When things are getting out of hand: Prevalence, assessment, and treatment of substance use disorder(s) and violent behavior

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Citation for published version (APA):
Kraanen, F. L. (2014). When things are getting out of hand: Prevalence, assessment, and treatment of substance use disorder(s) and violent behavior.
CHAPTER 7

Integrated treatment for substance abuse and partner violence (I-StoP): A case study

Abstract
Substance use disorders and intimate partner violence (IPV) perpetration frequently co-occur and it has been hypothesized that alcohol use and IPV perpetration are causally related. This led to the development of an Integrated treatment for Substance abuse and Partner violence (I-StoP). This case study describes the treatment of Henry, who repeatedly abused his partner and was diagnosed with alcohol and cannabis dependence. Treatment with I-Stop was highly successful with respect to IPV: at posttreatment and 6 months follow-up no IPV had taken place. However, Henry had not changed substance use. This can be explained by the spurious model that states that a third variable, such as inadequate problem solving skills (which was addressed in I-StoP) may be responsible for both IPV and substance abuse. Also, Henry’s partner was involved in treatment and became more assertive and, in contrast, he did change substance use. This case study illustrates that IPV is a very complex problem and that it is important to involve the partner.
**Theoretical and Research Basis for Treatment**

Although intimate partner violence (IPV) may have serious consequences for victims (for reviews, see: Campbell, 2002; Plichta, 2004) and children who witness violence between their parents (Wood & Sommers, 2011; Kitzmann, Gaylord, Holt, & Kenny, 2008; Holt, Buckley, & Whelan, 2008), the majority of IPV victims stay with their partner after being physically abused (Jacobsen, Gottman, Gortner, Berns, & Shortt, 1996; Zlotnick, Johnson, & Kohn, 2006). Therefore IPV offenders should be treated in order to prevent recidivism. To date, there are no evidence-based treatments available for IPV offenders. Two meta-analyses (Babcock, Green, & Robie, 2004; Feder & Wilson, 2005) demonstrated that the most studied treatments addressing IPV perpetration, i.e., feminist psycho-education (Duluth model) and cognitive behavioral treatment (CBT), were not effective or only marginally effective at best. Fortunately, some studies demonstrated more encouraging results, for example behavioral couples therapy (O’Leary, Heyman, & Neidig, 1999; Stith, Rosen, McCollum, & Thomsen, 2004). Also, Murphy, Taft, and Eckhardt (2007) showed that CBT was effective in reducing IPV perpetration in ‘normal anger’ IPV perpetrators. In this study it was recommended that IPV perpetrators should receive individualized treatment instead of the predominant “one-size-fits-all” treatment since IPV perpetrators comprise a heterogeneous group (e.g., Murphy & Eckhardt, 2005; Dutch Association for Psychiatry, 2009; Kraanen, Emmelkamp, & Scholing, 2011).

One respect in which IPV perpetrators may differ is whether or not they are diagnosed with substance use disorders. Studies reported that up to 50% of IPV perpetrators in domestic violence treatment were diagnosed with alcohol, cannabis and / or cocaine use disorders (e.g., Brown, Werk, Caplan, & Seraganian, 1999; Stuart, Moore, Kahler, & Ramsey, 2003; Stuart, Moore, Ramsey, & Kahler, 2003; Kraanen, Scholing, & Emmelkamp, 2010; 2012). Also, up to two thirds of patients entering substance abuse treatment committed physical violence toward a partner in the past year (e.g., Chermack et al., 2008; O’Farrell & Murphy, 1995; Vedel, 2007; Murphy & O’Farrell, 1994; Kraanen, Vedel, Scholing, & Emmelkamp, submitted). This leads to the conclusion that a substance use disorder combined with IPV perpetration is a frequently occurring dual diagnosis (DD).

Leonard and Quigley (1999) proposed three models that explain the relationship between alcohol use and IPV perpetration, i.e., 1) the proximal effects model (alcohol use causes IPV perpetration), 2) the indirect effects model (alcohol use harms the relationship which may lead to conflicts that result in IPV), and 3) the spurious model (a third variable is responsible for both alcohol use and IPV perpetration). Most evidence has been found in favor of the proximal effects model (Leonard, 2005): it is hypothesized that alcohol use leads to distorted evaluation of cues and to disinhibition which both increase the likelihood of IPV perpetration.
(Foran & O’Leary, 2008). This theory is supported by several studies that demonstrated that successful treatment of alcohol dependence in alcohol dependent IPV offenders led to decreased IPV perpetration (for reviews, see Murphy & Ting, 2009; Stuart, O’Farrell, & Temple, 2009). In addition, it was shown that patients who abstained from alcohol also abstained from IPV perpetration, whereas patients who relapsed into alcohol use also relapsed into IPV (O’Farrell, Van Hutton, & Murphy, 1999; Mignone, Klostermann, & Chen, 2009). The fact, however, that evidence has been found in favor of the proximal effects model does not rule out the other explanatory models. For example, the relationship between alcohol use and IPV perpetration may also be mediated by a third variable that is responsible for both, such as antisocial personality disorder (Moore & Stuart, 2005), a finding that agrees with the spurious model. As for the relationship between cannabis use and IPV, it is hypothesized that withdrawal from cannabis leads to irritability, which may result in IPV perpetration (e.g., Moore et al. 2008, Moore & Stuart, 2005; Hoaken & Stewart, 2003). Finally, cocaine use may lead to IPV perpetration because the pharmacological properties of cocaine affect the serotonergic signaling system, which may elicit aggression (e.g., Patkar et al., 2006). But again, personality pathology may be responsible for this relationship as well (Hoaken & Stewart, 2003).

