

Rates of Intimate Partner Violence of Women with Substance Abuse

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## Abstract

Intimate partner violence continues to be a serious problem in the United States. Recent studies demonstrate that the highest rate of intimate partner violence (IPV) occur in substance abusing women. Those in addiction recovery programs reported the highest rates of IPV with more than 36% reporting IPV in the previous year, and a lifetime prevalence of 73%. There is conflicting data regarding the relationship of age, education and income to rates of violence. This study looks at the significance of these 3 factors as being independent predictors of IPV. This study was conducted with 99 women in Livingston and Washtenaw Counties in Michigan who attend Alcoholic's Anonymous meetings and completed written surveys about 12 month and lifetime prevalence of IPV. Demographic data including age, income and years of formal education were collected, and the relationships of these factors as determinates of IPV were studied. Lifetime and 12 month rates of violence were consistent with national rates. The only statistically significant indicator of IPV was years of education ( $p = .035$ ). Nurse practitioners should implement screening of women for IPV, with special attention paid to those who are alcoholic and with less years of formal education. Further research should examine the relationship of participation in a substance abuse recovery program and decreasing rates of IPV among alcoholic women.

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## Chapter I

### Introduction

Recently, there has been a shift in the use of the phrase Domestic Violence when describing abuse in significant partner relationships. Intimate Partner Violence (IPV) is now the accepted and correct terminology that encompasses current or past partner relationships including heterosexual, homosexual, married or living with a partner, or even dating. With this in mind, women living in the United States face a high lifetime threat of intimate partner violence and sexual assault (Tjaden & Thoennes, 2000). In 2001, 20% of violent crime against women was IPV. One out of five (21%) of Michigan women with current partners reported sustaining some type of violence in that relationship (Michigan Department of Community Health, 2000).

Of particular concern is the suspected high amount of “unreported” intimate partner violence among all women. Healthcare workers appear to be falling short in identifying these women. Researchers and advocates have argued that healthcare providers can play a crucial role in detecting partner violence (Davison, Grisso, Moreno, King, & Marchant, 2001). In 1995, the American College of Obstetricians and Gynecologists recommended routine screening for IPV and provided screening guidelines for physicians (ACOG, 1995). Despite recommendations for universal screening, in practice, it appears that relatively few physicians screen for IPV (McCloskey et al., 2005). One of the reasons that many injuries sustained by women are not appropriately being reported as violent acts is that healthcare workers are failing to ask the question. Physicians and nurses report not wanting to embarrass their patient, or “she didn’t look the type”. According to Holt (2002, p. 29), “beatings, gunshot wounds and stabbings all occur in the world of drug and alcohol-related events. Of more sobering influence is the knowledge that

it is not only the ‘criminal or poor element’ who are victims in such incidents, but also those people who engage in the daily production machinery of America – lawyers, physicians, teachers.” This study specifically examined income and education and the occurrence IPV.

In addition, the study examined the incidence of IPV among women in recovery for substance abuse. Of the 15.1 million alcoholics in the United States, nearly one-third are women. There is evidence that supports an alarming increase in the amount of violence in the relationships of female alcoholics.

## Chapter II

### Theoretical Framework

For this study, a framework which uses awareness of choice and an enhanced sense of control as empowering factors for women was used and thought to contribute to their recovery efforts. This is the foundation of Margaret Kearney's midrange theory, "Truthful self-nurturing: a grounded formal theory of women's addiction recovery" (Kearney, 1998). She found that the basic problem of addiction was self-destructive self-nurturing. In other words, perceived pain and emptiness are controlled with self-destructive behaviors; alcohol, drugs, and sex. These behaviors provide intermittent short periods of "relief", but over the long run are destructive and end up causing greater pain. The basic process of recovery was truthful self-nurturing, which required a painful awareness shift in which addiction gained meaning as a problem. Subsequent recovery involved three areas of social-psychological change: abstinence work, self-work, and connection work. Consequences were enjoying simple pleasures, growing self-understanding, self-acceptance, and sense of belonging, and empowered connectedness. Identity revision, which involves taking on a new personal and social self, is a sustaining factor in health behavior change.

