Family Violence and Substance Abuse: A Vicious Cycle Perpetuated by Isolation

Susan sits and waits. Brad will be coming home. He will be drunk. He will wake her up by punching or choking her. She can't stand it anymore. She feels like she has reached the end of her rope. She no longer recognizes herself. The person she was years ago has been erased. She cannot reach out to anyone. There is no one left in her life. They have all been eliminated either by his rudeness and threats or by her humiliation. She is all alone. She reaches for another drink.

For a woman who is battered, alcohol becomes the ideal medication to ease the pain: it is readily available, it is affordable, it kills the feelings, it asks no questions, it leaves no memory of humiliation and, best of all, nobody has to see.

Formula for Abuse

There is a formula for violence and, by understanding that formula, it becomes easy to see how substance abuse fits into the battered woman’s life. The formula for abuse is: a history of abuse (plus) stress (plus) the opportunity for abuse (minus) support.

History of Abuse: Though it is not often mentioned in treatment programs—and when mentioned, it is generally ignored—many people who are chemically dependent come from a background of family violence and abuse (Windle et al., 1995; Senate Hearing 101-939, 1990). “A history of abuse” can mean abuse occurred in childhood or in an adult relationship. It can mean that the person was him/herself abused or saw another family member abused. The abuse can be physical, sexual or emotional. One relationship between family violence and substance abuse is that substances are used to kill the pain and shame of the abuse (Senate Hearing 101-939, 1990).

Stress: A person who has been effected by abuse is likely to be under stress. She has learned that the world is not a safe place. She is likely to become involved with someone who was raised with a similar level of abuse, and that person will bring his/her own dysfunctional behavior to the partnership, which further increases stress. In our society, alcohol and drugs are a common stress reliever. Many problems with alcohol begin with the habit of having “a few drinks to unwind” (at times on the advice of doctors). Unfortunately, alcohol and other drugs also are frequently involved in incidents of violent family behavior.

Opportunity to Abuse: Violence is a learned behavior and it is learned in context (Ganley & Harris, 1988; Family Violence Coalition, 1991; Spaccarelli, Coatsworth & Bowdey, 1995). Children learn from their own abusive families that the violence (whether physical or emotional) is a secret that must be kept inside the family. The family that suffers violence is typically an isolated family. The fewer contacts with society, the less anyone is likely to guess the family secret. Just as there are opportunities to abuse in the isolated family, so are there opportunities to drink. The less social contact one has, the more often one can get drunk without social sanction.

Lack of Support: Because of isolation, it is not easy to reach out for support. A lack of social support is a key factor in family violence because the very lack of social support increases stress in the family, increases the opportunity to abuse, and decreases resources that might help reduce stress. A lack of support is
also a factor in drinking/drugging. As the battered woman begins to drink more to kill the pain of the violence, she can easily justify isolating at home under the guise of doing what the abuser wants (staying home) so that he won’t become abusive. Because of the abuse she has suffered, she is filled with shame. The shame also keeps her from reaching out. She is ashamed because the abuse occurs and she can’t stop it. She is ashamed because she believes she is responsible for her own abuse. (“If only I hadn’t burned dinner, he wouldn’t have hit me.”) She is ashamed for anyone to find out the reality of her life.

With the presence of these factors, women are more vulnerable to the four basic kinds of behavior around which violence in the home centers: intimidation, humiliation, isolation and control. The physical violence that women experience comes only after these four deadly violators are firmly in place. A woman who is beaten before she has been sufficiently “trained” (brainwashed) by the use of these mechanisms will probably be able to find a way out. But after enough intimidation, humiliation and isolation, it is too late and she can then usually be controlled even without the physical violence. The physical violence might then be used only as a reinforcer to keep the control in place. If the abuser’s control begins to slip, he again uses physical violence in order to quickly reestablish that he is in charge.

Issues in Treatment

There are several issues involved in the chemical dependency treatment of battered women. Following are a few of the major issues that chemical dependency counselors must understand so that they do not put the battered woman at increased risk:

- **The woman may not know that she is battered.** Many abused women are from violent families of origin. When they were children, they saw violence in their family which no one identified as violence. Thus, they came to think of violent behavior as normal. In addition, the abuser will minimize and excuse the behavior in order to avoid taking responsibility for his actions. In order to help women who are chemically dependent understand the violence in their lives, they must first be educated about what violent behavior is, and what it means to have personal boundaries.

- **If she gets sober, she won’t be “controllable” anymore.** It is not in the abuser’s best interest for his battered partner to get clean and sober. Since the batterer is a first-class controller, however, he may very well appear to be in her corner and indicate that he wants her to get well. But if she gets sober, she will be able to remember all the violence that occurs. She will no longer believe the “you fell down the stairs” stories. The excuse that he had to use violence “to control your drunken behavior” will be invalid. And if she reaches out for help in her recovery, she will no longer be isolated... and can no longer be controlled by him.

- **When the battered woman begins to talk about the violence, especially when she starts making plans to get out, the danger to her increases substantially.** When a battered woman begins to talk about the abuse, it is usually when she decides to leave. And when she leaves her abusive relationship, her chances of being killed increase significantly (Wilson, 1989; Casanave & Zahn, 1986; Rasche, 1993; Dutton-Douglas & Dionne, 1991; Harlow, 1991). It is when battered women leave, not when they stay, that they are most likely to be killed. (Thus the first answer to the question, “Why does she stay?” Is “Because she wants to stay alive.”) Counselors must understand that it is critically important that no one hear about the abuse except from the battered woman herself or with her expressed permission.

Training is Imperative

Some research indicates that people who receive treatment for family violence as well as for chemical dependency stand a far better chance of achieving continued sobriety (Windle et al., 1995). This makes perfect sense because without treatment, the shame, guilt and isolation of family violence will greatly undermine treatment goals. However, knowledge of the battering may create a situation in which a little knowledge becomes a dangerous thing. Chemical dependency counselors who do not understand the dynamics of family abuse can inadvertently set a client up to be further battered or killed. A critical first step for a substance abuse treatment facility interested in dealing with clients’ abuse issues is to contact the local battered women’s shelter and ask for assistance. An exchange of information from shelter to treatment program, and vice versa, will begin to enhance the methods of treatment in both facilities.

---

Geri M. Redden, M.Ed.*
Founder & Executive Director
National Center for Violence Prevention
St. Louis, MO

* Ms. Redden, a former battered woman who is also in recovery from substance abuse, has worked in the field of family violence for the past 20 years.

**REFERENCES**


Cycles of violence and addiction frequently occur in tandem, although research indicates that neither causes the other. Individually, each is chronic, progressive and often lethal. Together, severity of injuries and lethality rates climb (Dutton, 1992). Yet, interdisciplinary screening for such multi-abuse trauma is often neglected. Barriers to women’s safety and sobriety are magnified when routine screening for both domestic violence and substance abuse fails to occur. Failure to ask key questions or recognize red flags often stems from a variety of factors including lack of time, sense of helplessness to assess client characteristics outside one’s own area of expertise, fear of “opening up a can of worms,” concerns about angering or hurting a client’s feelings, lack of knowledge of community resources, and little trust in providers from fields different from our own. These barriers are compounded if they exist within a work culture that simplifies or trivializes women’s issues or addresses a presenting problem without exploring the context.