From the above it follows that substance abuse and IPV perpetration should be treated concurrently, as several researchers have called for (e.g., Leonard, 2005; Smith Stover, Meadows, & Kaufman, 2009; Stuart, 2005; Leonard, 2001; Klostermann & Fals-Stewart, 2006; Kraanen et al., 2011). Easton et al. (2007) conducted a pilot study that compared the effectiveness of a combined substance abuse - IPV group therapy to a 12-step facilitation group in which IPV was not addressed. They found a trend that the combined treatment was more effective in reducing IPV than substance abuse treatment alone. However, in Easton et al.’s (2007) study the combined treatment took place in a substance abuse treatment setting and was offered to DD patients who were referred primarily for substance abuse treatment and were arrested for IPV in the past year. Many of this type of DD patients, however, are usually referred to a forensic mental health center for IPV. The question is whether such combined DD treatment is applicable in a forensic setting. Further, the Easton et al. treatment was conducted in a group format, whereas recent publications on IPV advocated individual treatment in order to better address the patients’ individual needs (e.g., Murphy & Eckhardt, 2005). For that reason, Integrated treatment for Substance abuse and Partner violence (I-StoP; Kraanen, Scholing, Vedel, & Emmelkamp, 2008a; 2008b) was developed; an individual treatment for IPV perpetrators who are diagnosed with substance use disorders. Kraanen, Vedel, Scholing, and Emmelkamp (2013a) compared the effectiveness of I-StoP to a regular cognitive behavioral substance abuse treatment, extended with one session to address IPV among IPV perpetrators in sub-
stance abuse treatment. Both treatments appeared effective in reducing IPV, with no significant differences between the two treatments. The aim of the present article is to inform of the applicability of I-StoP in forensic mental health care. The treatment involved a DD patient who was referred to a forensic outpatient treatment setting for IPV perpetration, and who at the same time appeared to suffer from several substance use disorders. The primary goal of the treatment was to stop IPV perpetration.

Case Introduction
This case describes the assessment and treatment of Henry, 50 years old, whose conflicts with his partner Eric had repeatedly gotten out of hand and, on many occasions, had resulted in verbal as well as physical violence. One day, when Henry had inflicted serious physical injuries to Eric's face, Eric insisted on Henry following treatment. Since Henry felt guilty about his behavior towards his partner, he sought treatment at a mental health care center which referred him to forensic outpatient treatment clinic De Waag, an institution with 8 branches in the west of the Netherlands. Eric did not accompany Henry during the intake session, but was willing to contribute to Henry's treatment by attending several sessions, which is in accordance with the treatment protocol. Henry and Eric both signed informed consent and gave permission that their data could be used anonymously for scientific research. They were also informed that they were free to withdraw consent and/or resign from treatment at all times. Since Henry was seeking treatment voluntarily, there would be no legal consequences in case Henry would discontinue treatment.

Presenting Complaints
Henry and Eric had been in a relationship for 12 years. Henry described the relationship as "satisfactory in general"; he and Eric enjoyed each other's company and shared the same sense of humor. In Henry's opinion communication between him and Eric was good, while also mentioning how arguments between the two of them had repeatedly gotten out of hand. These escalations occurred almost every weekend over the past 8 years, when Henry and Eric drank large amounts of alcohol, smoked marihuana, and/or used ecstasy. In such instances, Eric brought up sensitive issues that he would hold back when sober, such as the idea that Henry was being authoritarian. This in turn infuriated Henry, which regularly resulted in IPV. During some incidents both partners used violence, but Henry admitted that he was always the one who started the fight. On the other hand, Henry was often annoyed with Eric when Eric lost control over his behavior after alcohol and/or ecstasy consumption. On mornings after such incidents, Eric experienced blackouts, which Henry found difficult to cope with.
**History**

Henry came from a troubled family. His parents divorced when he was still young and his mother remarried. His stepfather was very violent and physically abusive toward Henry and his siblings. His stepfather also sexually abused Henry’s sister, and Henry felt that he had to protect her. In order to cope with the problematic situation at home, Henry started using cannabis, which helped him to calm down. Both his biological father (whom he had never seen again after his parents’ divorce) and his stepfather were deceased. Six years earlier, Henry had cut off contact with his mother, because he blamed her for failing to interfere with his violent stepfather. Henry felt that, because of his abusive childhood, he was very sensitive to injustice and he became easily aggressive if a loved one was treated unjustly.