It is evident that the women in my study are well described by Kearney's theory. The self-destructive self-nurturing is apparent not only in the compulsive drinking, but in the physical abuse as well. There is relief at having someone in their lives; a perceived caretaker who at times is able to offer them some security, but then that security is turned into a destructive force when the abuse begins again. The periods of relief initially out-weigh the pain of the abuse, but the self-destructive self-nurturing becomes more destructive as the abuse occurs more frequently and with more intensity.

Based on this theory, I expect that women in recovery from addiction have found ways to successfully self-nurture and therefore will have lower rates of current or recent IPV. Women in recovery therefore look for new and healthy ways to self-nurture. Some of the tools they may employ include increasing physical health through exercise and diet, returning to school to further their education, and seeking employment to become more self-sufficient. Healthy relationships are also pursued and nurtured. These behaviors enable women to have more choices; to be less likely to feel trapped in an abusive relationship.



## Chapter III

### Review of the Literature

In this chapter the research on intimate partner violence will be reviewed. Application to the current study will be discussed.

In 2004, Pearl found that a battered woman's attempt at abstinence may be sabotaged by her batterer as a mechanism of control. Substance use may even be encouraged or forced. Similarly, Fals-Stewart & Stewart (2005), found that 40-60% of married or cohabiting substance-abusing patients report episodes of partner aggression in the year preceding entry into treatment. They also reported that women experiencing domestic violence share the same feelings of isolation, guilt, shame, low self-esteem, and denial of problems, as do women with substance abuse issues. The findings of these two studies suggest a correlation between alcoholic women and violence in their relationships; a correlation worthy of further research.

Weinsheimer, et al (2005) examined the role of female alcohol use on rates of severe IPV. A survey was administered to 95 women in a trauma center. The survey included questions about past year and lifetime IPV and women and men's alcohol use. Nearly one half of the women reported a lifetime history of severe IPV, with 26% experiencing IPV in the past year. Past year IPV was identified in 59% of women with drinking problems, but in only 13% of those negative for drinking. Multivariate analysis showed that women with problem drinking (Odds Ratio = 5.8) and partner problem drinking (Odds Ratio = 8.9) were independent predictors of past year severe IPV. They found that alcohol problems among abused women and their partners are greater than those among non-abused women and that women and their partners' alcohol problems are each independently associated with IPV. The study also showed that one-third of female homicide victims are killed by an intimate partner and alcohol is often involved.

Though this study was conducted in a trauma center, it is useful in that it strongly links problems with alcohol with women experiencing IPV, supporting further study in this population. There could possibly be high rates of IPV in recovering alcoholic women in a non-clinic setting as well.

In a recent study, McCloskey, et al compared rates of IPV across different medical specialties in the metropolitan Boston area. These specialties included emergency departments, obstetrician and gynecology offices, pediatrics, primary care offices, and addiction recovery units. In these areas studied, 14% of women surveyed disclosed a 12-month occurrence of relationship violence. As many as 37% of women confirmed ever being in a violent relationship. McCloskey found that women in addiction recovery programs reported the highest rates of IPV; more than 36% reported IPV in the previous year, and lifetime prevalence was a staggering 73%. These rates are higher than the Weinsheimer study. Based on this, it is expected that rates in women in other alcohol recovery programs will be higher as well. Further study in this population that documents rates and explores other variables would be indicated.

In 2001, the Bureau of Justice Statistics reported that rates of domestic violence vary along several lines, including race, gender, economic and educational status, and geographical location. Their findings conclude that women made up 75% of the victims of homicide by an intimate partner, and 85% of the victims of non-lethal domestic violence; that is five times that of males. Black females experienced domestic violence at a rate 35% higher than white females, and about 22 times the rate of women of other races. They also found that domestic violence is most prominent among women aged 16 to 24. Poorer women experience significantly more domestic violence than higher income women. Women with less than a high school education experienced significantly more violence than women with at least some college education.

Finally, divorced or separated women were subjected to the highest rates of intimate partner victimization, followed by never-married women. Another interesting finding in this study is that Hispanic and African American women report IPV at the highest rate (approximately 65% to 67% of abuse is reported). For white females, only about 50% of the abuse is reported. This study suggests that income and education are important factors to examine when studying IPV. Moreover, from previous studies it would be helpful if additional research addressed education and income factors related to IPV.

