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Health Policy Brief

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The Link Between Intimate Partner Violence, Substance Abuse and Mental Health in California

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SUMMARY: This policy brief presents findings on the linkages between intimate partner violence (IPV), emotional health and substance use among adults ages 18-65 in California. Among the 3.5 million Californians who have ever been victimized by IPV as adults, over half a million report serious psychological distress (SPD) in the past year. Almost half of all adult IPV victims indicate that their partner was under the influence of alcohol or other drugs during the most recent incident. Two-fifths of adult IPV victims report past-year binge drinking and 7% report daily or weekly binge drinking. One in three IPV victims expressed a need for mental health, alcohol or other drug (AOD) services and almost one-fourth used mental health or AOD services during the past year. These disturbing findings can aid strategies to identify, intervene with and assist IPV victims who experience emotional and/or substance use problems.

"Intimate partner violence has both immediate and long-lasting effects."

In 2009, an estimated 3.5 million California adults ages 18-65 reported that they had been a victim of physical and/or sexual intimate partner violence since age 18 (14.8%).[1] Furthermore, nearly one-quarter of California adults who experienced IPV reported an incident occurring in the previous 12 months (24.1%). And nearly 82,000 adults in California (8.4%) indicated they were victims of a recent sexual IPV incident.[2] Women were more than twice as likely as men to have been a victim (20.5% vs. 9.1%); overall, almost 2.5 million women had experienced adult IPV.[3]

Unlike many injuries, the physical and sexual scars of IPV may have lingering consequences on the mental health and health behaviors of its victims.[4] Many adult IPV victims appear reluctant to discuss their experiences with others, including criminal justice authorities, friends, family members, health care providers or counselors.[5] Lack of disclosure can compound the trauma of IPV and result in decreased coping and increased anxiety, depression or other emotional health issues for the adult victim.[6]

Less apparent is whether there is any lingering psychological effect from long past but not forgotten IPV incidents. And although studies suggest an association between alcohol use and IPV, little is known about the extent of substance-related IPV or its effect on emotional health.[7]

Using data from the 2009 California Health Interview Survey (CHIS 2009), this policy brief illustrates how IPV impacts victims' emotional health, their use of substances, and their need for and utilization of mental health (MH) or alcohol and other drug services in California.

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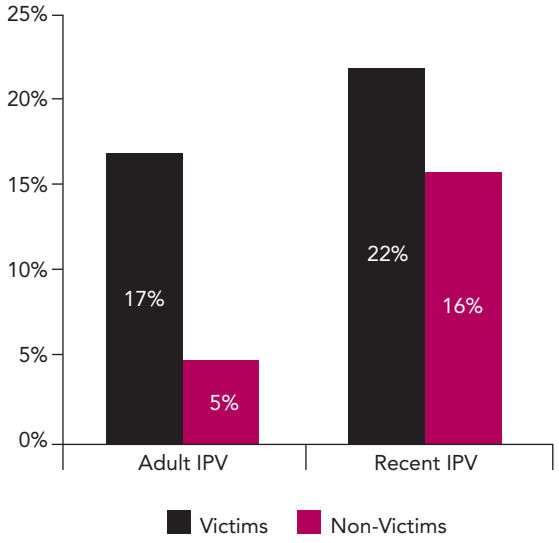
Exhibit 1

Serious Psychological Distress During the Past 12 Months by Adult and Recent Intimate Partner Violence, Ages 18-65, California, 2009



Note: *Non-Victims of Recent IPV* are Adult IPV victims who are **not** victims of a past 12 month incident.

Source: 2009 California Health Interview Survey

"More than half a million victims of intimate partner violence report serious psychological distress."

