Clinical and Research Perspectives on

FAMILY VIOLENCE

UNHAPPY FAMILIES

EDITED BY

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Happy families are all alike;
every unhappy family is
unhappy in its own way.

TOLSTOY, *Anna Karenina*

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PREFACE

The first sentence of *Anna Karenina* sends an enigmatic message to all concerned with family violence. "Happy families are all alike; every unhappy family is unhappy in its own way."

Families of victims of child abuse, child sexual abuse, and family violence all look alike to many professionals and public officials. This is due both to the biased case reporting process which favors poor families for identification and study, and to the superficial nature of practice in agencies where the task of protecting the victim is focused on a single decision point: whether to separate him or her from contact with kin.

The myth that family violence occurs only among the poor is dispelled somewhat by the few surveys of the prevalence of violence which avoid case reporting artifacts by selecting representative samples and asking individuals about their own experiences and practices. In our work at Children's Hospital, we have a continuing opportunity to observe how professionals assemble their knowledge and diagnostic formulations of childhood injuries and what they do about them. Our observations, and several studies, suggest that with regard to the problem of child abuse, class and race, as much as clinical severity, define who is identified as the victim.

That the myth persists indicates that it has some meaning. With respect to "child abuse," we believe the meaning is found in the way child abuse as a homogeneous entity functions to maintain our social equilibrium. Sociologist Richard Gelles, one of the contributors to this book, suggests that because we can point to the bad parents over there, what we do in our homes is OK. Professor David Gil, another contributor, carries the smokescreen metaphor a step further. The sensational nature of the child abuse problem, he argues, allows us as a society to ignore the fundamental needs of millions of our young, for food, housing, education, and health. We want and need "abusive families" to look alike, just so long as they are different from the rest of us.

The objective of this book is to provide straightforward and clear discussions of current practice and research on family violence in ways which will illuminate the many problems which we see in clinical work. Originally, these chapters were presented at interdisciplinary seminars for clinicians and researchers as a part of our Hospital's training program on family violence which is supported by research training grants from the Center for Studies of Violent and Antisocial Behavior of the National Institute of Mental Health and from the National Center on Child Abuse

and Neglect in the Federal Department of Health and Human Services.

We and the contributors have edited the chapters in such a way as to weed out unnecessary scientific and clinical jargon and to preserve the conversational tone. We have kept some questions and responses which probe particular issues and which serve to illustrate the diverse perspectives brought to bear on the subject by professionals from many disciplines.

Our hope is that this book will enable the reader to see each unhappy family as different and worthy of being treated respectfully and well.

Family violence is an issue which commands attention from all of us, and no one person can sufficiently well understand or help a victim and his or her unhappy family. We depend ourselves on our cherished associates whose personal and professional commitments to unhappy families make our work possible. The establishment of the training program and seminar series which led to this book was a substantial additional effort on behalf of our co-workers, and we thank them here knowing that simply listing their names does not do justice to the long hours, sleepless nights, and struggles to sustain communication in the face of the interpersonal and interprofessional conflicts which go with the territory when one works on family violence. These colleagues are Jessica Daniel, Barbara Danzell, Howard Dubowitz, Debbie Fenn, Robert Hampton, Drew Hopping, Sylvia Krakow, Joanne Michalek, Stephen Shirk, Betty Singer, Pamela Whitney, and Ellen Weiss. We are indebted to Marilyn Felt whose expert editorial work helped to keep in focus the most important issues in the text. Our wives, Carolyn Moore Newberger and Carole Rice Bourne are pillars of strength and patience without whose love and support we could not continue to carry forth in this unhappy field of work.

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January 16, 1985

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CHAPTER 1

Family Violence: What We Know and Can Do

Richard J. Gelles

It is important that clinicians and researchers understand that detrimental interactions within families are of many types. They may differ in kind, in impact, in cause, and in treatment and policy. For the sake of convenience, however, they have all been compressed by professionals and the media into the generic term, *abuse*. So we have child abuse, wife abuse, elderly abuse, and parent abuse. The word *abuse* has become a political concept which stands for things that are done to family members which are thought by many to be harmful and about which people want to take some kind of remedial or ameliorative action. Placing things like the physical beating of children, the emotional neglect of children, and the failure to thrive syndrome under the term *child abuse* is convenient for communication but inconvenient and misleading for both research and clinical practice. While neglect may be related to child abuse, and while sexual abuse may be related to physical abuse, they are distinctive phenomenon arising from different causes and often requiring different intervention and preventive strategies.

