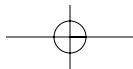
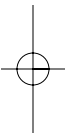
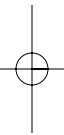
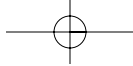


SECTION I

Family Violence



Chapter 1

VIOLENCE WITHIN FAMILIES THROUGH THE LIFE SPAN

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INTRODUCTION

Case Examples

Sixteen-year-old Susan awakens in a room unaware of her surroundings. During a senior post-prom party, Susan had consumed a large amount of alcohol and was high from smoking marijuana, leaving her incoherent and in a daze. This physical state of mind left Susan unaware of Howard's aggressiveness. Eighteen-year-old Howard, Susan's new boyfriend and captain of the football team, had been taking "ecstasy" which intensified his physical and sexual feelings when he sexually abused her. Susan had gotten a ride home from her girlfriend and during the ride, tried to explain what had happened. She was not able to provide a detailed statement of what had occurred due to her semi-consciousness during the course of the events. Her parents wanted her to sign a criminal complaint against Howard, but she vehemently refused. Susan felt guilty about her own excessive alcohol and marijuana use and did not remember if she said no to Howard when he undressed her and proceeded to have sexual intercourse with her. She noticed bruises on her arms, breasts, and thighs the next day, and had no recollection of how she got bruised. However, she did agree with her father that she would never date Howard again.

Naomi is a 34-year-old single parent who was chronically abused by her husband for seven years. During her childhood, her father abused her mother. Naomi is a high school graduate and has worked for the same company for the past 14 years as a customer service representative. She described her injuries as a "broken nose, he's tried to choke me so many times I feel that when I get older I will have cancer of the throat. I have bruises all over my body. I have a bad back, and on

4 Family Violence

Case Examples (*Continued*)

three different occasions my eye has been swollen from punches. He likes to punch me in the mouth. He does it without warning. The last time he strangled me in the kitchen, I faked passing out, and he left. He might have killed me if I didn't fake passing out." . . . Naomi finally left her husband after attending a support group for battered women . . . She went to court and got a restraining order (Roberts, 2002; p. 74).

Complainant was a 76-year-old female victim who was interviewed in the hospital. She had suffered multiple injuries to her head and a broken hip. Complainant stated that her son, daughter, and friends had held her prisoner for several days. They stated they would kill her if she left and beat her for no reason. (Brownell, 1996; p. 44).

These three cases illustrate the fact that family violence (also known as interpersonal violence) occurs throughout the lifecycle. Although domestic violence seems to be decreasing, physical and sexual assault remains prevalent among children, adolescents, adults, and the elderly. When violence against women occurs in the family context of a shared residence, it is usually more frequent and more severe than stranger-perpetrated violence. There is rarely any warning for when the next slap, punch, kick, or series of brutal assaults may intensify. But, the research has consistently demonstrated that women who stay in battering relationships for many years, eventually sustain numerous battering incidents and injuries. In sharp contrast, there is a group of young women in dating relationships who leave the batterer permanently after the first or second incident. They leave before the abuse becomes chronic. These women in short-term abusive relationships usually leave with the help of a restraining order, the support of a parent or older sibling, or a close friend who allows them to temporarily live in their house (Roberts, 2002).

Awareness of familial violence has come a long way in the past four decades. As a result of groundbreaking research, journal articles, books, and media attention, there are now, throughout the United States, over 15,000 programs for prevention and treatment of child abuse, rape crisis, domestic violence, and elder abuse. In 1962, C. Henry Kempe (Kempe, Silverman, Steele, Droegemueller, & Silver) developed the term "The Battered Child Syndrome." By 1971, Richard Gelles, under the guidance of Professor Murray Straus, had completed his doctoral dissertation at the University of New Hampshire. His was the first study to document police, hospital, court, and social service responses to the battering of women in a small town in New Hampshire. Almost three decades ago, two esteemed psychiatric/mental health nursing professors, Ann Wolbert Burgess and

Lydia Holmstrom (1974), completed and published their classic research study at Boston City Hospital and coined the term “Rape Trauma Syndrome.” At the same time, psychologists Morton Bard and Katherine Ellison were training nurses, social workers, and police officers in New York City in crisis intervention. Also, during the 1970s, several large medical centers developed rape crisis programs. By 1980, Albert R. Roberts, a prominent social worker and criminologist, had completed the first national survey of the organizational structure and functions of 89 shelters for battered women and their children. Roberts’s book, *Sheltering Battered Women: A National Survey and Service Guide* (1981), focuses on staffing patterns, funding sources, crisis intervention techniques, agency and decision-making boards, positive and negative perceptions of police encounters, attempts to obtain protective orders, self-reported strengths, and limitations of shelters for battered women. Noted sociologists Murray Straus, Richard Gelles, and Suzanne Steinmetz had completed the first national prevalence study of family violence by 1980 as well.

The 1980s seemed to be the decade in which awareness of domestic violence and an aid-for-crime-victims movement flourished. Within the women’s movement, local NOW chapters, statewide domestic violence coalitions, and legislative advocates all united in a call for specific domestic violence legislation, major federal funding initiatives, increased research and demonstration projects, and legal remedies. In 1984, the Victims of Crime Act (VOCA) was passed—the first major legislation that aided crime victims throughout the United States. In 1985, a child psychologist, Jane Nady Burnley, became the first Director of the new federal Office for Victims of Crime, in Washington, DC. She and her staff were responsible for distributing the VOCA funding to the states, and for monitoring and evaluating programs nationwide. By 1990, Albert Roberts, in his national survey of 184 victim/service and victim/witness assistance programs, indicated that more than 3,000 rape crisis intervention, sexual assault prevention, domestic violence intervention, and victim/witness assistance programs had been funded through the VOCA initiative.

The possibility that people might be injured or have their homes invaded by strangers is a frightening thought. But hundreds of thousands of Americans face an even more devastating reality when they are harmed, not by strangers, but by someone they trusted. Vicious crimes of violence are committed by or against children, parents, grandparents, spouses, and other close relatives. The family is still viewed as the center of society. To be abused by a partner, a parent, a trusted adult, or one’s own child, or to witness such abuse, leaves deeply ingrained fears and other serious consequences. Victims of domestic violence must wrestle with feelings of fear, loyalty, love, self-blame, guilt, and shame—all at the same time. These emotions are not experienced by victims of strangers. Adults become torn between

6 Family Violence

their desire to shield and help a loved one and their responsibility toward their own safety and the safety of others in the household. Children face the reality that those who should protect them are, in fact, sources of harm. For most people, home represents security. To domestic violence victims, home is a place of danger.

