

Joining Forces

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RESEARCH NEWS YOU CAN USE

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PROCESS ACTION TEAM REVIEWS DATA FROM SAN DIEGO CONFERENCE

The Process Action Team (PAT), chaired by Delores Johnson, Headquarters, Department of the Army, Family Advocacy Program Manager, met on 25 and 26 March 1997 in Washington, D.C. to review data from the 15 groups that met in San Diego. The meeting was organized to consider implementation of recommendations that emerged during the conference. To facilitate this process, outcomes and outputs developed for each subject area were summarized and compared to each group's overall objective. Additionally, the PAT reviewed the work of each group relative to a matrix that considered: the strengths and weaknesses of each group's report and recommendations, the evaluation plan, and actions that require further work.

Relative to implementing group recommendations, consideration was given to the subject area's value to the Army, the completeness of each group's task/assignment, implementation costs and time, and action responsibilities.

A final piece of the PAT's work during the meeting was the combining of similar work group content areas and, based upon the completeness of work group tasks, the identification of actions requiring the least amount of time and effort to implement. The PAT closed out the meeting by establishing a process to encourage and support the field in continuing the evaluation process begun

during the conference. So, for those of you who attended the conference, how is your homework assignment progressing?

THE CHALLENGES OF PARTNERSHIPS AND MULTIDISCIPLINARY TEAMS

Raymond Emanuel, LCDR, USNR

Ideally, the advantages of the multidisciplinary approach are: different expertise on a multifaceted problem, avoidance of service duplication, and the coordination of treatment plans. Often, the reality of the patient's situation and the clinical environment do not foster these advantages. Instead, members of each mental health discipline seem to establish their own turf and approach to the problem. Even within specialties, there are differences of opinion about etiologies and approaches to treatment.

Associated with the dilemma of different specialties and theoretical perspectives is the technical jargon that often hampers communication between mental health specialists. When there is no definitive approach, or even common consensus, about the solution to complex social problems, practitioners often resort to their own devices.

There is often a considerable overlap of roles and expertise in the disciplines addressing family violence that counter balance the

advantage of different clinical perspectives. With fewer dollars available to support a limited number of programs, the economic realities pressuring practitioners not to share patients or clients often fosters intense competition between specialties and discourages significant collaboration.

With family violence, there is an added level of complexity not usually present in other mental health or social problems. Family violence, like illicit substance use, is also a legal issue. However, unlike substance abuse, there is very little tendency on the part of our culture to see child or spouse abuse as a disease, or label it as "recreational."

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Therefore, clinicians trying to address perpetrator behavior and support the family may not receive the same kind of support as those who deal with substance abuse or other behavior problems. The legal aspect of violence adds law enforcement and the court system to family violence management. Mental health workers vary in their familiarity with the legal system. However, this interaction is an unavoidable reality.

The assessment and treatment of family violence is often fragmented. It is parceled out primarily to law enforcement and

social service agencies with more peripheral involvement by psychology and psychiatry. There is frequently poor or no effective communication between or within systems to foster either service coordination, collaboration, or data collection. At the recent Family Advocacy Conference in San Diego work groups focused on gathering evaluation data and tried to establish an empirical basis for improving FAP prevention and treatment programs.

The military offers some unique opportunities for multidisciplinary collaboration, partnerships, and data gathering. However, there are several questions/challenges aimed at a multidisciplinary approach to family violence that echo prevention and treatment themes.

Is there a coordinated multidisciplinary approach to family violence at your facility? If not, what changes can be made at your facility to foster partnerships and a more multidisciplinary approach to family violence? How do your current evaluation, prevention, and treatment strategies compare with the most effective prevention and treatment modalities recognized in the field? Do you have easy access to this information? What data do you think would be most useful for you as a program director/clinician to improve and monitor the success of your program? Are you collecting that data? What happens to it after it is collected?

The answers to these questions may move your programs further down the road to genuine partnerships and multidisciplinary team efforts.

COUNTS AND RATES - WHICH IS MORE IMPORTANT?

What is the question the commander often asks you? "How are we doing"? That, of course, translates into "How am I doing"? This is true whether the question is about FAP statistics, drug and alcohol use, or other indicators of "good order and discipline." What is your best answer? It depends! If he/she inquires about FAP, would you answer relative to the counts (frequencies) or the rates (reference to a population) of an occurrence? It is often thought that the rate is the better number.

Let us distinguish between a frequency and a rate. The frequency is the count of cases or any other event, e.g., the number of child abuse cases at Fort Installation during 1996 was 132. Of these, there were seven cases of child abuse with major physical injury.