Before his relationship with Eric, Henry had several other intimate relationships. The first one, in which IPV occurred as well, lasted 15 years. Although both partners were violent, it was Henry who initiated the violence. His second relationship lasted three years; Henry had ended it because the partner in this relationship had a severe alcohol use problem and tried to commit suicide several times. Henry quite often used both alcohol and marihuana. He drank mainly during the weekends, up to 12 cans of beer per occasion (about 16 standard units of alcohol). He used half a gram of marihuana each day. Henry was aware that alcohol triggered his aggression, but maintained that marihuana did not. In the past, Henry had used cocaine for ten years, but had stopped 11 years earlier. Further, he had been using ecstasy twice a month, but he quit 2 months before he entered treatment after noticing that ecstasy made him aggressive.

In the past, often while under the influence of alcohol, Henry had violent outbursts in other situations as well. For example, he had been physically violent in bars when he felt that someone had violated his boundaries. Another time he had beaten up a former boss at work so badly that the latter needed to be hospitalized. In recent years, Henry had been able to manage his anger in this type of situations; at the start of treatment he was only violent towards Eric. At the time of the intake, Henry was unemployed. He had been trying to find work, which he thought was difficult considering his age. Henry was satisfied with his social network.

**Assessment**

To classify substance use disorders, the Structured Clinical Interview for DSM-IV Axis I Disorders was used (SCID-I; First, Spitzer, Gibbon, & Williams, 1996; Dutch translation: Van Groenestijn, Akkerhuis, Kupka, Schneider, & Nolen, 1998). According to the SCID-I, Henry fulfilled diagnostic criteria for current alcohol and
cannabis dependence. Since Henry had not used ecstasy for two months, he did not fulfill criteria for current ecstasy abuse or dependence. In addition, recidivism risk was assessed using Forensic Outpatient Risk assessment Scale (FORS) (Van Horn, Wilpert, Scholing, & Mulder, 2008), a Dutch risk assessment tool that was developed specifically for forensic outpatient settings. At the start of treatment, Henry's recidivism risk was rated ‘moderate’ when sober and ‘high’ when under the influence of substances.

Case Conceptualization
A case conceptualization was formulated hypothesizing how Henry’s problems originated and which factors led to IPV perpetration (see Figure 1). Firstly, Henry grew up in an aggressive environment where conflicts were solved with violence. For that reason the therapist assumed that Henry had failed to develop adequate skills to solve interpersonal problems. This is in accordance with research demonstrating that children who witness violence are at increased risk to copy this behavior as an adult (e.g., Ehrensaft et al., 2003; Holt et al., 2008; Orndoff, Kelsoy, & O’Leary, 2001). Henry found it particularly difficult to talk about what bothered him about Eric’s behavior. For example: Eric sometimes made fun of Henry’s former boyfriends while intoxicated. This elicited thoughts in Henry such as: “He crosses my boundaries!”, and “He does not respect me!”. These thoughts made Henry both angry and sad. His lack of communication skills is demonstrated by the following example. One evening Henry found out that Eric had preferred to go to the cinema instead of staying at home to watch a movie, but had not told Henry. This led Henry to think: “He does not trust me!”, “He does not dare to communicate his wishes!”, and “He should tell me what he wants!”. This led to anger and disappointment in Henry. Henry and Eric were unable to solve these conflicts together. Instead, Henry often built up tension and eventually exploded if tension had risen too high. When Henry reached puberty, he started to use cannabis daily to cope with the situation at home and he continued his cannabis use throughout his life. So, secondly, the therapist hypothesized that withdrawal from cannabis made Henry more upset and thus increased the risk of IPV perpetration. His lack of adequate problem-solving skills complicated things even more. Thirdly, the therapist argued that Henry’s use of both alcohol and ecstasy led to impulse control problems, which increased the risk of misbehaving towards Eric. Regarding ecstasy use, studies document a correlation between ecstasy use and aggression (e.g., Curran, Rees, Hoare, Hoshi, & Bond, 2004). It was hypothesized that ecstasy use was also responsible for an increase in impulse control problems, which were likely to lead to IPV perpetration.

Alternatively one could reason with Leonard and Quigley’s (1999) spurious model in mind, that a third variable might be responsible for substance abuse and IPV perpetration. In Henry’s case, this third factor could be his lack of problem solving
Figure 1. Casus conceptualisation of Henry

Environmental influences: Eric discusses sensitive subjects and exhibits irresponsible behavior while intoxicated, and experiences blackouts caused by substance use.
skills. Finally, Eric contributed to the escalations by starting discussions about delicate topics and by behaving irresponsibly when under the influence of alcohol and/or ecstasy.

