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Psychosocial and substance-use risk factors for intimate partner violence

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Abstract

Objective: Few emergency department (ED) studies have described the relationship between family violence and subsequent intimate partner violence (IPV) or accounted for partner alcohol use in IPV victimization. This study sought to identify family history and substance-use factors associated with IPV among women presenting to an urban emergency department.
Methods: Case–control study in which cases (women identified as having IPV concerns and an IPV history) and controls (women without IPV) were frequency-matched by age group and race/ethnicity. Logistic regression was performed to calculate adjusted odds ratios (AOR) for any IPV, physical IPV, and sexual IPV.
Results: The sample included 182 cases and 147 controls. Living with a partner (not married) and witnessing parental violence were independent risk factors for any IPV (AOR 2.55 and AOR 2.21, respectively). Partner's alcohol use (AOR 1.22 for every five drinks consumed per week) and heavier drinking (AOR 5.07) were also significant risk factors, but not subject's substance-use. The pattern of risk factors varied only slightly for physical IPV and sexual IPV.
Conclusion: This study suggests a substantial relationship between partner alcohol use and IPV among women beyond the woman's substance-use and confirms previous reports regarding the cycle of violence in women's lives.

Keywords: Alcohol drinking; Alcohol dependence; Substance abuse; Child abuse; Partner abuse; Emergency medicine

1. Introduction

Intimate partner violence (IPV) has gained worldwide attention and is recognized as an important public health concern. International estimates vary widely, with 10–69% of women reporting physical assault by a male partner in their lifetime, and from 1 to 52% of women have experienced IPV in the previous 12 months, according to 48 population-based surveys from around the world (Krug et al., 2002). In the United States, 1% of all surveyed women and up to 14% of married or cohabiting women have reported IPV in the previous 12 months in national surveys (Gelles, 2000; Schafer et al., 1998; Tjaden and Thoennes, 2000a). Although this is a relatively small proportion in comparison to some of the higher prevalence countries, the impact is substantial with up to six million US women being affected each year.

Women are especially at risk for IPV as they are more likely to experience chronic and more severe IPV than men, and they are more likely to be injured as a result of partner violence (Tjaden and Thoennes, 2000a). Based on conservative estimates from the National Violence Against Women Survey (Tjaden and Thoennes, 2000a), which found that women often experienced multiple assaults in the preceding 12 months, approximately one-third of the five million IPV incidents perpetrated against women each year in the US result in medical care with the majority of women receiving treatment in a hospital setting (National Center for Injury Prevention and Control, 2003). Emergency department (ED) utilization, in particular, is substantial (Greenfeld et al., 1998; Centers for Disease Control and Prevention, 2001).

Acute physical trauma or injury resulting from IPV has been difficult to identify among women in ED settings,

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however, due to both patient and provider barriers (McGrath et al., 1997; Davis et al., 2003; Larkin et al., 1999). Patient characteristics associated with not being screened for IPV in the ED include presenting with non-psychiatric complaints, less severe complaints, and presenting during daylight hours (Larkin et al., 1999). Further, providers have expressed frustration that the victim would return to an abusive partner, concerns about misdiagnosis, lack of time and privacy, personal discomfort, reluctance to intrude into familial privacy, and lack of 24-h social service support (Davis et al., 2003; McGrath et al., 1997). Abused women have also reported that providers often do not ask about IPV, even when presenting with injuries, and they frequently report having negative experiences (e.g. condescending or uncaring attitudes) when they do disclose; other reasons for non-disclosure include fear of their partner, police, and the courts, shame, and embarrassment (Sleutel, 1998; Durant et al., 2000). As a result of these barriers, prevalence estimates have been quite low, ranging from 1 to 7% (Abbott et al., 1995; Dearwater et al., 1998; Feldhaus et al., 1997; Morrison et al., 2000; Petridou et al., 2002; Roberts et al., 1996; Sachs et al., 1998; Sethi et al., 2004; Stuart, 2004).