Understanding the impact of multi-abuse trauma may very well enhance a woman’s chances for achieving both safety and sobriety. Substance abuse occurs in 44 - 80% of domestic violence incidents depending on what research one chooses to cite (Mackey, 1992). While most battered women are not chemically dependent, substance abuse often occurs as a coping method which some battered women use to compensate for the ongoing threat of violence from partners (Bland, 1994). Some battered women may consider substance use less emotionally and physically damaging than facing daily bouts of physical, emotional and sexual abuse with little to blunt the pain. The Minnesota Coalition for Battered Women (1992) notes that women who have been abused may also use alcohol or other drugs for a variety of other reasons, e.g., coercion by an abusive partner, chemical dependency, cultural oppression, over-prescription of psychotropic medication, or, for women recently leaving a battering relationship, a new sense of freedom.

**Comparison of Addiction and Domestic Violence**

Clearly, domestic violence and addiction are two separate problems. The two have many differences although, at first glance, the similarities are striking. Domestic violence and chemical dependency both affect entire families—often harming three or more generations; and they are marked by the development of elaborate denial systems that include minimizing, rationalizing and blaming others. Both carry a great societal stigma and thrive within isolation, shame and silence.

Domestic violence and addiction, though, are vastly different. According to the American Medical Association (1994), domestic violence is a pattern of coercive behavior marked by physical, emotional or sexual abuse. Domestic violence is not a disease. It is a behavior one intimate partner chooses to use in order to gain and maintain power and control over another. Women who find themselves in relationships with batterers do not know on the first date what the future will hold. They expect to find “romance” and “love” and hope the relationship will “work out.” Abusers, however, want to exert power and will go to any length necessary to gain and maintain control, often mislabeling their behavior as a sign of affection, e.g., “I wouldn’t have to whoop you if I didn’t love you.” Many battered women do not want their relationships to end; they want the violence to stop and to have a happy, healthy relationship.

Continued on next page...
These women are victims of a violent crime. They do not cause the abuse and do not “like” it. They are not “sick” but often injured and traumatized by their partners. Victims of domestic violence are not “codependent,” they are survivors. They survive threats, intimidation and abuse that may not be obvious. Sometimes they do not survive.

Addiction, unlike domestic violence, is not a behavior. It is a disease. Alcohol and drugs affect judgment whether addiction is present or not. Addiction, however, is marked by the development of tolerance, loss of control, continued use in spite of adverse consequences and withdrawal symptoms.

Women often begin using alcohol or other drugs to “have fun” or “kill pain” with the belief that they can “control” their use. Although she may choose to use alcohol or other drugs, a woman does not choose how her body will respond. Addicted women do not want to stop using; they want the craving, the problems and the pain of withdrawal to stop. They have an illness, but typically believe they are well. This belief, along with the social acceptance of drinking or taking medication to kill pain, makes it hard for alcoholics and addicts to seek the help they need. Many times they do not seek help.

**Screening for Domestic Violence and Chemical Dependency**

Battered women and addicted women often blame themselves when they are unable to be safe or sober. If these women are one in the same, the level of guilt and shame is compounded. As a result, women facing the dual stigma of addiction and domestic violence may be reluctant to openly seek help. Additionally, these women have little reason to trust. That which they have sought comfort from—substances and love—have let them down. For these reasons, women generally do not routinely self-identify as either addicted or battered unless their safety is assured. Therefore, before a client will open up to a provider, she must feel safe.

Within this context, screening for chemical dependency and domestic violence can be very simple. Finding out whether these problems exist and being able to effectively intervene, though, require more than checking off boxes or asking questions from a list. Effective screening occurs within the framework of respect.

The first requirement for respectful screening is an honest evaluation of one’s own attitudes and beliefs about addiction and domestic violence. This involves conveying the message that addiction and violence can happen to anyone—that any woman could find herself having a problem with substances and/or an abusive partner through no fault of her own. Tell your clients, “All women are vulnerable; you are not alone should these problems be facing you.” We must not secretly be thinking to ourselves, “Why doesn’t she just quit?” or “Why doesn’t she just leave?” Additionally, conversations about addiction and violence need to take place in private. Children over the age of three should not be present lest they repeat what they hear, putting a woman at risk.

**Screening for Domestic Violence**

When screening for domestic violence, it is most useful to address the relationship first. My experience has taught me that many women find it easier to talk about a partner than themselves. This does not stem from co-dependency, but occurs because women are so often defined by their role rather than who they are as individuals. Many providers, however, are fearful of bringing up the subject of domestic violence. I recommend a subtle approach. The following is offered as a basic script; however, language should be adapted to suit personal styles when screening possible victims of domestic violence:

“We recognize that many women are dealing with stress in their relationships, and we are committed to your safety and health. As a team we are asking each woman we see the following questions so we may better meet their needs. This information is kept confidential.”

“How often do you feel stress in your relationship? When was the last time you felt threatened, controlled, afraid or abused by anyone in your relationships? How often does someone hurt you?”

“Does your partner show disapproval? When was the last time you felt threatened by your partner?”

All women clients should be routinely screened and given domestic violence brochures as well as local 24 hour help line numbers. Women can be told, “You may not need these numbers but we are giving them to all our women clients in case they have a friend who may need them.” Also be sure to advise a client that she can leave these brochures behind if it is not safe to bring them home.

Although the best way to find out about domestic violence is to ask, be aware that the following may be indicative of battering or abuse: injuries to face, neck, bathing suit area; bilateral injuries; injuries at multiple sites or at varying stages of healing; stories inconsistent with injury or no explanation for obvious injury given, vague somatic complaints; injuries during pregnancy especially to abdomen, breasts and genitals; and substance abuse, panic attacks, depression, PTSD symptoms, eating disorder, depression or suicidal ideation. Also be wary of client partners who refuse to leave a woman’s side, seem controlling, and/or speak for the client. Frequently missed appointments or cancellations of appointments by a client’s partner may also be red flags of domestic violence.

When a woman discloses abuse, acknowledge the problem. Assure her that:

“Information shared with us is confidential. This is not your fault. No one deserves to be abused. You are not alone; others are in this situation and help is available. We respect your ability to cope and are available to share safety options or just listen.”
Also, make a referral to your local victim service provider, e.g., shelter program or legal advocate (be sure you have established a working relationship with your local domestic violence victim service provider agency). When a woman chooses not to talk about the abuse she has disclosed, tell her: “If you want to talk about this in the future, we are committed to your safety and health, and we will be here for you when you are ready.”

A brief safety assessment is also important. Determine if the abuser is present now and, if not, where the abuser is. Find out if the woman is afraid to go home, whether weapons are involved, and whether threats of homicide or suicide have been made. It is also useful to know whether children are witnessing and/or experiencing the abuse so their safety can be assessed and appropriate referrals made.

Screening for Addiction

Screening for addiction is always a touchy business. Although recognized tools for assessing an individual’s alcohol use (e.g., CAGE, MAST) have been around for years, it has been my experience that women find it easier to discuss their partner’s substance use as opposed to their own. This is particularly true of women in abusive relationships whose abusers drink or use drugs. It is most important to convey the messages that drinking and drug use do not cause domestic violence, and that neither alcohol and drug treatment nor “anger management” alone ends abuse. Certified batterers treatment programs in conjunction with chemical dependency treatment may prove helpful but in no way guarantee a woman’s safety. Chemically dependent battered women may respond well to this clarification although there may be disappointment that getting clean cannot fix everything.

A conversation about an abusive partner’s substance abuse gives a provider an opportunity to explore the client’s history of substance use, abuse and possible addiction. When women disclose stories of domestic violence, I offer supportive statements such as, “It must be hard for you to believe someone who started out so nice could become so hurtful.” I then validate the fact that this woman has survived and praise her sincerely for finding a way to cope. This leads to a discussion that usually includes the following:

“You deserve credit for finding a way to cope. Tell me what made you able to survive?” and “Many women I see tell me when they have experienced pain they find a way to deal with it. Some women tell me they become compulsive cleaners, others, big spenders, some get into bingo or shopping, eating or not eating, sleeping a lot or working a lot. Have you tried any of these ways of coping? A lot of women tell me the best way to cope is to numb out by drinking or drugging? How often has this worked for you?”

