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REGULAR ARTICLES

Abuse and Violence History of Men and Women in Treatment for Methamphetamine Dependence

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The Methamphetamine Treatment Project offers the opportunity to examine the history of abuse and violence in a sample of 1016 methamphetamine users participating in a multisite study between 1999–2001. Reporting of abuse and violence was extensive, with 80% of women reporting abuse or violence from a partner. Men were more likely to report experiencing violence from friends and others. A high percentage of study participants reported a variety of threatening or coercive experiences with their partners. Past and current interpersonal violence is a characteristic of the lifestyles of the majority entering treatment for methamphetamine dependence. (Am J Addict 2003;12:377–385)

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The fields of substance abuse and health research have begun to acknowledge that abuse and violence are more widespread in their treatment populations than was believed before they came under more systematic scrutiny. Studies of persons with health problems, psychological and psychiatric illness, and substance abuse have all reported that significant proportions of their participants have histories of abuse and violence, often starting in childhood.[1–8] The effects of abuse and violence can be both direct (in terms of mortality and in admissions to emergency rooms) and persistent (in terms of PTSD, depression, and other illnesses).[8–13]

Individuals experiencing both past and current abuse and violence tend to be at increased risk for a variety of psychological problems, including poor self-esteem, depression and anxiety disorders, post-traumatic stress disorders, substance abuse, suicide attempts, eating disorders, and interpersonal and sexual relationship problems.[14–16] This population also has a high prevalence of persistent physical problems, such as abdominal pain, gastrointestinal symptoms, pelvic or genital pain, and chronic headaches.[15] Violence does not inevitably lead to PTSD, but multiple episodes increase the likelihood, as does physical and/or sexual abuse in childhood.[17–20]

Since methamphetamine users have only recently become the focus of investigation, studies of other stimulant users offer a place to begin looking at prevalence rates of abuse and violence. Najavits and colleagues studied the prevalence of lifetime traumatic events among 122 treatment-seeking cocaine-dependent outpatients. These patients completed the Trauma History Questionnaire and the PTSD Checklist before entering treatment. They experienced a large number of lifetime traumatic events (mean = 5.7). Men experienced more crime-related traumas and general disasters than women but less physical and sexual abuse.[21] Back and colleagues[22] found a high rate of PTSD diagnoses among cocaine-dependent individuals. These patients had significantly higher rates of exposure to traumatic events, earlier age of first assault, and more severe symptomatology, as well as higher rates of Axis I and Axis II disorders.

PTSD symptoms relate to drug use in a variety of ways that can be expected to affect drug use patterns, the ability to establish abstinence, and a vulnerability to relapse. A study of 150 opioid-dependent drug abusers in methadone treatment indicated the occurrence of persistent PTSD related symptoms was associated with greater drug abuse severity after controlling for gender, depression, and lifetime diagnosis of PTSD.[23] Sharkansky and colleagues found that patients with PTSD reported an increased frequency of alcohol and drug use in situations involving unpleasant emotions, conflict with others, and physical discomfort, as compared to those who did not have a PTSD diagnosis.[24]

However, until the last decade, few programs that treated the effects of abuse and violence regarded diagnosis and treatment of PTSD as part of their role. More recently, widespread efforts to diagnose and treat underlying problems as part of the active programs for substance abuse and dual disorders have been reported.[25–28]

Taking into account the multiple co-existing physical and psychiatric diagnoses, the life problems that appear to be related to a history of abuse, and the high number of clients in substance abuse treatment with histories of abuse, it is clear that this issue deserves significant attention at both the assessment and treatment intervention levels. As mentioned earlier, there has been some evidence[29–31] that this segment of the treatment population may have poor retention rates and treatment outcomes. However, some recent investigations of treatment strategies designed to address the multiple problems experienced by women suggest that implementing

treatment strategies designed to meet the unique needs of these women may increase retention and improve outcomes.[25,26,32]

This report will address the extent of abuse and violence among methamphetamine users entering outpatient treatment and how these characteristics may affect the ability of patients to stay in and respond to treatment for their substance dependence.

STUDY DESIGN AND METHODS

Between April 1, 1999, and July 1, 2001, 1016 methamphetamine-dependent persons were enrolled into the CSAT Methamphetamine Treatment Program (MTP). Because this is the largest randomized clinical trial of methamphetamine-dependent persons ever conducted, one of the major contributions it can make to the field is to thoroughly describe its population in order to help clarify the present limited understanding of treatment-seeking methamphetamine-dependent persons.

In order to be included, individuals had to meet the following criteria:

- be at least 18 years of age
- meet DSM-IV diagnostic criteria for methamphetamine dependence
- be willing to complete data forms and provide urine samples per protocol schedule
- understand scales and instructions
- understand English and be capable of participating in treatment
- be willing and able to understand and sign informed consent.