My concern as a researcher has been exclusively with physical violence between family members ranging from the normal kind of violence such as spanking, which is typically dismissed by clinicians as being part of family relations, up to lethal forms of family violence (for example, homicide), about which there is consensus that they are inappropriate in family relations. That is not to say that neglect, emotional abuse, or verbal abuse are not problematic and harmful, but to say that the act of physically striking another human being is conceptually and programmatically distinct from acts of omission.

FREQUENCY OF FAMILY VIOLENCE

The estimated incidence of family violence, child abuse, wife abuse, husband abuse, and elderly beating, varies on who is asked. It varies because of the variable and frequently imprecise definitions used and because most people base their estimates of incidence on cases that come

to public attention. In the state of Rhode Island in 1967, officially there were not any cases of child abuse. By 1977, it was in excess of 1500 cases, leading many people in that state to believe there was an epidemic. What was ignored were two social forces: one was the passage of a mandatory reporting law, and the second was an increased sensitivity on the part of clinicians that injuries to children may be inflicted by their parents.

Another problem with official statistics on child abuse and neglect is that they are skewed. Only certain injuries which occur to certain types of people in certain types of families are officially designated as abuse. Poor families, black families, non-English speaking families, and socially marginal families are disproportionately susceptible to having the label *abuse* attached to behavior in their households. Mainstream families, well-to-do families, and families of physicians, attorneys, and college professors find that injuries to their children are almost uniformly classified as accidents.

In order to correct this bias, in 1976 we carried out a study most people said could not be done. Believing that the studying of officially reported or clinical cases of child and wife abuse was not an accurate way of finding out how extensive family violence was, we interviewed a representative sample of 2143 American families. We knew that we could not march into the American household and ask if they had stopped beating their child, wife, or parents, so we used an instrument called the Conflict Tactics Scales. The scale begins by introducing the idea that all families have conflict between one another and typically use many ways of dealing with this conflict. We then read a list of some 20 items and asked if the subjects had used these techniques to deal with conflict and how frequently.

The first technique was, "We discuss the issue calmly." By item 16, we were asking respondents whether they slapped or spanked, and the last item on the list was how often they used a knife or a gun. The answers we got to the latter question amazed us. From the responses we could project that approximately 50,000 parents will use knives or guns against their children each year. Nearly half a million American parents have used knives or guns against their children while raising them; 175,000 siblings used a knife or a gun against a sibling in the previous year. And some 100,000 husbands and wives use guns and knives against one another in one year. That is not nearly as amazing as the fact that people reported these behaviors to us. It may be assumed that when people tell us that they used a knife or a gun against their child, they are not necessarily thinking that it is terribly wrong.

We combined the items we saw as abusive and violent to try to get a handle on how extensive the problem of child abuse and wife abuse is in the United States. We included kicking, biting, punching, hitting or trying to hit with an object, beating, threatening with a gun or a knife, or using a gun or a knife. For women, our estimate is 3.8% of women

living with men (either married to those men or living together in a family-like relationship) are abused each year (with a sampling error of ±1%). Child abuse involves 3.6% or 1.6 million children aged 3 to 17. That figure would go up if we included children under age 3 (we did not because of the nature of the study) and if we included single parent families (we did not because we also wanted to study spouse abuse). Consequently, one could realistically think about children at a rate of 4% or 2 million rather than 3.6% or 1.6 million. The figure for parents who are struck by their children, including only acts that could do harm (acts of children over 11 years old), is about 3.5%, between 500,000 and 1 million parents.

Considerable newsprint has been devoted to elderly abuse this year out of proportion to how much research has been done. Estimates are, however, that growing old does not insulate a person from family violence and that people over 65 who have frequent contact with their children also run a risk of abuse at approximately the same rate as other family relationships, between 3% and 4%.

For a clinician or a physician in practice, the percent figures and the million figures probably do not hold a lot of meaning. If abused people were distributed across the population evenly, which they are not, clinicians would then be seeing abused children at a rate of 1/22 children seen, and they would be seeing abused wives at a rate of 1/21 wives seen. They would be seeing battered elderly (and this is low because we are dealing with people over 65 who are married, who had children, whose children are still alive, and who may see their children) at approximately a rate of 1/22 elderly persons seen.

Family violence is far more extensive than any official statistics have ever indicated, yet the figures are in all likelihood underestimates because they are based on what people are willing to tell an interviewer in a 60-minute interview. My guess is that each of the abuse figures is low by a factor of 20% to 50%.

