

# Victims as Victimizers

## Physical Aggression by Persons With a History of Childhood Abuse

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**Background:** Substance abuse has been called the dominant characteristic of families involved in child abuse cases, but the frequency with which childhood victims become adult victimizers remains uncertain.

**Objective:** To examine whether a history of childhood sexual or physical abuse is associated with becoming a victimizer (ie, abusing or assaulting others) as an adult.

**Methods:** Interview data were collected from 439 persons in Providence, RI, from July 1997 through March 1998 who had a history of intravenous drug use. Victimizers were defined as adults who had ever physically abused or assaulted a family member or sexual partner (eg, kicked, hit, choked, shot, stabbed, burned, or held at gunpoint). We compared persons who had a history of victimizing others with those who did not have such a history by bivariate and multivariate analyses. Variables included demographic factors as well as a history of sexual or physical abuse before the age of 16 years.

**Results:** The prevalence of childhood physical or sexual

abuse was 51% for women and 31% for men. Seventeen percent of our subjects reported being victimizers. Among persons who reported being victims of either physical or sexual childhood abuse, 28% victimized others; among those who denied a history of childhood abuse, 10% victimized others. Two thirds of victimizers reported being intoxicated while assaulting others. When we used logistic regression to control for sex, having children, education, race, and history of incarceration, childhood abuse was significantly and independently associated with becoming a victimizer (odds ratio, 3.6; 95% confidence interval, 2.1-6.1).

**Conclusions:** Large numbers of intravenous drug users, both men and women, have victimized family members or sexual partners. We confirm a high rate of childhood abuse among this population and demonstrate that among intravenous drug users past abuse is associated with becoming a victimizer as an adult. Primary care providers should be alert to this cycle of violence.

*Arch Intern Med.* 1999;159:1920-1924

**P**HYSICAL ASSAULT is a common occurrence in the United States; according to 1994 estimates, 6.6 million men and 5 million women are assaulted annually.<sup>1</sup> Although men are, overall, victims of violent crime more often than women, women are 5 to 8 times more likely to be victims of assault in the context of intimate relationships.<sup>1,2</sup> Among men, approximately 150 000 reported violent crimes against them by an intimate partner each year; among women, 1 to 4 million are physically assaulted by intimate partners each year.<sup>3</sup>

Persons with a history of intravenous drug use commonly experience violence in their lives.<sup>4</sup> Urban living, unemployment, and homelessness are overlapping factors that contribute to this violence.<sup>5</sup> While violence among adults in the drug trade is common, many people

who abuse drugs have also experienced violence as children. In studies of populations with substance abuse, a history of childhood sexual abuse is as high as 60% and a history of childhood physical abuse has been reported in nearly 40% of women.<sup>6,7</sup> The relationship between physical or sexual assault and substance abuse, each potentiating the other, has been described in detail elsewhere.<sup>8</sup> Persons who experience childhood abuse but not abuse as adults have levels of physical and psychological problems as severe as those persons reporting current adult abuse; this again suggests that the effects of childhood assault are long-term.<sup>9</sup>

The cycle of violence (ie, victims of childhood abuse later become perpetrators of violence) has been studied intensively for the past decade by social scientists.<sup>10</sup> However, studies of victimizers have been limited to persons already within the

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## SUBJECTS AND METHODS

From July 1997 through March 1998, we recruited persons from the Providence, RI, Needle Exchange Program (NEP) and from Codac Inc, Rhode Island's largest methadone maintenance treatment program (MMTP), for a study of health service utilization among intravenous drug users. Inclusion criteria limited participants to those who spoke English, were not pregnant, were 18 years or older, and had a history of intravenous drug use. Individuals recruited from the Codac Inc MMTP were limited to those enrolled for at least 6 months. Individuals recruited from the NEP included anyone who had exchanged needles at least once and had received no formal drug abuse treatment in the last 6 months. The Rhode Island Hospital Institutional Review Board approved the study, and informed consent was obtained from all participants.