Intimate Partner Violence Victims Report More Psychological Distress

Among the 3.5 million Californians who have been victims of adult IPV, over half a million (594,000) reported symptoms in the past year associated with serious psychological distress, which includes the most serious kinds of diagnosable mental health disorders, such as anxiety and depression. Victims of adult IPV were also more than three times as likely as unexposed adults to have reported past-year SPD (16.8% vs. 5.3%, respectively).[8] Among victims of recent IPV, nearly 172,000 reported symptoms of SPD (21.6%) during the past year, a higher rate than among adults who have not had a recent IPV incident (16%; Exhibit 1).

For women who experienced adult IPV, 17.5% reported SPD in the past year compared to 5.9% of women who have never been IPV victims. Male adult IPV victims were also more likely to experience SPD compared to non-victims, with 15.3% reporting past-year psychological distress versus only 4.7% of male non-victims. While there are not significant differences by gender among adult IPV victims for past-year psychological distress (17.5% vs. 15.3%), larger numbers of female victims are affected by SPD (428,000) than male victims (166,000) since women make up the majority of IPV cases.

Violence-Related Substance Abuse

While alcohol or other drugs do not directly cause IPV, they may increase the risk of violent incidents in households where IPV has occurred in the past. Alcohol and other drugs may also play a role in escalating the frequency and severity of IPV incidents.

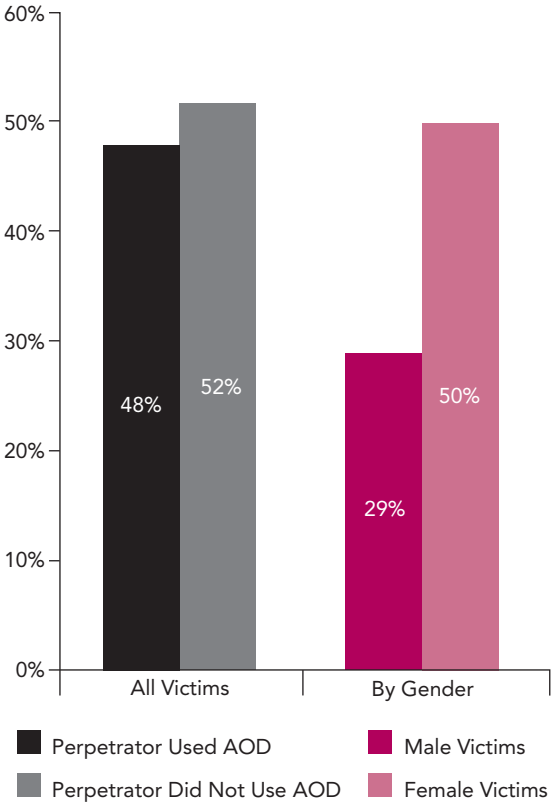
When asked if their partner appeared to be drinking alcohol or using drugs during the most recent violent incident, almost half (47.6%) replied in the affirmative (Exhibit 2). Women were significantly more likely to report that their partner was using alcohol or other drugs during the most recent IPV incident compared to men (49.6% vs. 29.4%; Exhibit 2).

Binge drinking is defined differently by gender. For males, binge drinking is having five or more alcoholic drinks in a row on a single occasion; for females, it is four or more drinks.

Alcohol may also be consumed by victims in an attempt to cope with the emotional and/or physical pain associated with violence. Adult IPV victims were more likely to report binge drinking in the past year (39%) than those who have never been a victim of IPV (34.2%).