The problem of family violence is not new. Women have been battered by their partners in almost every society in history. In the United States, the beginning of services for battered women and children dates back to 1885, when the Chicago Protective Agency for Women, established to help women who were victims of physical abuse, provided legal aid, court advocacy, and personal assistance. An abused woman could receive up to four weeks of shelter at a refuge operated by the Women's Club of Chicago. The agency helped women to secure legal separations, divorces, and equitable property distributions. Between 1915 and 1920, 25 cities followed Chicago's lead in developing protective agencies for women; by the 1940s, few shelters remained, due, in part, to casualties and marital separations during World War II (Pleck, 1987; Roberts, 1996).

Throughout history, records of childhood are replete with suffering that was well documented from biblical times to the present. The landmark *Wilson* case, in 1874, pricked the national social conscience and opened America's eyes to the plight of many children. Eight-year-old Mary Ellen Wilson lived with her adoptive parents in New York City. She was held there in chains, starved and beaten. The police responded but could do nothing because it was a "family matter," and parents held the "rights" (Zigler & Hall, 1989). A man named Henry Berg was contacted. He had founded a protective group the preceding year: The Society for the Protection of Cruelty to Animals. Berg was able to extricate Mary Ellen from her family torture chamber.

This chapter presents definitions and current statistical trends from a developmental perspective of family violence. It covers bullying behavior as a precursor to abusive dating relationships; courtship abuse; partner threat and violence; domestic violence and pregnancy; batterers' stalking patterns; domestic homicide; child abuse, neglect, and sexual assault; and elder abuse. The chapter also discusses key concepts of family violence: socialization into violence; learned socialized violence; the psychodynamics of violent behavior, including altered attachment, jealousy, guilt, and revenge; and the biology of trauma.

BULLYING BEHAVIOR

Bullying is the abuse of power by one child over another through repeated aggressive behaviors (Connolly, Pepler, Craig, & Taradash, 2000). For bullies, power may arise from physical strength and maturity; higher status within a peer group; knowledge of another child's weakness; or recruitment of support

from other children (O'Connell, Pepler, & Craig, 1999; Salmivalli, Lagerspetz, Bjorkqvist, Osterman, & Kaukiainen, 1996). As bullies age, they rely less on physical means to intimidate their victims and turn, instead, to indirect forms that entail verbal abuse and social exclusion (Olweus, 1991).

Like aggressive and antisocial children, children who bully often come from homes that are neglectful, and their parents often use harsh punishment (Olweus, 1993). Children who become bullies are at risk for continuing difficulties into adulthood, in the form of criminality, domestic violence, child abuse, and sexual harassment.

In a study of 1,758 students in grades 5 through 8, 196 young adolescents who self-reported they bullied their peers were compared to a control group of nonbullying youth. The results indicated that bullies started dating earlier and engaged in more advanced dyadic dating than comparison adolescents. Bullies were highly relationship-oriented, yet their views of their friends and boyfriends or girlfriends were less positive and less equitable than those of the comparison adolescents. Finally, bullies were more likely to report physical and social aggression with their boyfriends and girlfriends. The results suggest the hypothesis that adolescents whose peer relationships are characterized by bullying are at risk in their development of healthy romantic relationships (Connolly et al., 2000).

THE FAMILY

Because violence within families has only recently surfaced as a legal matter, research into the causes and consequences is limited. As a first step, definitions are provided in order to begin classification for the research process.

Due to the myriad of different statutes and regulations, there is no national legal definition of a family.

FAMILY VIOLENCE

Nowhere in the criminal law and its administration is the social construction of violent crime changing more rapidly than in what constitutes family violence and society's response to it (Reiss & Roth, 1993:222).

Data on family violence are classified by current marital status (married, separated, divorced, or single), spousal status (spouse/ex-spouse), or relationships among members of a household (cohabitants, child/parent, sibling, parent). Given these categories, statistics on family structure changes can be generated over time. For example, the Bureau of the Census (1990, 1991) has reported that the proportion of all households accounted for by two-parent families declined from 40% in 1970 to 26% in 1990. The number of

8 Family Violence

unmarried-couple households almost tripled between 1970 and 1980 and grew by 80% between 1980 and 1990, from 1.6 to 2.9 million. The proportion of children under 18 years of age living with two parents declined from 85% in 1970 to 73% in 1990. An estimated 15% of these children were stepchildren. And, in 1990, 19% of white, 62% of black, and 30% of Hispanic children under age 18 lived with only one parent.

Trends in family violence, according to Reiss and Roth (1993), must be interpreted against a decline in the percentage of households containing, exclusively, married couples and their biological children. Violence between growing numbers of same-sex and opposite-sex cohabiting partners is increasingly being regarded as family violence, regardless of legal marital status. Violence between divorced or separated ex-couples is also listed as family violence.

The National Research Council's Panel on Understanding and Preventing Violence (Reiss & Roth, 1993) considered all violent behavior within a household as family violence—specifically, spouse assault, physical and sexual assault of children, sibling assaults, and physical and sexual assaults of other relatives who reside in the household. Missing from this list are events such as verbal abuse, harassment, or humiliation, in which psychological trauma is the sole harm to the victim. This category is under consideration by the Panel on Research on Violence Against Women, which will also be considering threat assessment and stalking behavior.

Like the term “family,” the term “violence” has no universal definition. However, the definition published in the report “Understanding and Preventing Violence,” by Reiss and Roth (1993), may be useful. It states that interpersonal violence is “behavior by persons against persons that intentionally threatens, attempts, or actually inflicts physical harm.”

THE DYNAMIC NATURE OF FAMILY VIOLENCE

Several characteristics distinguish family violence from stranger violence (Reiss & Roth, 1993:222–223). While the continuing relationship among family members is similar to other relationships—teacher-student, employer-employee, child-caretaker, and so on—daily interaction and shared domicile increase the opportunities for violent encounters. Because family members are bound together in a continuing relationship, repeat violations by the offender are quite likely. An unequal power relationship makes the victim more vulnerable to the aggression and violence of the offender. Moreover, the offender often threatens additional violence if the incidents of violence are disclosed. The victim, anticipating stigmatization and denigration, may refrain from disclosure. Because

episodes of violence often occur in private places, they are invisible to others and are less likely to be detected or reported to police.

DEVELOPMENTAL ASPECTS OF THE FAMILY AND ITS STRUCTURE

Just as there are developmental stages and tasks for the child maturing into an adult, the family may be viewed as progressing through three developmental phases. The first phase begins with dating, courtship, and marriage; the middle phase includes partnership and work, with childbearing and parenting being an option; and the third phase continues a work focus, optional grandparenting, and retirement.

