ORIGINAL COMMUNICATIONS

TREATMENT OF VIOLENT FAMILIES

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Family violence is responsible for a significant proportion of homicides, a major cause of premature deaths in African-Americans. This article reviews the prevalence of family violence and explores associated risk factors. Principles and tips of treatment, along with a cognitive framework to guide the actual therapy, are outlined. Finally, issues of preventing family violence are discussed.

Key words • family • violence • treatment

Homicide is a significant cause of premature deaths in African-Americans,[1] and homicide from family violence has been shown to be disproportionately higher African-Americans than other ethnic groups.[2] As a result, any homicide prevention activities in black communities will have to include the prevention of family violence to have an impact on the rates of homicide for the group.[3]

The purpose of this article is to familiarize the reader with the prevalence of family violence and explore associated risk factors. Principles and tips of treatment are presented to increase the understanding of the treatment of violent families. The stages and strategies of actual treatment are also presented to increase the skill level of the clinician seeking to make an intervention in family violence. Finally, needs of families disrupted by violence and factors necessary to prevent family violence are briefly discussed.

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PREVALENCE OF FAMILY VIOLENCE

At some point, all intimate relationships must deal with conflict or aggression. The question is, "how often does family violence (ie, behavior that outside the family would call for police intervention) occur?" The answer to this question comes from divorce, clinical, emergency room, and general community surveys, as well as family homicide statistics.

Okun's work on the abuse of women noted that the prevalence of spouse abuse in divorce applicants varied but was significant.[4] Levinger[5] reported that 36.8% of women seeking divorce reported family violence, while Fields[6] found that 50% of wives who were applying for divorce reported family violence. A smaller percentage was noted by O'Brien[7] who found that 16.7% of divorce applicants complained of spouse abuse. Parker and Schumacher[8] quantified the assaults of wives seeking divorce and noted that 40% reported being assaulted three or more times, while 66% reported being assaulted at least once.

Clinical surveys also show a wide range of the prevalence of family violence. For example, Mowrer

and Mowrer[9] found conjugal abuse in 41% of couples seeking treatment, while Sanders[10] found 15.6% of couples in treatment reported violence between them. Similarly, emergency room surveys reveal a wide range of prevalence of reported family violence. Rounsaville and Weismann[11] reported that 3.4% of the women presenting to an emergency service were battered by their mates. Stark and Filtcraft[12] reported that 21% of all women who used the emergency surgical service were battered, and one-half of all injuries occurred from abuse. They also noted that one-fourth of all women who attempt suicide are battered women, and for black women, it is one-half of all suicide attempts.

In a general community survey by Straus et al,[13] 16% of marital partners had violence within the past year and 28% have had violence at some time during marriage. Goodwin[14] noted that 25% of all homicides occur between family members, 6% of children are abused each year, 3% of adults have kicked, punched, or bitten a child, 4% of wives are beaten severely each year, and 10% of wives are raped at least once during marriage. She also notes that 80% of spouse abuse, intrafamilial sexual abuse, and elder abuse victims are women. In another community survey in Kentucky, it was found that one out of 10 women had been physically assaulted by their partners the year of the survey.[15] Finally, a Texas survey revealed that 8.5% of the women surveyed were assaulted by their mates.[16]

Family homicide statistics are another indicator of the prevalence of family violence. Boudouris[17] found that 50% to 60% of murderous couples living together had not filed for divorce. Gelles[18] noted that in Atlanta in 1972, 31% of the 255 homicides were domestic. More recently, Straus reported that in 1984, 4408 intrafamilial homicides occurred and at least 2000 were spouse murders. Of the spouses killed, about two-thirds were wives.[19] Block,[20] however, notes that when looking at domestic homicide in blacks, more black wives kill their husbands than black husbands kill their wives. It is important to note that husbands are six to seven times more likely than wives to have initiated abuse and violence that resulted in the husband's murder than vice versa.

Since the beginning of the 20th century, the annual age-adjusted homicide rates of non-whites have been five to 10 times higher than for any other group, [21] and that a significant proportion of these homicides have resulted from domestic violence, strongly indicates that health professionals treating African-Americans should look for risk factors in families to prevent possible domestic violence.