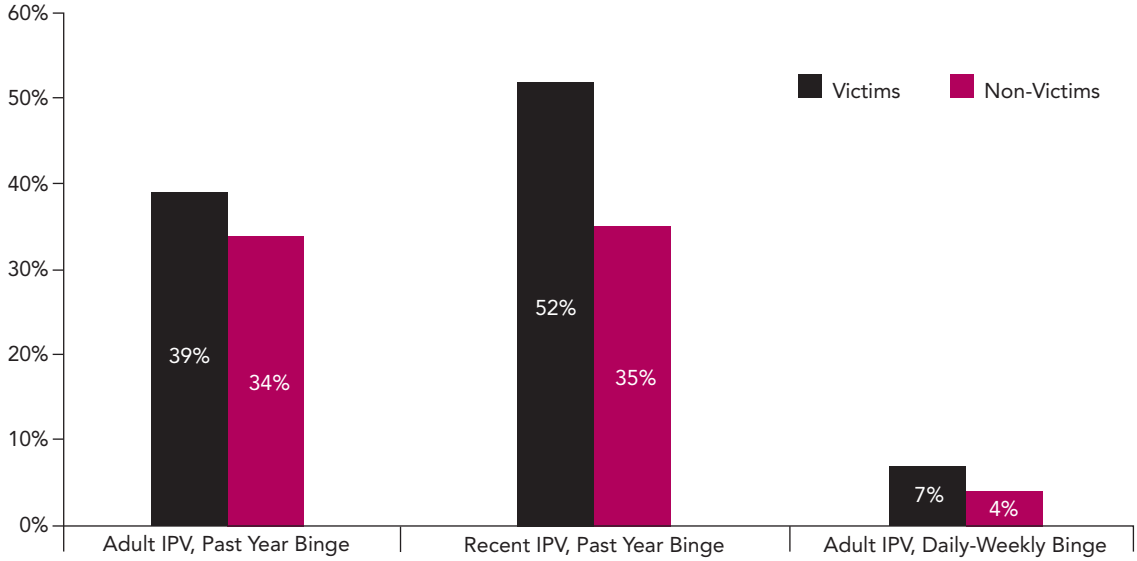
More than half of all IPV victims subjected to a recent incident (52.4%) report engaging in binge drinking over the past year, a significantly higher rate than those who have not experienced a recent IPV incident (35.1%). And 7% of recent IPV victims reported daily to weekly binge drinking, a level higher than that among those never exposed to IPV (4.5%; Exhibit 3).

Perpetrators Using Alcohol or Other Drugs During Most Recent Intimate Partner Violence Incident, Total and by Gender, Ages 18-65, California, 2009 **Exhibit 2**



Source: 2009 California Health Interview Survey

Past Year and Daily/Weekly Binge Drinking by Adult and Recent Intimate Partner Violence, Ages 18-65, California, 2009 **Exhibit 3**

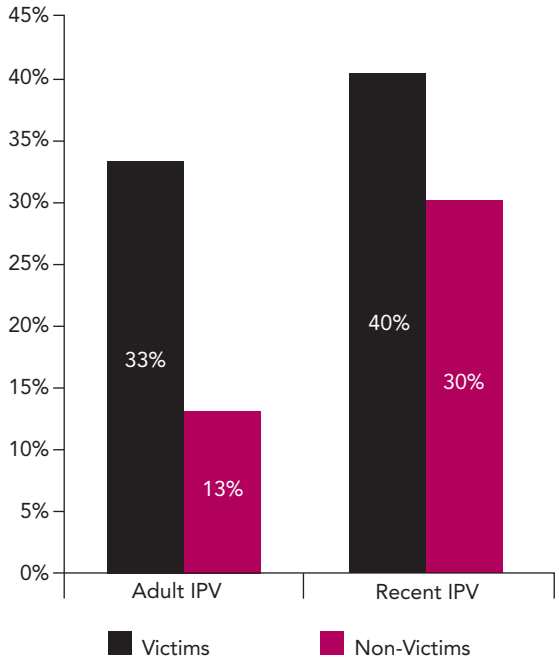


Note: *Non-Victims of Recent IPV* are Adult IPV victims who are **not** victims of a past 12 month incident.

