Assessment and Treatment of Family Violence

Karl Kirkland, PhD
Montgomery, Alabama

Recent statistics suggest that violence among family members in the United States is on the increase. Researching family violence, behavioral and social scientists have also seen a tremendous increase. This paper reviews recent research findings in the area of family violence which suggest that abuse among families is most often a product of the learning history of the batterer rather than a product of current marital or family system dysfunction. Social conceptions of the problem are changing, and new legislation in a majority of states now provides services and legal protection for victims. Also, in most cases, psychological treatment for poor anger control is being recommended for abusers in lieu of jail sentences. The author suggests a unique role for the family physician in terms of preventing and detecting family violence. Suggestions for routine assessment are offered and recent treatment techniques are discussed.

Violence in the family is emerging as a social crisis of tremendous dimensions. Americans are now more likely to encounter personal injury from the aggressive behaviors of family members and almost as likely to meet a violent death in their own homes as they are to encounter violence from strangers on the street.[1] Recent crime statistics indicate that 31 percent of homicides occur in the home, and of these, approximately one half result from altercations between spouses. Approximately one third of the police officers killed in the line of duty died while answering family disturbance calls.[2] It is estimated that 5 to 6 million children, spouses, and elderly individuals are neglected, battered, and abused in this country each year.

The purpose of this paper is to review recent findings on domestic violence and to emphasize the unique role of the family physician in the prevention and detection of situations involving family violence. Subscribing to such principles of family medicine as continuity of care, comprehensiveness of care, and care of the whole family allows the family physician to accumulate knowledge of patients and families. As a result, the family physician is in the most likely position to detect the occurrence of abuse or neglect. This was excellently illustrated by a recent study in which 56 of the 60 battered women studied from a group presenting with symptoms of physical illness were identified *only* because a physician specifically asked whether they had been beaten.[3] Less than a decade ago, a battered woman who sought protection from abuse had few options, and most health care and law enforcement professionals chose not to get involved in such "domestic" matters.

Legal Remedies

During the last five years, most states have passed extensive legislation on domestic violence.

From the Montgomery Family Practice Residency Program, Montgomery, Alabama. Requests for reprints should be addressed to Dr. Karl Kirkland, Montgomery Family Practice Residency Program, Post Office Drawer 4897, 219 Church Street, Montgomery, AL 36101.

0094-3509/82/040713-06$01.50

All but five states (Idaho, Mississippi, South Carolina, South Dakota, and Wyoming) have enacted legislation that creates new civil and criminal statutes to protect persons abused by family or household members.[4] Some of the statutes appropriate state funds for services to violent families (eg, domestic abuse shelters) while others specify the powers and duties of officials who answer domestic disturbance calls.

Thirty-five states have passed protection order laws, probably the most important form of legal intervention in violent families. These laws are not intended to erode the strength of the family unit but are based on clear constitutional principles that the individual, regardless of family status, has the right to be free from fear of physical abuse. A protection order (also called a restraining order or temporary injunction) is a court order issued to an abuser requiring the individual to make certain behavioral changes (eg, refrain from abuse or contact with the victim, move out of the residence shared with the victim, seek psychological treatment). The specific terms of such orders vary from state to state, but their general effect has been to clarify the legal status of victims and those professionals involved in reporting and intervening in family violence situations.

Within the legal system there has been a trend toward altering the manner in which family violence cases are prosecuted. Traditionally, acts of family violence have been difficult to prosecute because family members are reluctant to send the batterer to jail. Most victims of abuse do not want to destroy their family unit; they ask only to be free from the fear of further abuse. Incarceration of the abuser has proven to be an inappropriate response in all but those cases of severe abuse in which there is clearly no alternative but full criminal prosecution.[2] When permitted, the most promising alternatives to incarceration include court ordered psychological treatment for the abuser as well as protection and provision of services for the victim.