Because of the anonymous nature of needle exchange, we recruited NEP clients to a separate research site. During the initial study visit, all NEP subjects presented their study cards (received from the NEP coordinator), underwent urine toxicologic testing (to confirm heroin or cocaine use), underwent HIV testing using OraSure saliva-based testing (Epitope Inc, Beaverton, Ore), and received a 45-minute face-to-face interview with study staff. Persons recruited from the MMTP were interviewed at Codac Inc and underwent the same interview with study staff as well as HIV testing. The questionnaire included sections on demographics, health service use, and violence. Persons completing the research assessment received \$40. Information was collected in private rooms by 5 experienced female interviewers.

A history of childhood (age <16 years) abuse was obtained through 8 questions about physical and sexual abuse. A history of childhood physical abuse was assessed by the question, "Have you ever been physically abused or assaulted by a family member or someone you know (for example: kicked, hit, choked, shot, stabbed, burned, or held

at gunpoint)?" If subjects responded "yes," they were asked, "How old were you the first time you were physically assaulted?" A history of childhood sexual assault was assessed by the question, "Have you ever been sexually assaulted by a family member or someone you know (for example: unwanted sexual touching anywhere on your body, touching of genitals and/or breasts, or made to have oral sex or vaginal or anal intercourse against your will by force or threat of force)?" If subjects responded "yes," they were asked, "How old were you the first time you were sexually assaulted?" These 4 questions were repeated, asking about physical or sexual assault by a stranger. Persons reporting either physical or sexual abuse were asked, "Have you ever received counseling for your physical or sexual abuse?"

Victimizers were defined as persons who responded affirmatively to the question, "As an adult, have you ever physically abused or assaulted a family member or sexual partner (for example: kicked, hit, choked, shot, stabbed, burned, or held at gunpoint)?" If individuals responded that they were victimizers, they were also asked if they were intoxicated or high at the time.

Demographic characteristics of the sample were studied for the entire cohort and stratified by sex. Continuous variables were summarized as means; categorical variables were summarized as proportions. A study of the association of victimizer status with a number of demographic factors was conducted in 2 steps. Possible predictors of victimizing behavior were included individually in univariate logistic regression models with victimizer status as the response. All predictors associated with a significance level of  $P \leq .30$  were also included in a multiple logistic regression procedure that used a stepwise selection method requiring a significant improvement of fit ( $P \leq .05$ ) to enter the model and significance of the covariate ( $P \leq .05$ ) to stay in the model. All possible 2- and 3-way interactions among variables were tested, and those significant at  $\alpha = .05$  were kept in the final model. All analyses were performed using SAS statistical software (SAS Institute Inc, Cary, NC).

criminal justice system, to persons present at scenes of domestic assault, and to surveys of child protective service agencies, in which child physical abuse and neglect has again been linked to parental drug disorders.<sup>11,12</sup> Biases associated with recruitment of victimizers drawn from such sources are well known.<sup>10</sup> Nonetheless, substance abuse has been called the dominant characteristic of families involved in child abuse cases,<sup>13</sup> and drugs are commonly present in settings of domestic violence.<sup>11</sup>

The cyclical progression from childhood abuse to adult intravenous drug use to victimizing others is the subject of this report. We are aware of no studies that examine the epidemiological characteristics of assault in a population that commonly seeks medical care. In this study, we (1) determined the prevalence of previous childhood abuse in a population of intravenous drug users; (2) determined the prevalence of intravenous drug users victimizing others; (3) identify factors, including a history of childhood sexual or physical abuse, that are associated with becoming a victimizer; and (4) describe how frequently victimizers report intoxication at the time of assault.

