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Article

Motivation to change substance use among offenders of domestic violence

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Abstract

Substance use alone leads to increased rates of violence, reduction in adherence to treatment regimes, and other negative psychiatric sequelae. Given the high rates of co-occurring substance use and family violence-related problems, substance use was assessed among offenders of domestic violence who were mandated by court to attend anger management classes. Rates of substance dependence diagnoses ranged from 33 to 50%, while rates of substance abuse diagnoses ranged from 60 to 75%. This study evaluated the effectiveness of a motivational enhancement intervention on readiness to change substance use. Two anger management groups were targeted to assess substance use, violence, and motivation to change substance use behaviors. One group was randomly chosen to partake in a motivational enhancement intervention session. The comparison group was offered standard anger management classes. Forty-one clients were evaluated for substance abuse and dependence diagnosis using criteria from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. A brief motivation to change survey, adapted from the Readiness to Change subscale of the Stages of Change Readiness and Treatment Eagerness Scale was administered pre- and postsession. Results indicate that a motivational enhancement intervention is feasible and effective in increasing readiness to change substance use among domestic violence offenders. The results illustrate the importance of assessing and treating substance use among offenders of domestic violence, as this may be an important indicator for higher dropout rates and reoffenses among this population.

Keywords: Substance use; Motivation; Family violence; Treatment; Offenders

1. Introduction

Rates of co-occurring substance use and domestic violence are high, ranging from 40 to 92%. Brookoff et al. (1997) showed that 92% of assailants used alcohol or drugs on the day of the domestic violence assault, 44% had prior arrests for charges related to violence, and 72% had arrests related to substance use.

Other researchers have tried to assess the variables that place individuals at risk of being a perpetrator of family violence. The common risk factor for family violence is substance use.

In fact, one of the correlates of domestic abuse is early onset of drug- and alcohol-related problems (Bennett et al., 1994).

Substance use is also related to severity of violence. For example, Holtzworth-Munroe and Stuart (1994) found that alcohol and drug use was highest among a moderate to highly violent group of batterers. Rivera et al. (1997) found alcohol and illicit drug abuse to be related to an increased risk of violent death in the home.

Despite these high rates of co-occurring substance use and domestic violence, treatment for these problems is often ordered separately. Domestic violence arrests will most likely lead to standard anger management or domestic violence treatments. It is only when the batterers incur repeated offenses and show glaring evidence of substance use that courts refer patients to substance abuse treatment (Collins et al., 1997).

There is some initial evidence that when substance use and domestic violence are addressed in an integrated way, there are better treatment outcomes (Goldkamp et al., 1996.) For example, Goldkamp et al. (1996) examined treatment outcomes and same-victim reoffending in clients who attended an integrated substance use-domestic violence treatment program versus clients who did not participate in this hybrid approach. The findings showed that the integrated treatment approach was more successful at getting offendees and probationers to attend treatment (43% of the control group were no-shows, as compared to 13% of the integrated treatment group). The integrated treatment approach had a greater success in keeping participants in treatment as well as having lower rates of same-victim reoffending.

Alternatively, studies with alcohol-dependent patients in the VA system designed to target alcohol-related problems in the context of couples therapy yielded results that showed lower levels of marital violence (O'Farrell & Murphy, 1995). Additionally, after this treatment, there was a de-

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crease in drug use, longer periods of abstinence, and fewer drug-related arrests (Fals-Stewart et al., 1996).

Although these studies show some promising results, the data involve a population of subjects that may be different than domestic violence offenders referred to a family violence program. There is very little information on substance use behavior change in a population of individuals referred to these psychoeducational programs.

With this in mind and knowing that substance use alone leads to increased rates of violence, reduction in adherence to treatment regimes, and other negative psychiatric sequelae, a preliminary study was designed to further assess substance-related treatment needs among batterers. A study was designed to evaluate the effectiveness of a motivational enhancement intervention on readiness to change substance use within this population. The population evaluated was a heterogenous group of male batterers referred by court because of a recent domestic violence charge.