The Treatment Perspective

From the perspective of psychological treatment abuse has typically been referred to as "battering." Clinicians providing treatment for violent behavior in families have found a need to employ broader definitions of abuse than are used in the legal system, primarily because those intervening are by nature and training more concerned with continuity and comprehensiveness of care and, as a result, are more interested in the total nature and effects of the ongoing relationship among the abuser, the victim, and other family members.

Two leading clinicians, Anne Ganley and Norm Nickles, have provided the most comprehensive, treatment based definitions in this area.[5] Battering is broadly defined as acts of physical violence between intimates, which distinguishes the behavior from stranger-to-stranger violence. For preventive purposes in treatment some clinicians would use an extreme definition of battering, for example, touching another person when angry. Forced sexual abuse, with and without the threat of physical abuse or actual violence, is also included in the definition. Other forms of battering include the destruction of personal property and pets and psychological battering. The destruction of property and pets is important because it forces the victim to continually ask, "When will this rage turn on me?" Psychological battering includes all threats of future harm and forcing another to perform degrading behaviors as well as forcing isolation from others. The power of psychological battering comes from the history of prior physical abuse in a relationship. Solving problems with violence changes the nature of relationships in the family. Apprehension and fear become common responses of victims.

Consequences and Characteristics of Family Violence

Victims of family violence have been likened to prisoners of war and individuals experiencing rape trauma syndrome.[3,6] In contrast to stranger-to-stranger violence, domestic violence may span an entire developmental period of life (an unending threat) and involves an intense relationship with the batterer. Walker proposes that victims eventually evidence learned helplessness in response to the unpredictability of violent encounters (eg, most victims report that the battering often comes without warning and with a lack of correlation to victim behavior).[7] The victim learns that his or her own responding is independent of when violence will be encountered. Seligman, who originally proposed the model of learned helplessness as an explanation of depression, notes that the syndrome is

characterized by passivity, difficulty learning that responses produce relief, lack of aggression, anorexia, ulcers, stress, and norepinephrine depletion.[8]

Hilberman and Munson describe a uniform psychological response to violence that was identical for their entire sample of battered women.[3] The stress-response syndrome they describe includes agitation, anxiety bordering on panic, chronic apprehensiveness, perpetual vigilance, insomnia, hopelessness, depression, and lowered self-esteem. Passivity and denial of anger are not signs of adjustment to the situation; rather, they may be the last desperate defenses against homicidal rage.[3,9]

Role of the Family Physician

Physicians are probably second only to law enforcement officials in frequency of contact with family violence situations. In response, the family physician can risk legal problems by ignoring or avoiding such situations or directly address them in practice by (1) increasing a personal awareness of the problem, (2) re-examining one's belief system about the problem, (3) routinely assessing how anger is expressed in families, and (4) developing a knowledge of local referral sources for services for violent families.

Awareness of the Problem of Family Violence

The recent increase in research on domestic violence has resulted in significant increments in knowledge about the clinical characteristics of violent families. Awareness of these findings is important in the detection and prevention of further abuse. Much of the research has focused on characteristics of abusive couples.

Similarities have been noted among abusive husbands.[1,9] Marked jealousy and possessiveness characterize the majority of men who abuse their mates. The husbands make direct attempts to keep their wives isolated from others, thereby corroding any attempts for external support. The abusive husbands are also excessively dependent on their spouses. Paranoia about infidelity and constant, suspicious "detective" behavior are very common in most clinical samples. The relationships as a whole are characterized by a pervasive lack of individuation.

Rosenbaum and O'Leary recently completed a well-designed empirical study comparing abusive couples with satisfactorily married couples and with maritally dysfunctional but nonviolent couples.[10] The couples were compared in terms of responses to standardized measures of assertion, marital adjustment, alcoholism, and sex role attitudes. Abusive couples were differentiated from satisfactorily married couples on almost every measure. Abused wives, however, responded very similarly to nonabused but unhappily married wives, suggesting that discord per se is not associated with abuse. Within the abused sample there were no significant correlations between the amount of abuse and degree of marital discord.