## RESULTS

**Table 1** demonstrates the demographic characteristics of the population of 439 intravenous drug users. This group had a mean age of 39 years and included 40% women. Fifty-four percent were recruited from the MMTP and 46% from the NEP. Sixteen percent were married, 76% were white, 26% had completed more than a high school education, 81% had a history of incarceration, and 66% had children. Women were less likely than men to be recruited from the NEP and to have been in prison, but they were more likely to have had children. The mean age of first drug use was 23 years.

In **Table 2**, we describe demographic characteristics according to reported history of childhood physical or sexual abuse. A history of being physically or sexually abused prior to age 16 years was reported by 38% of the subjects (51% women, 31% men). Forty percent of women reported childhood physical abuse and 39% reported childhood sexual abuse. Twenty-six percent of men reported childhood physical abuse and 12% reported childhood sexual abuse. There was no significant differ-

**Table 1. Demographics of Study Population by Sex\***

Characteristics	No. of Subjects (%)		
	Total (N = 439)	Women (n = 174 [40%])	Men (n = 265 [60%])
Mean, age, y	39	38	40
Needle exchange program	204 (46)	67 (39)	137 (52)
Methadone maintenance treatment program	235 (54)	106 (61)	129 (49)
Married	69 (16)	24 (14)	45 (17)
Race/ethnicity			
White	334 (76)	128 (74)	205 (78)
African American	65 (15)	31 (18)	34 (13)
Hispanic	29 (7)	10 (6)	19 (7)
Other	10 (2)	4 (2)	6 (2)
Education			
Less than high school	164 (37)	65 (37)	99 (37)
High school or GED	163 (37)	62 (36)	101 (38)
More than high school	112 (26)	47 (27)	65 (25)
Ever in prison	353 (81)	119 (68)	234 (89)
Had children	288 (66)	127 (73)	161 (61)

\*GED indicates General Educational Development certificate.

**Table 3. Factors Associated With Victimizer Status\***

Variable	No. of Subjects	No. of Victimiters	Odds Ratio (95% CI)
Abused before age 16 y	165	46	3.6 (2.1-6.1)
Physically abused before age 16 y	54	38	3.0 (1.8-4.9)
Sexually abused before age 16 y	98	25	2.1 (1.2-3.6)
Ever incarcerated	349	62	1.7 (0.8-3.6)
Had children	282	53	1.6 (0.9-2.8)
Some education after high school	112	25	1.5 (0.8-2.7)
Completed high school only	161	21	0.8 (0.4-1.4)
Currently married	69	8	0.6 (0.3-1.3)
Women	168	32	1.3 (0.8-2.2)

\*CI indicates confidence interval.

ence between the 2 recruitment sites in the prevalence of reported child abuse. Age, race, marital status, education, history of incarceration, and having ever had children were not associated with a history of childhood abuse.

Seventeen percent of our subjects (n = 72) reported being victimizers. Fifteen percent of men and 18% of women were victimizers. Among persons who had never experienced any form of childhood abuse, 10% became victimizers (9% women, 11% men). Among the 169 people who reported either physical or sexual abuse in childhood, 28% became victimizers (equal proportions of men and women). Overall, 67% of victimizers reported being intoxicated or high while assaulting others.

When we used a multiple logistic regression model (**Table 3**) to control for sex, having children, education, race, and a history of imprisonment, persons re-

**Table 2. Demographic Characteristics According to Reported Childhood (Age <16 y) Physical or Sexual Abuse\***

Cohort	No. of Subjects		
	Abused as a Child	Not Abused as a Child	Total
Methadone maintenance treatment program	90	144	234
Needle exchange program	79	125	204
Sex			
Men	81	183	264
Women	88	86	174
Age, y			
18-30	32	48	80
31-40	67	101	168
>40	70	120	190
Race			
White	131	202	333
Person of color	37	67	104
Marital status			
Currently married	25	44	69
Not currently married	144	224	368
Education			
Less than high school	69	94	163
High school or GED	61	102	163
More than high school	39	73	112
Ever in prison			
Yes	135	217	352
No	33	51	84
Children			
Yes	112	175	287
No	57	94	151