Chase, et al (2003) completed a study describing the extent of IPV among female alcoholic patients and the factors associated with it. They report the following demographic background variables as predictors of increased violence; less educated, lower incomes, and a trend toward being younger than the non-violence counterparts. The two significant variables were education ( $p = .02$ ), and couple income ( $p = .017$ ). Again, further research that validates these variables should be conducted.

The 2004 Uniform Crime Report compiled by the Michigan State Police stated that young women age 16-24 experience the highest rate of domestic violence – 16 per 1000 persons. In contrast, Dr. Weitzman (2000), in her book, “Not to People Like Us: Hide Abuse in Upscale Marriages”, studies the wives and partners of professors, lawyers, doctors, banker and traders. What emerged was a profile of women with a joint income of more than \$100,000 per year, who live in upper middle class or higher neighborhoods, perceive themselves to be upper middle class or upper class, and hold at least a bachelor’s degree. Although these women are equally vulnerable to domestic violence, they are isolated from the social services available in abusive relationships and are forced by shame and community pressure to hide behind a self-imposed veil of silence. “Intimate partner violence is an epidemic affecting Americans in all

communities, regardless of age, economic status, race religion, nationality or educational background” (National Coalition Against Domestic Violence, 2004). This statement is somewhat contradictory to the prior studies that identified lower age, income, and education as predictors of higher rates of IPV making it important to conduct further research.

The 2004 Uniform Crime Report compiled by the Michigan State Police states that from October 2003 to September 2004, domestic violence programs in Michigan received 55,208 crisis calls, an average of 151 crisis calls per day. Approximately 65% of these involve intimate partner violence. From 1999-2001, a total of 316 violent deaths connected to intimate partner relationships were registered in the Michigan Intimate Partner Homicide Surveillance System. Of these 316 fatalities, 192 were intimate partner homicides and 124 were intimate partnership-related deaths. This crime report broke down the reports of IPV by Michigan counties. For the purposes of this study, two county’s statistics are reported. There were 369 reports of IPV in Livingston County. Washtenaw County statistics reveal 1,432 reports of IPV for the same year. Based on these numbers, which are similar to the national rates of IPV in the general population, research conducted in these counties on IPV will be likely to identify cases of IPV.

To summarize, the review of the literature showed that there are high rates of IPV across the country. There are many factors that influence these rates including substance abuse. There is considerable controversy regarding the variables of age, income and education as their relationship to IPV. Further research that identifies factors predictive of IPV is needed.

## Chapter IV

### Research Question

The purpose of the study was to examine the following: Do age, income and/or years of education play a role as predictors of IPV among alcoholic women in Washtenaw and Livingston Counties?

The following hypotheses were proposed:

Hypothesis #1: The majority of women studied will have a high lifetime prevalence of IPV.

Hypothesis #2: Those women who are older and have higher levels of income and higher levels of education will experience less one year prevalence of IPV.

### Definition of Terms

The definitions used in the study are as follows:

IPV is defined as physical, sexual, verbal or psychological abuse that controls or intends to control another person's behavior.

Substance abuse is defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as a substance use disorder characterized by the use of a mood or behavior-altering substance in a maladaptive pattern resulting in significant impairment or distress, such as failure to fulfill social or occupational obligations or recurrent use in situations in which it is physically dangerous to do so or which end in legal problems, but without fulfilling the criteria for substance dependence.

Alcoholism is the habitual excessive drinking of alcoholic liquor, or a resulting diseased condition.

Alcoholic's Anonymous (1939) is a fellowship of men and women who share their experience, strength, and hope with each other in order that they may overcome their alcoholism. The 12 steps of recovery are utilized.

## Chapter V

### Methodology

The study examined predictors of IPV in women in a substance abuse recovery program. A convenience sample (n = 99) of women age 18 and older who attend Alcoholic's Anonymous meetings in Livingston and Washtenaw Counties during the fall of 2006 were asked to complete a demographic data sheet and a 10 item questionnaire. The demographic data included age, marital status, personal and household income, years of education, and current employment status. Permission by its author for the use of the 10 item tool was granted. This tool included six questions from the Severity of Violence Against Women Scale (SVAWS), two questions from the Abuse Assessment Scale (McFarlane, Greenberg, Weltge, & Watson, 1995), and two questions from another screening instrument validated in Emergency Departments (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995). Women were coded as having experienced recent IPV if they endorsed at least one of the ten items assessing experiences with IPV within the previous 12 months. The last four questions were also used to determine past experiences with IPV (See Appendix A for individual items). This anonymous and voluntary survey instrument was distributed and immediately collected by the researcher at (after) Alcoholic's Anonymous meetings. Also included in the participant packet were an explanatory cover letter (Appendix B), and a list of community resources (Appendix C).