2. Methods

2.1. Subjects

Forty-one male subjects, aged 18–64 years, mean age 36 (SD = 13.4) participated in the study. The sample was 100% male and consisted of the following racial composition: 58% African American, 29% Caucasian, and 7% Hispanic. Refer to Table 1 for demographic characteristics. The participants were 41 male offenders of domestic violence who were referred by court to attend 10 weeks of psychoeducational classes on anger management.

Clients were specifically referred by the Family Relations Division of the Superior Court after they received a domestic violence arrest. The classes were performed on an outpatient basis. This program is designed to prevent violence and if clients successfully complete 9 out of the 10 of the classes, their sentence is likely to be suspended.

This *Family Violence Education Program* (Scott, 1990) consists of psychoeducational classes that focus specifically on the following topics per week: Understanding Anger (wk. 1); Controlling Anger (wk. 2); Effective Communication (wk. 3); What We've Learned From Our Families (wk. 4); Effects of Violence on Children (wk. 5); What We've Learned From Our Culture (wk. 6); The Dynamics of Power and Control (wk. 7); Learning to Live With Stress (wk. 8); Substance Use and Violence (wk. 9); and Effects of Violence on Women (wk. 10).

In general, clients entering this program are *not* assessed for substance use or any other co-occurring mental health problems. Hence, clients may be participating in classes under the influence of alcohol, a psychoactive substance.

Two anger management groups were targeted at session 9, the session that focuses on standard anger management and substance use. The groups were targeted to assess substance use, violence, and motivation to change substance use behaviors. One group was randomly chosen to partake in a motivational enhancement intervention session. The comparison group was offered the standard class, which discusses the relationship between substance use and violence.

The motivational enhancement used a style that was empathic, avoided confrontation, rolled with resistance, used double-sided reflections, pointed out discrepancies in what clients were disclosing, elicited positive self-statements for change, and promoted self-efficacy. This style was designed to elicit discussion/disclosure of substance-related problems and steps to change these problems. The motivational enhancement procedure was modeled from Project Match NIDA Motivational Enhancement Treatment Manual (Miller et al., 1995).

2.2. Assessments

Forty-one clients were evaluated for substance abuse and dependence diagnoses using a self-reported version of the Schedules for Clinical Assessment of Neuropsychiatry (SCAN) (American Psychiatric Association, 1994) instrument. This diagnostic interview assessed only substance-related disorders. The criteria are based on the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (*DSM-IV*; American Psychiatric Association, 1994). This instrument is a reliable and valid diagnostic tool and has been widely used (Dawson et al., 1994; Chou et al., 1994; Easton et al., 1997; Room et al., 1996). The substance use and demographic self-reports were administered at the onset of the sessions. A brief motivation to change survey, adapted from the Readiness to Change subscale of the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES; Miller & Tonigan, 1996), was administered pre- and postsession. This subscale was chosen based on preliminary studies showing its positive relationship to engagement and retention in treatment. Additionally, at postsession, both groups were given a sign-up sheet with an address and appointment time for a follow-up to a confidential substance use evaluation.

2.3. Statistical analyses

Prevalence of substance abuse and dependence diagnoses was calculated via each clients endorsement of *DSM-IV* criteria (the diagnoses included a lifetime diagnosis). A percentage was calculated via a frequency of tally counts per subject (three of seven criteria for substance dependence diagnosis; and one of four criteria for substance abuse diagnosis).

Group differences in demographic, legal, violence, and substance use variables were analyzed using a one-way analysis of variance (ANOVA) for continuous variables and the χ^2 test for nominal/categorical variables. Significant differences in demographic and substance use characteristics were analyzed using separate one-way analyses of covariance (ANCOVAs). Significant differences were further evaluated by Tukey post-hoc comparisons. Significance was assumed at $p < .05$.