On the basis of this conceptualization, I-StoP was chosen as treatment. Several treatment goals were formulated. Since IPV was likely to be elicited by Henry’s use of alcohol, withdrawal from cannabis and ecstasy use in the past, the first aim for Henry was to stop or control the use of these substances. Secondly, Henry had to learn to cope effectively with feelings of anger and irritation. Thirdly Eric, who appeared unassertive and seemed to utter his feelings only while under the influence of substances, had to learn to communicate more adequately. As a fourth aim, Eric should decrease his substance use as well. To enhance safety, the first step in the treatment was to invite Henry and Eric together to discuss the “time-out-procedure” (for a description of the time-out procedure, see below). Then Henry started I-StoP.

**Course of Treatment and Assessment of Progress**

**Description of the treatment protocol (I-StoP)**

I-StoP is a structured treatment that addresses substance use disorders as well as IPV perpetration. I-StoP is mainly an individual treatment, but the partner is invited to certain sessions as well. The interventions addressing IPV perpetration are based on the work of Dutton (Dutton & Golant, 2000; Dutton, 2007) and involve cognitive behavioral treatment. The interventions targeting substance abuse are derived from evidence-based cognitive behavioral treatment for substance use disorders (Emmelkamp & Vedel, 2006). In addition, I-StoP includes motivational interviewing interventions to enhance motivation for change (i.e., assessing pros and cons of substance use and IPV perpetration and assessing pros and cons of changing substance use and IPV perpetration) (Miller & Rollnick, 2002). But also, therapists are encouraged to apply the four general principles (also called the general spirit) of motivational interviewing throughout I-StoP, i.e., 1) expressing empathy, 2) developing discrepancy, 3) rolling with resistance, and 4) supporting self-efficacy (Miller & Rollnick, 2002). I-StoP consists of 16 weekly sessions and alternatingly addresses substance abuse or IPV perpetration. A workbook for patients accompanies the treatment protocol and consists of psycho-education, homework assignments, and daily registration forms that address substance use / craving and IPV / anger. On the IPV registration forms one can fill out what caused the anger; how the patient noticed that he/she was angry (bodily sensations); what the patient said to him-/herself that increased and decreased the anger; and the patient’s behavior in the specific situation. The substance use registration forms involve describing the situation, the emotions, the intensity of the craving, the coping style chosen in that particular situation, and the consequences of the specific coping-style in that situation. The principal interven-
The central intervention addressing IPV is the “Cycle of Violence” (Walker, 1979). The “Cycle of Violence” consists of three phases: 1) the tension building phase, 2) the explosion (the actual IPV) and 3) the reconciliation phase. This cycle is discussed with the patient (and preferably with the partner as well), to inform them about how to recognize signals that reveal that tension is building up (such as specific thoughts, bodily sensations, and certain behavior) and to discuss how to prevent escalation, for example by asking for a time-out (for a more detailed description of the negotiated time-out procedure, see Rosen, Matheson, Stith, McCollum, & Locke, 2003). The central intervention addressing substance abuse is making functional analyses of substance use on the basis of which interventions are chosen. In addition, I-StoP addresses the following topics:

- Explanation of the treatment rationale;
- Examination of types of IPV that take place in the specific relationship;
- Assessment of pros and cons of substance use;
- Assessment of pros and cons of IPV;
- Formulation of treatment goals regarding substance use and IPV;
- Description of self-control steps regarding substance use;
- Anger management;
- Coping with craving and emotions that could lead to substance use;
- Discussion of the relationship between thoughts, feelings, and behavior and the connection with IPV and substance use;
- Communication training;
- Relapse prevention.

Each session follows the same structure. First, IPV and substance use (if any) since the last session are discussed, based on the completed registration forms as well as specific homework assignments; then a new topic is introduced, and the session ends with new assignments based on the topic discussed. In addition, since patients differ, for example, in motivation to change and/or level of functioning, the protocol can be adapted according to the specific needs of an individual, which is in accordance with the responsivity principle (Andrews & Bonta, 2010). For instance, it can be necessary to spend extra time to enhance a patient’s motivation to change substance use and/or IPV, or to take extra time for intellectually disabled patients. In Henry’s case (see below), motivation to change substance use was repeatedly addressed throughout the treatment (not just in the beginning as described by the treatment protocol) because his motivation to change alcohol use fluctuated and he did not think it was necessary to change cannabis use.

