DOCUMENT RESUME

ED 326 804 CG 023 014

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TITLE The Relationship between Victim's/Perpetrator's Alcohol Use and Spousal Violence.
SPONS AGENCY National Inst. on Alcohol Abuse and Alcoholism (DHHS), Rockville, Md.
PUB DATE Nov 90
CONTRACT R01AA07554
NOTE 24p.; Paper presented at the Annual Meeting of the American Society of Criminology (Baltimore, MD, November 7-10, 1990).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Alcohol Abuse; *Alcoholism; *Battered Women; *Family Violence; Females; *Marital Instability; Spouses

ABSTRACT

This study examined the relationships between alcohol abuse and spousal violence for 56 women in alcoholism treatment as compared to these comparison groups: 78 women receiving mental health treatment; 98 women receiving services for family violence; 91 women from a random sample of households; and 100 women in a driver education program following arrest for driving while intoxicated (DWI), 41 of whom were classified as alcoholics. Respondents completed face-to-face interviews that included both structured and open-ended questions. Adult alcohol use was measured by questions on quantity-frequency of use and the Michigan Alcoholism Screening Test. Based on the Conflict Tactics Scale, verbal aggression, moderate violence, and severe violence were measured. The findings indicated that women in alcoholism treatment reported high levels of spousal violence when compared to women in the general population, women in mental health treatment, and DWI women. Levels of spousal violence were not as high for women in alcoholism treatment as were levels found in battered women receiving treatment for family violence. Regression analyses suggest that although alcoholism predicts spousal violence, spousal violence does not predict alcoholism. Despite some support for the relationship between spousal violence and women's alcohol problems, alcoholism does not appear to explain much of the variance in spousal violence. (NB)

THE RELATIONSHIP BETWEEN VICTIM'S/PERPETRATORS ALCOHOL USE AND SPOUSAL VIOLENCE

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Presented at the Annual Meeting
of the American Society of Criminology in Baltimore, Maryland

November 7-10, 1990

This research is funded in part by the National Institute on Alcohol Abuse and Alcoholism, (Grant No. R01AA07554)

ACKNOWLEDGMENT

The authors thank the research staff, Beverly Artis, Brenda Brown, Jeanne Farallo, Angeliki Keil, Pat Mahoney, and Mary Ann Snyder; the agencies, who allowed us access to their clients; and especially, the women who shared their stories with us.

REVIEW OF THE LITERATURE

As spousal violence has received more attention from researchers during the past fifteen years, the extent of the problem has become well documented. In 1975, estimates of family violence were obtained from self-report data for a nationally representative sample of 2,143 families (Straus, Gelles, and Steinmetz, 1980). This nationwide survey was repeated in 1985 with 6,002 families and comparisons to the original survey were made (Straus and Gelles, 1990). In the year before the survey for both 1975 and 1985, 16% of the couples reported violence[1] (Straus and Gelles, 1990). Despite the evidence of family violence and the central role of families in our society, there is an incomplete understanding of how alcohol/drug problems affect family relationships, family stability, and family violence.

A large body of descriptive data suggesting that alcohol use and/or intoxication may be related to spousal violence has been presented (Byles, 1978; Coleman & Straus, 1979; Hilberman & Munson, 1978; Leonard, Bromet, Parkinson, Day & Ryan, 1985; Van Hasselt, Morrison, & Bellak, 1985). Male batterers and their victims commonly report that the batterer had been drinking or was drunk during many of the abusive incidents (Chimbos, 1978; Gayford, 1975; Gelles, 1972; Nisonoff & Bitman, 1979; Pernanen, 1979). Other studies have assessed whether the male batterer had a drinking problem (Fagan, Stewart, & Hansen, 1983), or whether he was an alcoholic (Roy, 1982). In a random household survey, Kantor and Straus (1989) reported that 70% of the husbands who had severely assaulted their wives reported being drunk one or more times during the survey year as compared to 50% of the husbands who victimized their wives with more moderate violence and 31% of the husbands who did not victimize their wives.

