Joining Forces

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IN THIS ISSUE...

Domestic violence can be understood through an ongoing evaluation of beliefs about aggressive family conflict. We are pleased to have Dr. Dan O'Leary as a contributing author. He is a distinguished domestic violence researcher. Dr. O'Leary discusses commonly held beliefs about the escalation of domestic violence, risk factors for partner aggression, and typologies of aggression.

Contrary beliefs about the "battered husband syndrome" and cultural beliefs about domestic violence in Singapore are explored.

Beliefs about risk factors and the use of risk assessment instruments are presented along with a description of sampling which is a method of collecting research data to explore inquiries and beliefs about family violence issues.

In April, the Army celebrates the Month of the Military Child. It is a time when the Army, along with other Federal, State and local governments, private and public agencies, and community organizations highlight the prevention of child abuse. During April, recognition is given to parents and other caretakers who ensure that the day-to-day needs of children are adequately met. The prevention of child abuse requires community collaboration and concerted initiatives to protect children and support the well-being of families.

TAILORING INTERVENTIONS TO MEET THE NEEDS OF PARTNER ABUSE CLIENTS

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Approximately 30 to 50% of young men and women are in relationships characterized by some physical aggression used in anger against their intimate partners. Evidence for these prevalence figures comes from numerous sources, including large samples of junior and senior high school students, engaged partners, newlyweds, and randomly selected young married men and women. Physical aggression against an intimate partner starts some time between 12 and 15 years of age, the junior high school years, and by senior high school, about 30% of students report being in a relationship where there has been some physical aggression in the past year. In early marriage, the prevalence of physical aggression increases to a point where over half the men and women are in relationships characterized by physical aggression. The type of physical aggression engaged in by the majority of young adults is slapping, pushing, shoving; a very small percentage use the more severe forms of aggression such as beating, threatening with a knife or gun, or using a knife of gun. The prevalence of physical aggression is so high in the general population that it is now clear that we need to understand how physical aggression escalates in some relationships, while in others the partner(s) desist from using such aggression.

Recently I reviewed developmental factors and physical aggression against partners. Physical aggression declines across the age span. In a sample of 11,000 army personnel, for every ten years increase in age, the odds of being aggressive declined by 29%. Similarly, in a civilian sample, the older one gets, the less likely one is physically aggressive toward an intimate partner. The overall annual prevalence of physical aggression against a partner declined from 37% at age 20-24 to 2% at age 65-69.

The military is comprised primarily of young men and women, the majority of whom are in their twenties. Partner aggression by both genders in the teens and early twenties is far too prevalent for criminalization of the behaviors to be practical. Moreover, providing interventions

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for all those men and women in physically aggressive relationships would be prohibitively costly unless the interventions were primarily educational. However, simply because the behavior is common, even perhaps normative in some groups, does not mean that the behavior is without important negative consequences. For some individuals, repeated aggression leads to marital discord and contributes to the high divorce rate in our society. For others, the aggression escalates to battering and serious injury.

Unfortunately, we do not know why some individuals escalate their use of physical aggression and why some individuals stop aggressing. While we have studied some risk factors for increases in partner aggression in a longitudinal study of young married civilians, the military is an excellent place to study such risk factors across time since active duty personnel can be tracked more readily than can civilians.

Table 1 describes factors which are most likely to be associated with the continued use of aggression.

Table 1

Factors Associated With Continued Aggression

- Use of physical aggression several times per year and use of physical aggression across a two-year time span
- Alcohol abuse, not simply alcohol use
- High levels of psychological aggression
- Marital discord
- Attitudes that condone use of physical aggression against a partner
- Having personality problems such as an aggressive personality style or a borderline personality organization
- High levels of anger/hostility, especially anger toward a partner
- Jealousy
- Violence in one's family of origin
- Use of power and control tactics other than physical aggression

To provide some order to the vast array of physical aggression in intimate relationships, several researchers have presented typologies for aggression. For example, Johnson (1995) described two types of violence against women, "patriarchal terrorism" and "common couple violence." He argued that the distinction between the two types of aggression is important because it has implications for the implementation of public policy and for the development of educational and intervention strategies. Patriarchal terrorism referred to situations where women are terrorized by systematic male violence. Such aggression was defined as abuse that happens in excess of once per week and, overtime, becomes more serious. Husbands usually initiate the violence and most wives do not counter with aggression. Common violence among couples was described as periodic outbursts of aggression from either partner. The aggression is seen as no more likely to be initiated or enacted by men than by women and is not part of a pattern in which one partner is trying to exert control over his/her partner. Further, Johnson stated that national surveys are most likely to uncover the common couple violence whereas studies with shelter and public agency samples are most likely to see the aggression characterized as patriarchal terrorism. I portrayed four levels of aggression against a partner: (1) psychological aggression, (2) moderate physical aggression (3) severe physical aggression, and (4) murder of a partner. Whether the different