This also is a good time to acknowledge: “Many women tell me their partners don’t want to drink or drug alone. How often have you found yourself stuck using when you didn’t want to?” This is a useful way to get information without threatening a woman. It also gives one an opportunity to explore drug related domestic violence. Many women disclose that their partners put them on the street to trade sex for drugs, and some IV drug users have never shot up alone—their partners have done it for them. One way of maintaining power and control is through maintaining a drug supply. A form of abuse occurs when a batterer deliberately uses dirty needles or cottons or misses a vein on purpose. Exploring O’Neil’s (1996) Power and Control Model for Women’s Substance Abuse (see figure 1 on page 17) with a client can be very helpful, in addition to using standard tools such as the CAGE or MAST. The CAGE is a tool which, according to NIDA (1990), can be self-administered or given by a clinician. The CAGE asks respondents the following yes/no questions about their drinking:

C=attempts to Cut down on drinking?
A=Annoyance with criticism about drinking?
G=Guilt about drinking?
E=using alcohol as an Eye-opener?

Affirmative responses to two or more of these questions is generally considered a positive screen for alcohol abuse (Ewing, 1984). The MAST (Michigan Alcoholism Screening Test) also can be self- or professionally administered, and it measures consequences of alcohol on a person’s life (Selzer, Vinokur & van Rooijen, 1975). Other instruments (e.g., Drug Abuse Screening Test (DAST) and Drug Use Index (DUI)) are similar tools for assessing use and consequences of drugs other than alcohol.

It is also very helpful to be alert and notice if your client has the odor of alcohol on her breath, red eyes, pin-point or dilated pupils, track marks on arms, hands or feet, or other cues which, if not directly indicative of addiction, at least indicate that substance misuse may be occurring. Rapid speech, difficulty tracking, scratching and picking at arms or face during a visit may also indicate drug use, as does lethargy, nodding and cigarette burns (which may also be indicative of domestic violence). Generally speaking, I find it most useful to note these observations and directly mention them to my client. A sample way to deal with the obvious problem head on is as follows:

“You and I both know you have been under a lot of pressure lately. And you and I both know anyone will look for a way to feel better. I’m concerned about you because you and I both know you have been drinking this morning. Lots of women I see do the same thing. How can I help you find a safer way to cope?”

I find it engages the client to bring her into the discussion by positively recognizing that she knows what is going on, as do you. Expressing care and concern rather than being critical is also more useful, particularly when confronting chemically dependent battered women who are often on the receiving end of unkind comments.

Intervention Strategies

Once you have thoroughly assessed the situation, the challenge in working with a chemically dependent battered woman is...
EXCELLENCE IN ACTION

Addressing Substance Abuse and Family Violence Through Community Collaboration and Treatment for the Whole Family

The Tarzana Treatment Center, Inc. (TTC), a full service chemical dependency treatment agency, has been serving men in Los Angeles County for over 20 years. In 1989, TTC opened an additional facility in Long Beach, CA to provide day treatment and residential services to women affected by substance abuse and HIV. In 1993, TTC received an Abandoned Infants Assistance grant, from the U.S. Department of Health and Human Services’ Children’s Bureau, to establish the Infant Abandonment Prevention Project (IAPP). This project, which operates out of TTC’s Long Beach facility, serves women who are affected by substance abuse and/or HIV, and who are pregnant or have an infant or young child.

IAPP includes four major service components: (1) case management and counseling; (2) training for caregivers; (3) respite care for caregivers; and (4) transitional housing for mothers and siblings at risk. Additionally, IAPP provides a full range of HIV services, an on-site therapeutic nursery, weekly family groups, and a continuum of services for immediate and extended family members, as well as foster caregivers and kinship caregivers. These services are provided by a staff consisting of a project director, two case managers, a psychologist, a health educator, a parenting coach and several MFCC interns.

Most of the women served by IAPP are African American or Latina, and many are homeless and lacking primary medical care, financial resources, independent living skills, caregiving knowledge and skills, and family support. Additionally, approximately 98 percent of the women served by IAPP have experienced family violence, and at least 45 percent of them are currently in violent relationships.

Services for Women Affected by Family Violence

In response to the high, and increasing, incidence of violence in families affected by substance abuse, IAPP has incorporated education about family violence into all components of the program. For instance, the 12-week “Life Skills” course, which all women participating in IAPP are required to complete, addresses issues related to domestic violence and its relationship to substance abuse. The weekly family support group for IAPP clients and their families also addresses these issues.

Additionally, within their first two contacts with the project, all women referred to IAPP are screened for family violence using a bio/psychosocial assessment and a demographic assessment. Both these instruments, which were developed by TTC, include questions about past and current mental and physical abuse. When women respond affirmatively to these questions, safety planning and individual counseling around domestic violence issues are incorporated into their case management service plans. The counseling is provided by a full-time therapist, as well as the case managers, who are social workers trained in family violence and required to obtain at least eight hours of additional training in this topic each year.

IAPP also has a contract with a local domestic violence shelter, Interval House, whose staff co-facilitate a weekly domestic violence group session at TTC’s Long Beach facility. This group, which is open to all women participating in IAPP as well as other women in the community, focuses on self-esteem, empowerment and education about resources in the...
When women graduate from IAPP (after approximately six-to-nine months), they are often referred to Interval House for long-term counseling. Graduates can also obtain individual counseling from IAPP staff as needed for an indefinite period, and they are invited to participate in a monthly graduate support group at TTC.

**Working with the Perpetrators**

IAPP recognizes the strong perpetuating relationship between substance abuse and violence and attempts to break these cycles by including women’s partners in their treatment plans when appropriate. To this end, IAPP case managers educate women about the likelihood of relapse if they go back to the same violent relationships from which they came, and they encourage clients to bring their partners with them for meetings once a week. The TTC therapist also provides couples counseling for IAPP clients who are in violent relationships, and conducts a weekly couples group.

Additionally, approximately two years ago, TTC established a separate program component to work with perpetrators. A Domestic Violence Group for perpetrators meets two times per week at TTC’s Long Beach sight in a trailer separate from the main facility. This group, which is open to anyone in the community, is facilitated by a male therapist, who also provides individual counseling for perpetrators and participates in regular client staffings. Also, when indicated, IAPP staff refer partners of women in the program to other community programs, including TTC’s residential treatment program for men, which is located at a different site.

**Services for Children**

IAPP also recognizes the effects of violence on children and the importance of addressing children’s needs individually and as part of a family unit. To this end, the staff therapist provides family counseling, as well as individual counseling, to children of women in the program. These children also receive special attention in IAPP’s on-site therapeutic nursery, as their parents receive education about how to care for them. Additionally, some children are referred to Cedar House, a community agency which provides counseling to children up to age 18, play therapy and a full range of early intervention and other developmentally appropriate services.

**Conclusion**

IAPP staff realize that they cannot fully protect women or children from returning to violent situations after they complete the six-to-nine month program. However, by educating women about the relationship between substance abuse and violence, providing intensive, comprehensive services directly, providing appropriate referrals, and collaborating with other agencies, the program helps women to recognize abusive relationships, improve their self-esteem, and ensure the safety of themselves and their children. Also, by addressing the needs and issues of the entire family—and each individual in it—IAPP helps to affect systemic change, rather than simply treat the symptoms of larger, more complex family issues. Finally, in addition to continually increasing their own education about family violence and its relationship to substance abuse, IAPP staff conduct one-day trainings, on a quarterly basis, to educate staff from local domestic violence programs about substance abuse issues. These efforts are all designed to help community members better recognize the relationship between substance abuse and family violence and address these issues more comprehensively.