While several studies have investigated the male aggressor's alcohol and/or drug problems, few studies have examined the alcohol and/or drug problems of the women who are victimized by spousal violence. However, there is some evidence that women with alcohol and drug problems are more vulnerable to spousal violence. Kantor and Straus (1989) reported that 46% of the severely assaulted women in their sample were drunk one or more times during the survey year, contrasted to 36% of the minor violence victims and 16% of the nonvictimized women. Similar relationships between the victim's use of drugs and spousal violence have been found. In a study of drug users and distributors in New York City, Goldstein, Bellucci, Spunt, and Miller (1988) found that 20% of the female regular cocaine users and 31% of the moderate cocaine users experienced violence from a spouse or lover. Not only has alcohol/drug use of the victim been associated with a greater risk of spousal violence occurring, but also, a greater risk of frequency and duration of abuse, and a greater risk of serious injury (Fagan & Wexler, 1987). Our preliminary work comparing alcoholic women in treatment to a random sample of women indicates that alcoholic women were much more likely than the random sample to experience spousal violence (Miller, Downs, Gondoli, 1989). However, this preliminary work did not compare alcoholic women with other samples of women who may also experience high levels of spousal violence.

Women with alcohol/drug problems may be at a higher risk of spousal violence because they are viewed by their partners as acting inappropriately. Kagle (1987) has noted that a drunken man is viewed as funny while a drunken woman is seen as obnoxious or unfeminine. Sandmaier (1980) contended that when women drink, they have a tendency to become more verbally aggressive. This aggression violates the gender role norms. Thus, societal norms may

tolerate male aggression towards women, when women are viewed as not behaving in an acceptable feminine manner.

This study examines the relationships between alcohol abuse and spousal violence for women in alcoholism treatment as compared to four comparison groups, including a sample of battered women. Controlling for demographic differences, the study then examines whether spousal violence predicts alcoholism, and whether alcoholism predicts spousal violence.

METHOD

A total of 466 women are included in these analyses, drawn from a larger study funded by NIAAA on family violence and alcohol problems in women. Women between 18 and 45 were eligible to participate in the study. No attempt was made to include only women with spousal partners, although virtually all the women had at least one partner for whom questions on spousal violence were appropriate. Women were recruited from 1 of 5 samples: women in outpatient alcoholism treatment, women in mental health treatment, women receiving services for family violence, women in a driver education program following arrest for driving while intoxicated, and a random sample of women from the community.

Alcoholic women were currently receiving treatment for alcoholism through one of six clinics in Erie County. They were recruited at the clinics either through personal contact by one of the interviewers or through flyers which were given to eligible women by their counselors. No minimum length of sobriety was set by the study design for alcoholic women; however, individual

clinics set times ranging from 6 weeks to 6 months as the minimum length of sobriety before they would allow access to their clients.

The majority of the battered women (77%) were recruited during their stay at a shelter for battered women through personal contact with one of the interviewers during one of the house meetings. The remainder were receiving counseling services for battered women at an agency affiliated with the shelter. They were either given flyers by their counselors or contacted by an interviewer before the start of their group counseling session.

Women in mental health treatment at six different clinics in Erie County were recruited through flyers which were given to them by their counselors. Women who were either actively psychotic or suicidally depressed were excluded. In the first instance, actively psychotic women were not expected to be able to provide reliable data for the study. In the second instance, the exclusion was based upon the concern for the women; the interview dealt with extremely sensitive issues and there was concern that the interview process might contribute to negative consequences for the women.

The DWI sample consisted of women who had been arrested for driving while intoxicated and chose to attend driver education classes in order to maintain a conditional license. Women arrested for DWI who chose to have their license suspended or who had been arrested more than once in the past 5 years for DWI did not participate in the classes. One of the interviewers described the study at the end of one of the classes and offered women the chance to participate.

The random sample was recruited through random digit dialing in the Buffalo area. If there was a woman in the household between the ages of 18 and 45 the study was described briefly to her and participation was solicited.

Out of a total of 331 contacts with a woman 18-45 living at the residence, 34% refused before hearing the description of the study, another 29% refused after hearing about the study, 7% agreed to be interviewed but failed to establish or keep appointments, and 30% were interviewed.