Phase 1: Courtship and Marriage

The first phase of family life includes dating, courtship, and marriage. Although dating does not necessarily lead to courtship or marriage, it is instructive to review data on early relationship problems and dating aggression (Riggs, 1993). Theories of both marital aggression (Gelles & Straus, 1979) and dating aggression (Riggs & O'Leary, 1989) identify conflict as an important causal factor that can lead to aggression between partners. Dating violence appears to begin as early as age 15 or 16 (Durst, 1987; Henton, Cate, Koval, Lloyd, & Christopher, 1983). Typical tactics include slapping, pushing, beating, and threatening or attacking with weapons. Recurring and escalating episodes of violence in a relationship are quite common if the relationship is not terminated. Research has indicated that approximately 44% of acquaintance rape victims, in comparison to less than 1% of stranger rape victims, are likely to be sexually assaulted "more than once by the same offender" (Gidycz & Layman, 1996). About 50% of the victims do terminate the relationship (Cate, Henton, Koval, Christopher, & Lloyd, 1982; Henton et al., 1983; Laner, 1983; Roscoe & Benaske, 1985). Victims of acquaintance rape may be in a state of denial in the aftermath of the rape, and they often present for treatment years after the assaultive incident (Jackson, 1996). In a national study of 3,187 female college students, 52 of the respondents reported being raped by strangers versus 416 victims of acquaintance rape. Only 1.7% of the acquaintance rape victims informed the police and sought crisis intervention services. In addition, 27.8% of the acquaintance rape victims considered suicide and progressed to the point of selecting a lethal method (Petretic-Jackson & Tobin, 1996).

Although large-scale surveys have documented the prevalence of abuse in teen dating relationships [i.e., more than 25% of male and female high school

10 Family Violence

students report having experienced some form of physical abuse in a dating relationship (O'Keefe & Lebovics, 1998)], the abuse often escapes attention or concern. Research indicates that a large number of college students experience physical aggression in dating relationships. Estimates of the prevalence of dating aggression among college students range from 20% (Cate et al., 1982; Makepeace, 1981) to as high as 50% (Sigelman, Berry, & Wiles, 1984).

Violence often continues within marriage. According to some researchers, spousal assault is the single most common cause of injuries for which women seek emergency medical attention. In a study of emergency treatment of women in a metropolitan hospital, the investigators reported that battered women were 13 times more likely than other women receiving emergency care to be injured in the breast, chest, and/or abdomen, and three times as likely to be injured while pregnant (Boes, 1998).

In 1988, the National Crime Survey (NCS) (Bureau of Justice Statistics, 1990) began to report annual estimates of the extent of family violence for persons age 12 and older. The NCS, however, lacks the necessary information to determine the full extent of family violence. For example, the data collection process excludes violence among coinhabitants and does not collect information on children under age 12. Given these limitations, the 1989 victimization statistics are still useful. For example, the report states that 59% of the assaults were by a spouse (41%) or ex-spouse (18%), and 29% were by other relatives. Parents inflicted 7% of the assaults, and children inflicted 5%.

The Conflict Tactics Scale developed by Straus (1979) is the main measure of domestic violence and is used in most surveys. The scale includes verbal and aggressive acts. Violent acts range in severity from hurling objects to using a deadly weapon such as a gun or knife. Using the scale in an initial national telephone survey of couples in 1975, and in a repeat of the survey in 1985 (Straus & Gelles, 1991), Straus, Gelles, and Steinmetz (1986) reported that 16 of every 100 couples admitted that at least one incident of physical aggression had occurred during the year before the survey. The prevalence of severe violence in both surveys was 4 in 100 females, and 5 in 100 males. These statistics are believed to be low because the sample excluded unmarried couples and missed segments of the population that do not have telephones (Reiss & Roth, 1993).

National estimates of the total number of women battered by their partners (spouses and cohabitants) range from 2.1 million to over 8 million annually (Dwyer, Smokowski, Bricout, & Wodarski, 1996; Roberts, 1996).

Stalking

Kurt (1995) reminds us that stalking is part of the constellation of behaviors associated with partner violence, especially when there is a difficult breakup with

an intimate partner. Stalking takes various forms and has varying definitions in some states. From a legal point of view, stalking is willful, malicious, repeated following and harassing of another person, with fear of violence resulting in the victim. Meloy (1998) describes it as abnormal social behavior.

In a pilot sample of self-reported batterers, 36 (out of 120) who stalked and were charged with domestic violence were identified as belonging to one of three stalking groups. In the first group, discrediting was the key; in the second, love turned to hate, and in the third, there was a violent confrontation with the ex-partner (Burgess et al., 1997). A second study, involving 165 batterers, suggested that stalking behaviors varied from seemingly benign acts, or efforts toward being reasonable, to hidden, threatening, frightening behaviors. Batterers were said to be contacting estranged partners for two major reasons that elicit a range of contradictory and ambivalent emotions. The *conscious* motive, for the most part, appears altruistic; the emotions range from longing and confusion to hostility and revenge. In contrast, individuals with secret and clandestine behaviors were angry and aggressive and indicated a propensity for abusive action. Clinicians need expertise in the treatment of batterers who stalk, and victims and their families should be encouraged to keep in contact with law enforcement units, for safety reasons (Burgess, Harner, Baker, Hartman, & Lole, 2001).

Violence and Pregnancy

It has been estimated that as many as one in five teenagers is a victim of domestic violence during pregnancy (Parker, McFarlane, Soeken, Torres, & Campbell, 1993). Recent research has estimated that, in as many as two-thirds of teenage pregnancies, adult males are the fathers. Teenagers partnered with adult men are more likely to become pregnant than those with peer-aged partners. Domestic violence during pregnancy is often preceded by a history of abuse, but pregnancy may act as a trigger that increases the frequency and severity of the violence. This increase may be related to financial implications of the pregnancy and birth, stress surrounding altered relational and sexual roles, and increased attention toward the growing pregnancy. Additionally, pregnancy disclosure, especially when the paternity is questionable, may potentiate an already volatile situation.

Phase 2: Assaults on Children

Various commissioned governmental studies have reported on assaults on children. The U.S. Advisory Board on Child Abuse and Neglect, created by the 1988 amendments to the Child Abuse and Prevention and Treatment Act, estimated that, in 1989, at least 1,200 and perhaps as many as 5,000 children died as

12 Family Violence

a result of maltreatment, and over 160,000 children were seriously harmed (U.S. Department of Health and Human Services, 1990:15) The advisory board noted that, in 1974, about 60,000 cases of child maltreatment were reported. This figure rose to 1.1 million in 1980 and more than doubled to 2.4 million in 1988 (U.S. Department of Health and Human Services, 1988:x). The increases may, however, partially reflect the use of more inclusive definitions of abuse and neglect and an increase in professional recognition of maltreatment, rather than an increase in incidence per se (U.S. Department of Health and Human Services, 1988:xxv). It is also likely that cases of child maltreatment are reported to public health or educational agencies and not to the social services agencies that provide the "countable" case figures. Many cases of intrafamilial or third-party assaults on children are never reported to any professionals concerned with the health or welfare of children (Reiss & Roth, 1993:228).