## Chapter VI

### Reliability of the Tool

The alpha coefficient for the survey instrument was high ( $\alpha = 0.85$ ), indicating internal consistency. The six items chosen from the SVAWS represented three different types of abuse that women may face: threats, physical assault, and sexual assault. Although these items were culled from a longer instrument, they had high internal consistency ( $\alpha = 0.88$ ) and convergent validity. A factor analysis conducted on these items indicated that they represented a single underlying latent construct. The four other items used to assess patients' experiences with IPV came from two scales that have been used in studies conducted in medical settings. The two items from The Abuse Assessment Scale ask about behaviorally specific types of physical and sexual violence that the women may have experienced and had high specificity with the SVAWS; 93% of women who did not report any physical violence on the six-item SVAWS also did not report any violence on the two-item Abuse Assessment Scale. The two items derived from the study by Abbot, et al in the emergency departments were used because they assess broader forms of violence that include threats and fear.



## Chapter VII

### Results

In this chapter a description of the sample and the statistical analysis of the data related to the research question and hypotheses will be presented. Data was collected from 99 participants ( $n = 99$ ) and the data was entered and verified. There was no missing data on any of the items. The only change in data coding was on the demographic sheet under education. The items “Less Than High School” and “High School” were collapsed into one item, now called “High School or Less”. The reason for doing this is that there were no participants with “Less Than High School”, so the corresponding cell would have contained a “0”. Demographic data included age, marital status, household and personal income, education, and employment status.

The minimum age of the subjects is 18 and the maximum being 71. The mean age is 42.99 with a standard deviation of 11.74. Marital status, personal and household income, employment status and education are described in percentages in frequency tables 1, 2, 3, 4 and 5.

Table 1

#### Marital Status of Participants

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<u>Marital Status</u>	<u>Frequency</u>	<u>Percent</u>
Single	24	24.2
Married	33	33.3
Divorced	26	26.3
Separated	3	3.0
Widowed	3	3.0
Living with partner	10	10.1

Table 2

Household Income

<u>Amount</u>	<u>Frequency</u>	<u>Percent</u>
<\$20,000	18	18.2
\$20,000 - \$49,999	34	34.3
\$50,000 - \$99,999	31	31.3
>\$100,000	16	16.2

Table 3

Personal Income

<u>Amount</u>	<u>Frequency</u>	<u>Percent</u>
<\$20,000	41	41.4
\$20,000 - \$49,999	44	44.4
\$50,000 - \$99,999	12	12.1
>100,000	2	2.0

Table 4

Employment Status

<u>Status</u>	<u>Frequency</u>	<u>Percent</u>
Unemployed	27	27.3
Employed	72	72.7

Table 5

Education Level


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<u>Level</u>	<u>Frequency</u>	<u>Percent</u>
High School or Less	10	10
Some College	28	28.3
College Degree	34	34.2
Post-graduate	27	27.3

Only 43% of the participants are actually living in a home with a significant other. It is impossible to report whether the remaining 57% of women are involved in a significant relationship. A great majority (73%) of the women surveyed report that they are currently employed, and personal income levels greater than \$50,000 are only 14%. When household income is reviewed, that percentage rises to 47%.

The reported education data reveals a highly educated group. The vast majority (90%) report at least some college. Only one person reported less than a high school education.

Rates of IPV are also described in percentages in tables 6 and 7. The percentage of women experiencing IPV in the past 12 months is 20%, while those women reporting a lifetime prevalence of violence is 76%.

Table 6

IPV in the Last 12 Months

<u>IPV</u>	<u>Frequency</u>	<u>Percent</u>
Violence	19	20.0
No Violence	80	80.0

Table 7

IPV – Lifetime Prevalence

<u>IPV</u>	<u>Frequency</u>	<u>Percent</u>
Violence	76	77.0
No Violence	23	23.0

Chi square testing was performed on the variables education and employment. The results are that the two variables are not associated and can be considered as independent predictors of violence:  $X^2(3, N=99) = 3.606, p=.307$ .