Source: 2009 California Health Interview Survey

Exhibit 4

Self-Reported Need for Mental Health and/or Alcohol and Other Drug Services During the Past Year, Ages 18-65, California, 2009

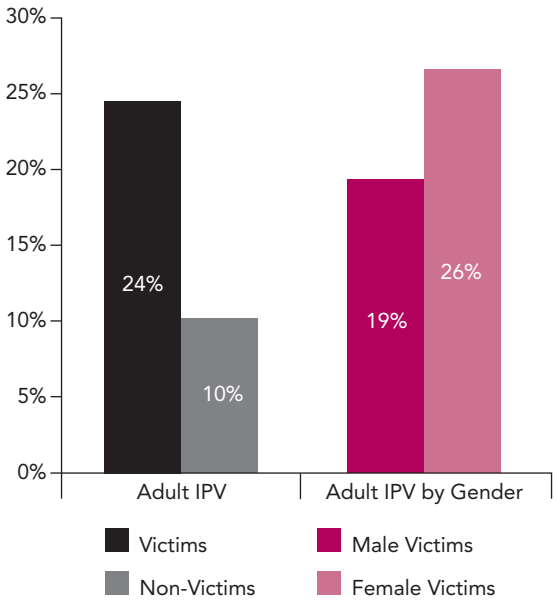


Note: *Non-Victims of Recent IPV* are Adult IPV victims who are **not** victims of a past 12 month incident.

Source: 2009 California Health Interview Survey

Exhibit 5

Utilization of Mental Health and/or Alcohol or Other Drug Services By Adult Intimate Partner Violence and by Gender, Ages 18-65, California, 2009



Source: 2009 California Health Interview Survey

Intimate Partner Violence Victims Need More Mental Health and Substance Abuse Services

Nearly one in three adults who reported being an adult IPV victim said they needed help for a mental or emotional, or alcohol or other drug problem (33.1%). In contrast, just 12.6% of non-victims in California noted needing similar help. And 39.9% of adults who recently experienced an IPV incident expressed a need for emotional health or AOD counseling, services or treatment compared to 30.3% among those adult IPV victims who did not have a recent IPV incident (Exhibit 4).

No gender differences among victims of adult IPV emerged, with both female victims (33.6%) and male victims (31.9%) acknowledging a similar need for help. When victims are compared to non-victims by gender, among women, adult IPV victims were more than twice as likely to express a need for emotional or AOD help than non-victims (33.6% vs. 14.5%). Regarding men, 31.9% of adult IPV victims said that they needed assistance for MH or AOD problems compared to just 10.9% of non-victims.

More than 2.7 million Californians reported seeing a health care provider or therapist for emotional or mental health and/or for alcohol or other drug issues in the past year (11.6%). Of these, adult IPV victims were 2.5 times more likely than non-victims to report seeing their primary care physician, a psychiatrist, social worker or counselor in the past year for problems with their psychological or emotional health and/or use of alcohol or other drugs (23.9% vs. 9.5%; Exhibit 5).

Female victims of adult IPV were more likely than male victims to report visiting a general practitioner, mental health or AOD professional for counseling or treatment in the past year (26.2% vs. 18.7%). Female victims of adult IPV were also more than twice as likely to report mental health or AOD visits during the past year (26.2%) compared to female non-victims (11.4%). The male pattern was similar: 18.7% of male adult IPV victims had such visits compared with only 7.9% of non-victims (Exhibit 5).

Discussion and Policy Implications

In 2009, over 3.5 million Californians said they were adult IPV victims and of those, over half a million reported experiencing symptoms associated with serious psychological distress. While it is understandable that recent IPV incidents would have a strong association with feelings of poorer emotional health, what seems notable from these findings is that Californians who have been victimized by an intimate partner—often years earlier—reported past year symptoms of SPD at higher rates than those never exposed to IPV. Although SPD is due to multiple causes, it appears likely that harboring emotional feelings from long-past IPV victimization may be influential. IPV victims are also more likely to express a need for mental health or AOD services at significantly higher levels than non-victims. Similarly, victims of adult IPV are visiting primary care doctors, social workers and other counselors for emotional health, alcohol or other drug problems at often twice the rate as non-victims of adult IPV.

