationship between domestic violence and client drug and/or alcohol use amongst this population was found to be important in a number of ways. Perpetrators had an earlier onset of regular drinking and had a more severe alcohol problem. Female perpetrators were much more likely to abuse drugs.

Our findings relating to intoxication found that clients reported being more often intoxicated when they were verbally or physically aggressive towards their partner and they reported that the aggression was more severe when they were intoxicated. This contrasts to clients reports of their partners drinking behaviour when they were verbally or physically aggressive towards the client.

There is a suggestion that genetic factors may have been important in some perpetrators in terms of their alcohol consumption, and there could conceivably be a link to other behavioural factors such as aggression and impulsivity.

By assessing demographic and psychological factors, we were able to examine those characteristics which distinguished perpetrators as well as victims. The influence of the family of origin, which was found to be strong, both in terms of exposure to parental drug and alcohol use and also the level of parental conflict and aggression directed towards the client, differed for perpetrators, victims and the mutual violence group. The effect of modelling appeared to be influential in the later development of the clients own domestic relationships.

A psychological profile for both victims and perpetrators was established; this was consistent with previous studies of perpetrators in particular. Because of the small

sample size we were unable to distinguish specific typologies of perpetrators within our client group and can not therefore not comment on others established typologies, for example, schizoid/borderline, antisocial/narcissistic and dependent/compulsive.

We believe that the mutual violence group warrants further investigation. It is quite likely that many clients in this category are being assessed as victims or perpetrators when in actual fact they are neither in an exclusive sense. Depending on circumstances they can present as either and management as a result can be ineffectual without taking the relationship rather than the individual into consideration.

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