American society has a major public health and criminal justice problem to remedy as a result of the prevalence of child abuse and neglect. In 1999 alone, state child protective service agencies received 2.97 million reports of alleged maltreated children. The youngest group, children under 6 years of age accounted for approximately 86 percent of the child abuse and neglect related fatalities (Osofsky, 2001). Violence against children is a growing concern in the field of violence prevention and delinquency prevention.

Using the expanded definitions of child abuse and neglect, the second National Incidence Survey, published in 1988 (NIS-2) and commissioned by the National Center for Child Abuse and Neglect, estimated that the majority of countable cases involved the following situations (U.S. Department of Health and Human Services, 1988:3–8):

Case Category/Percentage		Number of Children per 1,000	Total Number of Children
Child neglect	(63%)	15.9	1,003,600
Physical neglect	(57%)		157,600
Educational neglect	(29%)		292,000
Emotional neglect	(22%)		223,100
Child abuse	(43%)	10.7	675,000
Physical abuse		5.7	358,000
Emotional abuse		3.4	211,000
Sexual abuse		2.5	155,900

Source: U.S. Department of Health and Human Services, 1988: 3–8.

Family violence sometimes escalates to homicide. Assessments of the risks of intrafamily homicide are considered to be more accurate than for other forms of

assault (Reiss & Roth, 1993:234). Several patterns are noteworthy: Newborns, infants, and children ages 1 to 4 years are more vulnerable to homicide than are children ages 5 to 9 years (Federal Bureau of Investigation, 1990:11); infants and small children are more likely to be killed by their mothers than their fathers, perhaps in part as a result of differential risk exposure; and the risk of homicide for children under age 5 years is greater for male than female children, according to a recent case control study (Winpisinger et al., 1991:1053–1054).

Most incidents of spouse abuse do not end in homicide. During 1991, almost 2,000 deaths were found to be homicides between intimate partners (Mechanic, 1996). Slightly over two-thirds of the victims were females killed by their male partners; the other 30% were males killed by female partners (Mechanic, 1996). Men's overall homicide risk is three times that for women, but women face a greater risk of homicide by their spouses than do men (Federal Bureau of Investigation, 1990:8); intrafamily violence accounted for 15% of all family homicides in 1989; 44% involved husbands and wives. Three different studies of battered women who kill found that 57% to 83% of the women experienced death threats, from the batterer, aimed at themselves or close relatives (Browne, 1987; Roberts, 1996). Therefore, it is important to understand the self-defensive nature of spousal homicides committed by battered women against violent batterers. In Roberts's (1996) New Jersey study of 105 homicidal battered women, the overwhelming majority of the battered women had received very specific death threats in which the batterer described the method, time, and location of the woman's demise.

Phase 3: Assaults against the Elderly

The National Research Council (NRC) (1993) recommends that priority be given to the collection of more precise information about the prevalence, incidence, and consequences of violence toward the elderly. Surprisingly little is known about its occurrence in families—for several reasons. First, most studies do not distinguish between elder abuse and elder neglect. Second, families are unlikely to report the abuse because the responsible person may be a son or daughter. Third, many elderly people are homebound and no one can see what is happening to them.

National estimates of the prevalence of elder abuse indicate that 1 out of every 20 senior citizens, or over 1.5 million older people, are victims of elder abuse (Brownell, 1996; Roberts, 1996). In a stratified random-sample study of all persons 65 and older in the Boston metropolitan area, it was estimated that between 2.5 and 3.9 persons per 1,000 had experienced physical violence, verbal aggression, or neglect. Results were similar in a national survey of elder abuse in Canada.

14 Family Violence

There is a dearth of research on elder abuse and neglect. Dr. Sidney Stahl, at the National Institute on Aging, noted that a lack of the most basic scientific research in the field prevents service providers and others from knowing the real scope of the problem and ascertaining whether their interventions are working. His suggested seven-point agenda focuses on: (1) prevalence and risk factors; (2) accurate measurements; (3) natural history of abuse and neglect; (4) lack of diagnostic specificity; (5) lack of scientifically verified prevention interventions; (6) issue of self-neglect; and (7) institutional abuse and neglect (Stahl, 2000). The fact that 13% of the nation's population is over the age of 65—a figure that will rise to almost 20% in the next two decades—emphasizes the need for more research in this area.

EXPLANATIONS OF FAMILY VIOLENCE

Most theories about the causes of family violence are only partial explanations. Either they attempt to explain a single type or a few types of family violence, such as partner assault, or they seek to identify a particular factor or set of factors that can account for some of the observed variations in behavior between violent and nonviolent persons or acts (NRC, 1993). The leading explanations of family violence are derived from social, cultural, and biopsychosocial perspectives.

The Social and Cultural Perspectives

Gelles (1983) attempted to develop an integrated theory of several cultural and structural determinants and social learning. For example, feminist theory asserts that the unequal power distribution between men and women subjects women to male dominance in all spheres of life (work, family, and community life). Male power extends to the sexual relationship as well as to work and social relationships. The various ways in which coercion is used depend on men's use of their physical and social power to maintain that dominant position (Finkelhor, 1983).

The unequal distribution of power is also the basis for explaining parental physical and sexual abuse of children. The exercise of parental power over a child victim leads to disempowerment of the child and renders him or her helpless (Finkelhor & Browne, 1986:183).

Growing up within the framework of a patriarchal society that emphasizes male dominance and aggression and female victimization, children are socialized into their respective sex roles (Dobash & Dobash, 1979). In addition, they *learn* through their experience in the family or their exposure to the media. This

learning becomes reinforced in the larger community, where male and female roles similarly rest on elements of macho culture.

Recent changes in family organization and structure may account for some family aggression. Changes that affect social and moral bonding among family members are probably most significant. One such change, since the 1970s, has been the deinstitutionalization of children without families, the mentally ill, the homeless, and the disabled. Temporary placement of children in foster homes, adoption, and informal placement of children with relatives may expose the children to violence from caretakers for whom the minimal moral constraints of the parenting role are less salient (Reiss & Roth, 1993:241).

A second major change is the increase in the number of children who are not living with their natural parents. These numbers are substantial, owing to serial cohabitation, divorce, and desertion (Reiss & Roth, 1993), as well as the incarceration, substance abuse, or death of the caretakers.

Social Isolation

Social isolation has been identified as a characteristic of some families that are at high risk of physical and sexual abuse of a spouse or children (Dwyer et al., 1996; Garbarino & Crouter, 1978; Pike, 1990). The isolation may be forced on the partner by the abuser. On the other hand, shame may prompt a visibly battered spouse to seek even further withdrawal. Victims often become isolated from their friends, their family of origin, their neighbors, or anyone who could become acquainted with the ongoing events. Some families isolate themselves by having an unlisted telephone number or no telephone. Their lack of a means of transportation is offered as a reason for not visiting others, and their homes may be physically shuttered against the gaze of outsiders. They often lack community ties of any kind (Garbarino & Sherman, 1980). Resick and Reese (1986) suggest that violent families rarely invite visitors to their homes, so as not to engage in social and recreational activities. They place little emphasis on personal growth and development.