— Amy Price, MPA
National AIA Resource Center

This article was based on a conversation with Kimberly Lister, Project Director for Tarzana Treatment Center’s Infant Abandonment Prevention Project (IAPP).

---

**ATTENTION RESEARCHERS...**

The University of New Hampshire Family Research Laboratory (FRL) has one-year fellowships for research on family violence starting in the summer and fall of 1997. These NIMH-funded positions are open to new and experienced researchers with doctorates in the fields of psychology, sociology, social work, law, nursing, public health and medicine.

The fellowships are intended for work in the area of child abuse, marital violence, elder abuse, sexual abuse, child victimization, rape, homicide and other family-violence related topics with special attention to mental health impact. Scholars may use the fellowships to collaborate with FRL faculty on a current FRL project or one of their own projects. Fellows must be able to reside within commuting distance to UNH, and will be provided with an annual stipend.

To apply, please send a statement of intended use of fellowship, curriculum vita, three letters of recommendation, and publications or work sample to: David Finkelhor, Co-Director, Family Research Laboratory, University of New Hampshire, Durham, NH 03824. Applications will be accepted up until March 1, 1997.

For more information, contact David Finkelhor at the above address, (603) 862-1888, or David.Finkelhor@unh.edu.
Wounded Bystanders:
Children Who Witness Violence

Mommy and Daddy fight and Mommy called the police and they took Daddy but Daddy got to come back when he got his thinking cap on. Now he can only drink a little beer at my house.

—Ashley, Age 5

Violence has besieged our nation. While there has been a great deal written about perpetrators of violence and causes of violence, much less has been written about children who are by-standers to violence. The number of children who witness violence is astounding. A New Orleans survey of school aged children revealed that over 90 percent of those questioned had witnessed some type of violent incident, 70 percent had observed weapons used, and 40 percent had seen a dead body (Osofsky, et al., 1993). In Los Angeles, Pynoos & Eth (1986) estimated that between 10 and 20 percent of homicides in that city are witnessed by children. In Garbarino et al.’s (1991) study of 536 elementary school children in Chicago, they noted that 25 percent had seen someone shot and 35 percent had witnessed a shooting.

Perhaps most horrifying is the number of children who witness violence in the place traditionally thought to be a safe haven—their own homes. A study of 115 mothers and children at the pediatric outpatient clinic at Boston City Hospital revealed that one of every ten children witnessed a shooting or stabbing before the age of six; the average age of children in this study was 2.6 years (Taylor et al., 1994). Half of these incidents occurred in the home. A survey by the Massachusetts Department of Probation (1993) revealed that each year 43,000 children in Massachusetts are exposed to domestic violence; 63 percent of these children are eight or under. Nationwide, an estimated minimum of 3.5 million children may witness domestic violence each year (Jaffe, Wolfe & Wilson, 1990).

Many children who witness domestic violence are also living with chronic substance abusers. The literature on alcohol abuse and domestic violence indicates that men with substance abuse problems are at high risk of being abusive to their spouses (Kantor, 1993; Collins & Messerschmidt, 1993). In almost half of the reported cases of domestic violence, alcohol is a factor (Collins & Messerschmidt, 1993). Women who are victims of domestic violence also have higher rates of their own substance abuse (Miller & Downs, 1993), and a high percentage of these couples have children. In families where there is domestic violence, the majority of children are believed to have seen or heard the violence (Gelles, 1987).

Effects on Children who Witness Violence

Clearly, children do not have to be direct victims to suffer severe consequences from domestic violence. Children who witness domestic violence are at very high risk for major complications in their development. When children are faced with multiple issues of violence and substance abuse, they are even more likely to be adversely affected because these issues compound each other (Parker et al., 1988).

Most attention has been paid to elementary school aged children and adolescents who have witnessed violence. Less focus has been on children under eight, the youngest and most vulnerable bystanders of domestic violence. In response to this need, The Child Witness to Violence Project was established in 1992 at Boston City Hospital (now called Boston Medical Center). Since its inception, the need for such a service has been well established. Over 150 children and their families have been seen in therapy, and numerous consultations and trainings have been provided to families, social service agencies, schools, courts, and law enforcement personnel. Much has been learned about the impact of violence on young children and about effective interventions.

"Children who witness domestic violence are at very high risk for major complications in their development. When children are faced with multiple issues of violence and substance abuse, they are even more likely to be adversely affected . . ."
The symptoms of PTSD are potent and dismaying. Many children have sleep disturbances such as nightmares, trouble waking, and/or a fear of falling asleep. Some demonstrate aggressive behavior, while others withdraw from friends and family. Some have such a high activity level that their symptoms may be mistaken for Attention Deficit Disorder. They may be hypervigilant or emotionally aroused by any new, even innocuous stimuli, worrying frequently about possible danger to themselves or to their families. Others are so traumatized that they are emotionally numb and appear to be oblivious to violence and anger. They may take risks that defy their knowledge of simple hazards. School problems are common and include school refusal, difficulties concentrating and a loss of previously mastered skills.

While all children are affected by exposure to violence, children who see violence between adults in their own homes are most seriously affected (Groves et al., 1993). Those who see caregivers using violence to solve problems come to believe that violence is a natural and appropriate way to solve conflicts. Children who live with domestic violence tend to be more aggressive in their play with peers which, among other consequences, limits their abilities to form healthy relationships. Violence is understood as a vehicle to gain control of one's self and others. Later in life, violence may become part of an intergenerational cycle (Bell, 1996). Living with violence also sculpts a child's view of the world in terms of gender roles. Males are viewed as violent, and females are seen as helpless victims.

Interventions to Support Healing

All caregivers (e.g., child care providers, teachers, family members, foster parents) have a unique opportunity to facilitate the healing process for children who have been traumatized by witnessing violence. In fact, the adults who care for children in typical settings such as home or school can offer the daily sustenance that is critical to moving on and regaining the sense of safety that may have been forfeited. Therapeutic work with a clinician, who focuses on working through the trauma, is augmented and strengthened when children spend their day in a supportive environment with a supportive caregiver. The strategies we have found to be most effective do not involve highly innovative or technical ideas. They rely on a basis of developmentally appropriate and sensitive interactions.

The foundation for intervention is the establishment of an environment which is physically and emotionally safe. (See "Principles..." below for specific interventions.) Even when children are still living with violence in their homes, spending time in a safe place gives them a powerful message that there are other ways to live and relate with people. This safety involves a range of factors including predictable schedules, consistent and reasonable rules, an openness to discussing difficult issues, and participation in a network of support services. Most importantly, it necessitates being willing to share one's self and to use the relationships established with children to exemplify trust.

Continued on page 20...

Principles of Support for Children Who Witness Violence

1. Healing begins with relationships. The adult helping relationship is the most powerful tool we have to help children heal from traumatic events.

2. Help children know what to expect. Offer a structured environment where children can predict what will come next.

3. Give children permission to tell their stories. It helps children to be able to talk about the violence in their lives with trusted adults.

4. Give parents help and support. Help parents and other caregivers understand that young children think differently than adults and need careful explanations about scary events.

5. Foster children's self-esteem. Children who live with violence need reminders that they are lovable, competent and important.

6. Teach alternatives to violence. Help children learn conflict resolution skills and non-violent ways of playing.

7. Model nurturing in our interactions with children. Serve as role models for children by resolving issues in respectful and non-violent ways.