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depictions of physical aggression in intimate relationships are best characterized as types or places on a continuum is not yet clear, and the typology/continuum debate is a perennial one in psychiatry and psychology. Nonetheless, it seems clear that there is a very small number of men who escalate from one form of aggression to another. Others engage in psychological and moderate levels of physical aggression. They do not simply escalate to the severe levels of aggression.

One key conclusion that can be drawn from the data on developmental trends and characterizations of types or levels of aggression is that no intervention is equally suited to all forms of physical aggression. Fortunately, the Family Advocacy Programs of the military generally provide an array of services to their members, and since there are different needs of the service members, they have been seeking different types of help. Such help may include the use of several different forms of aid, including anger management, marital therapy, financial consultation, parent training, individual therapy, and alcohol treatment. For some men who engage in very severe forms of physical aggression against their partners, legal and punitive actions may be the most appropriate forms of action. Initially, gender specific treatment for men and women may be needed to allow some men and women to profit from marital therapy, and DOD has developed a policy suggesting such ordering of services (at least for men). While such a recommendation makes sense with the kind of physical aggression called patriarchal terrorism, it would not seem appropriate for the much more common couple violence. As has been stated by many, including Dr. Gelles in the January 1999 issue of "Joining Forces", there is no evidence that one form of intervention with physically aggressive men is better than another. Given this state of affairs, there is a strong need to evaluate different intervention and prevention models that are based on clear theoretical models of partner abuse. Further, since long standing physical aggression seems so difficult to change, it is important to evaluate prevention efforts with individuals with some documented risk for escalating physical aggression. Whatever the intervention, it is time to recognize that different types of physical aggression in intimate relationships would be best served by attempts to tailor the interventions being provided to the needs of the clients. For example, in our own post-treatment evaluations of partner/wife abuse, we found that parent training was the area where the clients felt they most needed additional help. Listening to the voices of the clients about their needs makes excellent sense since in a national survey, arguments about parenting were the most common source of disagreement.

Reference: Johnson, M. P. (1995). Patriarchal terrorism and common couple violence: Two forms of violence against women. Journal of Marriage and the Family, 57, 283-294.

WOMEN AND DOMESTIC VIOLENCE

Editor's Note:

The Family Violence and Trauma Project USUHS has received several inquiries regarding research about the perpetration of domestic violence by women. In light of these inquiries, we provide the following brief report about women and domestic violence. It is not our intention to diminish the seriousness of violence committed by men towards women. Such violence continues to be a major problem.

Violence by women has not been extensively discussed in the research literature. However, both the 1975 and 1985 National Family Violence Surveys (Straus and Gelles, 1986) indicate that men and women abuse each other at almost the same rate. A comparison of the 1975 survey with the 1985 data reveals a decline in the prevalence of husband-to-wife violence but an increase in the prevalence of wife-to-husband violence. The trends were noted even though the changes from 1975 to 1985 were not statistically significant.

One of the first published research articles that drew attention to violence perpetrated by women was by Susan Steinmetz (1977-1978). The article entitled "The Battered Husband Syndrome" described the unknown prevalence and hidden nature of female violence against men. Information in the article attracted considerable attention from the news media and generated debate

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and controversy among family violence researchers and women advocates. It was controversial because it raised many questions about the reality of the battered husband syndrome. Even though Steinmetz's research was controversial, it stimulated much thought about the prevalence and motives of domestic violence by women.

Alternative interpretations of Steinmetz's conclusions have been presented. Pagelow (1984) countered generalizations and refuted interpretations made from Susan Steinmetz's research. Pagelow strongly asserted that the overwhelming proportion of victims of domestic violence are women. In admitting that perhaps 3 or 4 percent of husbands are abused by their wives, Pagelow stated that domestic violence by women may not be self-initiated but in self-defense. She admitted that many women may be extremely violent but asserted that there is insufficient evidence of a "battered husband syndrome" that compares to violence committed by men against women.