**Course of the treatment of Henry**

*Session 1 (with both partners present).* In the first session the therapist disclosed
the treatment rationale; it was explained that substance use and IPV perpetration often co-occur and that substance use is a well-known risk factor for IPV perpetration. From the first session onwards Henry and Eric were motivated to stop or decrease substance use. Eric mentioned that he had already cut down on his alcohol intake by drinking 2 cans of beer (about 3 standard units of alcohol) twice a week. Also, the therapist inventoried the different forms of violence that took place in the relationship. Henry and Eric agreed on the following expressions of violence: verbal violence (Henry offended Eric, called him names, belittled him in front of others, did not take his opinions seriously), physical violence (Henry pushed, grabbed, hit, and kicked Eric), controlling behavior (e.g., when Eric was abroad for business, Henry forced Eric to go back to the hotel immediately after the conference instead of going out for dinner with colleagues), and demanding care. To obtain insight in the situations in which Henry got angry and experienced craving, the therapist asked him to complete the diary cards on a daily basis.

Sessions 2 and 3. The following sessions focused primarily on substance use. Following the motivational interviewing principles described by Miller and Rollnick (2002), the therapist asked about the pros and cons of alcohol and ecstasy use to enhance Henry’s motivation for change (see Table 1). Henry (as well as Eric) had already decreased his alcohol intake and experienced several advantages. Above all, Henry was relieved that Eric was now free of blackouts and that he did not have to keep an eye on him anymore. Henry still used cannabis regularly, but he was not prepared to discuss the topic since he denied that it was a problem. The therapist tried to entice Henry to examine his cannabis use with him by finding out the pros and cons of cannabis use. When Henry refused once more the therapist decided to drop the issue for the moment and to bring it up in another session. In addition, the treatment goals regarding substance use were formulated. Henry did not want to give up on drinking alcohol completely. He eventually agreed on staying sober during weekdays and on drinking 3 cans of beer (about 4 standard units of alcohol) at the weekends when staying at home, and “some more” when going out. Although the therapist considered this goal not specific enough, he decided to shelve the topic to prevent resistance.

Sessions 4 and 5. The following sessions focused primarily on IPV. The pros and cons of IPV were examined to enhance motivation to stop IPV perpetration (see Table 2). Henry noticed that the pros occurred in the short term but that in the long term, IPV led to important disadvantages. Based on this discussion, Henry committed himself again to the treatment goal of desisting from violent behavior towards Eric. The pros and cons of his cannabis use still were no subject for discussion.
Session 6 (with Eric) and 7. Eric attended session 6 in which a misunderstanding between the couple became apparent. Eric explained that he was still afraid of Henry, although no violence had taken place since the beginning of treatment. The previous Saturday Eric wanted to go out instead of staying home and watching a movie, as was Henry’s plan. Eric was afraid to tell Henry for fear of sanctions. Henry, on the other hand, thought he did Eric a favor by staying home and watching a movie, because this was something Eric enjoyed very much. It became evident that the communication between both partners often was a problem. The ‘Cycle of Violence’ was discussed in terms of the incident. Henry and Eric agreed that the event had led to increased tension and the situation might have gotten out of hand. In addition, Henry mentioned that he did not consider screaming at Eric as a form of IPV. Eric, on the other hand disclosed that the screaming made him anxious and that to him yelling was IPV. The next session, Henry mentioned that he had managed to keep from screaming at Eric. When asked whether he and Eric had discussed sensitive topics, Henry did not know. For the next week, Henry was assigned to ask Eric whether he was still anxious to discuss certain things with Henry. In addition, functional analyses of alcohol and cannabis use were made in order to assess determinants and reinforcers of substance use.

Table 1. Pros and cons of alcohol and ecstasy use for Henry.

<table>
<thead>
<tr>
<th>Alcohol use</th>
<th>Cons</th>
<th>Ecstasy use</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>It tastes good</td>
<td>IPV</td>
<td>Escaping after a</td>
<td>IPV</td>
</tr>
<tr>
<td>Enhances atmosphere</td>
<td>Difficulties controlling his</td>
<td>week of hard work</td>
<td>Having a hangover</td>
</tr>
<tr>
<td></td>
<td>behavior</td>
<td>Enhances</td>
<td>for 3 days</td>
</tr>
<tr>
<td></td>
<td>Comments of Eric that Henry kept</td>
<td>experiencing music</td>
<td>Being moody and consequence</td>
</tr>
<tr>
<td></td>
<td>harping over things</td>
<td>Feeling ‘speedy’</td>
<td>loosing job</td>
</tr>
<tr>
<td></td>
<td>Hangovers</td>
<td></td>
<td>Brain damage (long term)</td>
</tr>
</tbody>
</table>

Table 2. Pros and cons of IPV perpetration for Henry.

<table>
<thead>
<tr>
<th>Intimate partner violence perpetration</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control on Eric’s behavior</td>
<td>Eric avoids and distrusts Henry</td>
</tr>
<tr>
<td>Helps making points clear</td>
<td>Chance to lose Eric</td>
</tr>
<tr>
<td>Having power over Eric</td>
<td>Feeling guilty about/ regretting IPV</td>
</tr>
<tr>
<td>Forcing Eric into conversation</td>
<td>Chance to physically harm Eric</td>
</tr>
<tr>
<td>Putting an end to unwanted conversation</td>
<td>Distrust by Eric</td>
</tr>
<tr>
<td>Setting boundaries</td>
<td>Feels ‘stupid’</td>
</tr>
</tbody>
</table>
Sessions 8 and 9. The following two sessions focused on handling anger. Specifically, the relationship between thoughts, feelings, and behavior was discussed, as well as the difference between feeling angry versus behaving aggressively. Henry still did not fully understand the difference between the two. It was also discussed how anger can function as a cover for other feelings. Henry recognized that his anger sometimes masked his jealousy. Before starting treatment, his jealousy had sometimes made him aggressive but since being in treatment he had learned to discuss these feelings and to control his anger.