Nevertheless, ED studies have been useful in identifying important risk factors for IPV in these populations, particularly, alcohol and drug use. Alcohol use or abuse has been identified as an independent risk factor for current and previous IPV victimization among men and women in ED studies controlling for demographic and drug use (Ernst et al., 1997) or demographics alone (Rhodes et al., 2002), and cocaine use has been associated with a history of IPV victimization among women controlling for demographic factors (Brokaw et al., 2002); the latter two studies assessed exposure to drug and alcohol use separately.

While general population studies suggest that partner's alcohol or drug use may be an independent risk factor for IPV (Cunradi et al., 2002) or IPV-related injury (Tjaden and Thoennes, 2000a), few ED studies have taken partner substance-use into account in examining the independent risk factors for IPV (Grisso et al., 1999; Kyriacou et al., 1999; Rhodes et al., 2002). Intentionally injured women were two to four times more likely than controls to have a partner with alcohol or cocaine use, respectively, in the study by Grisso et al. (1999), after adjusting for the woman's alcohol and drug use, psychosocial, and demographic factors. Similarly, Kyriacou et al. (1999) found that women intentionally injured by their partner were approximately 3.5 times more likely than controls to either have a partner who abused alcohol or used drugs, after adjusting for subject and partner demographic and substance-use factors.

Other important psychosocial factors related to IPV have been suggested in studies drawn from the general population, including childhood abuse and witnessing parental violence (Ehrensaft et al., 2003; Cunradi et al., 2002; Tjaden and Thoennes, 2000a). Cunradi et al. (2002), for example, found that women reporting childhood physical abuse were nearly five times more likely to have experienced severe IPV and male partners with a history of childhood physical abuse were three times more likely to perpetrate severe IPV, beyond the effect of alcohol problems and drug use in women and their partners. This is consistent with the literature, which suggests that childhood abuse and parental violence may lead to substance abuse and IPV later in life (Ehrensaft et al., 2003; Jouriles et al., 2001; Stein et al., 2002). In the emergency medicine literature, however, few studies have described the relationship between family violence and subsequent IPV. A history of childhood abuse was associated with both a violence-related injury by a current male partner (Grisso et al., 1999) and a history of IPV (El-Bassel et al., 2003) among women seeking care in the ED, although neither of these studies reported childhood abuse as an independent risk factor for IPV.

The main objective of this study is to determine the independent sociodemographic, family violence, and substance-use risk factors for IPV among black, white, and Hispanic women presenting to an urban ED in the U.S. This study also attempts to further discern the independent contribution of partner alcohol use on IPV victimization. We hypothesized that family violence and substance-use, particularly alcohol use among partners, would be independent risk factors for IPV victimization.

2. Methods

2.1. Study setting and design

The study sample is drawn from a case–control hospital-based study of white, black, and Hispanic adult female patients admitted to an urban ED in Dallas, Texas from May through October 2002. Cases were defined as ED patients referred to the Violence Intervention and Prevention (VIP) Center of the study institution as a result of concerns related to IPV victimization identified during the ED visit by either the health care provider or the patient. Controls were selected from patients in the same ED as cases and during the same time period that cases were recruited into the study. They were approached for study recruitment in the ED waiting room by VIP caseworkers 24 h a day, all days of the week. Controls were defined as women not referred to the VIP center. Controls were frequency matched to cases by age group and race/ethnicity.To further establish IPV history, cases and controls were asked during the study interview about the occurrence (yes or no) of 10 physically violent behaviors and 1 sexual violence behavior in the previous 12 months that their partners may have perpetrated against them. These items were adapted from the Conflict Tactics Scales, Form R (Straus, 1990a). For the purposes of this paper, both cases and controls also must have been married or living together in a relationship for at least 3 months in the previous 12 months in order to ensure equal probability of exposure; subjects must have presented to the ED to obtain care for themselves to accurately reflect the ED population; and demographic data