RISK FACTORS

It should be noted that there is a difference between irrational and impulsive behaviors. Family violence is not a sporadic, irrational act; rather, there is usually a reason and pattern leading to the violence, although it is often impulsive. Risk factors increasing the likelihood of these impulsive acts of family violence are classified as physiologic, psychologic, current interpersonal/family relationships, cultural/family background factors, and situational risk factors.[22,23]

Physiologic/medical factors that increase the risk of family violence are mental retardation (for child abuse), dementia in adults (for elder abuse) and current hyper-irritability, hostility, or a "short fuse." Past medical history risk factors are perinatal and early childhood brain insult, brain injury from head trauma, childhood history of serious attention deficit disorder and learning problems, and a childhood history of severe hyperactivity and restlessness. Substance abuse, habitual alcohol abuse and dependence, and poly drug use are also biologic risk factors. Other risk factors are partial complex seizures, intense paroxysmal affects, and sudden mood swings.

The psychologic risk factors are low self concept, failure to achieve, low frustration tolerance, inability to delay gratification, inability to tolerate criticism, and inability to examine one's own behavior. Personality problems that lead to interpersonal conflict are also associated with role distortions, dominance and control issues, and distorted dependency feelings. Additional risk factors are: recent personal history of assaultive behavior, as well as a past history of recurrent violent and assaultive behavior, a history of child abuse or neglect, and a history of juvenile delinquency with under-socialized features. Impulsivity is a risk factor that may manifest as a history of repeated traffic violations, repeated suicide attempts, hypersexuality, emotional lability with excitability and intense interpersonal emotions, and a propensity for acting out dysphoric feelings. Other psychologic risk factors are approval of violence, egocentricity, ie, self-centeredness, social unconcern, and entitlement, cathectic lability, ie, labile object relationships and non-sustained pursuits, and severe or pervasive psychopathology with persecutory delusions.

The next group of risk factors are the current interpersonal or family relationship factors. There may be a symbiotic relationship between the victim and offender that results in hostile dependency that often encourages the isolation, as well as confused and distorted interpersonal attachments, and an unequal

distribution of power and status commonly found in family violence. A good rule of thumb is that if there is an "out-of-control" adolescent, there may be violence in family relationships. Another dynamic may be that one or more members of the family may lack interpersonal skills or become incompetent in the face of stress, resulting in interpersonal frustrations that may culminate in violence. There may be jealousy, interpersonal "paranoia," ie, blame of one's sense of incompleteness, and distorted cognitions and attributions, ie, always expecting an attack. Other factors are pregnancy, previous threats to leave, and child abuse.

The family origin may contribute risk factors, such as violence in the early home environment, and severe psychopathology in parents, ie, alcoholism and sociopathy. The culture of origin may also contribute or decrease the risk of violence in the family. For example, intrafamilial homicide is much less common in Hispanics than in African-Americans or whites.[20,24,25] It is important to obtain a family history of violence and to learn: who in the family was violent to whom? When? How often? It is also important to differentiate whether the violence was expressive or instrumental.[26] Such questions help identify the multifaceted causes of family violence and identifying dynamic family risk factors.

Situational factors may be social or cultural and these two situational factors should be conceptually differentiated, because it is easier to change situational sociologic factors contributing to violence than it is to change cultural situational factors. Violence is commonly associated with the situational sociologic variable of poverty and, in fact, when the variable of poverty is held constant, the disparity between the homicide rates of blacks and whites vanishes.[27] Thus, it appears "the subculture violence"[28] explanations of homicide may be much less important in explaining the higher rates of black homicide, while subcultural factors may explain the lower rates of Hispanic intrafamilial homicide. Other situational factors that increase the risk of violence are the presence of firearms, social isolation, social and structural stress, the perceived level of violence in the immediate community and the need to protect oneself from being victimized, and unstable resources.

PRINCIPLES AND TIPS

Once a violent family has been identified, intervention should be immediate. Unfortunately, the ability of the social service and medical communities to meet the need for intervention is not optimal. There are not enough services or professionals skilled in the intervention of family violence. Thus, it is important to clarify essential principles and tips that strengthen a conceptual framework from situations in which to actually intervene.

The therapist must interrupt the escalating cycles of violence and reduce stress in the family. Violence may have begun with one person, sometimes two, but the pattern may now be a functional part of the family's dynamics. The family will need an opportunity to ventilate, help in making certain they are not "crazy," and help in putting their thoughts, behaviors, and childhood experiences in perspective. The family will also need help with referral to other services and agencies, along with specific guidance in personal and non-personal matters. Violent families need help in gaining control over a life that is out of control and setting consistent limits.