Perhaps more importantly, several characteristics clearly distinguished abusive from nonabusive husbands, regardless of degree of marital disharmony. Abusive husbands were significantly less assertive with their wives. Other researchers have also suggested that abusive husbands lack communication skills and further that they tend to turn all feelings into anger, the one emotion they feel comfortable expressing. The abusive husbands were also more likely to have been abused as children or to have witnessed parental spouse abuse in their own families. The researchers also found that alcoholism in the abuser and basic value conflicts in the relationship were present in abusive couples significantly more often than in the nonviolent dysfunctional or the happily married couples in their sample.

The detection of family violence is also facilitated by the consistent finding that victims tend to seek frequent medical care.[3,11] Chief complaints of victims may include somatic complaints, conversion symptoms, and psycho-physiologic reactions (eg, gastrointestinal disorders, back pain, pelvic pain, choking sensations, headache). Symptoms are often connected to previous sites of battering. A more complete listing is found in Table 1.

Myths and Belief Systems

In 1969, 20 percent of all Americans approved of slapping one's wife.[12] Surprisingly, the figure increases with income and education (eg, 25 percent among the college educated). In an earlier time when wives were regarded as private property, medieval theologians advised that "a man has permission to castigate his wife and beat her for correction."[13] The social myth that a man's

Table 1. Physical and Behavioral Indicators of Family Violence

Type of Violence	Physical Indicators	Behavioral Indicators
Physical Abuse	Unexplained bruises and welts On face, lips, mouth, torso, back, buttocks, thighs In various stages of healing Clustered, forming regular patterns Reflecting shape of article used (electric cord, belt buckle) On several different surface areas Regularly appears after absence, weekend, or vacation Unexplained burns Cigar, cigarette burns, especially on soles, palms, back, or buttocks Immersion burns (socklike, glovelike, dougnut shaped on buttocks or genitalia) Patterned, like electric burner, iron, etc Rope burns on arms, legs, neck, or torso Unexplained fractures To skull, nose, facial structure In various stages of healing Multiple or spiral fractures Unexplained lacerations or abrasions To mouth, lips, gums, eyes To external genitalia	Emotional constriction or blunted affect Wary of adult contacts Extreme withdrawal or aggressiveness Extreme rejection or dependence on caretakers Apprehension, fearfulness Afraid to go home Depression Paranoia
Physical Neglect	Poor hygiene, consistent hunger, inappropriate dress Consistent lack of supervision Unattended physical problems or medical needs Failure to thrive	Begging, stealing food Constant fatigue, listlessness Delinquency (eg, thefts, vandalism) Victim reports that there is no parent, guardian, caretaker

(Continued)

home is his castle and all that occurs there is private is now defunct, largely as a result of the legal changes discussed earlier and social changes coming from the women's movement.

Another equally damaging belief has been that women stay in abusive relationships because they are masochistic or because they really deserve the beatings they receive. Waites has argued eloquently that theories of female masochism are grossly inadequate explanations because domestic violence is consistently characterized by external restriction of choice for the victim.[14] Battered women give many rationalizations for staying in abusive relationships. Fear, however, seems to be the most common factor.[15] It is obvious that American society is currently responding to such outmoded myths by making appropriate legal changes. Nevertheless, the legal changes will not be enforceable without broadly based public support.

Assessment

Ganley and Nickles have suggested a routine assessment procedure for the detection and pre-

Table 1. Continued

Type of Violence	Physical Indicators	Behavioral Indicators
Sexual Abuse	Difficulty in walking or sitting Torn, stained, or bloody underclothing Bruises or bleeding in external genitalia, vaginal, or anal areas Venereal disease, especially in preteens Pregnancy	Sleep disturbances Withdrawn or regressed behavior Secondary enuresis or encorpresis Bizarre, sophisticated, or unusual sexual behavior or knowledge Poor interpersonal skills Sexual promiscuity Self-report of abuse Anorexia Extreme self-blame Extreme fears
Physiological Abuse	Speech disorders Developmental delays Failure to thrive	Habit disorders (nervous tics, suckling, biting, rocking) Antisocial behaviors Sleep disorders Withdrawn, inhibited behavior Phobias, obsessions, compulsive behaviors Overly adaptive behavior, inappropriately infantile or inappropriately adult Suicidal ideation or gestures