A logistic regression analysis was performed with the dependent variable being violence (either 12 month or lifetime prevalence) and the independent variables being education, employment, age, and household income. Which of these factors has the highest correlation with violence after taking other factors into account? Education is the dominant predictor of violence with a  $p = .027$ , as seen in table 8. Those with post-graduate education are 95% less likely than those with a high school or less education to be exposed to violence in the past year. None of these variables were predictors of any lifetime violence.

Table 8

Past Year Violence as it Correlates with Age, Income, Employment and Education

Variable	B	S.E.	Significance
Age	-.037	.031	.240
Income	-.032	.811	.969
Employment	-1.086	.742	.143
Education	-2.333	1.058	<b>.027</b>

## Chapter VIII

### Discussion

This chapter consists of the discussion related to the hypotheses. Recommendations for further study are included.

Margaret Kearney's Truthful Self-Nurturing Theory speaks about women in addiction demonstrating self-destructive self-nurturing behaviors. Certainly being a victim of alcoholism is self-destructive, as is being a victim of abuse. Therefore, this theory can also be descriptive of a female victim of IPV. As Fals-Stewart & Kennedy found in their 2005 study, women experiencing IPV share the same feelings of isolation, guilt, shame, low self-esteem, and problem denial as do women with substance abuse issues. Alcoholism and partner abuse are both examples of self-destructive, self-nurturing. The women in this study are all alcoholic and the vast majority are, or have been, victims of violence. However, the same vast majority are able to achieve truthful self-nurturing, most likely due to entering a recovery program. As Kearney states, there are three areas of change required; abstinence work, self-work, and connection work. By utilizing the recovery program of Alcoholic's Anonymous, healthy behaviors became more desirable than the unhealthy ones. Abstinence from alcohol and abusive relationships is the first step in this process of change. The self-work is the most formidable. It involves changing not only what you do, but also how you think. The connection work with others in recovery and with a "higher power" eases the enormity of the self-work. This connectedness offers hope, security, and unconditional love. The majority of women in this study have found new and healthy ways to nurture themselves. Therefore, the findings of this study are supported by Ms. Kearney's theory.

The rate of lifetime prevalence of IPV among the women in this study is 76%. This is consistent with what McCloskey reported in her 2005 study. It is remarkable however that while such a vast majority report IPV at some time in their lives, the percentage of women reporting violence in the past 12 months is actually below the reported national average. Again, this is most likely due to the fact that the women surveyed were all in a substance abuse recovery program where they focused on positive self-nurturing. This setting of recovery may be protective of IPV or incompatible with IPV.

In the 2005 Weinsheimer study of women in trauma centers, 12 month IPV was found in 59% of those who were still drinking, but down to 13% for those not drinking. Similarly, this study demonstrates comparable results when looking at the past 12 months, as the rate of IPV dropped to 20% from a lifetime rate of 76%. It is unclear, from this study, whether being in recovery from alcohol is protective of IPV or coincides with a decrease in IPV as the length of time in recovery and length of time away from the violent relationship was not examined.

In this study, age was not a significant predictor for IPV, which is inconsistent with the 2001 Bureau of Justice Statistics' statement. The Bureau's report concluded that IPV is most prominent among women 16-24 years of age. One of the limitations of this study is that only women 18 years and older were surveyed.

Of the variables measured, only education was shown to be a statistically significant indicator for IPV ( $p = .035$ ). Those with post-graduate education are 95% less likely than those with a high school or less education to be exposed to violence in the past year.

Several previous studies have suggested a relationship between IPV and the variables of age, income, and education. The data in this study does not support these findings, except in education. It is possible that higher income and age were cancelled out as factors that decrease

rates of IPV in the general population when combined with the more predictive factor of alcohol abuse.