Although the treatment of family violence should be approached from a system's perspective, do not overlook an individual cause for family violence in an effort to understand family dynamics. Look for individual psychiatric diagnoses, such as organic brain syndromes, psychosis, affective disorders, and personality disorders. Be aware of patterns of behavior, such as habitual delinquency with or without undersocialized or socialized features, ie, a conduct disorder, ego dystonic destructiveness, ie, a disorder of impulse, or sudden alterations in consciousness, ie, a dissociative disorder, that may be at the root of violence. Violence in a family can also be generated by an individual who is re-experiencing a trauma, ie, a post traumatic stress disorder, or having a maladaptive reaction to a stressor, ie, an adjustment disorder.[23]

The clinician should be aware that the primary target is not the psyche, but the behavior. Intervention must be immediate, with no opportunity to rationalize or deny behavior or consequences. Insight does not help, nor does coercion, rescuing, rumination, or emotive directives. One must be very problem-oriented, with the focus on stopping the violence by using supportive confrontation, enhancement of self-esteem, improving problem-solving, structured exercises and practice of skills to control violence, development of affective awareness, and honesty. The therapist must slow down escalations, allow ventilation, clarify stress, develop alternatives, mediate negotiations, encourage perseverance, and remain optimistic. Isolation of the family must be prevented, and the family's resources must be developed and stabilized. The secondary target for intervention is the environment or misinformation that

support the violence. The tertiary target is the psyche, and the use of insight or traditional therapy is useful in this regard.

There is a therapeutic dilemma involving men who batter due to their feelings of low self-esteem and powerlessness. How does one increase a batterer's self-esteem while rejecting their behavior? The solution is to reject the behavior, not the person, but this is a difficult distinction to get across to patients and requires exceedingly clear verbal and affective communications. In this regard, it is good to be aware of the weakness and brittleness of the violent person. Another dilemma is the batterer's motivation for treatment. Is it just to impress the court? Or is the motivation for change internally based? Does it make a difference whether the motivation is external or internal? The best predictor of outcome is a batterer who is motivated enough to accurately report the extent of his violence.[4] Other important principles of treating violent families to keep in mind are transference and counter-transference issues, the safety of the therapist, and the duty to warn of impending violence, but these are beyond the scope of the this article.[29]

There are some controversies about how to approach the intervention in family violence. One controversy is whether a family therapy approach takes the violent family members off the hook for their individual behavior. A traditional family therapy approach may cause the victim to support the perpetrator and to accept too personal a role in their victimization. Different geographic regions and different advocates vary in their philosophy towards intervention and treatment. For example, some child abuse and elder abuse prevention advocates support decriminalization, while some spouse and intra-family sexual abuse prevention advocates support recriminalization of their issues. There is also controversy over the ability to predict violence.[30] It is enough to say that the certainty demanded in a legal circumstance is far greater than that needed in a clinical situation. In a family with documented violence, the clinician should always err in favor of the potential victim.

The most rapid impact is with interventions aimed at risk factors in the physiologic/medical category, ie, the use of medication in a violent bipolar or demented patient and the life stress/resource category, ie, the situational factors by using traditional crisis intervention techniques. Lasting changes require interventions on the psychologic and current interpersonal/family relationship factors. It is important to remember that there is no one answer to every family's problem with violence, but the preceding principles and tips should be used as guidelines while doing the actual interventions and therapy.

ACTUAL THERAPY

The actual therapy consists of crisis intervention, initial assessment, and a complete evaluation, brief therapy, and long-term treatment.[31]

Crisis intervention is most often done by the police, but sometimes by the clinician. To prevent having to intervene in an episode of family violence within a family session, a clinician should be proactive and not allow interpersonal arguments to escalate into physical altercations. Volatile couples should be separated (at least outside of striking distance, possibly with a large table separating them), and it is important that the therapist not take sides due to risking antagonizing the aggressor or incurring the wrath upon the victim. Two therapists can be neutral or supportive of each side. Should violence occur, it is important to remain in control and stay calm, but insist that the violence stop. Training in disrupting fights is useful.

The initial assessment and treatment have four steps. The first is to gather basic information about the family, but, also to pay attention to each individual's story and part. Assess past and present stress along with the capacity and techniques used to cope. Screen for the quality and quantity of violence and what weapons are available. If the information gathering threatens to get provocative and dangerous, separate the family during this phase. Despite the risk of scape goating or singling out the primary assailant, the therapist must focus on the violent behavior to get it under control. The next step is to assess what are the real family needs necessary to reduce stress and deal with supplying those needs.