\*GED indicates General Educational Development certificate.

porting childhood abuse were more likely to become victimizers than persons who reported no history of childhood abuse (odds ratio [OR], 3.6; 95% confidence interval [CI], 2.1-6.1). Persons who reported childhood physical abuse were more likely to become victimizers (OR, 3.0; 95% CI, 1.8-4.9) than persons who reported no history of abuse. A history of childhood sexual abuse was also associated with becoming a victimizer (OR, 2.1; 95% CI, 1.2-3.6) and differed by sex (OR, 1.6; 95% CI, 0.7-3.8 for men; OR, 2.4; 95% CI, 1.2-5.3 for women). The significance of 1 predictor, having completed more than a high school education, increased markedly in the multivariate model ( $P = .22$  in a model that included education alone;  $P < .05$  in a model that included a history of physical abuse), suggesting an interaction between higher education and a history of abuse.

Among persons who reported childhood abuse, 30% had received counseling. Persons who received counseling were as likely to victimize others as those who never received counseling (27% and 28%, respectively).

## COMMENT

According to the cycle of violence hypothesis, intravenous drug users who have experienced childhood abuse are at high risk for perpetrating assault as adults. In this study, we demonstrated that 17% of persons with a history of intravenous drug use had victimized family mem-

bers or sexual partners. We also demonstrated the strength of the association between the experience of childhood abuse and becoming a victimizer. These findings, in conjunction with the fact that drug users often interact with health care providers, suggest that open discussion of the risk of victimizing others should be included in the care of this population.

**O**UR FINDING of a 51% prevalence of physical or sexual childhood abuse in women substance abusers is similar to that in previous reports.<sup>6,7,14</sup> The finding that 31% of men with a history of intravenous drug use experienced childhood abuse is higher than rates found in non-drug use samples.<sup>15,16</sup> Rates of childhood sexual and physical abuse that are reported to child protective services among the general population are 2.1 and 5.0 per 1000 children, respectively.<sup>17</sup>

It is important to note that in our study the majority of those who were abused as children did not become victimizers. While childhood abuse increases the risk of becoming a victimizer, it is likely to be 1 among a constellation of risk factors.<sup>18</sup> In addition, unidentified correlates of childhood abuse that are independent risk factors for becoming a victimizer could explain the positive results of our study. Further research is needed to better understand the mechanisms that link childhood victimization to violent adult behavior.

Although the lives of persons who use intravenous drugs are often violent, we were surprised to discover that 17% of our sample reported victimizing others. To maximize truthfulness, we did not include detailed questions about who was victimized. Victims may have been adults or children, and we did not obtain information about the timing of the victimizers' assaults. We do not know whether the assaults occurred recently or in the distant past. However, 67% of victimizers reported being intoxicated or high at the time they committed assault. We also did not obtain information about the frequency or intensity of the assaults. The listed behaviors have a range of potential injury outcomes (ie, the effects of hitting are different from those of stabbing).

Only 30% of the cohort who reported childhood abuse had received counseling. Screening patients for childhood abuse and referring them for counseling should be part of the primary care of this population. While counseling was not associated with lower rates of victimizing others in our study, we did not obtain information regarding the timing of such counseling; it may be that individuals only sought counseling after becoming victimizers themselves.

Our study is unique in reporting violence toward sexual partners or family members that may not have resulted in criminal charges. Other investigations documenting an intergenerational cycle of violence have only considered adult criminality or violent criminal behavior rather than the broader categorization of violence we used in our study.<sup>10,19,20</sup> By including only criminal violence, these studies may have been confounded as a result of the process of reporting abuse or by referral bias in the judicial system. Previous findings may have also

underestimated the relationship between early childhood victimization and subsequent violence by truncating the follow-up of persons with a history of child abuse in early adulthood.