Sessions 10, 11, and 12. Taking time-outs had worked very well for Henry and Eric so no violence had occurred since the beginning of treatment. Substance abuse, however, still posed a problem. Henry’s alcohol use had increased again and he drank about 12 to 15 cans of beer (about 16 - 20 standard units of alcohol) per week over 2 - 3 days whereas Eric, in contrast, had quit drinking. Henry had cut down his cannabis use from 2 to 1 joint per day. The therapist tried again to discuss the pros and cons of cannabis use and to motivate Henry to fully abstain from cannabis, at least for a restricted period, but to no avail. The following sessions focused primarily on substance use. The concept of craving was discussed. Henry did not crave for alcohol but did experience craving for cannabis. Since cutting down on cannabis he had severe nightmares, which in the therapist’s opinion was a symptom of withdrawal. Different techniques to cope with craving were examined. The session also focused on emotions that could lead to substance use. Henry recognized that feelings of frustration and irritation led to cannabis use, but he was not willing to look at other means to handle these emotions. He explained that he used alcohol only to set the mood, not as a means to cope with negative feelings. Finally, permissive and rewarding thoughts that encouraged substance abuse were discussed. Henry recognized two rewarding thoughts (i.e., using substances to reward himself), but he said he no longer used these as an excuse for substance use.

Sessions 13 and 14. The communication between Henry and Eric was discussed in relation to the last escalation that took place 6 months earlier. Henry became aware that at that time he expressed angry feelings in a way that was intimidating to Eric. Eric, on the other hand, used to hide his anger when he was irritated. Henry mentioned that recently Eric had readdressed a topic that was annoying to him. Instead of becoming mad at Eric, Henry had listened to him and had agreed that Eric was right. Both were pleased with the new behavior. However, Henry would prefer that Eric be upfront about sensitive issues instead of bringing them up later. The therapist explained that Eric should be given time to experiment with new behavior. Furthermore, the therapist readdressed Henry’s alcohol use and tried to motivate Henry to stop for 2 weeks since it posed a risk for IPV. Henry
was still reluctant to do so; he was convinced that IPV was something that had occurred in the past and that it would not happen again.

Session 15 (with Eric). The aim of the last session was to evaluate the treatment. Eric expressed that he was pleased with how things were going at home. He was now able to set boundaries in his relationship with Henry, which Henry took well. Henry was content that Eric was more assertive. They illustrated these changes with an example. Last week, a friend of theirs was coming over. Eric was late and called that he would not be home on time. Henry became irritated and asked Eric to hurry up. Eric requested a time-out. Henry refused since he thought all conflicts should be solved immediately. Eric, however, insisted on taking a time-out, which was granted. Eventually, Henry and Eric were both satisfied with the outcome: unlike in the past, Eric was being assertive and persistent. The situation had not gotten out of hand and Eric’s assertive behavior had gained Henry’s respect. The treatment goals were assessed. Henry admitted that the treatment goal regarding substance use was not met, but the treatment goal regarding IPV, Henry’s main concern, was fully achieved. So he was content with the overall result.

7.3 Assessment of progress
The Revised Conflict Tactics Scales (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1997) was used to assess prevalence and frequency of IPV in time-frames of 8 weeks. The CTS2 consists of 39 item pairs addressing perpetration and victimization of verbal, physical, and sexual IPV, injuries resulting from IPV, and the use of negotiation strategies. An example of an item pair is “I hit my partner” and “My partner did this to me”. Substance use was assessed using the Quick Drinking Screen (QDS; Sobell et al., 2003). The QDS is a self-report questionnaire containing 5 aggregate summary questions about alcohol use. Several studies (Dum et al., 2009; Roy et al., 2008; Sobell et al., 2003) found that QDS results were very similar to results obtained by the often-used Timeline Followback Interview (TLFB; Sobell & Sobell, 1996). The QDS was modified to assess drug use as well. Henry completed the CTS2 and QDS at pretreatment, halfway treatment, post treatment, and 6 months follow-up; Eric completed the CTS2 at pretreatment, posttreatment, and 6 months follow-up. Results are displayed in Table 1.