The third step is the contract to stop violence which should be simple and manageable to build short-term control and self-esteem. To accomplish this, the clinician must understand the sequence of events and identify the critical points of violence. Behavior must be specific and structured to stop the violence. Examples include: mandating the use of crisis numbers and the removal of readily available loaded guns. Other ways to structure behavior are mandating the use of time-out behavior by identifying warning signs of impending violence and cues to facilitate breaking off escalation of arguments, coaching the family to anticipate stress, identifying conflicts, and avoiding disruptions by negotiating instead of dictating. The family should communicate about anger, fears, hopelessness, conflicts, feelings, and worries without verbal or physical abuse. Let the family know the contact is for

them and not the therapist. The family should be challenged to beat their own sabotage and asked how the contract to stop the violence can fail.

The therapist should get an idea about the family's resistances to the contract, as well as getting information about flaws, loopholes, or unclarity. Cooperation of violent family members can be increased by support and reducing their sense of hopelessness. Discussion of the worse case scenario, ie, legal separation or increase in violence and preparation for possible separation with specific steps of action, should be outlined. This preparation may often reduce the stress of the actual worse case scenario if it happens. The final step consists of ways to deal with the most dangerous situations: separation, medication, hospitalization, and intense family and friend involvement.

The complete evaluation consists of medical histories, identification of more community resources, and histories from other sources, and it should be done in the second session. It is important to realize that the second session is usually very different from the first session, as the family's defenses will be up, giving a more realistic prognosis.

The brief therapy component should focus on short-term goals, with every session being treated like it was the last. If they are predisposing factors, such as helplessness, intolerance to life's stress, and using the therapist to combat isolation, they should be tolerated by the therapist, and should be met with crisis intervention. The therapist should use firm but gentle confrontation of denial and rationalization. Stabilization of resources during this stage is essential. The family should be guided by giving tasks to restore normal functioning and increasing flexibility, along with more realistic expectations. Skills training should be used to improve competence of the abuser and the victim to increase social skills and assertiveness and social control over behavior. Actual dependency must be replaced by mutual respect, with encouragement of hostile dependent members to separate and allow each other to develop healthy differentiation. Individuation needs to be encouraged by advocacy of a family member's right to emotional comfort, self-fulfillment, and adequate role performance. The family should learn to identify maladaptive thoughts and self statements prior to, during, and after an event, ie, cognitive restructuring, may be useful.

New techniques for the expression of anger and the resolution of conflict must be developed. Techniques to consider are relaxation training, development of a signal to break off communications, nonviolent conflict resolution skills to build negotiation skills, "fair fight" training (practiced in session), and "blaming without response" exercises being done by both parties equally (designed to extinguish he mutual blaming that prevents identification and modification of behavior).

When to start the final phase of treatment, ie, long-term, varies. Some families drop out before the assessment and contract phase. Most drop out with symptom remission following brief treatment, but a few stay for the long-term. Because the completeness of treatment varies, relapse is very common, so treatment may occur in stages. Couple's groups, multi-family groups, and long-term family therapy are the treatments of choice aimed at changing psychologic and interpersonal/family interactional dynamics. Such group modalities reduce isolation and give support. A good prognosis is indicated by the number of sessions attended, the perception that the violence was severe, and an accurate report of the violence from all involved. Unfortunately, some families come for help after the violence has disrupted the family, and clinicians need information about what such families need. Disrupted families with victims in a shelter have different needs—help with assertiveness, anger, and self-esteem. In addition, they will require life-planning options, such as help with child support, child care, welfare, property issues, public housing, and unemployment, as well as with sex roles, separation, divorce, independence, and problem-solving.

CONCLUSIONS

Family violence results in significant damage to the public's health. Healthcare and social service professionals should try to intervene as early as possible to prevent from having to get involved after the loss of life during post mortem activities. This article was written to try to fill a perceived gap in the knowledge and skills necessary to make secondary homicide prevention efforts possible.[26]

It is hoped that public health initiatives can be effective in the primary prevention of homicide by preventing attitudes and values that promote initiation of family violence. Efforts that would reduce readily available, loaded guns, eliminate violent norms, reduce stress (eg, provide full employment, eliminate poverty, guarantee health care, and prevent unwanted children), cease sexism, change child rearing habits, and change a legal system that does not intervene could all aid in the prevention of family violence.

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