Generational Transmission of Violence

The transmission of violence from one generation to the next is as much a component of subculturation as any other learned behavior. Straus and colleagues (1980) reported that among adults who were abused as children, more than one-fifth will later abuse their own children. Although Widom (1989:161) cautions that the methodological limitations in these studies, especially those with retrospective design, restrict the validity of conclusions about the long-term consequences of abuse in childhood, most professionals are concerned about the potential dangers.

16 Family Violence

The Biopsychosocial Perspective

A child's perceptions of family members, and of their interactions with him or her and with each other, are important factors in a child's development. Essentially, early life attachments (sometimes called bonding) translate into a blueprint of how the child will perceive situations outside the family. A positive attachment based on warmth, affection, caring, protective behaviors, and accountability leads to basic trust, and trust is at the core of building a social human being. Through attachment, the child gets feedback for the emerging of self. Around 18 months of age, there is consolidation of a sense of self. Early development of the ability to self-soothe provides an inner core of calmness and an ability to avoid being overwhelmed by stimuli, and this ability results in an integrated sense of self.

Social bonding can fail or become narrow and selective. Caretakers might ignore, rationalize, or normalize various behaviors in the developing child or, through their own problems (such as violent behavior), they might support the child's developing distortions and projections. An ineffective social environment can result from ignoring aggressive or sexual behavior or failing to intervene to correct such behavior.

A child who lacks a caretaker's protection experiences tremendous anxiety, is overwhelmed, and may survive through dissociating himself or herself from the trauma. Such dissociation inhibits a sense of feeling connected to the outside world. In the earliest manifestations of this numbing, children are cruel to animals, siblings, friends, and even parents or grandparents. These children lack sensitivity to the pain of others and may develop a distorted association of pain with various events. Some children become isolated and disconnected from others. In a Massachusetts case, a 14-year-old youth took a 7-year-old retarded boy into a wooded area and beat him to death. He had told people he was going to do this, but no one intervened.

Similar cruel and detached behavior can be noted in date abuse that may occur in junior and senior high schools. In a high school in Glen Ridge, New Jersey, there was a gang rape of a developmentally disabled girl. Several male students inserted objects into the girl's vagina while other male students watched. They had no sense of their impact on the victim.

Attachment theory was intended as a revision of psychoanalytic theory, but it has been infused with biological principles, control systems theory, and cognitive psychology (Crittenden & Ainsworth, 1989). It began as an attempt to understand the disturbed functioning of individuals who had suffered early separations or traumatic losses, but it evolved as a theory of normal development that suggests explanations for some types of atypical development (Bowlby, 1969, 1973, 1980). Since Bowlby's preliminary formulations (1958), attachment theory has stimulated research into socioemotional development

and the growth of interpersonal relationships. For example, it suggests a causal relationship between the anomalies of attachment in the parent and abuse of the child (Ainsworth, 1980).

Family violence has been linked to mental illness and personality disorders, but the links have been established for clinical populations rather than by using case control methods or general population surveys. Studies of populations in women's shelters (Cascardi & O'Leary, 1992; Frieze & Browne, 1989:197) report that depression is quite common among women who are chronic victims of domestic violence. Clinical studies have consistently found high incidences of bipolar depression, anxiety disorders, posttraumatic stress disorder (PTSD), panic disorder, and suicide ideation among chronically abused women (Housekamp & Foy, 1991; Petretic-Jackson & Jackson, 1996; Walker, 1985). A large group of batterers was diagnosed to have borderline personalities along with a constellation of behavioral shifts: angry outbursts, rage, intense jealousy, blaming, recurring moods, trauma symptoms, haunting fear of isolation and loss, binge drinking, and repetitive self-destructive thoughts.

People prone to depression may be more prone to violence. A number of studies report that abusive mothers, as well as males who physically abuse their partners, show signs of depression (Zuravin, 1989) but the causal direction is not clear. Some sources of depression (e.g., repressed anger toward others) may cause the abuse; however, the depression may result from being labeled abusive, or from other consequences of the violent act (Reiss & Roth, 1993:238).

Assaultive and Homicidal Behavior

How do we explain interpersonal violence, especially partner violence and homicide? Explanations are difficult because violence is a transgression of a basic sense of connectedness between people, and we wonder how this kind of behavior can exist. We know that early attachment disturbance and the impairment of self-regulation are major diagnostic issues with traumatized children (Van der Kolk & Fisler, 1994). In courtship violence, the aggressor may not want the relationship to end. Terrorizing death threats, stalking behavior, monitoring a house by parking outside it, and making harassing phone calls are among the tactics used. Harassers cannot tolerate separation. They feel abandoned, angry, and depressed, and they may become suicidal. Rage is often behind their depression. Rejection is an attack on their ego. Frequently, they feel that they cannot manage on their own. Their limbic system is actually affected. They may lack impulse control. Fantasy calms them temporarily, but it is filled with rage directed at the partner. The distorted thought is: "I killed her because I love her."

In a study of murderers (Ressler, Burgess, & Douglas, 1988), three negative factors were identified as contributing to the development of the hostility. The

18 Family Violence

first factor is early childhood trauma, in the form of physical or sexual abuse. The developing child encounters a variety of life events, some normative and others unusual and extraordinarily negative. Within the context of the child's dysfunctional social environment, the distress caused by the trauma is probably neglected or mishandled. The child is neither protected nor assisted in recovery from the trauma; his or her external environment does not address the negative consequences of the events.

The second important factor contributing to the formative events component is developmental failure. For some reason, the child does not readily attach to his or her adult caretaker. As a result of this negative social attachment, the caretaker has no influence over the child—and later, over the adolescent.

The third factor, interpersonal failure, is the inability of the caretaking adult to serve as a role model for the developing child. Among the various reasons for this failure is the caretaker's being absent or serving as an inadequate role model (e.g., an abusive parent). The child may witness a violent home environment in which aggression during drunken fights becomes associated with the sexual behavior of adult caretakers.