Flynn (1990) analyzed violence by women against their intimate partners and discussed problems created by the downplay of such violence. He compared the aggressive behavior of men and women during marriage and courtship. In his discussion of prevention and treatment services, he stated that such services cannot be effectively implemented until there is some acknowledgement that relationship violence by women actually exists. He blamed the non-recognition of violence by women for the absence of treatment programs for female abusers and battered husbands.

In the Army, the Family Advocacy Program must develop prevention and treatment interventions that address the full parameters of abusive marital relationships. Therefore, research is needed to better understand the interactive dynamics of such relationships regardless of who is identified as the victim or offender.

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Straus, M. A., & Gelles, R. J. (1986). Societal change and change in family violence from 1975-1985 as revealed by two national surveys. Journal of Marriage and the Family, 48, 465-479.

Pagelow, M. D. (1984). Family Violence. New York: Praeger.

Flynn, C. P. (1990). Relationship violence by women: issues and implications. Family Relations, 39, 194-198.

Steinmetz, S. K. (1977-78).The battered husband syndrome. Victimology, 2, 499.

RESEARCH AND FAMILY VIOLENCE IN SINGAPORE

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It is important to be aware of the cultural context within which domestic violence occurs. The following report calls attention to the dimensions of domestic violence in Singapore and how they are grappling with some of the same prevention and treatment issues we face in the United States.

Singapore is an island country in South-East Asia with a population of 3.2 million. Because its laws are strictly enforced and adhered to, the crime rate is generally low.

Family violence appears to be on the rise in Singapore. According to research findings, (Wong, 1998) there has been a two-fold increase in family violence in one year. Several factors may account for the phenomenal growth in numbers of people reporting abuse. It may be that, because of widespread community education by organizations such as the Society against Family Violence, people are now becoming more aware of and open to reporting cases.

In response to the continued efforts of lobbyists, the authorities are in the process of conducting research, changing laws and providing services that facilitate reporting and the development of interventions. However, 25.5% of family doctors think that child abuse seldom occurs and 6.6% perceive that child abuse rarely occurs. Research is clearly needed to determine factors that are associated with physician's perception of child abuse incidents.

Although the exact incidence of spousal aggression is not known, research indicates that about 6 women per day make a police report of domestic violence. The victims usually lodge reports at a police station or neighborhood police post. If there are visible injuries, the police will advise the victim to seek medical examination at the Accident and Emergency Department of any

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general hospital and to procure a medical report. In 1996, approximately 130 cases were treated at the Accident and Emergency hospital of one government hospital.

Studies show that 94 percent of the victims of spousal violence are women. In 1997, about 900 people, or close to half of all reported cases, suffered injuries that resulted in bruises. In six out of 10 cases, victims were punched, pinched, scratched, pushed, kicked and slapped. One in 10 aggressors used knives, scissors, belts and household items such as irons, pots and pans. Twenty victims were hospitalized for more serious injuries. About three or four were beaten until they passed out. Ten percent of victims were battered while pregnant and some miscarried as a result.
In 1998, the High Court dealt with four family-related killings, three involved men who killed their wives.

In another study of 70 consecutive referrals to the Department of Psychological Medicine, National University Hospital for the treatment of drinking problems, it was found that family violence occurred in 30 percent of the cases, (Kua, et al., 1991). While there was no relationship between family violence and the ethnicity of the drinkers, those who battered their wives and children were generally younger and had more severe dependence on alcohol than the non-violent drinkers.

Research is underway to determine how to strengthen the existing legislative powers of protection. Similar to the U.S. Army, efforts are ongoing to evaluate intervention models to determine how interventions might be tailored to meet individual needs and specific theoretical approaches to domestic violence. It is hoped that such research will inform legislative and treatment initiatives. Consequently, Singaporeans who are victims of family violence and abuse will feel supported by the government and community.

References:

Wong, B. (1998). Times are bad. Straits Times.

Kua, E.H., & Ko, S.M. (1991). Family violence and Asian drinkers. Forensic Science International, 50, 43-46.

RISK ASSESSMENT AND FAMILY ADVOCACY

A definition of risk from epidemiology (the branch of medical science that is concerned with finding the causes and distribution of diseases in humans) is the probability of an individual developing a disease in a given time period (Rothman, 1986). Although most epidemiological models are constructed to help us understand diseases, they are also applicable to other areas of science in which causes are sought for behaviors. Think of risk factors for family violence. It is thought that abuse in one's family of origin (cause) results in the perpetration of family violence (effect). The concept of risk attempts to tie a particular cause to an effect. In over-simplified form, a risk factor is an identified cause and an outcome is an observed effect (or event).