Adapted from Broadhurst DD, MacDicken RA: Training in the prevention and treatment of child abuse and neglect. Children's Bureau, National Center on Child Abuse and Neglect. DHEW publication No. (OHDS) 79-30201. Government Printing Office, 1979

vention of family violence for all patients[5] that can easily be incorporated into the physician's history taking process. These clinicians have found it useful to assume that anger exists in the general assessment of a relationship. The important question is, "How is anger expressed?" Such direct questions cut through the denial system of the batterer and give the person permission to talk about arguments and fights. Similarly, by directly asking, "Sometimes we hit others when we are angry. What do you do?" much valuable information can be learned about level of impulse control, amount of marital discord, and the frequency and severity of violent behavior.

A thorough physical description of a recent incident is also helpful in determining the dangerousness of a given situation. Alcohol or drug abuse, availability of local support groups (eg, crisis line, friends, family, church), availability of weapons in the home, suicidal potential of victim and batterer, and the severity and frequency of prior abuse, all affect the risks involved in abusive couples.

The family physician may choose to address mild forms of abuse in the management of family problems among patients. Obviously, more serious forms of abuse, in terms of severity and frequency, should be referred to appropriate legal and/or treatment agents. In cases in which voluntary treatment is sought, the potential for future violence is assessed as low, and the motivation for behavior change is high, the batterer and his fam-

ily may be best served by a direct referral to a psychologist, thus circumventing the need for law enforcement involvement.

The first aim of any treatment approach is to protect the victim from further violence. Frequently this can be accomplished by confrontation of the batterer's tendency to minimize, deny, and blame others for the violent acts. The treatment agent points out that while the relationship may be dysfunctional, it is not to blame for the violence. The batterer is given sole responsibility for any and all battering behavior. Continuation of treatment can be made to be contingent on the cessation of battering. The focus of treatment then becomes one of teaching the individual more appropriate, adaptive expressions of anger. The batterer learns that there are an infinite number of alternatives to further violence.

Raymond Novaco's work on cognitive-behavioral control of anger has been the most promising specific treatment approach applied to batterers.[16,17] This therapeutic approach, which involves cognitive regulation and skills training for the management of anger, has been evaluated experimentally and has been shown to be successful in the treatment of severe anger problems. A basic goal of treatment is to promote flexibility in one's cognitive structuring of situations. Relaxation training is a standard part of treatment.

Local Referral Services

In most major cities and in every state, there are now shelters or other services offered to abused family members.[18] Most shelters provide primarily a haven for victims of family violence. More comprehensive programs also provide counseling, child care, and psychological and vocational evaluation. In addition, many programs provide counseling services for the abuser. Most shelters operate 24-hour crisis lines and attempt to keep their location a secret by meeting victims at a neutral location, such as a hospital emergency room, before admission to the shelter.

Complete familiarization with local ways of dealing with family violence would include learning how local police handle family disturbance calls, how local laws affect the reporting of abuse cases by health care professionals, what social services are available, and how the problem is viewed by local county and city judges.

In summary, it is hypothesized that examination of personal feelings about domestic violence, awareness of the characteristics of abusive relationships, knowledge of local means of handling such cases, and routinely assessing the anger control skills of patients will significantly improve the family physician's ability to detect and prevent family violence. The unique role of the family physician in terms of continuity and comprehensiveness in the care of families suggests that family practice is one of the most likely professions to deal successfully with the problem of violence in the family. It is suggested that, in the long run, this is the best approach to the protection of rights of the individual and to strengthening the family unit.

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