Incidence data simply establish the nature of the problem and indicate how much concrete economic and social resources have to be brought to bear. If categories of victims are added up, it is evident that this problem affects some 8 to 10 million American families of the 56 million in the United States.

Labeling Bias

After determining incidence, the second question is, in which families are these violent events most likely to occur and why? This is where I want to discuss definitions and labeling. Two modes of research most frequently used by family violence researchers are: 1) drawing cases of abuse from the local protective service agency; or 2) if that agency happens to be particularly nasty toward researchers, which is sometimes the

case, making a friend with a mental health agency or a hospital such as Children's Hospital and drawing cases from their clinical case load, and then finding some kind of matched comparison group and drawing conclusions and analysis.

There is a distinct problem in these research modes, and it was made clear in a study of 76 pediatricians in Baltimore, Maryland. The pediatricians were presented with a contrived medical file which had all of the normal social and medical information about a child's family. They were presented with a medical file and asked to review the information in it, and to assess an injury that had occurred to the young child in the medical record. They were then asked if they thought this injury is child abuse, how severe it is, and whether they would report it to the authorities in the state of Maryland. What the physicians did not know was that one factor was manipulated in the medical record. Half the physicians received a file in which the child's father was identified as a truck driver. The other half got a child whose father was identified as a salesman. Everything else including the injury, the x-rays, and social information was identical. The son of the truck driver was 40% more likely to be reported as a case of child abuse than the son of the salesman. In the second administration, another single factor was varied, and that was the race of the child. Occupations were the same. Everything was the same in both files only one child was described as black, and one child was described as white. The black injured child was 33% more likely to be reported as abused than the white injured child.

If one then bases research conclusions on an analysis of cases of child abuse diagnosed by physicians, then one would conclude that manual laborers and blacks have higher rates of child abuse when, in fact, being a manual laborer or being black contributes to getting caught as much as it does to who actually carries out the act.

Correlation with Family Violence

In the early discussions of family violence as well as in current discussions, we employed a "kind-of-person" model, to try to explain which people abuse children and which children would be abused. The "person model" is still in favor. It is in favor because people who make diagnoses are trained epidemiologically to look at kinds of people; physicians, psychiatrists, and social welfare personnel are trained to look at individuals and find differences between individuals. The "kind-of-person" model reached its highest point of absurdity when an author wrote in a prominent medical journal that parents who abuse their children were characterized by an inability to control their aggressions, and thereby the personality trait of inability to control aggressions should be looked for in diagnosing child abuse. As in this case, it has happened frequently

that the proposed cause of child abuse has, in fact, been a synonym for the words child abuse.

It is generally agreed now that, at most, 10% of wife abuse and child abuse cases are attributable to mental illness and character disorders or, in other words, to "kinds of people." The other 90% of the abusers defy clinical classification as suffering from individual aberrations. They are not different psychologically from most people.

Generally four factors are found to be related to family violence. Note, "found to be related," should be understood as a probability statement, not a determining statement. The first factor is that family violence is, in many cases, transmitted intergenerationally. An abused child's chances of becoming an abusive adult are, in some instances, a thousand times greater than a nonabused child. However, the base rate of child abuse is not especially high, 3.6%; so a thousand times greater does not mean that every abused child grows up to be an abusive parent. In terms of my own research findings, there is only about a 50% chance that an abused child will become an abusive parent. For a social scientist, that is a strong association. For a clinician, that is too weak to base a prediction on. It is important for clinicians to realize that although the social scientists jump for joy over strong associations, strong associations do not necessarily make predictive instruments.

The second factor is that abuse of all kinds is more likely to occur in lower socioeconomic families. Families below the poverty line have rates of wife and child abuse which exceed the rates of those making $25,000 or more per year by a factor of two. But again, all poor people are not abusers, and abuse can be found in some fairly well-to-do families.

The third factor is that abusive families of all kinds are characterized by significant social isolation which can be identified by noticing how few organizations in the community abusive families belong to, how little contact they have with neighbors and relatives and families, and how many moves they make. Abusive families typically do not live in the same neighborhood for a long time. One of the factors that we have found very strongly related was living in a house in a neighborhood less than two years.

The fourth factor is social stress. The higher the social stress the greater the chance that the family will be abusive.