8. Don't try it alone. Identify and collaborate with other caregivers and agencies in the child's life.

9. Take care of your own physical and emotional needs. Discuss concerns and issues with a supervisor or supportive colleague.
NEVERMORE:
A Psychotherapeutic-Educational Approach
to Treating Abusive Partners

Any comprehensive approach to working with those who need treatment for domestic violence must include a focus on issues such as entitlement, power and control, the cycle of violence, victim safety/lethality, and responsible behavior. This article addresses what we consider to be additional intervention targets that should not be omitted in the treatment of abusive behaviors.

Program Overview

NEVERMORE is a twenty hour therapy/education program for treating physically, verbally, and/or psychoemotionally abusive behaviors. The format includes four individual sessions (one hour each) and eight group sessions (two hours each). The individual sessions are used for initial and ongoing assessment. These sessions help to determine a client’s readiness for group endeavors, but are also instrumental in identifying alcohol or other drug abuse (AODA) and/or mental health issues that may need addressing for optimal intervention to occur. (This, by no means, is meant to imply that AODA or mental health problems cause domestic violence, but that they may be variables that warrant attention).

The individual sessions also fine tune or improve upon the information, knowledge, skill development and therapeutic interventions that are derived from the group process. Following the completion of the program proper, our team of psychotherapists is available for couples, marital, family or relationship sessions for those who opt to partake. We have found that many of the families that we work with are interested in staying together if an end can be brought to the abuse. This approach by no means is intended to place any of the responsibility for the abuse on the victims, but rather to increase the potential for ensuring that the abuse does not continue.

...abuser treatment should be a component of a combined community response [which views] the perpetrator of violence as a human being with a problem that needs remedy.

The goals of the program are to end abusive behavior; to ensure the safety of victims; and to hold abusers accountable for their illegal, inappropriate, and morally wrong behavior. There is a focus on imparting strategies for gaining and maintaining healthier, non-abusive interpersonal relationships. The optimal goal of the program is to bring about a personal transformation (in some individuals) that not only renders those with whom they live and interact with safe, but also makes the community at large a safer place for women and children in general. Because we are aware that this personal transformation does not occur for every program participant, and that some program participants are uninterested, unwilling and/or incapable of change, we espouse the view that abuser treatment should be a component of a combined community response. A combined community response should include: law enforcement, the criminal justice system, the medical system, community based organizations, and the educational system.

Working with the Perpetrator

When discussing our intervention strategies, it is important to note that while we are intensely focused on ending the violence and harm to others, we view the perpetrator of the violence as a human being with a problem that needs remedy. Thus, while we hold the person accountable and responsible for the violence, we approach the client from a helping stance. How can we (NEVERMORE and the client) help you (the client) to: end the violence in your relationship, have a healthier relationship, maintain your freedom, and satisfy your obligation to the criminal justice system.

To date, relatively few studies have addressed the efficacy of domestic violence treatment or, for that matter, what treatment components lead to acceptable outcomes. Our agency, The Milwaukee Women’s Center, Inc., is presently involved in a research project.
with the Center for Disease Control, to gather information on clients and programs to ascertain whether matching clients and modalities will improve outcomes. One of the substantial arguments against solely focusing treatment endeavors towards the outcome of ending the violence is that many men sincerely discontinue their physical abuse after being confronted with the reality of arrest/jail. There is, however, usually an escalation in verbal and emotional abuse. This is an indicator that issues such as power and control have not been adequately dealt with and thus a recycling of physical abuse is, in many situations, inevitable.

NEVERMORE recognizes the need to address legal issues (domestic violence is illegal and violators should be prosecuted), societal issues (including the historical context of outdated entitlement and misogyny concepts), and interpersonal issues (e.g., the cycle of violence, the nature of a healthy relationship, communication patterns, anger management). The program attempts to go beyond these traditional treatment efforts by including a therapeutic focus on potential intrapersonal problem areas. NEVERMORE seeks to impact participants in four intrapersonal areas:

1. **perception** or viewing of stimuli related to domestic violence
2. **thinking**, interpreting and/or processing that which is perceived
3. **feelings** or emotions connected to the perception and thinking processes
4. **actions** or behaviors that stem from the above

It is our belief that if we can bring about change in the way that a client filters and views conflict (with his significant other), there is the potential for altering the interpretation and processing of that which is perceived, as well as the related emotional components. If the client views, thinks about and emotes differently, there is greater potential for a change in behavior (i.e., ending the violence).

**Case Example**

The following anecdote from early in my treatment career illustrates this approach. A rather pompous young man appeared for treatment, indicating that he had been referred for “hitting his girlfriend.” He added that he hit her because she was “bumping her gums [arguing with him] too much.” Treatment endeavors uncovered that the client perceived his significant other (and mother of his only child) to be his possession. He viewed her arguing with him to be challenging to his authority and possibly deteriorating the stability of his household. He interpreted this to be conflict that warranted attending to. He thought that he needed to take action relative to her defiance. His perceptions and interpretations were found to be instrumental in his feelings of anger, hurt, and fear. He shook inside and he hit her.

The therapy focused on putting the client in tune with how he viewed his significant other: as a possession—his girlfriend; less than his equal—he hit her; and derogatorily—“bumping her gums.” The therapeutic process helped to contrast his erroneous “head-stuff” with the reality that he was in love with the mother of his only child, and that he had chosen to make a home with this person. The faulty attitudes and beliefs through which he filtered information and stimuli were significantly altered by pulling his significant other out of the equation and replacing her with his mother. It was readily apparent to him that he would not hit his mother if she argued with him. With this realization, the door to change was ajar.

**Conclusion**

NEVERMORE has program elements that address each of these intrapersonal components. For example, when working in the processing domain we include decision making and problem solving skill development. We have discerned that to assume that clients have effective skills in this area is often erroneous. Another important revelation that has surfaced is that many of our program participants enter treatment with a rather restricted range of emotions. Asking clients how they cope with feelings of hurt, shame or guilt often elicits no response. We believe that failure to include program elements to address these issues can result in less than optimal problem resolutions.

We also recognize the need for different treatment modalities to accommodate varied populations. Self help, spiritual and educational models have proven to be effective in bringing about change (i.e., ending violence). However, we believe that our psychotherapeutic-educational model, which includes an intrapersonal focus and specific program elements, is a viable treatment approach which should be considered in work with abusive partners.

— Les Higgenbottom, MS, CICSW, CADCIII Director, Clinical Services Milwaukee Women’s Center, Inc.
On September 16-17, 1996, the National Abandoned Infants Assistance (AIA) Resource Center convened the first national conference to address key links between housing, substance abuse and child welfare. Inadequate housing is often a primary factor leading to foster care or further involvement with the child welfare system, especially for women who have young children and are struggling with alcohol or drug addiction. In order to remain clean and sober and keep their families together after an intensive treatment program or emergency shelter, women need a range of safe, affordable housing with necessary support services to help them move toward independent living. Developing this range of service-enriched housing requires cooperation, coordination and commitment from public and private agencies in child welfare, substance abuse, housing and homeless services, as well as financial officers, private foundations/corporations, landlords and community members.

The AIA conference, *Service-Enriched Housing for Families: A Key Link to Recovery and Family Preservation*, brought together professionals from all of these arenas to discuss key linkages, learn about model programs, and explore innovative strategies for establishing a range of safe, affordable housing with a continuum of supportive services for families. The conference was held in Knoxville, TN, and participants came from 26 different states. The tremendous diversity among participants provided an excellent opportunity for information sharing, networking and advocacy on behalf of families. One participant commented that the conference "heightened my awareness of policy and critical decisions, acts, programs, funding sources, creativity needed, networking possibilities and resources that I did not have before."