Exclusionary criteria for the study included:

- presence of a medical and/or psychiatric impairment that precludes participation
- requiring detoxification for opioids, alcohol, or other drugs
- not having used methamphetamine in the past thirty days unless confined to a controlled environment
- having been enrolled in another treatment program in the past thirty days or currently being enrolled in another clinical treatment program
- presence of medical, legal, housing, or transportation issues that would preclude safe and/or consistent participation.

Participants were recruited at eight outpatient treatment programs located in California, Hawaii, and Montana. At intake, eligible participants were randomly assigned to either a standardized Matrix treatment or the treatment typically provided at the site ("treatment as usual"). Matrix is a manualized cognitive behavioral treatment designed to teach early recovery and relapse prevention skills, and connect clients to the Twelve-Step self-help system in their community. Treatment as usual varied greatly from site to site along many dimensions, including program length, intensity of program, and services provided.

Participants were assessed at intake and had data-collection visits weekly during treatment, at treatment end, and at six and twelve months post-enrollment. Instruments used at intake that are included in this analysis included the Addiction Severity Index (ASI), the Beck Depression Inventory (BDI),[33,34] the Brief Symptom Inventory (BSI), and the Abuse and Violence history section of the Women's Interagency Health Study Assessment.[48]

Psychologically relevant variables in this paper were derived from three instruments: the Beck Depression Inventory-II (BDI),[33,34] the Brief Symptom Inventory (BSI), and the ASI. The BDI is a self-report 21-item scale on which respondents choose one of four descriptive responses for each item that represents the level of severity for that symptom over the prior thirty days. Each item is scored from 0 to 3 relative to severity. Total range is from 0 to 63, with scores of 0–13, 14–19,

20–28, and 29–63, indicating minimal, mild, moderate, and severe depression, respectively.

The BSI is a 53-item scale derived from the Symptom Checklist-90.[35,36] For each item, respondents rate themselves on a five-point Likert scale that ranges from "not at all" (0) to "extremely" (4) for the week preceding administration. The BSI yields nine primary dimensions (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism) and three global indices (Global Severity Index [GSI; average response on each item], Positive Symptom Total [PST; number of items with responses >0], and Positive Symptom Distress Index [PSDI; sum of item scores divided by PST]). BSI scores are expressed as population-based T-scores by gender, with a score of 50 corresponding to the mean.

Questions on abuse and violence were taken from two different instruments, and the questions about these experiences were not worded in the same way. The ASI asks about physical abuse, but the WIHS asks about physical violence, which may be perceived differently because it was reported more frequently in this study. This distinction will be noted in the data.

The current paper compares men and women participants. It focuses on differences between the genders in their histories of physical and sexual abuse and violence and the psychiatric and psychological problems associated with these histories. Summaries of the histories are presented by gender. Then, history of various types of abuse is examined in association with scores on the psychological instruments administered in the project at baseline. These analyses ask questions like, "is a history of sexual abuse associated with elevated ASI psychiatric composite scores or BSI subscales, and is the relationship of the abuser a mediating effect between abuse and psychiatric symptomatology?" For all analyses, alpha is set at 0.05. It should be stressed that this analysis is descriptive in nature rather than predictive.

RESULTS

Reports of abuse and violence were extensive in this population, with many respondents reporting more than one source. Some history of physical violence was reported by most study participants; four of every five women reported some partner abuse or violence. While significantly more women than men reported violence from a partner, relatively more men than women reported experiencing violence from friends and others (see Table 1).

A history of sexual abuse and violence was reported by 57.6% of the women in the study and 15.7% of the men (see Table 2). Women were more likely than men to report a history of sexual abuse from each of the categories asked.

TABLE 1. **Physical Violence Reported, by Source of Violence**

Violence Reported "Ever"	# Women	%	# Men	%	*p*
Total reporting "yes"	480	85.4	316	69.6	< 0.001
Source: Parent	178	35.0	109	32.4	0.435
Sibling	84	16.6	60	17.8	0.649
Partner	407	80.0	89	26.3	< 0.001
Friend	54	15.9	113	37.5	< 0.001
Stranger/Other	56	14.4	118	43.4	< 0.001

TABLE 2. **Reported History of Sexual Abuse or Violence**

"Were you ever forced to have sex?"	# Women %	# Men %	*p*
Total reporting "yes"	321 57.6	71 15.7	< 0.001
Source: Parent	58 14.2	6 11.3	< 0.001
Sibling	89 21.8	10 6.3	< 0.001
Partner	130 31.6	11 6.9	< 0.001
Friend	145 35.5	38 24.0	0.009
Stranger/Other	78 19.3	16 10.1	0.009

Study participants were also asked about other threatening or coercive experiences with current or previous partners. Specifically, they were asked if a partner ever threatened to hurt or kill them; prevented them from leaving or entering their house, seeing friends, or making phone calls; prevented them from getting or keeping a job or education; prevented them from seeking medical care; or prevented them from seeking drug treatment. They were also asked if they ever felt that their partner might try to kill them. Responses to these questions are shown separately for men and women in Table 3.