With regard to other factors related to family violence, blacks and whites show no difference in rates of child abuse. That should not have been the case on two grounds. One, the reported cases are so disproportionately black that we were led to believe that blacks were more abusive than whites. Also, on a national scale, blacks make less money, have less education, and have poorer jobs. By and large the black sample we surveyed corresponded to blacks in our society, and yet despite their low income and high stress, they were not more abusive. The explanation for this was that our study showed that blacks, compared to whites, had more

contact with relatives, more community membership, and more contact with the church. They were able to network both on a community and a relationship basis to ameliorate the stress that might have led to child abuse. This same networking, however, did not ameliorate the chances of wife abuse, and the rates in the black community were considerably higher than rates among whites.

Some Other Data of Interest

Agnostics and atheists have higher rates of abuse. Another factor is that abuse is more likely to happen in young families than in older ones. Since violence is more likely to be found in young people, and younger marriages have more transitions, that finding makes a good deal of sense. Education did not prove to be the factor we thought it would; low education was not related. Income, as I said, was related. Manual workers do have higher rates of abuse than white collar workers, and part-time and unemployed workers had higher rates of family violence than men who were employed full-time, with the rate for the few part-time workers being double the rate for husbands with full-time jobs. The last factor is the power structure of households. If a family moves toward sharing decisions and an egalitarian household, the chances of violence taking place may possibly be reduced by half.

CAUSATION

Causal explanations are few to be found. People abuse family members because they can. There are rewards to be gained from being abusive: the immediate reward of getting someone to stop doing something; of inflicting pain on someone as revenge; of controlling behavior; or of having power. All of these rewards are evident in other social settings. Why don't people beat up their neighbors when they return the lawn mower broken? Why don't people beat up their boss, when he makes them stay late on the night they have show tickets which cannot be returned? Why don't people beat up their annoying co-workers? The motivation is there and is, perhaps, as strong as the motivation in families. They do not because the costs are too high. Beating up a boss could result in being kicked back, fired or having the police called. The police are known to respond faster when people are beating up a stranger than when they are beating up a family member. Beat up a stranger and the result could be assault charges or incarceration. Very few of those controls operate in families. A person does not lose his job for beating his wife or beating his children. The risk of official social control is rarely run; judges are despondent when faced with a choice of leaving a family intact or criminally prosecuting the abuser. The tradition in families is for a more powerful

person to beat on someone less powerful, someone who cannot return and inflict even physical costs.

From my point of view, exchange theory and social control theory are the explanations. In a therapeutic setting, the abuser might say to the therapist: "I really like my kids, I really feel guilty, I feel terrible about it, but they got me so mad, I could not help myself," or, "I drank so much, I could not control myself," or, "Wouldn't you do that if you had such and such happen to you?" If a therapist buys in on the theory that kids can be so maddening, that alcohol makes a person so loose, that wives can nag so much that a person cannot control himself, that therapist licenses that person to abuse again. Anytime a clinician buys in on these rationalizations, or agrees that he would do the same thing under that stress, he takes away the costs that should have impact on the internal social control of the abuser.

CLINICAL INTERVENTION AND SOCIAL POLICY

That statement begins a rather brief discussion of how we apply knowledge to clinical practice. Very briefly, very generally, from the point of view of diagnosis it is important not to be ruled by single factor explanations. Nor is the intergenerational transmission of abusiveness so strong that a positive diagnosis can be made from that information alone.

Child abuse is not a pathology in the medical sense, and it is not amenable to either a germ explanation or diagnosis. Full medical, psychological and sociological information is required in order to diagnose how an injury occurred and whether it was accidental or inflicted.

From the point of view of treatment, I cannot say that I am wedded to any particular modality. I do have a bias toward family treatment as opposed to individual treatment because the family system is what spawns the violence, not an attribute of the individual. The treatment goal and the most general way of presenting it is this: if the cause of family violence is that people abuse family members because they can, the goal of the clinician is to make it so they cannot.

A clinician should not accept, even if he believes them, the rationalization, "I cannot control myself, I drink too much, I've got an alcohol problem." He should not make such a rapport with the abuser that he minimizes the impact of what the abuser has done. The clinician must consider ways of raising the costs without damaging the self concept of the abuser and other family members. It does not do much good to spend numerous therapy sessions getting the abuser to not only accept responsibility for the act, but to accept the pejorative term child abuser. Instead, generating informal mechanisms of social control in that household should be emphasized, ie, getting somebody to play bystander or, at worst, policeman. Homemakers serve two wonderful functions: one, they alleviate stress