Workshop and panel presentations offered a wealth of information on developing, accessing and financing various types of service-enriched housing for families. Rita Zimmer, Founder and President of *Women In Need, Inc.*, in New York City, set the tone for the conference with an inspirational and provocative opening keynote in which she outlined the challenges in developing service-enriched housing for substance using women and their children, and illustrated how WIN has overcome many of these barriers. Mary Lee Allen, Director of the *Children’s Defense Fund’s Division on Child Welfare*

Lisa Hamburger, Senior Program Officer, *Corporation for Supportive Housing*

and Mental Health, presented a challenging yet optimistic closing keynote in which she reviewed some common elements in service-enriched housing for families, and provided timely information about the potential impact of welfare reform.

Additionally, several conference participants had the opportunity to tour *Great Starts*, an AIA program that provides residential treatment for women and their children. Conference participants were also treated to a wonderful reception, sponsored by *Child & Family, Inc.*, in the foothills of the Great Smoky Mountains.

As follow-up to this conference, the AIA Resource Center has convened a national working group to further explore permanent service-enriched housing options for chemically addicted women and their children. For more information on the conference or follow-up activities, contact Amy Price at (510) 643-8383 or amyp@uclink2.berkeley.edu.
Applying Harm Reduction to Services for Substance Using Women in Violent Relationships

Harm reduction has been described as a philosophy wherein the health care/service provider sets aside all judgments in order to meet a client at her/his own level regarding a problem or crisis (Denenberg, 1993). Harm reductionists view the relationship between worker and client as egalitarian—one in which the worker is a consultant who assesses the client’s needs, provides information and options, and allows the client to set her/his own goals. Services based on a harm reduction model are user-friendly, respect confidentiality, and avoid paternalism in that they do not assume that the client should know what the worker knows. Instead, the approach offers tools and support.

The advent of HIV/AIDS was a factor in the development of harm reduction models, which emerged initially in the mid-1980s as a way of addressing the negative consequences of drug use. Perhaps the most widely known example of a harm reduction strategy is that of needle exchange programs designed to prevent HIV infection among intravenous drug users. In the past several years, the harm reduction movement has grown considerably, attracting the attention and support of an array of providers and advocates with a history of and ongoing interest in designing successful, relevant and life-enhancing services and policies. Harm reduction strategies are promoted for active users, individuals who are seeking to end their dependency or addiction, and non-drug users who engage in a range of potentially risky behaviors or live in environments which pose a threat to their health and well-being.

While there has been much speculation about the potential role that harm reduction can play in preventing and intervening in domestic violence situations, few specific recommendations for philosophy or practice in this area have emerged from either the domestic violence or substance abuse treatment fields. (Note: in an effort to de-stigmatize drug-using populations, harm reductionists most often refer to substance use rather than substance abuse. Recognizing the extent to which histories of violence lead women to use substances, this article refers primarily to use, not abuse. The term abuse is used only in relation to services and treatment.)

Limits of Traditional Domestic Violence and Treatment Programs

The domestic violence movement, which emerged at the grassroots level during the women’s movement of the early 1970’s, understandably shied away from addressing women’s alcohol and drug use in an effort to make it clear that alcohol and drugs do not cause violence. Although domestic violence shelters are aware of the need to address alcohol and drug use, limited funding and safety concerns have impeded their ability to provide appropriate services to chemically addicted women. The result, unfortunately, has been a lack of attention on the part of the movement to the needs of these women who are involved in violent relationships. Battered women who use—and who are thus extremely vulnerable—are too often judged harshly and denied services by domestic violence shelters.

The male-centered, de-politicized, confrontational nature of traditional substance abuse treatment programs, particularly 12-step approaches, has to an even greater extent hindered the development of appropriate services for battered, substance using women (Brown, year unknown). With its emphasis on “control,” grounding in disease/medical models, and original target of white, upper-middle class males, the 12-step model has been unsuccessful with women in general, and particularly with women who have current or past physical or sexual abuse histories. Twelve-step programs rarely address the impact of post-traumatic stress disorder and fail to acknowledge the situational nature of substance use. Simply put, violence causes pain and gives rise to feelings that lead to the desire to use drugs and alcohol as a way of alleviating that pain. Bepko and Krestan (1990) suggest that an addictive behavior is a way of avoiding shame, which often comes from the failure to live up to the dictates of society’s rules and boundaries about what it means to be a woman.

Traditional substance abuse treatment models are alienating to battered women in a number of other ways. The assumption that addiction is a progressive disease which can only get worse, rather than context-dependent, can be daunting to women with histories of violence who may be using in order to cope, and may have every intention of refraining as soon as the violence stops. The concept of codependency, which can imply that women’s need to care for and nurture other people is dysfunctional rather than a result of female socialization, supports the common misunderstanding of women’s reluctance to leave battering relationships (e.g., they are presumed crazy or masochistic for wanting the violence to stop but the relationship to continue). Finally, the expectation that when entering treatment one must be “in control” may seem ridiculous to the battered woman who has for long periods of time been controlled by tactics of fear and intimidation (Draizen, 1996).

Linking Domestic Violence Services and Treatment Programs Through Harm Reduction

The links between substance use and violence make harm reduction a logical concept to embrace in the course of developing domestic violence services and treatment programs. Yet, organizations representing these two fields have only recently begun to explore ways of tailoring services to meet the needs of women affected by both issues. This
seems ironic given the degree to which many domestic violence organizations have adapted the "stages of change" model—widely used by harm reductionists—into their work with battered women. The parallels between the stages of deciding to leave a battering relationship and deciding to enter substance abuse treatment are clear (see Table below).

Domestic violence advocates assume, for instance, that most women make an average of eight attempts to leave violent relationships before they actually do so successfully, and that disclosure contemplation and preparation (safety planning) are key elements of the process of leaving. Most domestic violence interventions developed for use within the health care setting are also based upon the stages of change model in that they urge providers not to counsel women to leave violent relationships; instead they try to educate patients, assist them with safety planning, and make appropriate referrals (see Bland article on p.3). Unfortunately, like domestic violence advocates, health care providers are largely ill-equipped to work with substance using women.

A growing number of individuals from domestic violence, substance abuse treatment and related fields are refusing to ignore the clear links between domestic violence and women’s substance use by developing gender-specific services which draw from neither traditional domestic violence nor treatment modalities, but which recognize the cycles and stages of both substance use and domestic violence. These services acknowledge that “the big problem is that the women who need help are complete and whole human beings, but the system treats them as separate problems belonging to separate people” (Washington State Coalition on Women’s Substance Abuse Issues, 1995, p. 4). Harm reduction, with its emphasis on establishing trusting, supportive relationships between providers and clients and accepting the client at her/his own level, can in many ways be viewed as a bridge between fragmented domestic violence and substance abuse treatment services. The goals of treatment for parenting women impacted by substance use and domestic violence are: (1) to help the woman become more conscious of her risky behaviors and situations, and (2) to help her develop a plan(s) for reducing the risk to her personal safety and the safety of her children. Following are a number of recommendations for those interested in furthering the development of programs and policies which support this vision:

- Educate yourself and others in your organization about the relationship between women’s substance use and violence, and about harm reduction, and make sure your organization addresses these issues in ongoing and orientation trainings. It is important for providers to understand that they are not responsible for “saving” women, but that their response to each woman’s situation is a critical step in what could be a lengthy process of leaving a relationship or addressing chemical addiction.
- Explore the possibility of using harm reduction methods within your organization. If organizational policy or funding requirements prohibit use of a harm reduction approach, explore organizational values to determine for whom the values exist (e.g., to satisfy/protect staff or to best serve clients), and advocate for change at the appropriate level(s).
- For substance abuse treatment agencies: develop and implement policies which require that all women be screened for violence, and train staff appropriately. Research has shown that asking women directly about violence increases rates of disclosure. Individuals from communities that are socially ostracized, e.g., the substance using community, are less likely than other women to disclose unless asked directly. When a woman does disclose, it is important to emphasize that the battering is not her fault; to reduce the stigma; to educate her about domestic violence and substance abuse; and, perhaps most importantly, to ASK HER how you can best be of assistance.
- For domestic violence organizations: work with substance abuse treatment providers to develop innovative services for substance using battered women.