In domestic murders, the killing may be spontaneous. For example, in June 1995, two young boys died of hyperthermia after being buckled into car-seat belts and abandoned for 8 or 10 hours while their 20-year-old mother partied and fell asleep at a Tennessee motel. This case did not involve intentional killing. However, some domestic murders are staged and involve careful planning, as in the case of Diane. In 1983, in Springfield, Oregon, at about 10:30 P.M., Diane pulled into a hospital emergency area and screamed for help for her three children, who had been shot. Her 7-year-old daughter Cheryl was dead on arrival; her 8-year-old daughter Christie had two small-caliber bullet wounds in her left chest and a third bullet wound through the base of her left thumb; and her 3-year-old son had a bullet entry to his spinal column. Diane had a gunshot wound in her arm. She said she had been driving in her car when she noticed a man standing in the middle of the road. She stopped and got out, and the man pulled out a gun, reached through the window, and shot the children and herself. She said she then pushed him and kicked him in the leg, jumped in her car, and sped off for the hospital. The story fell apart when her daughter Christie proved to be an eyewitness to the crime. She saw her mother go to the trunk of the car, where a gun was stored, come around the car, and shoot Cheryl, then her brother, and then herself. Another witness testified to seeing Diane's car creeping along the road at about 10:15 P.M., apparently waiting for the children to die before she drove to the hospital. Her diaries, and unmailed letters to a married letter carrier with whom she was having an affair, contained incriminating statements, such as: "You know I don't want a daddy for my kids . . . you would never be left alone with them." Her motive was to eliminate the obstacle (her children) to her fantasized relationship with her lover.

A history of Diane's background revealed child abuse, neglect, and incest. Little, if any, attachment occurred with protective caretakers. The result was clearly a flaw in human development and attachment.

We do not deny that other environmental stressors play a role in shaping moral development, but case after case will address the issue of failure of attachment and how it excludes the welfare of others. The abuser imitates the behavior of others. Such behavior is not drawn out of true individuation and appreciation of the uniqueness of others.

Elder Abuse

Aggression toward the elderly is multifaceted. Abuse may be inflicted on parents who had been abusive and exploitative. One needs to distinguish between elder spousal abuse and abuse by elder persons' children. The dynamics are different, despite many common antecedents.

Child and spousal abuse have received increasing attention in family violence research, but very little is known about the nature of elder abuse. The characteristics of individuals and families associated with abuse of the elderly need to be researched, as do the features of interventions designed for other forms of family violence. They may be adaptable to this problem.

INTERVENTIONS

There are no easy answers to problems of family violence. A comprehensive set of family support programs, or a continuum of services for families within each of the developmental phases of family life, does not exist. Although services are needed for ongoing abuse cases, it is critical to identify families at risk for potential violence. Rather than waiting for incidents of violence, counseling and education services need to build on an integration of existing interventions, and to design proactive approaches that are responsive to community needs and are feasible with community resources. Other suggestions follow.

COURTSHIP VIOLENCE

Recent research has provided a better understanding of relationship problems that lead to dating violence. In Riggs's study (1993), although aggressors generally reported more problems than did nonaggressive individuals, the difference appeared to result from specific problem areas. These included jealousy, interference of people outside the relationship (such as friends and parents), and more fighting and conflict between the couple. If one conceptualizes jealousy as a reaction to

20 Family Violence

the threat of loss, writes Riggs (1993), it is possible that such a threat will also result in anger, which could lead to aggression. Other issues that may be related to jealousy, such as possessiveness and control, may also lead to aggression.

ASSAULTS ON SPOUSES

Police Response

Most research has focused on testing police arrests of the abuser in preventing recurrences of domestic violence. Arrest, in replication studies, has been shown to *not* be an effective deterrent; indeed, it may well increase the incidence of domestic violence of unemployed males with low socioeconomic status (Sherman, 1992). Research is recommended on police responses as well as police referrals to social service and substance abuse treatment agencies, and to battered women's shelters.

Shelters and Other Services

In the past few decades, programmatic efforts have focused on providing shelters for battered women—residences where abused women and their children can stay safe and receive emotional support. Approximately 1,200 shelters offer temporary emergency housing (a typical stay is from two days to three months) to more than 300,000 women and children each year (Reiss & Roth, 1993). A national survey of 622 shelters indicated that their average annual operating budget was between \$135,000 and \$160,000. The average staffing pattern at each shelter consisted of six full-time and four part-time paid staff and 25 volunteers (Roche & Sadoski, 1996).

The primary goal of shelters is to provide a safe and secure haven for battered women and their children. Other services are designed to help the women become self-sufficient. They include relocation assistance, day care for children, and welfare advocacy. Services directed at increasing self-esteem include support groups and courses on parenting, job readiness, and budgeting. Services for children who have witnessed family violence are often incorporated into shelter programs.

The Duluth Minnesota Domestic Abuse Intervention Project (DMIP) conducted a 12-month follow-up study in which battered women were asked their opinion of the intervention that the Project had used in an effort to have the batterer change his violent habits. Of the women studied, 60% said they felt there was improvement when the batterer took part in education and group counseling, whereas 80% of the women stated that the improvement had resulted from a

combination of involvement from police, courts, group counseling, and the shelter (Pence & Paymor, 1993).

Programs to reduce partner assault include public education and awareness campaigns for batterers. Educational programs help children to develop non-violent ways of coping with anger and frustration. Public awareness programs emphasize that family violence is a crime, and help is available. Courts also mandate that batterers attend programs that will teach them alternative ways to behave. Alcohol and drug abuse programs are required for batterers whose chemical abuse is an issue.

Pharmacological interventions may be useful. Based on the understanding that depression may affect the severity of maltreatment of children as well as lead to their neglect, medical treatment of depression may be indicated. If a significant subgroup of abusive parents or caretakers suffers from affective disorders, especially major depression, then chemical and other forms of treating depression may be a means of controlling family violence. This approach assumes that reasonably effective means are available for controlling affective disorders, particularly any volatile mood swings associated with them (Reiss & Roth, 1993:239).

CHILD ABUSE

Foster care placement is a major intervention in child abuse cases. An estimated 15% of victims of child maltreatment are placed in unrelated foster homes (American Humane Association, 1979). Several studies have noted that the more changes in placement a child experiences, the greater the likelihood of his or her adult criminality and violent criminal behavior (Hensey, Williams, & Rosenbloom, 1983; Lynch & Roberts, 1983; Widom, 1990).

Home nurse visitation is one proactive means of detecting maltreatment of infants and preschoolers. Olds (1988) and Olds and Henderson (1989) studied this intervention in high-risk groups—poor, unmarried, teenage mothers having their first child—and found that it decreased but did not totally eliminate the incidence of child abuse when compared with groups not receiving the intervention. In this study, there was a 5% rate of child abuse or neglect, suggesting a need for additional preventive or ameliorative interventions. However, there were additional positive effects of the home nursing intervention. At 12 and 24 months, infants of mothers in the high-risk group showed improved intellectual functioning on development tests. Improved family functioning was noted, along with less evidence of conflict and scolding, and less punishment of infants. Olds and Henderson also concluded that although the nurse can link families to community and social services—to ameliorate the effects of poverty, violence, and drug

22 Family Violence

use—a lack of employment opportunities in the neighborhoods where these families live poses severe constraints on their continued improvement, especially when the intervention stops.