These findings also reveal strong connections between IPV and substance use. Victims report high levels of partner AOD involvement during the most recent incident. Women are more likely to report that their partners were using alcohol or other drugs during the most recent incident compared to men. In the aftermath of violence, some victims may turn to alcohol, perhaps as self-medication to cope with or mask their pain.

The associated risk factors identified in this brief appear to have the greatest impact on women. While male victims suffer much of the same trauma and may seek out similar coping strategies as females, the sheer number of female Californians affected is noteworthy.

Several policy changes and interventions can help protect and aid in the healing of adults subjected to IPV. There continues to be a critical need for additional mental health, substance use and domestic violence services. According to the Substance Abuse and Mental Health Services Administration, national spending on mental health and substance abuse account for a decreasing share of health care spending.[9] Despite passage of a national mental health parity law, a recent survey indicates that only 10% of Americans have heard of the law and almost half do not know if their insurance would cover mental health services (45%).[10] And although the California budget was recently passed, additional mental health, AOD and domestic violence program cuts are still possible if future revenues do not materialize.

"There is a critical need for additional mental health, substance use and domestic violence services."

"Screening for IPV, for emotional health, and for substance use problems should be expanded, standardized and made routine."

Health screening for IPV, for emotional health, and for substance use problems among patients/clients, regardless of gender, should be expanded, standardized and made routine.[11] Medical doctors and other health care providers can be proactive by screening and referring IPV victims with emotional health and AOD problems to appropriate services. Mental health and substance abuse counselors should also initiate IPV screening and, if needed, referrals for counseling, shelters and legal advice. Counselors of IPV victims need to routinely screen for mental health and AOD concerns among victims.

Finally, public health messages about the links between IPV, mental health and substance abuse can raise awareness and foster outreach to those who may need medical, IPV, AOD and mental health services.

Data Source

This policy brief reports data from the 2009 California Health Interview Survey (CHIS 2009). All statements that compare rates for one group with those of another group reflect statistically significant differences ($p<0.05$). For more information on CHIS, please visit *www.chis.ucla.edu.*

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Endnotes

1 *Adult IPV* is defined as any physical and/or sexual IPV since age 18. Adapted for CHIS 2009 from the modified Conflict Tactics Scale (CTS), IPV physical incidents are defined as *"being hit, slapped, pushed, kicked, or physically hurt in any way by any current or former husband, wife, boyfriend, girlfriend, or someone that the adult lived with or dated since the adult turned 18 years old."* IPV sexual incidents are defined as *"being forced by a current or past intimate partner into unwanted sexual intercourse, oral or anal sex, or sex with an object by force or threats of harm since the adult was 18 years old."* Straus MA, Hamby SL, Boney-McCoy S, and Sugerman DB. The Revised Conflict Tactics Scales (CTS2): Development and Preliminary Psychometric Data. *Journal of Family Issues*, 1996: 17(3): 283-316.

2 *Recent IPV* (defined as occurring in the past 12 months) questions ask: *"During the past 12 months did an intimate partner: a) throw something at you that could hurt you?; b) push, grab or slap you?; c) kick, bite, hit, choke, or beat you up?; d) threaten you with or use a gun, knife or other weapon on you?; e) physically force you to have unwanted sex?"* Straus MA, et al., Ibid. 1996.

3 Racial/ethnic 2009 IPV findings mirror the CHIS 2007 pattern. In 2009, American Indian/Alaska Natives (28.1%), African Americans (19.4%) and Whites (17.8%) were significantly more likely to report adult IPV than were Latinos (12.6%) or Asians (6.5%). Due to small sample sizes, the Native Hawaiian/Pacific Islanders' rate was too unstable to report. Zahnd EG, Grant D, Aydin M, Chia YJ and Padilla-Frausto DI. *Nearly Four Million California Adults Are Victims of Intimate Partner Violence*. Los Angeles, CA: UCLA Center for Health Policy Research, 2010.