Interview Procedure and Operationalization of Measures. Each participant completed a 2 1/2 hour, face-to-face in-depth interview that included both structured and open-ended questions. The interviews were conducted between March 1989 and September 1990. Interviews included questions about current family, relationship with spouse/partner, and her own and her partner's alcohol and drug use. There were also a number of self-administered questions, including measures on mental health. Respondents also consented to have the interview tape-recorded.

Adult alcohol use was measured by both questions on quantity-frequency of use and the Michigan Alcoholism Screening Test (Selzer, 1971). These measures insured that alcoholic women were not included in the random sample and provided a standardized means to divide the battered, mental health, and DWI women into alcoholic and nonalcoholic groups. Scores greater than 5 are considered to indicate alcoholism. Since the MAST has been criticized as having a high false positive rate (Jacobson, 1983), in order to be considered alcoholic, at least one heavy drinking period (at least 6 drinks per regular drinking occasion) had to be present for women with MAST scores higher than 5 but less than 10.

Three forms of violence were measured, verbal aggression, moderate violence, and severe violence, based upon the Conflict Tactics Scale (CTS) (Straus, 1979; Straus et al., 1980 and Kantor and Straus (1989). Some additional items to these scales were added, based upon our preliminary work

(Miller, Downs, Gondoli, 1989, and Downs, Miller, Gondoli, 1987). Verbal aggression was comprised of four items: said something spiteful, insulted or swore at you, threatened to abandon you, insulted or swore at you in a sexual manner. Five items comprised moderate violence: threatened to hit, throw/smash/hit/kick something, throw something at you, push/grabbed/shoved you, slapped you. Eight items comprised severe violence: kicked/bit/hit, hit with object, beat up, burned, threatened with knife or gun, threatened life in some other way, used knife or gun, forced sex. For each of the forms of violence, three different measures were formed: the number of items indicated ever occurring, experiences of high frequency of conflict, and the highest frequency ever reported occurring. The number of items was simply a count for each form of violence, based upon a dichotomous formation of the variables (1=occurred, 0=not occurred). The experiences of high frequency of conflict were based upon computing whether the woman reported ever experiencing any form of verbal aggression on a frequency level of once a month or more often. This same method was repeated for moderate and severe violence. The highest frequency is simply the highest frequency of violence ever experienced for any of the items comprising each of the three forms of violence. The frequency variable ranged from a low of 0 to a high of 6.

Other questions assessed race, age, income, education, and marital status. Socioeconomic status was calculated using the Hollingshead index for their current family. As a measure of psychological adjustment, the SCL-90 (Derogatis, Lipman, Covi, 1973), an expanded version of the Hopkins Symptom Checklist, was administered to assess general psychiatric symptomatology. The global score is used in these analyses with the higher scores indicating greater symptomatology. The scale consists of ninety items divided into nine

subscales, seven of which were used (hostility, anxiety, somatization, obsessive-compulsive, interpersonal sensitivity, depression, phobic anxiety). Items are scored on a five point scale ranging from "not at all" to "extremely". Alpha coefficients for the subscales range from .77 to .90.

RESULTS

Before we could address the problem of whether women in alcoholism treatment were more likely to have spousal violence problems, we needed to address the issue of overlap in the five different samples. All five samples had women who met our criteria for alcohol problems/alcoholism. In the random sample, the number of alcoholic women was too small to allow comparisons between alcoholic and nonalcoholic random women. The alcoholic women (n= 8) in the random sample were eliminated from the analyses. Within the samples of battered and mental health women, there were no significant differences in the spousal violence variables between nonalcoholic and alcoholic women. However, for the DWI women, differences in the spousal violence variable were significant for the DWI alcoholic and DWI nonalcoholic women. Therefore, our subsequent comparisons show the DWI group split into alcoholic vs. nonalcoholic women.