One implication of this study for nurse practitioners includes screening for high risk women. Many studies support that routine screening should be implemented for IPV, yet healthcare professionals continue to be lax in this area. There continues to be a reluctance to ask women, even those with obvious trauma, if they feel safe in their environments. This reluctance has been blamed on not wanting to embarrass the woman, especially if she comes from middle to upper class home. Yet McCloskey and others have shown that “asking” is the key to revealing the truth. Many screening tools have been created and validated, yet there is still great resistance at pursuing the topic of partner abuse. Nurse practitioners are in a strategic position to become pro-active at recognizing women at risk, and then launching appropriate treatment and referral. This study, along with several others, assists in the identification of high risk women. The most obvious factor is the history of substance abuse, especially for those women who have not entered a recovery program. It also supports the conclusions that the more years of formal education a woman receives, the less likely she is to be in a violent relationship.

As healthcare providers, we are expected to function under guidelines provided by the American College of Obstetrics and Gynecology, the American Heart Association, the American Cancer Society, etc... We screen patients for cancer, hyperlipidemia, diabetes, etc., with screening tools that are considered standards of care. The information presented in this study supports the need for a standard of care for women in substance abuse treatment programs that include routine screening for IPV.

As stated earlier in this discussion, one of the limitations of this study is that no women younger than 18 were included. Another limitation is that the size of this convenience sample is



only 99 subjects. Therefore, the results are more difficult to extrapolate to the general population. Also, this convenience sample was from two counties in Michigan that are predominantly white and middle to upper class. This limits the external validity of the results. If this study was to be duplicated in a different population, it is possible that the results would differ.

This study certainly illustrates areas for further research. As mentioned earlier, it would be revealing to know how long these women had been in active recovery from alcoholism and when they last experienced IPV. There appears to be a correlation between recovery from alcoholism and decreased rates of IPV. Further qualitative or quantitative research might examine this relationship in more detail. In depth interviews of women in this setting could shed light on this.

## Chapter IX

### Conclusion

Intimate Partner Violence is a growing concern in the United States. Females are at a much higher risk than their male partners. Alcoholic females are one of the highest risk groups. Traditionally, healthcare workers are reluctant to question women about partner violence, despite the research that supports doing so, and organizations that advocate regular screening. Nurse practitioners are on the front-line of primary and secondary prevention in healthcare and employ multiple screening tools in their endeavors. It is not easy to recognize a woman who is being abused, as this abuse is not restricted to the poor, the uneducated, or the young. As this study supports, the only statistically significant variable is that of formal education, with those women having the highest number of years of formal education having the least risk. Abuse happens in all socioeconomic arenas, so screening those women most at risk is essential for early identification, treatment, and referral.

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Appendix A

Demographic Data and Questionnaire

## Demographic Data

1. **Age. Please state your current age in years.** \_\_\_\_\_

2. **Marital status. Please circle one.**

Single      Married      Divorced      Separated

Widowed      Living with partner

3. **Your household income. Please circle one.**

<\$20,000      \$20,000 - \$50,000      \$50,000 - \$100,000  
>\$100,000

4. **Income earned by you. Please circle one.**

<\$20,000      \$20,000 - \$50,000      \$50,000 - \$100,000  
>\$100,000

5. **Are you currently employed? Please circle one.**

Full-time      Part-time      Unemployed

6. **If employed, please enter your job title.** \_\_\_\_\_

7. **Your years of education. Please circle one.**

Less than high school      High school      Some college

College degree      Post-graduate

**For each of the following questions, circle either Yes or No.**

**In the past 12 months,**

- |   |     |    |
|---|-----|----|
| 1. <b>Has a partner</b> threatened to hurt you? | Yes | No |
| 2. Pushed or shoved you?                        | Yes | No |
| 3. Slapped you around your face and head?       | Yes | No |
| 4. Punched you?                                 | Yes | No |
| 5. Threatened you with a gun?                   | Yes | No |
| 6. Physically forced you to have sex?           | Yes | No |

**At any time in your life, has any partner**

- |  |     |    |
|--|-----|----|
| 7. Hit, slapped, kicked, or otherwise physically hurt you?               | Yes | No |
| 8. Forced you to have sexual activities?                                 | Yes | No |
| 9. Made you feel stressed or afraid through threats or violent behavior? | Yes | No |
| 10. Made you fear for your safety during arguments?                      | Yes | No |

Appendix B

Cover letter



Hi, my name is Laura Goldman. I am a Family Nurse Practitioner student at the University of Michigan – Flint. I am conducting a study that looks at women with substance abuse and the rates of intimate partner violence.