Continued on next page...

---

The Stages of Change
(applied to harm reductionists and domestic violence advocates)

Views of the Change Process

**Harm Reductionist:** there are stages of readiness to enter substance abuse treatment

**Domestic Violence:** there are stages of readiness to leave a battering relationship

**Harm Reductionist & Domestic Violence:** lapse does not have to mean relapse; people cycle in and out of both substance abuse and violent relationships.

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Harm Reductionist</th>
<th>Domestic Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>substance abuse is not a problem</td>
<td>violence is not a problem; batterer will voluntarily end violent behavior</td>
</tr>
<tr>
<td>Contemplation</td>
<td>admit problem to self/friend/provider</td>
<td>admit problem to self/friend/provider</td>
</tr>
<tr>
<td>Preparation</td>
<td>explore treatment options</td>
<td>lethality assessment, safety planning, explore legal options</td>
</tr>
<tr>
<td>Action</td>
<td>enter treatment</td>
<td>leave batterer; take criminal or civil action</td>
</tr>
<tr>
<td>Maintenance</td>
<td>lifetime support to maintain the change</td>
<td>lifetime support to maintain the change</td>
</tr>
</tbody>
</table>

Shelter beds, though necessary, are far from the only way to assist a woman in a violent relationship. Explore other ways of supporting and advocating on behalf of women who use, e.g., support groups, office visits with advocates to develop safety plans or take legal action, and alternative shelter settings which do not immediately require abstinence. Be creative and committed to the rights of all women to violent-free relationships.

- Initiate dialogue with other organizations in your area; familiarize yourself with their services; invite them to participate in task forces, coalitions and collaboratives; develop cross-training programs; and work together on education and training about harm reduction, violence and substance use.
- Advocate locally and beyond within the "prevention" arena for the development of youth violence and substance abuse prevention strategies which take into consideration the high rates of dating violence and sexual assault among teens, and acknowledge that experimentation with substances is a normal part of adolescent development.
- Advocate within the batterer treatment field to raise awareness of the link between violent behavior and substance use. Encourage substance abuse treatment programs for men to assess patients for histories of violence, and to establish links with batterer treatment programs.
- Advocate at the local, state and federal levels for research and funding which take into account the connections between women’s substance use and past and current violence.

Amy Hill, Violence Prevention Project, Contra Costa Health Services

The author would like to acknowledge and thank Carol Draizen of the Center for Young Women's Development in San Francisco, CA, for her contribution to many of the ideas and suggestions expressed in this article. For more information, contact Ms. Draizen (510/336-3624); Ms. Hill (510/313-6827); or the East Bay Harm Reduction Coalition in Oakland, CA (510/444-6969).

REFERENCES


MOMS/Women’s Recovery: A Model Program

For a number of years, individuals and agencies at the local community level have been working to provide gender- and culturally-appropriate services to women dually impacted by substance use and domestic violence. While few of these programs would be described by staff as based on harm reduction philosophy, they in many ways mimic (and in some instances pre-date the emergence of) harm reduction approaches. For this reason, they should be credited and recognized when harm reduction is being presented as a “new,” innovative concept.

One such program, operated under the auspices of the Tacoma/Pierce County Health Department’s MOMS and Women’s Recovery Centers, is developing a model that recognizes how the relapse cycle, cycle of violence, and post-traumatic stress are interrelated and impact substance use. Funded by a grant from the State of Washington’s Division of Substance Abuse, MOMS/Women’s Recovery is working with the Pierce County YWCA to assist with their domestic violence shelter in changing its policy to allow access for battered, substance using women.

The MOMS/Women’s Recovery project is based on the belief that women are socialized to internalize—and thus take out on themselves—their pain, and that the trauma of being a victim of violence increases the risk for substance use/abuse, eating disorders, unsafe sex, self-mutilation and suicide. In the context of the YWCA shelter, the project advocates women specific treatment which meets each woman at her own level. Key elements in the development of the project included:

- Expanding the shelter’s information and referral capabilities;
- Raising the visibility of alcohol and drug use as a women’s issue;
- Providing shelter staff with substance use/abuse education and assessment skills; and
- Developing a curriculum to use in training shelter residents about the relationship between violence and substance use/abuse.

As a result of this project, the State of Washington’s Coalition on Women’s Substance Abuse Issues has sponsored collaborative training for substance abuse, domestic violence and sexual assault workers. Since completing the training, Tacoma agencies formed the Women’s Integrated Network Services (WINS) Coalition, which meets monthly to share information, establish more effective referral mechanisms/agreements, and present and discuss difficult cases.

Additionally, the MOMS/Women’s Recovery Project has developed the following resources: Killing the Pain: Women Victimized, a comprehensive project description and implementation guide that includes chapters on planning, staff training, organizational changes and evaluation; and She's Got All Kinds of Troubles, a curriculum designed for use by social service workers who are helping women with multiple problems involving substance abuse and chemical dependency, domestic violence, adult sexual assault, and child sexual assault.

For more information on the program or resources, contact Sue Winskill, Domestic Violence/Substance Abuse Outreach Worker, Tacoma-Pierce County Health Department, 3629 South D Street, Tacoma, WA 98408-6897. Ph: (206) 591-6500.
to intervene and motivate her to begin the lifelong process of recovery. Because people are people, there will be ups and downs along the way. Abstinence is merely a part of the recovery process, as is relapse. Likewise, victims of domestic violence often do attempt to leave. Each year in King County, Washington State, more than 11,000 women and children fleeing violent homes are turned away from shelters due to lack of space (Love Shouldn’t Hurt Campaign, 1994). The limited shelter resources available for women attempting to flee abuse make it important for providers to be knowledgeable about a variety of legal and other options, as well as local referrals. The goal for providers is not necessarily to get a woman to leave, but to support her process, provide information, assist with safety planning, and convey the...
The notion that no one ever has the right to hurt her to get their way. This message is especially important for the chemically dependent battered woman to hear. Many times she buys into the internally oppressive societal view that alcoholic/addicted women are worthless and deserve to be punished. Additionally, she may be having a hard time gauging her safety due to euphoric recall or bouts with blackouts. Advocacy based counseling, while optimal, may need to be very basic as judgment may be impaired and ability to think and reason hampered by chronic alcohol and other drug use.

**Safety Planning**

Safety planning and relapse prevention are key issues for chemically dependent battered women. Part of safety planning involves helping women determine safer coping mechanisms than drug and alcohol use. Clear explanations, which are given in a non-judgmental way and describe the impact of substances on an individual’s ability to make safe decisions, can be very useful. Explaining blackout, euphoric recall, and how this disruption can make it difficult to assess danger, are also helpful, as is a discussion about the probable response of other helpers (e.g., 911, judges, shelter staff) when confronted with an intoxicated client.