At pretreatment (before starting I-StoP but after 4 sessions of risk assessment), Henry admitted that he had pushed Eric once, grabbed him twice, and yelled at him twice in the past 8 weeks. Once treatment had started, physical IPV ceased completely. At posttreatment, Henry admitted that he had once yelled at Eric and had once walked away angrily during an argument, whereas Eric reported no IPV victimization (verbal or physical). With regard to substance use, at pretreatment Henry reported drinking on average 21 cans of beer (about 28 standard units of
alcohol) per week as well as smoking 3.5 grams of cannabis per week. He had not used ecstasy in the 8 weeks prior to the treatment. Halfway treatment, cannabis use had decreased by half, but at posttreatment, Henry was back at the pre-treatment level. Alcohol use had not changed during the course of treatment. Henry remained abstinent from ecstasy. In contrast to Henry, Eric reduced alcohol consumption to 5 cans of beer (about 7 standard units of alcohol) once a week. As a consequence, much to Henry’s relief, Eric did not exhibit irresponsible behavior when going out nor did he experience blackouts.

Complicating Factors
One factor that obstructed treatment was that Henry did not want to explore his pattern of cannabis use. He kept saying that it was not harmful. In the case conceptualization the therapist hypothesized that withdrawal led to irritability and IPV perpetration. Henry, however, maintained that this was not the case. After an extensive discussion in our team about the issue, it was decided not to push Henry about his cannabis use, for fear of resistance and for fear that Henry might quit therapy altogether. This is consistent with motivational interviewing principles that stipulate that ultimately it is the patient who decides whether or not to change substance use (Miller & Rollnick, 2002). In addition, Henry was ambivalent about changing alcohol use. At the start of treatment, Henry and his therapist formulated a treatment goal that comprised abstinence on weekdays and consumption of up to 3 cans of beer (about 4 standard units of alcohol) per day during the weekend. However, Henry’s alcohol use had not changed much during the course of treatment (i.e., at posttreatment Henry drank 12 to 15 cans of beer (about 16 - 20 standard units of alcohol) over 2 - 3 days at the weekend (which can be considered binge drinking) and ‘a small number of drinks’ during weekdays). The therapist shared his concern about his drinking habits and the ensuing risk of renewed interpersonal violence. Henry maintained that his alcohol use was not problematic despite continuous and detailed psycho-education about the possible adverse effects of alcohol. At the end of treatment, however, Henry achieved his primary treatment goal, i.e., physical IPV perpetration had ceased.

Follow-Up
Six months after treatment completion, Henry and Eric completed follow-up questionnaires that assessed IPV and substance use in the past 8 weeks (CTS2 and QDS) by mail (see Table 1). Henry and Eric reported that no physical and verbal violence had taken place in the past 8 weeks. Regarding substance use, Henry reported that his alcohol intake and cannabis use had not changed and that he started using 0.25 gram of MDA (a drug that resembles MDMA and is also known as the ‘love drug’) twice a week. Also, the first author contacted Henry by telephone at 6 months follow-up and Henry reported that things were going very well between him and Eric. In his opinion, treatment had been effective and he was
very satisfied with the way it had improved their relationship.

**Table 3.** Acts of IPV perpetration by Henry and IPV victimization of Eric in the past 8 weeks at pretreatment, halfway treatment, post treatment, and at 6 months follow-up.

<table>
<thead>
<tr>
<th></th>
<th>Henry IPV perp.</th>
<th>Eric IPV vict.</th>
<th>Henry Alcohol (units/week)</th>
<th>Henry Cannabis (grams/week)</th>
<th>Henry Ecstasy (pills/week)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-treatment</td>
<td>Physical IPV</td>
<td>3</td>
<td>0</td>
<td>28</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Verbal IPV</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injuries</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Halfway treatment</td>
<td>Physical IPV</td>
<td>0</td>
<td>-</td>
<td>30</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Verbal IPV</td>
<td>0</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injuries</td>
<td>0</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-treatment</td>
<td>Physical IPV</td>
<td>0</td>
<td>0</td>
<td>28</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Verbal IPV</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injuries</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months follow-up</td>
<td>Physical IPV</td>
<td>0</td>
<td>0</td>
<td>32</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Verbal IPV</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injuries</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

perp. = perpetration; vict. = victimization; IPV = intimate partner violence.