A rate has two figures, a numerator and a denominator. Therefore, it contains more information than the frequency (which is usually the numerator figure). The numerator is the number of cases. The denominator is the population at risk. In this case, "population at risk" is defined as the number of people capable of becoming a case (or, the population of children).

Suppose your commander wants details about cases that have been classified as major physical injury and you want to fully answer the question. What data do you need?

First, you need the count of cases of major physical injury for the time period in question, say last year. **Second, you need to** know the size of the population at risk. Now that you have the frequency (number of cases) and

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the size of the population at risk, you can calculate a rate, say the number of cases per 1,000 children. Third, you need to know if there were any events that might have affected your numbers such as a change in the post environment, changes in the reporting rules or standards, new members on the CRC that may make their views known in definite ways or anything else that might have a bearing on your numbers.

Let's plug in some numbers. In 1995 you found 6 cases of major physical injury to children in a population of 5,500 children. In 1996, there were 7 cases of major physical injury in a population of 5,000 children. So, you had a population decrease in the number of children and your number of cases has increased by one. Now, what are the rates and how do you calculate them? The rate per thousand is a simple proportion. If you have 6 cases for 5,500 population in 1995, what would the rate be if you had only 1,000 children? You divide 6 by 5,500 and then multiply by 1,000. Your rate per thousand is 1.09 in 1995 and 1.4 per thousand in 1996.

In this case, is the rate the most meaningful statistic? It is probably misleading and you would be better off quoting the frequencies. Why? If you tell your commander you had this increase in the rate, it may not be very meaningful. The picture would probably be magnified beyond what you want to describe.

I would report that the number of cases (frequency) was about the same. Find out the circumstances of the cases and see if there are any patterns.

If, in 1997 your population of children decreases to 3,000 and you have 10 cases, something is happening and you need to

determine what it is so you can apply a remedy.

There is no hard and fast rule for when to use a frequency and when to use a rate. Common sense may be the best guidance. Look for a continuity in numbers (trends) and have some sense of the facts behind the numbers.

CAUSALITY- HOW DO YOU THINK ABOUT IT?

Causality is one of the most importance concepts in science. If you think about causality and comparison in regard to your work, you are probably in a good position to address serious issues more clearly than if you did not consider them. Take child sexual abuse, for example. There is considerable literature on the effects of childhood sexual abuse on adult psychiatric symptoms and other impairments of adult life. Are these latter events caused by childhood sexual abuse? Maybe they are. If, however, you are inquiring about the science of the research, you have to look carefully at the research methodology. A thoughtful article on this subject was published in Journal of Psychiatry and the Law. Pope and Hudson (1995, Vol. 23, pp. 363-381) provided an interesting discussion of causes in relation to childhood sexual abuse. The authors provide information on sources of bias in selection, conduct of the research, and the nature of causality in research. They ask the reader to consider *selection bias*, *information bias*, and *association versus causality*.

Selection bias occurs when the subjects in a study are selected from different popula-

tions. For example, Pope and Hudson describe a hypothetical study of eating disorder patients who attended a clinic for treatment and a control group recruited from the community. Those who participated in the study did not come from the same population. The ones with eating disorders may have sought therapy more than the controls. It is also possible to select a population of controls that are "supernormal," that is, free from occupational or psychiatric impairments. The remedy is to make sure that the subjects are selected by identical recruitment methods from the same population.

Information bias occurs when the investigator obtains information from one group differently than the other. In this case, if the interviewer knows which group the patients are from, there may be a tendency to give subtle cues or to ask more questions of the treatment group than the control group. The remedy here is to use the same information gathering tools and to not know which group the interviewee represents. Another form of information bias occurs when the subjects provide additional information beyond that which has been requested. In other words, the person with the problem may have reflected on the origin of the problem, read more material, or had more treatment than the person without the problem. This may also be referred to as "recall bias" and is difficult to remedy. One approach suggested by Pope and Hudson is to use only severe cases so that recall bias is minimized.

The difference between association and causality should be familiar. We have probably heard about it but may ignore it

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SPIRITUAL WHOLENESS AND THE USE OF PHYSICAL VIOLENCE BY MEN

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Editor's Note: Congratulations to Major Freeman who completed his doctorate at Catholic University in October 1996.