The picture gets a little more complicated when we think of positive and negative risk factors. Risk factor language may also seem paradoxical. For example, positive risk factors are associated with harm while negative risk factors are associated with protection. In the Family Advocacy Program, abuse in the family of origin is thought of as a positive risk factor because it may result in harm associated with domestic violence. A supportive environment in the family of origin would be a negative risk factor (protective factor) because it may protect the individual against stresses that could result in violence.

Risk usually applies to a group and not to individuals. For example, a group of overweight individuals who are smokers, have hypertension, and lead a sedentary life are at an increased risk for a stroke. However, it is not known if any individual in the group will have a stroke. We have all known people, who smoked a pack or more of cigarettes a day for most of their lives who lived longer than people who did not smoke.

Risk assessment is technically and socially complex. Wald and Woolverton (1990) discussed the increasing use of risk assessment instruments in the United States by child protective service agencies to more efficiently allocate resources and improve decision-making. The article: 1) explored deficiencies in risk assessment approaches, 2) clarified the strengths and weakness of the risk assessment process, and 3) discussed how risk assessment procedures should be incorporated into decision-making by child

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protection services. Relative to conceptual issues, the authors pointed out that there is a considerable lack of clarity and inconsistency in the use of the term risk assessment. Consequently, risk assessment has been used to describe at least three procedures. First, it has been used to define the process of assessing whether a harmful act will be repeated in the future. Second, it has been used to categorize the seriousness of present harm or injury. Third, it has been used synonymously with needs assessment. Problems associated with using risk assessment instruments were also discussed. It was concluded that such instruments have limited utility because they are often used in lieu of addressing more fundamental agency problems.

Inadequately designed or researched risk assessment instruments were reported to result in poor decision-making because they may be mechanically applied without appropriate levels of clinical expertise. Despite conceptual problems involved in the implementation of risk assessment systems, Wald and Woolverton concluded that such systems could stimulate major changes in the area of child protection.

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Rothman, K.J. (1986). Modern Epidemiology. Boston: Little, Brown, and Company.

Wald, M.S., & Woolverton, M. (1990). Risk assessment: The emperor's new clothes? Child Welfare League of America, LXIX,(6), 483-511.

SAMPLING IN RESEARCH DESIGN

In the two most recent editions of the newsletter we discussed two issues that can affect the interpretation of research results: confounding and bias. In this article, we introduce the topic of sampling. Sampling is done when it is not feasible to contact every member of a population. For example, in studying deployment, you cannot contact all deployed and non-deployed soldiers. So, in studying deployment, you derive a sample from the population you want to study. There are many unanswered questions on this topic: (1) Are soldiers who are deployed more prone to family violence than those who are not deployed? (2) Is the length of deployment related to increased family violence? (3) Is one category of family violence affected more than another category (spouse or child abuse; minor injury vs. major injury)? (4) When are the effects of deployment most likely to be seen (before, during, or after deployment)?

How do you sample a population? Do it in such a way that you can provide an unbiased estimate of the effect you are measuring and in the most efficient manner in terms of time and money. A random sample is almost always the most desirable goal. A random sample is one in which every person in the population has an equal chance of being selected.

Construct your sample to reduce error. One way of reducing error is to stratify or break up the population into groups of interest. For example, if you know your population contains more women than men, break up your population into women and men and take a sample from both groups. Stratification would ensure that your sample has enough male and female subjects. Stratification has been a problem in previous military research. Because of the small proportion of women relative to men in the active duty force, a random sample of the Army, in general, may not have enough female participants.

How do you know when your sample is large enough to provide a valid estimate of that which you are estimating? If you have a measure that has a high frequency of occurrence such as height or weight, you do not need to select as many subjects as you would for a measure that has a low frequency of occurrence such as left-handedness.

In conclusion, what should you consider when reading a publication that uses a sampling methodology in its research design? Important considerations are: Was the sample drawn randomly? Was the sample drawn in such a way to eliminate obvious biases? Is the sampling procedure as efficient as possible? Is the sample large enough to show the effect you are investigating? Sampling is one of the most important concepts to consider when it is not feasible or realistic to measure an entire population.

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