It is also useful to role play a safety plan that may include assembling important papers and records, knowing who to call for help, having a code word your children will recognize to let them know it’s time to call 911, removing weapons from their usual spot in the home, understanding how to get a protection order, and a host of other safety options, all of which are easier to effectively carry out when one is sober. Currently, for example, the Providence Medical Center Emergency Department in Seattle, as well as many clinics in the Medalia HealthCare System, provide routine screening for domestic violence. Once identified, women are referred to a social worker and given safety plans that include sobriety tips, as well as local shelter resources and help line numbers including both the state domestic violence hot line and the Alcohol Drug Help Line. All callers to the Alcohol Drug Help Line are routinely screened for domestic violence. Referred to chemical dependency treatment when indicated, callers are also routed to a batterers’ treatment program or a victim service provider if a domestic violence problem is identified. Callers to battered women’s shelters in Seattle are also routinely referred to the Alcohol Drug Help Line for referrals to self-help groups, counselors, detox or treatment programs when warranted. This access to information empowers women seeking advocacy based counseling and makes safety planning easier.

**Integrated Support Groups for Relapse Prevention**

Along with safety planning, integrated strategies drawing from both fields are useful in addressing the needs of chemically dependent battered women. Support groups that recognize women’s needs to maintain both safety and sobriety, rather than prioritizing one at the expense of the other, are most effective.

*New Beginnings for Battered Women and their Children,* in Seattle, WA, has held a shelter based support group for chemically dependent battered women since 1990. Women leaving the shelter were anxious to continue this integrated support group, so in 1992, *New Beginnings* began offering a community based support group to any woman seeking safety and sobriety. *New Beginnings* also provided monthly groups for a residential women’s chemical dependency treatment center in Burien, WA, *Residence XII South,* as well as for other women’s chemical dependency treatment providers. The success of these groups led to the development of the Alcohol Drug Help Line’s Chemical Dependency/Domestic Violence Intervention and Prevention Project. This project provides support groups for women impacted by both domestic violence and their own or another’s substance abuse at all four confidential battered women’s shelters in Seattle and King County, as well as at several other women’s shelters and transitional housing programs. Additionally, Help Line staff are available for case consultation, trainings, advocacy and routine screening and identification of women who may benefit from integrated options addressing both safety and sobriety.

Using techniques that are applicable for reaching both goals of safety and sobriety, the integrated support groups offer women a format to heal. The major goal of the group is to provide a safe place where women can tell their stories, be believed, and begin the healing and reconnection process. Women brainstorm ways to recognize an abuser as well as ways to recognize substance abuse. Techniques for identifying and dealing with post traumatic stress are included. Normalizing nightmares, jumpiness and intrusive memories, as well as brainstorming safe ways to survive them, are all part of the group. Tools such as HALT are utilized. Women realize they are likely to drink or drug as well as contact an abusive partner if they are: Hungry, Angry, Lonely, or Tired. (Note: Women often add “horny” under “H” as both a relapse issue and an issue that may drive them back to a dangerous partner).

Partners in recovery, a buddy system similar to an AA sponsor, acts as a support system dedicated to end isolation. Persons, places and things that may lead to substance use or partner contact are brainstormed in group. Positive affirmations are encouraged as a way to undo negative abusive messages. Women also explore the cycle of addiction—craving, use, sick and sorry—and compare it to the spiral of violence—tension, explosion and calm. Through the group, they are able to identify continuums of both addiction and violence and note how both problems are very different and require separate interventions.

At no time is addiction equated with violence. We remind women that, although they are responsible for choosing to use a substance, they are not responsible for their addiction. They are responsible for their recovery, though, and have the power to improve the quality of their lives. We also remind women that they are never responsible for any abuse done to them by another person regardless of the circumstances. They are, however, responsible for keeping themselves and
their children as safe as possible. This is why alternative coping skills to using substances are critical for women addressing violence in their lives.

**Conclusion**

Safety and sobriety are easiest to achieve one day at a time within a coordinated community response to domestic violence and women’s substance abuse issues. Recognizing that healthy mothers mean healthy children is only one reason to endorse such a view. If safe and sober women are our goal, many will in time become healthy mothers who will, as a matter of course, rear healthier, happier children. Routine screening and identification of multi-abuse trauma issues saves lives and improves communities. A recent survey taken at Medalia Family Medical Center in Seattle discovered the number one response to the question, “How would you feel if someone asked you about domestic violence in your life?” was, “I’d feel like somebody cared!” Not a bad reason to begin screening clients today.

— Patricia J. Bland, MA, CCDC

**REFERENCES**


O’Neil, M.T. (1996). A power and control model for women’s substance abuse. Adapted from: *Domestic Abuse Intervention Project,* Duluth, MN.

fatigue” (Figley, in press), it refers to the emotional strain experienced by providers who deal with traumatized individuals.

Many caregivers who work with this population find themselves plagued with burnout and compassion fatigue. They take on the symptoms of the children with whom they work: despair, isolation, anger, sadness, and horror. Specifically, they may have difficulty with sleep, eating, and concentration.

We at the Child Witness to Violence Project have developed a three part model to cope with this phenomenon. It includes professional peer support, clinical supervision, and focus on balancing our own physical and emotional health needs. Peer support offers a network of people who can truly understand the difficulty of leaving work issues at work and of coming in day after day to find that families are often in the same unhealthy place in spite of intervention. Confidential sharing with peers who do similar work can be remarkably vitalizing.

Clinical supervision offers providers a place to share concerns, review cases and strategize with a knowledgeable clinician who can offer both emotional support and concrete feedback around casework. Time spent with a skilled supervisor ensures a higher quality of services to families and job satisfaction.

It is important for providers to balance their own health patterns, including diet, exercise and sleep, in order to continue to work effectively with traumatized children. Having a passion that is self-nurturing (e.g., quilting, reading, hiking) and indulging in it may also increase the likelihood that professionals will be able to give of themselves when a child needs them.

**Conclusion**

Living with violence can take a lasting toll on children and interfere with developmental growth. Adults can mediate the consequences by being exquisitely aware of and attention to one’s own needs.

— Amy Bamforth, MS
Maxine Weinreb, EdD
Child Witness to Violence Project
Boston Medical Center

**REFERENCES**


**The Source**

Editor
Amy Price

Production
Betsy Joyce

**Contributing Writers**
Amy Bamforth, Patricia J. Bland, Les Higgenbottom, Amy Hill, Ruth Pontiflet, Amy Price, Geri M. Redden, Maxine Weinreb

IN THIS ISSUE:

- Family Violence and Substance Abuse: A Vicious Cycle Perpetuated by Isolation
  PAGE 1
- Strategies for Improving Women's Safety and Sobriety
  PAGE 3
- Addressing Substance Abuse and Family Violence Through Community Collaboration and Treatment for the Whole Family
  PAGE 6
- Wounded Bystanders: Children Who Witness Violence
  PAGE 8
- NEVERMORE: A Psychotherapeutic-Educational Approach to Treating Abusive Partners
  PAGE 10
- Reflections on an AIA Conference
  PAGE 12
- Applying Harm Reduction to Services for Substance Using Women in Violent Relationships
  PAGE 14
- Resource Reviews
  PAGE 21
- Conference Listings
  PAGE 24

The Source is published by the AIA National Resource Center through grants from the U.S. DHHS/ACF Children's Bureau (#90-CB-0005). The contents of this publication do not necessarily reflect the views or policies of the Center or its funders, nor does mention of trade names, commercial products, or organizations imply endorsement. Readers are encouraged to copy and share articles and information from The Source, but please credit the AIA Resource Center. The Source is printed on recycled paper.

University of California, Berkeley
School of Social Welfare
AIA Resource Center
1950 Addison Street, Suite 104
Berkeley, CA 94704-1182
(510) 643-8390

Address Correction Requested