The use of violence by men to resolve conflicts with their wives or partners is a problem thought to have grown to an epidemic proportion. Although a great deal is known and understood about men who are violent, there is a dearth of knowledge about the influence that spirituality has had upon their conflict resolution techniques. Currently, there are no empirical studies on the role of spirituality among violent men. The research reported here was designed to determine if there was a relationship between spiritual wholeness and the level of physical violence used by men. The researcher relied upon Jungian, transpersonal, and archetypal theory to provide the theoretical underpinnings of the study.

The cross-sectional study involved 133 men who were in treatment for domestic violence in Northern Virginia and Central Maryland. The researcher utilized a multivariate correlation design to test the relationship between the components of spiritual wholeness (awareness of spiritual energies or archetypes that promote ego development; a sense of purpose in life or existentialism; a relationship with God or transcendent being) and physical violence.

The study hypothesis was:

controlling for age, race, alcoholism, income level, and time in treatment, there would be a negative relationship between the components of spiritual wholeness and the level of physical violence.

Statistics showed that there was a significant relationship between the participant's awareness of the spiritual energies that promote ego development and the use of physical violence. The more these men were aware of the spiritual energy that promotes compassion, nurturing and caring for others, the less violence they used. However, the more they became aware of the spiritual energy that enables them to experience their sense of separateness and vulnerability, the more physical violence they used. Age was negatively related to physical violence and alcohol was positively related to physical violence. Existential well-being was also a statistically significant variable. The greater the participants sense of purpose in life or existentialism, the less physical violence they used. Spiritual energy that promotes separateness, awareness of one's vulnerability, pain, and victimization was most predictive of physical violence.

This data suggest that age, alcoholism, and being disconnected from the soul or having a lack of purpose was significant in the use of physical violence by men. However, their most significant problem was their lack of spiritual awareness at the ego formulation level. The data also showed that violent men were ambivalent about identifying with the spiritual energies that promote trust, nurturing, and assertiveness.

The results from this study empirically validates prior assumptions about violent men being inhibited from reaching

spiritual maturity because of their underdeveloped ego. This study also confirms that spiritual issues are significant, and should be considered in understanding and treating domestic violence.

PREVENTION OF CHILD PHYSICAL AND SEXUAL ABUSE IN GERMANY

**Dipl.-Psych. Susanne Bruns
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In Germany, physical or sexual abuse during childhood is not rare. It is not known exactly how many children experience such violence, however, there is a need for prevention.

Different types of prevention can be distinguished. Primary prevention is done by some child welfare organizations or state health departments. They inform people about the harm that violence does to children and that using violence is not appropriate. The social welfare system in Germany is probably one of the world's best. Financial help lowers some risk factors for family violence like poverty or bad housing situations.

Secondary prevention programs work with families at risk, for example offering counseling or courses about non-violent discipline. However, this is criticized by German experts. They believe no factor can predict violence precisely, and for ethical reasons people should not be stigmatized as potentially violent.

In Germany, prevention is mainly tertiary. If a child is abused, the first thing needed is protection. Some experts advise that in the case of intrafamilial sexual abuse, the pediatrician



should inform the police only in emergency cases when it does not go against the child's will. They recommend talking to the parents, offering family therapy and separating the victim and the perpetrator. This often means that someone has to be removed from the family. Separation is often done by placing the child in a foster home.

An alternative to foster homes are the so-called "Frauenhäuser" (Houses of Ruth). They offer shelter to mothers and their children. During the past 25 years, 376 Frauenhäuser were built in Germany. Each year about 40,000 women live in them for up to four weeks. Most of the women are between the ages of 20 and 40 and bring one or two children with them. Approximately 40% move to their own apartment afterwards, and some live with relatives or friends. About one-third go back to their still-violent husbands. In the big cities of West Germany, nearly 50% of these women are foreign nationals. Many Frauenhäuser have long waiting lists, which suggests that family violence is a severe problem.

To remove perpetrators from the family, legal action is necessary and the police have to be informed. However, many people hesitate to report others to authorities. In the former East Germany there was even the fear that admitting the existence of crimes like child abuse would bring discredit on the state. Therefore, after 1981, pediatricians and researchers faced the problem that officials did not allow publications about child abuse. Also, the subject could not be raised in meetings with foreigners.

In conclusion, there is a reluctance in Germany to interfere in situations of family violence not only among ordinary people but

also among physicians, social workers, police, etc. Many know little about the subject and deal very differently with suspected cases. There are no common concepts of how to treat family violence. However, the public has little confidence in the success of existing prevention programs. There are demands for reporting laws, heavier sentences and compulsory treatment for perpetrators.