FAMILY VIOLENCE CASES BY TYPE OF CRISIS: A NEW TYPOLOGY

Clinical typologies and classificatory schemas help to define, group, organize, and structure persons by a set of rules or patterns. Types or categories are often organized around “prototypes” or “typical examples,” but they often have somewhat vague end points or boundaries. The “ideal” or prototype of each crisis is easy to visualize (e.g., a traumatic crisis or a psychiatric crisis), but the boundary between the two types is fuzzy. Nevertheless, clinicians learn best about classificatory schemas or typologies through typical case illustrations and applications. This concluding section focuses on a summary description of each of the seven types of crisis and presents a clinical case vignette.

The stress-crisis continuum classification devised by Burgess and Roberts (1995) is an adaptation and expansion of Baldwin’s (1978) crisis typology. Seven types are identified: (1) somatic distress, (2) transitional stress, (3) traumatic stress-crises, (4) family crises, (5) serious mental illness, (6) psychiatric emergencies, and (7) catastrophic crises. When there is advancement from type 1 to type 7, the internal biopsychosocial conflicts of the client become more serious, chronic, and lethal in nature. This continuum focuses on violence within families in crisis.

Most crisis-intervention and time-limited treatment models fail to take into account the different levels and types of acute crisis episodes. The following descriptions of the different types of acute crisis episodes among victims of family violence are based on Burgess and Roberts’s (1995) seven-level stress-crisis continuum. The discussions include the nature and extent of violence, the nature of injuries, types of emotional abuse, alcohol or substance abuse, suicide attempts, and psychiatric diagnosis.

1. SOMATIC DISTRESS

Somatic distress is associated with a medical presentation of symptoms. The abuse issue is usually not disclosed. Examples of this type of crisis precipitant in domestic violence cases include bruises, fractures, and bleeding. Generally, the patient responds to this type of stress-crisis with fear, anxiety, and/or masked depressive symptoms. The etiology of the crisis is physical injury and psychological abuse. Primary care providers or emergency department staff generally diagnose and treat somatic stress-crisis. Intervention typically involves treatment of the

injury, identification and confirmation of the abuse, and referral for crisis intervention and shelter. The police or family court may be contacted if the victim wishes to file for a restraining/protective order.

Case Example

Doris was a 23-year-old divorced mother of two children, ages two and four years. Her husband's abusive behavior caused multiple visits to an emergency room. While Doris was pregnant, her husband repeatedly would punch her in the stomach, throw her to the ground, and tell her how she repulsed him. Her terror of him increased because he would periodically strangle her and she noted that "his eyes were popping out." After the divorce and during a visitation, his abuse occurred in the presence of the couple's children. Doris sought medical assistance, but she never reported that she was being abused; instead, she provided a reason for each injury. She reported the following during her most recent emergency room visit. "He knocked the front teeth out of my mouth. I was in a bar and I never went to a bar while we were married. But, he started rejecting me and telling me I was ugly and stuff. He found me there and said, 'What are you doing here with all these guys looking at you?' I wasn't even looking at them. He called me a slut and punched me in the mouth with a glass and broke my teeth and bashed my head in front of everyone in the bar. I went to the emergency room but they really couldn't do anything for me but stop the bleeding. They told me to go to a dentist. I had to get two false teeth. The doctors were helpful but I lied to them because he was standing over me. I told them I fell and did it to myself."

2. TRANSITIONAL STRESS

Transitional stress is precipitated by life transitions over which the patient may or may not have substantial control. Abuse related to family violence may occur during pregnancy or after the delivery of the baby. In a frequent example, family members visit maternity, pediatric, and nursery units, and arguments about paternity, infidelity, or custody ensue. Sometimes, prior child protective services contacts and/or family court orders of "No contact" are not communicated to staff. These arguments, directed initially at spouses, frequently escalate into physical violence and may endanger nursing staff members who intervene. Critical-incident planning is needed to provide prior guidance and define roles for staff. Instantaneous communications (panic button, cell phones, electronic pendants, portable radio, dedicated phone line) and closed-circuit TV (taped and monitored) should be ongoing so that security staff can be summoned and may observe incidents.

24 Family Violence

Case Examples

“I was pregnant, had my daughter. He couldn’t be found till I was released. The doctor told him to his face that I had eight stitches and we couldn’t have sex for four to six weeks. He said he was going out drinking with the boys. He came back drunk and wanted to have sex. I fought him off for about one hour, but I was so weak. I was all bloody ’cause the stitches popped; he just pulled all my clothes off and raped me. I went to his parents’ house and they told me to go to the police. So I did, but they said there is no such thing as a marital rape law. They wouldn’t let me press charges.”

A two-day-old infant was abducted from his hospital bassinet while his mother was in the shower. Hospital security was notified immediately and a search was initiated. Local police were called into the investigation within an hour of the abduction. A search of the apartment of the mother’s ex-boyfriend revealed the infant. He was returned, unharmed, after a 14-hour search. The abductor told police that his girlfriend had acknowledged that he was the baby’s father, but said she would not give him visitation rights. The case was referred to family court for resolution.

3. TRAUMATIC STRESS-CRISES

Traumatic crises are precipitated by externally imposed stress that overwhelms the individual. Examples include stranger rape, acquaintance/date rape, spouse assault, marital rape, and battering among cohabiting partners. The individual’s response includes intense fear, helplessness, and behavior disorganization.

Case Example

A college sophomore and her roommate took the campus bus to study at the school library. After studying for three hours, two male students invited the young women back to their dorm to play cards. The game required the loser to drink a glass of beer. Over the next few hours, the four became intoxicated and the women missed the bus back to their dormitory. The young men said they would sleep on the couch and offered their beds to the women. Nancy fell asleep immediately but was awakened to the presence of one of the young men who removed her clothes and proceeded to force sex on her, despite her protests. The next morning, the women returned to the dorm and attended classes. Nancy became increasingly anxious and distressed. She could not get the thought of the

Case Example (*Continued*)

rape out of her mind. She was unable to concentrate in class, do homework assignments, continue her part-time job, or attend social functions. By the end of the semester, she had failed two courses and was on academic probation. Her roommate encouraged her to report the rape to the Women's Health Center, which she did. She also reported the rape to local police, but criminal charges were not filed. A civil suit was filed against the university and later settled out of court. Nancy received short-term counseling and attended group sessions at the local rape crisis center (Burgess & Roberts, 2000).

4. FAMILY CRISES

Family crises reflect serious disruption in partner or caregiver relationships. These crises involve failure to master developmental issues such as dependency, value conflicts, emotional intimacy, power and control issues, or attainment of self-discipline. The problem is especially noted through relationship difficulties. Examples of events that precipitate family crises include child abuse, the use of children in pornography, parental abductions, adolescent runaways, battering and rape, and domestic homicide.

Case Example

Emily died on March 13, 1995, at the age of nine months. She was the youngest in a family known to the Department of Children and Families for over three years. Emily suffered a broken leg, with no reasonable explanation, only three weeks before the injuries that led to her death.