To address whether the women in alcoholism treatment reported greater levels of spousal violence than the comparison groups, comparisons were made for the three forms of violence (verbal aggression, moderate physical and severe physical violence) based upon the three different measurements (number of items, experiences of high frequency of conflict, and highest frequency of violence experienced). Table 1 shows these results. Women in alcoholism

treatment were more likely than women in the random sample and significantly less likely than the battered women to have experienced all three forms of violence, regardless of the measurement method. Women in alcoholism treatment averaged 2.4 different types of verbal aggression (from a possible total of 4), 2.5 different types of moderate physical violence (from a possible total of 5), and 1.5 different types of severe violence (from a possible total of 8). While this is significantly less than the battered women (3.3, 4.1, and 3.9, respectively), this is almost twice as many types of moderate physical violence and over three times the number of severe physical violence items, as compared to the random sample (2.5 vs 1.4 and 1.5 vs 0.4, respectively).

Nearly three fourths of the women in alcoholism treatment had experienced a high frequency of verbal aggression, defined as experiencing some form of verbal aggression on a monthly basis. A high frequency of moderate physical and severe physical violence was experienced by half and one quarter, respectively, of the women in alcoholism treatment. In comparison, women in the random sample were much less likely to have experienced a high frequency of negative aggression (36%), moderate physical violence (14%) or severe physical violence (3%). As expected, women in the battered sample were significantly more likely than the women in alcoholism treatment to have experienced a high frequency of verbal aggression (93%), moderate physical violence (86%), and severe physical violence (63%).

Using the highest frequency of violence ever experienced, an identical pattern emerges. Women in alcoholism treatment reported significantly more verbal aggression than the random sample (4.15 vs. 2.43) and significantly less than the battered (5.42). Likewise, measures of moderate and severe physical violence were significantly greater for the women in alcoholism

treatment as compared to the random sample (moderate= 3.10 vs. 1.38 and severe=0.68 vs. 0.37) and significantly less as compared to the battered women (moderate=4.80, severe=3.96).

Comparisons between the women in alcoholism treatment and the other three groups generally show that women in alcoholism treatment were significantly more likely than the mental health treatment sample to have experienced moderate and physical violence but not verbal aggression. Comparisons with the DWI groups show that the women in alcoholism treatment were significantly more likely to have experienced all three forms of violence than the DWI women, although the strength of these differences is less dramatic with the DWI women who were identified as having alcohol problems.

While these data are suggestive of a relationship between women's alcohol problems and their victimization by spousal violence, demographic differences between the women in alcoholism treatment in treatment and the other five comparison groups need to be considered. Table 2 reveals these differences. Women in alcoholism treatment are an average age of 33 years and nearly 40% are black or another minority status. Nearly two-thirds of the women in alcoholism treatment are from a lower socioeconomic status, less than a third are employed, approximately 40 percent receive their income from salary/wages, a fourth have less than a high school education. Only a fifth were married or cohabitating at the time of the study.

Both the battered women and the mental health women have very comparable demographics. The battered women are younger and more receive income from salary or wages. Fewer of the mental health women are minorities and fewer have less than a high school education. Differences in the demographics are substantial from both the random sample and the DWI women, however. Thus,

demographic differences must be controlled in examining the relationships between alcoholism and spousal violence.

An additional concern is the potential overlap in the mental health status of the women in the various comparison groups. Using the Global SCL-90 score to assess severity of mental health problems, the women in alcoholism treatment in treatment were compared with the other five groups. Women in alcoholism treatment had a significantly better mental health score as compared to the battered and the mental health women (whose scores were virtually identical). However, women in alcoholism treatment in treatment were significantly higher than the random sample and the nonalcoholic DWI's, indicating that the women in alcoholism treatment had more psychiatric problems. There was no significant difference between the women in alcoholism treatment in treatment and the alcoholic DWI women in the Global SCL-90 score.