Study participants were also asked the same questions about current experiences with abuse and violence, specifically, whether or not it had ceased or occurred in the month prior to entering treatment. Table 4 shows that physical abuse continued to be a problem for many entering treatment.

DISCUSSION

Interpersonal violence is characteristic of the lifestyles of the majority of persons entering treatment for methamphetamine dependence. It is difficult to assess from these data how much of a contribution this particular drug makes to the pattern of abuse and violence reported. Methamphetamine has the reputation of being associated with violence, but other studies have also found that abusers of other drugs also have histories marked by violence and abuse. For example, Medrano and his colleagues[37,38] reported that in a community sample of intravenous drug users, 60% of the women reported sexual abuse; Ross-Durow and Boyd[39] reported sexual abuse rates of 61% in a sample of women using crack cocaine; Teets[40] reported that 68% of the chemically dependent women in a long-term residential program had a history of sexual abuse; and Gil-Rivas and her colleagues[41] found that 61% of the

TABLE 3. **History of Other Threatening or Coercive Experience**

Answered "yes"	# Women %	# Men %	*p*
Has your partner ever...			
threatened you?	352 63.2	119 26.3	< 0.001
isolated you from others?	383 65.2	166 36.6	< 0.001
prevented you from going to job?	206 37.0	56 12.4	< 0.001
prevented medical treatment?	94 16.9	8 1.8	< 0.001
prevented drug treatment?	78 14.0	18 4.0	< 0.001
Do you ever feel that your partner might try to kill you?	38 9.1	5 1.9	< 0.001

TABLE 4. **Ongoing Physical Abuse Reported by Men and Women**

Physical abuse has not stopped	# Women %	# Men %	*p*
Abuser: Parent	23 11.7	8 7.0	< 0.001
Sibling	23 22.3	13 17.3	< 0.001
Partner	46 11.1	24 23.3	< 0.001
Friend	33 29.5	17 12.8	< 0.001
Other	26 25.7	8 5.2	< 0.001

women in an outpatient substance abuse treatment reported a history of sexual abuse.

One very large-scale study (N = 24,959) of substance abusers in treatment reported abuse rates by gender.[42] For women with a history of abuse, 70% reported "any abuse," 21% reported "physical abuse only," 8% reported "sexual abuse only," and 40% reported "both sexual and physical abuse." For men in the study with a history of abuse, 29% reported "any abuse," 20% reported "physical abuse only," 2.5% reported "sexual abuse only," and 7% reported "both sexual and physical abuse." Lack of standard measurement instruments makes it difficult to compare results across studies. Finklehor and his colleagues[43] have called for an integrative conceptual model to describe childhood victimization that offers consistent definitions and permits exploration of the effects of different types of victimization. In our own study, we measured both adult and childhood physical abuse with the same questions, so our ability to examine more specific and detailed associations is limited.

IMPLICATIONS FOR TREATMENT

The current emphasis on dissemination of manualized treatments developed through research has the goal of bringing more consistency and better outcomes to the treatment field. However, it is equally important to retain focus on individualized treatment that addresses the pressing needs of the patient. McLellan and his colleagues[44–46] have demonstrated that matching individual problem profiles with specific treatment activities designed to address those needs results in better retention and other outcomes. It is possible that the beneficial effects of a well-constructed CBT model will be obscured in situations where there is insufficient attention to adequate intervention for these problems.

The high number of individuals in this study reporting a history of abuse and violence and/or a current experience of threatening behavior or coercion strongly indicates a need to provide thorough assessments with this population to identify possible co-existing problems and psychiatric disorders. The findings from this study suggest that integrated treatment approaches designed to address victimization, PTSD issues, and/or substance abuse disorders may be needed for a significant proportion of the methamphetamine treatment population, especially women. Failure to address these issues may interfere with treatment retention and effectiveness and may contribute to relapse. In the past few years, integrated treatment approaches that address PTSD, victimization, and substance abuse have been developed, and clinical trials utilizing these approaches with women have been conducted with favorable results.[32,47] Since most of participants in this study have experienced at least one form of physical abuse, sexual abuse, or domestic violence, it is imperative to provide assessment and treatment, when implicated, for psychiatric

symptoms and disorders as part of the standard treatment for methamphetamine-dependent individuals. Failure to provide adequate treatment for those individuals may result in lower retention rates and treatment outcomes.

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