This study is totally voluntary and anonymous. Attached is a questionnaire that should take you about 5 minutes to complete. After completion, please place it in the box provided. If you do not wish to complete this form, simply turn it back blank, or throw it away. Again, this is a completely anonymous and voluntary survey. If you have any questions about this study, please contact the University of Michigan – Flint Nursing Department at 810-766-6858. Thank you for your time in considering participation in this study.

Appendix C  
Community Resources

## Community Resources

### Washtenaw County:

The Domestic Violence project/SAFE House provides support, assistance and information for survivors of domestic violence. Their 24 hour crisis line number is 734 995-5444.

The U of M Sexual Assault Prevention and Awareness Center provides services for the U of M community. Their 24 hour crisis line number is 734 936-3333.

The MWorks Employee Assistance Program offers consultation and counseling services to UMHS faculty, staff and their families. Contact the MWorks EAP at 734 763-5409.

First Step Domestic Violence & Sexual Assault: 734 459-5900

### Livingston County:

National Domestic Violence Hotline: 800 799-7233  
OR 800 787-3224

Lacasa 2895 W. Grand River Ave. Howell  
517 548-1350

Women's Resource Center 3471 E. Grand River Ave. Howell  
517 548-2200

Livingston Family Center 4736 E. M-36 Pinckney  
810 231-9591

## Appendix D

### Institutional Review Board Approval



Flint Institutional Review Board (IRB) • 530 French Hall, 303 E. Kearsley St, Flint, MI 48502 • phone (810) 762-3383 • fax (313) 593-0526 • [research@umflint.edu](mailto:research@umflint.edu)

**Date:** 8/1/2006

**To:** Dr. Constance Creech

**Cc:** DRDA, IRB Flint

**Subject:** Initial Study Approval

**The Flint Institutional Review Board (IRB)** has reviewed and approved the research proposal referenced below. The IRB determined that the research is compliant with applicable guidelines, state and federal regulations, and the University of Michigan's Federalwide Assurance with the Department of Health and Human Services (HHS).

**Any proposed changes/amendments in the research (e.g., personnel, procedures, or documents), no matter how minor, must be approved in advance by the IRB unless necessary to eliminate apparent immediate hazards to research subjects.**

**The approval period for this project is listed below. Please note your expiration date.**

If the project is scheduled to continue beyond this date, submit a Scheduled Continuing Review application **at least two months prior** to the expiration date to allow the IRB sufficient time to review and approve the project. **If the approval lapses, no work may be conducted on this project until appropriate approval has been obtained, except as necessary to eliminate apparent immediate hazards to research subjects.**

**The IRB must be informed of all unanticipated or adverse events** (i.e., physical, social, or emotional) or any new information that may affect the risk/benefit assessment of this research.

The online forms for amendments, adverse event reporting, and scheduled continuing review can be obtained by accessing the eResearch workspace for this approved study at <https://eresearch.umich.edu>.

**It is expected that only the current IRB-approved version of the informed consent document(s) will be used in conjunction with this research.** To obtain and download a copy of the current IRB-approved informed consent document(s), PIs and Study Staff should access the eResearch workspace for this approved study and view the "Documents" tab.

**Submission Information:**

Title: Rates of Intimate Partner Violence of Women with Substance Abuse

Full Title:

IRB File Number: HUM00006616

Initial IRB Approval Date: **8/1/2006**

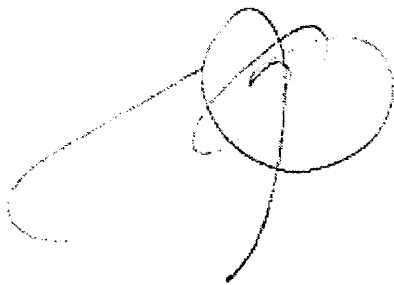
Current IRB Approval Period: **8/1/2006 - 7/31/2007**

Expiration Date: **7/31/2007**

eResearch workspace: [Rates of Intimate Partner Violence of Women with Substance Abuse](#)

UM Federalwide Assurance: FWA00004969 Expiration May 10, 2009

Sincerely,

A handwritten signature in black ink, consisting of several loops and a long horizontal stroke extending to the left.

**Marianne McGrath**  
Chair, IRB Flint