To address the question of whether alcoholism predicts spousal violence, all the demographics listed in Table 2 were entered into a regression equation, along with the Global SCL-90 score. Then a variable indicating alcoholism or no alcoholism was entered. Separate regression equations were completed for experiences of high frequency of verbal aggression, moderate violence, and severe violence (1=yes, 0=no), as the dependent measure. The battered women were excluded from these analyses because of their skewed distribution on the dependent variable. Table 3 shows the results of these analyses. Controlling for demographics and SCL-90 scores, being alcoholic contributes significantly to the equation to predict all three forms of spousal violence (verbal aggression, moderate violence, and severe violence). The SCL-90 scores also predict spousal violence with higher scores (more severe mental health impairment) associated with higher levels of violence.

In the verbal aggression and the severe physical violence, income is negatively associated with spousal violence; the higher the income the less likely that spousal violence will occur.

To address the opposite question, does spousal violence help us to predict alcoholism, the same demographics and SCL-90 score were entered, with the experiences of high frequency of verbal aggression, moderate violence, and severe violence entered in three separate regression equations on the last step. The dependent variable was a dichotomous variable indicating alcoholic or not alcoholic. In none of these equations was spousal violence a significant predictor of alcoholic status (see Table 4).

DISCUSSION

Our findings indicate that women in alcoholism treatment in treatment do report high levels of spousal violence when compared to women in the general population, women in mental health treatment, and DWI women. However, levels of spousal violence are not as high for women in alcoholism treatment as are found in a sample of battered women obtained through a battered shelter. Regression analyses suggested that alcoholism predicts spousal violence, however, spousal violence did not predict alcoholism. Despite some support for the relationship between spousal violence and women's alcohol problems, alcoholism does not appear to explain much of the variance in spousal violence.

The relationships between spousal violence and women's alcohol problems may be more complex than what we have depicted in these analyses. First, there may be a threshold of alcohol problems that must be reached before

spousal violence occurs. Our definitions of alcoholism included women who are indicating alcohol problems but who were not as the same level of problems as the women in alcoholism treatment. Second, there may in fact be a curvilinear relationship between women's alcohol problems and spousal violence. A threshold may exist before an increase in spousal violence is noted; however, as a woman's alcohol problems increase in intensity, there may actually be a reduction in spousal violence experiences because the spouse leaves and/or there are not the same type of interactions occurring between two partners when one of them is heavily involved with alcohol problems. A third consideration that needs to be made is the alcohol problems of the male partner. Additional analyses are planned to examine the interaction effect between alcohol problems in the male partner and alcohol problems in the woman.

The levels of spousal violence that are reported by women in alcoholism treatment are high. Further work is planned to understand how these events may be connected. Indepth interviews have provided us with descriptive accounts of the most traumatic experience and these experiences will be analyzed through a content analyses method to determine whether there are specific patterns connecting alcohol problems and spousal violence.

FOOTNOTES

1. Severe violence is defin d by the following acts directed towards an individual in the family: kicking, biting, punching, hitting or trying to hit with object, beating, threatening with a gun or knife, using a gun or knife. Moderate violence is defined by the following acts directed towards an individual in the family: threatened to hit or throw something, threw or smashed or hit or kicked something, threw something at individual, pushed grabbed or shoved, slapped.

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TABLE 1

COMPARISONS OF ALCOHOLIC WOMEN IN TREATMENT WITH OTHER SAMPLES OF WOMEN ON INDICATORS OF SPOUSAL VIOLENCE

Indicators of Spousal Violence	Alcoholism Treatment (n = 96)	Random Household (n = 91)	Battered Shelter (n = 98)	Mental Health Treatment (n = 78)	DWI - Alcoholic (n = 41)	DWI - Not Alcoholic (n = 59)
Number of Items on Subscale						
Negative Verbal	2.41	1.54***	3.3***	2.28	2.17	1.39***
Moderate Physical	2.50	1.35***	4.13***	1.95*	1.76*	0.85***
Severe Physical	1.47	0.41***	3.85***	0.86*	0.80*	0.22***
Experiences of High Frequency of Conflict						
Negative Verbal	74%	36%***	93%***	62%	49%**	31%***
Moderate Physical	53%	14%***	86%***	29%**	29%**	10%***
Severe Physical	28%	3%***	63%***	14%*	7%**	0%***
Highest Frequency of Violence Experienced						
Negative Verbal	4.15	2.43***	5.42***	3.72	2.83***	2.05***
Moderate Physical	3.10	1.38***	4.80***	2.09**	2.10**	0.85***
Severe Physical	1.68	0.37***	3.96***	0.88**	0.73**	0.15***