**Treatment Implications of the case**

First and foremost Henry’s case demonstrated the complex nature of IPV and its treatment. As mentioned above, treatments for IPV perpetrators using a “one-size-fits-all” approach were not effective in reducing IPV (Babcock et al., 2004; Feder & Wilson, 2005) and therefore it has been advocated that treatments should be tailored to the needs of individual IPV perpetrators. IPV perpetrators with substance abuse problems comprise a large subgroup and research demonstrated that IPV decreased significantly after successful alcoholism treatment in alcohol dependent IPV perpetrators. As a result several researchers claimed that treatment for IPV and substance use should be integrated. However, this case study also demonstrated that it is too simplistic to assume that in all substance abusing IPV perpetrators alcohol and drug use disorders should be treated effectively in order to stop IPV. Even though Henry was still using alcohol and drugs, IPV had stopped completely and had not returned 6 months posttreatment. One contributing factor might be that Henry had learned problem solving and communication skills during treatment and Eric had learned to address sensible topics at a convenient time (i.e., when both were sober and before anger had built up). Also, Henry took time-outs and was understanding when Eric took a time-out, although this was still challenging to him at times (see paragraph 7.2; session 15). These findings are in accordance with the spurious model (instead of the proximal effects model) that states that a third factor might be responsible for both IPV perpetration and substance use. In Henry’s case, this third factor might have been his lack of problem solving and communication skills. In addition, Eric had also
changed during the course of treatment; he reduced his substance use and became more assertive. Both factors might have contributed to the cessation of IPV. Moreover, these hypotheses fit in with the favorable outcomes for behavioral couples therapy for IPV perpetrators (O’Leary et al., 1999; Stith et al., 2004) and underscore the importance to involve the partner in IPV treatment, unless there are contra-indications.

It should also be noted that this case study described the treatment of a homosexual couple. Although IPV perpetration in same-sex couples with substance abuse problems has been understudied (Klostermann, Kelley, Milletich, & Mignone, 2011), the available data suggest that IPV in homosexual couples has much in common with IPV in heterosexual couples (e.g., Cruz & Firestone, 1998; McLennan, Summers, & Vaughn, 2002). It was also our own experience that treating a same-sex couple was no different than treating a heterosexual couple. However, there are some aspects of IPV in homosexuals that are unique and might apply to individual cases. For example, homosexuals who hide their sexual orientation may be pressured by an abusive partner into disclosing their sexual orientation (Kulkin, Williams, Borne, de la Bretonne, & Laurendine, 2007). Or, in case a homosexual IPV victim does not want to disclose his (or her) homosexuality, this might prevent him from seeking help (Kulkin et al., 2007).

Further, despite the pessimistic results from Babcock et al.’s (2004) and Feder and Wilson’s (2005) meta-analyses, the case of Henry demonstrated that it is indeed possible to treat IPV perpetrators effectively, given the fact that 6 months after finishing treatment still no relapse into IPV had occurred. However, it should be noted that even though this case study can be seen as a ‘failure turned into success’, we still consider Henry’s alcohol and drug use a risk factor for IPV perpetration. A longer follow-up period is necessary in order to demonstrate whether or not Henry and Eric will relapse into their old pattern. Along the same lines, we believe that special attention is required for patients who are initially unwilling to change their substance use. Although I-StoP includes motivational interviewing techniques, more time and rehearsal of these techniques may be necessary to engage the patient in the treatment goals.

**Recommendations to Clinicians and Students**

In the first place, the case described above emphasizes that IPV is complicated. IPV always involves two partners. In some cases there is a relatively clear distinction between the perpetrator on the one hand and the victim on the other hand; in other cases the partners involved are both perpetrator and victim. And even in the first scenario, therapists should be aware that both partners contribute to the interaction that eventually is responsible for IPV. It follows that it is mandatory to always analyze the interaction between both partners before choosing interven-
tions. In addition, comorbidity may play a role, such as substance use disorders. As is documented by a large body of previous research, there is a relationship between substance abuse and IPV perpetration as well as victimization (for reviews, see: Stith, Smith, Penn, Ward, & Tritt, 2004; Schumacher, Feldbau-Kohn, Slep, & Heyman, 2001). Consequently, it is important not only to assess substance abuse in IPV perpetrators and victims, but also to screen patients entering substance abuse treatment for IPV perpetration and victimization, for example with the Jellinek Inventory for assessing Partner Violence (J-IPV; Kraanen, Vedel, Scholing, & Emmelkamp, 2013b). If both IPV perpetration and substance use disorders are present, it is recommended to treat both problems at the same time, as we did with I-StoP. However, this case study demonstrates that the spurious model (a third factor leading to both substance abuse and IPV) should not be overlooked as an explanation for the relationship between substance use and IPV perpetration.

Further, since IPV is such a complex problem, it is important to involve a patient’s partner in the treatment, in order to hear both sides of the story, to gain insight in the dynamics between partners, and to enhance safety by discussing the time-out procedure and by dealing with substance abuse in the partner as well. Since there are no evidence-based treatments for IPV perpetrators, we advise to treat patients according to Andrews and Bonta’s (2010) treatment model for offenders. Andrews and Bonta (2010) found evidence that effective treatment for offenders should adhere to three core principles: 1) the risk principle, 2) the need principle, and 3) the general responsivity principle. The risk principle involves matching treatment intensity with the risk level of offenders; the need principle includes targeting dynamic risk factors, such as antisocial cognitions or substance abuse; and the general responsivity principle concerns employing cognitive behavioral oriented interventions and skill building strategies. Finally, since evidence-based treatments for IPV perpetrators are lacking, we call for randomized controlled trials to investigate the effectiveness of IPV treatments.