A review of the case revealed several points at which the extreme danger to children in this family might have been recognized. First, the multiple injuries to a sibling, during the sibling's first year of life, were never recognized as suggestive of abuse by medical staff at a local hospital, during sporadic clinic appointments. When severe medical neglect of another child was reported to the Department of Children's Services, the serious consequences of that neglect were not sufficiently understood, medical information concerning the siblings was not sought (which would have revealed a pattern of possible abuse), and the case was closed. In October 1991, the police arrested the mother for risk of injury. The arrest record states that the officers found two children hanging out of an open third-story window. There were no adults in the unheated (52 degrees F) apartment, there was animal excrement on the beds, and no food was available. The responding police officers placed the children with a relative, arrested the mother, and did not

26 Family Violence

Case Example (*Continued*)

call the Department of Children's Services until the next day. The last opportunity to avert tragedy came in February and March of 1995, when Emily presented at a local hospital emergency room with a spiral fracture of her leg. This injury was reported by the hospital to the Department of Children's Services six days after the child was initially treated by an emergency care physician and an orthopedist. This referral was handled by a social worker who believed the inconsistent explanation ("accidental injury") given by the mother. Emily remained in the home and was fatally raped and abused at the age of nine months (Burgess & Roberts, 2000).

5. SERIOUS MENTAL ILLNESS

Serious mental illness reflects preexisting psychiatric problems. Examples include diagnoses of psychosis, dementia, bipolar depression, and schizophrenia. The patient's response will be disorganized thinking and behavior. The etiology is neurobiological in nature. Persons with long-term and recurring severe mental illness require a mix of traditional medical and long-term treatments that are helpful in sustaining their function and role. Roberts's (1991, 1995) crisis intervention model may be used to reduce symptoms in an acute crisis. Case monitoring and management are indicated, as well as an assessment for in-patient hospitalization or sheltered care. Medication will be needed to counteract psychotic thinking. Continuity of care is critical with this level of crisis and is generally accomplished through the case manager. Other services should include referral for vocational training and group therapy.

Case Example

An editor of the *Congressional Quarterly* magazine was shot and killed on June 4, 1995, in Arlington, Virginia, because he happened to arrive home at the wrong time, according to police. The 34-year-old editor and two of his roommates were killed by an emotionally disturbed man who was a cousin of one of the roommates. According to reports, the man arrested in the triple slaying went to the house intending to kill two of the victims—his cousin and her boyfriend, with whom the killer was believed to have had ongoing problems. The killings were triggered by an argument over a bicycle, living arrangements, and other problems (Burgess & Roberts, 2000).

6. PSYCHIATRIC EMERGENCIES

Psychiatric emergencies involve situations in which general functioning has been severely impaired. The result is threat or actual harm to oneself and/or others. Examples include drug overdose, suicide attempts, stalking, aggravated assault, death threats, rape, and homicide. The clinician needs to be confident in his or her skills to manage out-of-control behavior of the client and/or to have adequate assistance available.

Dangerous and volatile situations should be handled by police and local rescue squads; these units can provide rapid transportation to a hospital emergency room. The basic intervention strategy involves: (a) rapid assessment of the patient's psychological and medical condition; (b) clarifying the situation that produced or led to the patient's condition; (c) mobilizing all mental health and/or medical resources necessary to effectively treat the patient; and (d) arranging for follow-up or coordination of services to ensure continuity of treatment as appropriate. In this type of psychiatric emergency, the skills of the crisis therapist are tested to the limit. He or she must have a capacity to work effectively and quickly in highly charged situations, and to intervene where there may be life-threatening implications of the patient's condition (Baldwin, 1978; Burgess & Baldwin, 1981).

Case Example

Mindy, age 22, a visiting nurse with a five-year-old son, described vivid scenes of violent assaults wherein her boyfriend would hit her with a lead pipe and with empty beer bottles. In an attempt to cope with the abuse, she took drugs and attempted suicide. In the words of Mindy: "I O-D'ed on cocaine intravenously. Purposely. I couldn't take it anymore. I was real depressed and upset and afraid that he was going to beat our son. I went to the hospital. They pumped my stomach and then told me I was a drug addict. They put me in a 90-day inpatient drug program which I didn't complete. The psychiatrist put me on an antidepressant and she completed short-term counseling" (Burgess & Roberts, 2000).

7. CATASTROPHIC CRISES

Catastrophic crisis combines a type 3 traumatic crisis with type 4, 5, or 6 stressors. Often, the victim is a battered wife and actual or threatened escalation includes the partner as well as the children. The victim has a history of unresolved

28 Family Violence

traumatic or family crises during childhood or early adolescence. For example, Lila was the second oldest child in a family of 10. Her father was stabbed to death when she was 13. She moved out of the home at age 16, when she was pregnant with her first child. She missed out on high school and social activities because she had to work to support her child. She married at age 20 and had four more children. Her husband was physically abusive; he punched and kicked her, and burned her with a lit cigarette. He threatened, during a year when they were separated, that he would burn the house down when she and the children were inside. In a 1995 Maryland case, an estranged husband lured his wife and three children into his car under the pretense of driving them to a local mall to buy school clothes and supplies. He detonated a car bomb while parked in the mall parking lot, killing all five and injuring others in the vicinity.

Case Example

Police received an emergency call that a pregnant woman and her husband, driving home from a childbirth class, had been shot by an unknown assailant. The couple was located and rushed to a local hospital. Surgeons were unable to save the young woman. Her baby was born by caesarean section but died 10 days later. Following a lengthy investigation, the police identified the husband as their prime suspect. Prior to his arrest, the husband jumped off a bridge and drowned. The husband's brother was arrested and charged with aiding in a felony; he had disposed of two bags containing jewelry and the murder weapon. Police divers later located the evidence. This case qualifies as a catastrophic crisis because of the deaths of the mother and her infant, the disclosure of the wife as a silent battered woman during the marriage and pregnancy, and the suicide of the abuser.

CONCLUSION

This chapter has suggested that health care and mental health professionals need to be cautious and innovative in their initial assessment of a client's type of crisis. Many clients in a crisis state will fit one of the seven types of crisis; others will not fit at all. The seven types of acute crisis appear to be "ideal types"; they are not. A person may have two crises simultaneously—traumatic and family crises. The primary diagnostic task of the crisis clinician is to determine whether—based on the client's symptoms, characteristics, and behavior—she or he fits one of the seven types. There will always be diagnostic and

classificatory uncertainty. This chapter has provided a structured and organized typology that can yield partial resolution of diagnostic uncertainty of acute crisis episodes. Identification of seven types of crisis provides clinicians with a classificatory schema and concrete intervention strategies. The case illustrations indicate the complexity of clients' presenting problems and other biopsychosocial variables.

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32 Family Violence

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