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HELPING PARENTS TOLERATE THE STRESSES OF ADOLESCENCE

Catherine Levinson, LCSW-C

The summer months often herald an increase in conflicts between parents and their adolescent children. The stresses of these conflicts frequently bring families in contact with family advocacy workers who are then faced with helping parents deal with the turmoil and other problems that emerge during this developmental period. Helping to educate parents can often **alleviate some of the stresses of** this difficult period and promote mental health for all family members.

Every parent who has an adolescent is likely to agree with both Erik Erikson, who explains that adolescent youths are engaged in a struggle of trying to find themselves that amounts to a "physiological revolution," (1978, p. 261) and Peter Blos who writes of the "maturational dislocation" caused by physio-logical imbalances as glandular changes occur (1976, p. 255). Adolescents are faced with the task of coping with physical changes in their bodies; they are experiencing a surge of sexual drives at the same time that they are struggling to answer the question, "Who am I?" They are preoccupied with concerns over what they feel they are, compared to who they believe they are, and what they appear to be in the eyes of their peers. Adolescents and their parents often experience conflict over both the need and fear of becoming independent. Adolescents struggle hard to achieve independence from their families and establish their own social reality which is often defined by their peer group. They also struggle with coming to terms with the strengths and weaknesses of their parents.

Typically what happens between an adolescent and a parent is that the parent becomes stressed or anxious when he or she believes the adolescent is not doing what they feel they should be doing. The stresses become so great that parents often impulsively respond with their own internal stresses and anxieties by either **ordering, demanding** or **directing**. The adolescent responds to these statements by feeling more stressed, anxious and angry.

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NEW PARENT SUPPORT PROGRAM (NPSP) ALIVE, WELL, AND GROWING

A wealth of information was shared when staff members from HQDA FAP, J&E Associates Inc., Research Triangle Institute, Cornell University, Uniformed Services University, and representatives from various New Parent Support Programs met to coordinate their ongoing work in support of NPSP. Participants focused on the importance of home visitation programs for the prevention of family violence and examined different home visitation models that currently provide services to families. It was the first time that all of the principle players in the NPSP equation met together since J&E Associates Inc. was contracted to operate the program.

The agenda for the meeting primarily focused upon administrative, team building, and research procedures. Additionally, representatives from various installations discussed operational issues that pertained to their specific sites. This sharing was very beneficial to the new hires for either ongoing or "start-up" programs. Due to the overwhelming success of NPSP, thirteen new sites have been identified. In CONUS, they are: Fort Belvoir/ Fort Myer, Aberdeen Proving Ground, Redstone Arsenal, Fort Stewart, Fort Polk, Fort Campbell, Fort Riley, and Fort Drum. OCONUS sites are: Bad Kreuznach, Wiesbaden, Darmstadt, Vicenza, and Camp Darby.



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if the issue seems important enough. If the factors of selection and information bias have been carefully considered, this gets to the heart of the discussion. Pope and Hudson continue their discussion of childhood sexual abuse and adult psychiatric disorders by asserting in their hypothetical study that, an association was found, i.e., people with a history of childhood sexual abuse have more psychiatric disorders than those without such a history. Three possible explanations are: (1) childhood sexual abuse causes adult psychiatric disorders, (2) adult psychiatric disorders causes childhood sexual abuse, and (3) that both childhood sexual abuse and adult psychiatric disorder are caused by some other factor or by a confounding variable. The authors give good examples regarding the three possibilities. (Confounding, is worth another discussion and will be pursued here later.)

Let us close with a reminder to be critical of what you read. Relative to personal beliefs and experiences, pay attention to how bias and other confounding variables may affect the outcomes of a study.

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These feelings can lead to more negative, regressive or irresponsible behaviors that heighten anxiety and anger in the parents. The parents respond with even louder **threats, admonitions** or **preachings** and "should and ought to" solutions. Parents also give **advice, solutions** and **warnings**. When none of these work, parents may resort to

statements such as "you're acting like a three-year old!" in the hope that this will change the adolescent's behavior.

The task of the family advocacy worker is to help break this escalating cycle of conflict. This can only be accomplished by helping parents and adolescents improve their verbal communications. Improved verbal communication often opens the door to more effective problem solving. Establishing the right balance of limit setting, structure, and independence for adolescents is often very difficult for parents.

A goal of the family advocacy worker can be to help parents decrease the negative repercussions of power struggles and establish positive levels of communication and problem solving. Accomplishing this goal often prevents adolescents from becoming vulnerable to severe behavioral and emotional problems.

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