4 Campbell JC and Lewandowski LA. Mental and Physical Health Effects of Intimate Partner Violence on Women and Children. *Psychiatric Clinics of North America*. 1997:20-353-74; Sullivan TP and Holt LJ. PTSD symptom clusters are differentially related to substance use among community women exposed to intimate partner violence. *Journal of Traumatic Stress* 2008 Apr; Vol.21 (2):173-180.

5 In CHIS 2007, victims were asked if they had talked to anyone about what happened to them during the most recent IPV incident. Only over half (56.6%) said they talked to someone about their trauma. While women were more likely to discuss the incident compared to men, over one-third of female victims and over one-half of male victims did not disclose the incident to anyone. Zahnd EG et al., *Ibid*. p. 8, 2010. This question was not in CHIS 2009 due to space and time constraints.

6 Various barriers to disclosing IPV have been cited in the literature, including emotional trauma, shame, fear of retaliation, concern about partner harm to one's children, the threat of child loss to Child Protective Services, partner-enforced isolation, and reluctance to discuss IPV unless directly asked by one's doctor. Health provider barriers to IPV screening (e.g. limited training, lack of knowledge of IPV protocols or where to refer victims) may also hamper patient disclosure. *Parenting in the Context of Domestic Violence*. Judicial Council of California/Administrative Office of the Courts: March 2003:1-45; Rodriguez MA, Sheldon WR, Bauer HM, Perez-Stable EJ. The factors associated with disclosure of intimate partner violence to clinicians. *Journal of Family Practice*. 2001:50:338-44; Walker LE. *The Battered Woman Syndrome*. 1984: New York: Springer.

7 Thompson MP and Kingree JB. The roles of victim and perpetrator alcohol use in intimate partner violence outcomes. *Journal of Interpersonal Violence* 2006: 21(2):163-177; Caetano R, Schafer J and Cunradi CB. Alcohol-Related Intimate Partner Violence among Whites, Blacks and Hispanics. *Alcohol Research and Health* 2001: 25(1):58-65; Zahnd E, Klein D and Needell B. Substance Use and Issues of Violence among Low-Income, Pregnant Women: The California Perinatal Needs Assessment. *Journal of Drug Issues* 1997: 27(3), 563-584.

8 Serious psychological distress (SPD) is measured by the Kessler 6 scale; the scale's cutoff point of 13 or more is the optimal level for assessing the prevalence of SPD in the adult national population. Kessler RC, Barker PR, Colpe LJ, Epstein JF, Gfroerer JC, Hiripi E, Howes MJ, Normand S-LT, Manderscheid RW, Walters EE, Zaslavsky AM. Screening for Serious Mental Illness in the General Population. *Archives of General Psychiatry* Feb. 2003, 60(2):184-189.

9 National Expenditures for Mental Health Services and Substance Abuse Treatment: Changes in U.S. Spending on Mental Health and Substance Abuse Treatment, 1986-2005, and Implications for Policy. *Health Affairs*, Feb. 2011, available at *http://www.samhsa.gov*.

10 "Your Mental Health: A Survey of Americans' Understanding of the Mental Health Parity Law," American Psychological Association Interactive Jan. 2011 (PDF), available at *http://www.apa.org/news/press/releases/parity-law.pdf*.

11 The Department of Health and Human Services recently released guidelines that will require new health insurance plans to cover women's preventive services, including domestic violence screening, without charging co-pays, however screening males for IPV risk is not included. *http://www.hhs.gov/news/press/2011pres/08/20110801b.html*.

This publication contains data from the California Health Interview Survey (CHIS), the nation's largest state health survey. Conducted by the UCLA Center for Health Policy Research, CHIS data give a detailed picture of the health and health care needs of California's large and diverse population. Learn more at: ***www.chis.ucla.edu***

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