* $p \leq .05$
** $\leq .01$
*** $\leq .001$

TABLE 2

COMPARISONS OF ALCOHOLIC WOMEN IN TREATMENT WITH OTHER SAMPLES OF WOMEN ON DEMOGRAPHICS AND GLOBAL SCL-90 SCORE

	Alcoholism Treatment (n = 97)	Random Household (n = 92)	Battered Shelter (n = 98)	Mental Health Treatment (n = 78)	DWI - Alcoholic (n = 42)	DWI - Not Alcoholic (n = 59)
Age	32.7	32.6	30.5*	33.1	28.6***	27.8***
Race/Minority	38.8%	22.8%**	49.0%	21.8%*	4.[illegible]	1.7%***
Low/Lower middle Socioeconomic Status	63.5%	25.0%***	63.3%	55.1%	35.7%**	24.1%***
Employed	30.6%	76.1%***	26.5%	41.0%	92.9%***	88.1%***
Income from Salary/Wages	43.3%	85.9%***	60.2%*	43.6%	88.1%***	84.7%***
Married/Cohabitating	20.4%	58.7%***	31.6%	26.9%	28.6%	13.6%
Less than High School Education	26.8%	5.4%***	31.6%	9.0%**	7.1%**	8.6%**
Global SCL-90 Score	.95	.49***	1.30***	1.25**	.80	.33***

* $p \leq .05$
** $p \leq .01$
*** $p \leq .001$

TABLE 3

ABILITY OF ALCOHOLISM TO PREDICT SPOUSAL VIOLENCE CONTROLLING FOR DEMOGRAPHICS AND SCL-90

High Frequency Verbal Violence	Independent Variables	B	Beta
	SCL	.17	.22*
	Race	-.03	-.02
	Marital Status	.04	.04
	Low SES	.07	.07
	Age	.00	-.05
	Low Education	-.09	-.06
	Income	-.14	-.14*
	Alcoholic	.16	.16*

R^2 = .13

High Frequency Moderate Violence	Independent Variables	B	Beta
	SCL	.12	.17*
	Race	.02	-.02
	Marital Status	-.02	-.02
	Low SES	.07	.08
	Age	-.00	-.00
	Low Education	-.01	-.01
	Income	-.10	-.10
	Alcoholic	.16	.18*

R^2 = .11

High Frequency Severe Violence	Independent Variables	B	Beta
	SCL	.08	.16*
	Race	-.08	-.10
	Marital Status	-.04	-.06
	Low SES	.00	.01
	Age	.00	.05
	Low Education	-.06	-.06
	Income	-.10	-.16*
	Alcoholic	.09	.13*

R^2 = .12

* $\leq .05$

TABLE 4

ABILITY OF SPOUSAL VIOLENCE TO PREDICT ALCOHOLISM CONTROLLING FOR DEMOGRAPHICS AND SCL-90

Independent Variables	B	Beta
SCL	.17	.24*
Marital Status	-.04	-.04
Low Education	.19	.14*
Age	.00	-.00
Race	.04	.03
Low SES	.07	.07
Income	-.03	-.03
High Frequency Verbal	.08	.08*

R^2 = .12

Independent Variables	B	Beta
SCL	.18	.25*
Marital Status	-.04	-.04
Low Education	.18	.13*
Age	.00	-.00
Race	.04	.03
Low SES	.07	.07
Income	-.03	-.03
High Frequency Moderate Violence	.06	.06

R^2 = .12

Independent Variables	B	Beta
SCL	.19	.27*
Marital Status	-.04	-.04
Low Education	.19	.14*
Age	.00	-.01
Race	.03	.03
Low SES	.08	.08
Income	-.03	-.03
High Frequency Severe Violence	-.01	-.01

R^2 = .12

* ≤.05