Community-based studies have distinguished assaulting children from assaulting adults.<sup>21</sup> In a survey of 11 662 individuals at 4 sites, 1.4% reported abusive behavior toward children. Those reporting abusive behaviors were more likely to have alcohol or drug abuse disorders than matched controls.<sup>21</sup> Data from the National Survey of Families and Households revealed that 4.9% of married men and 6.2% of married women had become physically violent during an argument in the past year, and 1.1% of women and 0.3% of men reported that they were cut, bruised, or seriously injured during an argument.<sup>22</sup>

Our cohort provided a unique opportunity to examine the prevalence of violent behaviors in a population at high risk for violence. There are limitations to this study in addition to those already discussed. Because there is no criterion standard for violent action, this survey relied on self-reporting; self-reporting remains the only data source for a broad range of violent behaviors. It is possible that the observed data may be a result of a differential willingness to report certain actions. Therefore, the fact that men and women reported equal rates of victimizing others may be a true result or may be owing to differential responses (ie, women's greater willingness to acknowledge and disclose certain information). Additionally, equal rates of perpetration of violence may not translate into equal rates of injury. It is possible that women who are victimizers may be responding to violence directed at them; our questions did not assess who initiated the violence or whether the action was performed in self-defense. Finally, while we have no strict definition of substance abuse, this cohort of intravenous drug users clearly had a history of chronic illicit drug use, and nearly half are currently in methadone treatment programs. Still, we cannot extrapolate our findings to persons with lesser patterns of substance use. It may be that intravenous drug users are more susceptible to negative outcomes because of their history of childhood abuse and have poorer skills for coping with early trauma than other populations. While our study allowed us to compare persons with and without histories of childhood abuse, we did not have a control group of non-drug users.

Confirming a cycle of violence and establishing its effect size allows us to clearly understand the importance of developing interventions that are focused on this population that is at risk for becoming victimizers. Violence, particularly family violence, is of special interest to health care providers, who may readily detect behaviors that are never reported to criminal justice agencies. The experience of child abuse, like drug abuse, is commonly concealed from persons other than health care professionals. The cycle of violence suggests that yesterday's victims become tomorrow's victimizers. Social scientists have urged early identification of childhood abuse because of evidence that the earlier the child can begin recovery from this trauma, the better the prognosis for improved adult functioning.<sup>23-25</sup> Seen in this light, screening intravenous drug users for a history of childhood abuse may be seen as a form of preventive medicine not only for the victim but also for potential family

members and intimate partners who may be at risk for future violence.

Two questions that may be used to screen for and open communication with high-risk patients are: "People who have had experiences like you describe often have difficulties resolving conflicts. Do you find that you have problems resolving conflicts without becoming very angry?" and "All couples and family members have disagreements. When you have a conflict how do you usually resolve it?" If a patient responds affirmatively, clinicians may then probe further regarding victimization and violent behavior (ie, "Have you ever been hit, slapped, or had things thrown at you? Do you ever hit, slap, or throw things at someone?"), or physicians may choose to refer a patient who responds affirmatively for counseling. Clinicians must be aware of laws that mandate the reporting of any violence involving children, the elderly, the disabled, or in which a weapon is used. Treatment options for violence prevention are limited and usually focus on those mandated by the courts. For referral numbers, health care providers should call their local rape crisis hotline or domestic violence shelter.

Our results suggest that when caring for intravenous drug users with a history of childhood abuse, health care providers should screen for and address the risk of aggressive behavior toward family members or intimate partners. As clinicians, we must be mindful that the purpose of screening is not to pass judgment but to prevent future episodes of violence.

Accepted for publication January 25, 1999.

This study was supported by grant RO1-DA-10567 from the National Institute on Drug Abuse, Bethesda, Md.

Presented at the 20th Annual Meeting of the Society of General Internal Medicine, Chicago, Ill, April 23-25, 1998.

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