0022-3018/94/1821-0583$03.00/0
THE JOURNAL OF NERVOUS AND MENTAL DISEASE

Vol. 182, No. 10
Printed in U.S.A.

Brief Reports

Psychosocial and Diagnostic Characteristics of Individuals Initiating Domestic Violence

The National Family Violence Survey, conducted in 1975, collected information from a representative sample of couples using the Conflict Tactics Scales (Straus, 1979), and found that 16.0% of the couples interviewed had engaged in some type of interspousal physical violence during the previous year. For 6.1% of the couples, the violence was considered severe, including punching, kicking, choking, and stabbing (Straus and Gelles, 1990a). These numbers are congruent with the rates from a follow-up study conducted in 1985, which found that 16.1% of the couples surveyed had engaged in violence, with 6.3% having physical contact that was rated as severe (Straus and Gelles, 1990b). Other studies report similar rates of physical violence among married (Hornung et al., 1981) and heterosexual dating couples (Murphy, 1989). Partner abuse has also been found to occur at comparable rates among gay (Island and Letelier, 1991) and lesbian couples (Renzetti, 1992).

Based on the large number of individuals affected by intrafamilial violence every year, it is surprising how little is known about the processes that motivate the perpetrators of domestic violence. The following case histories were selected to illustrate some of the psychological and accompanying physiological changes that occur in individuals when they exhibit violent behavior.

Methods

Subjects. The patients presented in this report were selected as a sample from a large number of subjects who responded to a newspaper advertisement soliciting individuals who "lose control" and are physically violent toward their spouses or significant others. These patients participated in a variety of biological and psychological assessments while hospitalized at the National Institutes of Health Clinical Center on the National Institute on Alcohol Abuse and Alcoholism research unit. All subjects were alcohol and drug free for at least 3 weeks at the time of the interviews.

Procedure. Written, informed consent was obtained from all subjects before the study. An extensive physical examination, including a brain magnetic resonance image and EEG, was performed to ensure that the participants were in good health. The reported information was gathered through interviews with both the person initiating domestic violence and his or her significant other. There were no major discrepancies between the two independently obtained histories. Diagnoses were made according to DSM-III-R criteria (American Psychiatric Association, 1987). The interviews were conducted by a trained, research social worker, using the Structured Clinical Interview for DSM-III-R-Patient Edition and the Structured Clinical Interview for DSM-III-R-Personality Disorders (Spitzer et al., 1990a, 1990b). Final lifetime diagnoses were determined through blind rating.

Case Reports

Case 1. Mr. A., a 34-year-old, twice-divorced Caucasian male with a partial college education, typically worked in construction, but was unemployed at the time of the interview. His income when working was approximately $600 a month. Mr. A. presented with a long history of involvement in physical violence beginning at the age of 7. Violent behavior persisted throughout childhood, taking the form of frequent physical fights with neighborhood children and his four sisters. During one episode in elementary school, he overturned desks in the classroom and punched a female teacher. Mr. A. reported that both of his biological parents were physically abusive to their children and each other, with his father threatening the entire family with a shotgun when the patient was 6 years old. Mr. A. began to drink alcohol in a dependent fashion in high school. After finishing high school, he joined the Army, continued to engage in regular fights with his peers, and was finally discharged subsequent to striking a superior officer. In both his second marriage and his current relationship, Mr. A. has initiated physical encounters, including slapping, punching, hair pulling, and choking. He has also destroyed a considerable amount of property during violent episodes. These episodes have occurred both with and without prior alcohol consumption. According to self-report and that of his significant other, Mr. A. has demonstrated a number of physical symptoms prior to initiating physical violence, including increased heart rate and sweating, changes in breathing, redness of the face, and increased motor activity, such as pacing and "nervous" legs. Mr. A. has indicated concomitant feelings of nervousness and losing control, and has stated that he feels irrational and insecure. These feelings often come on suddenly and without apparent provocation, and set the stage for almost inevitable aggression. Mr. A. has been incarcerated approximately 12 times for assault. He had previously been hospitalized twice for depression and once after a suicide attempt. Mr. A. fulfilled criteria for the DSM-III-R diagnoses of alcohol dependence, cannabis and opioid abuse, and borderline personality disorder.

Case 2. Mr. B., a 51-year-old Caucasian male with a Master's degree in engineering, was employed full time as an engineer, with a monthly salary of approximately $7,000. He had been married for 29 years at the time of the interview. Mr. B. recalled regular childhood fights with his brothers such that their mother had to physically separate them and was often hit in the process. Growing up, Mr. B. had weekly fist fights with a friend that only ended when one of them was bloodied. Mr. B. hit this friend with a lead pipe during one of their altercations. Mr. B. described his father as a strict disciplinarian who regularly beat him and his five siblings at the request of their mother. Mr. B. recalled his mother hitting him once with a broom and once throwing a pan of water on him during a fight. Mr. B. denies any alcohol abuse. As an adult, his only violent encounters have been with one son, whom he hit twice when the son was 19 years old, and his wife. Violent

verbal fights with his wife, that have also involved pushing and shoving, occur weekly. More severe, physically abusive behavior has occurred approximately two times per year, and has included hitting, slapping, tripping, and hair pulling. Immediately before an episode of physical violence, Mr. B. reported feeling trapped, out of control, and cornered. He has noticed an increase in heart rate, sweating, shaking, and rapid breathing. His wife has reported that he becomes tense and very impatient, wanting her to acquiesce to his demands (such as leaving a restaurant) immediately. Mr. B. has never been incarcerated and has never attempted suicide. He fulfilled criteria for the DSM-III-R diagnoses of social phobia, generalized anxiety disorder, and past major depression.

Case 3. Ms. C., a 38-year-old Caucasian female with a high school education, was unemployed at the time of the interview and living on welfare. She had been fired from her last position as a custodial worker due to chronic absenteeism. Ms. C. was divorced at age 33 after 14 years of marriage. As a child, she was often involved in schoolyard fights, and became known in her school as "the best girl fighter." She often used sticks and rocks to hit her opponents. This pattern of repeated physical altercations continued into adulthood. She reported that there was no physical violence in her family of origin; however, her father often encouraged her to fight with her peers. She began spontaneously seeking alcoholic beverages at age 12. Ms. C. has been hospitalized for alcohol detoxification on seven different occasions. She has been hospitalized on psychiatric units twice, once after an overdose and once after threatening to kill herself. Presently, violent episodes are directed at her significant other, and include hitting, slapping, and tearing out his hair. Immediately before an incident, her face gets red, her thoughts and speech become incoherent, she begins pacing and shaking, she feels agitated and trapped, and she breathes more rapidly than usual. She has often thrown objects in an attempt to discharge her aggressive feelings. Ms. C. has a history of panic attacks. She fulfilled criteria for the DSM-III-R diagnoses of alcohol, cannabis and stimulant dependence, cocaine abuse, major depression concurrent with alcohol dependence, borderline personality disorder, antisocial personality disorder, obsessive-compulsive personality disorder, panic disorder, and generalized anxiety disorder.

Case 4. Mr. D., a 42-year-old African-American male with a 10th grade education, was employed full time in a hospital, with a monthly salary of $1,800. He had been divorced three times and, at the time of the interview, was living with a female companion. Mr. D. presented with a history of violent behavior dating to childhood. At age 10 he lost control in the classroom, chased classmates, overturned desks, and punched a female teacher in the stomach. At age 11 he hit another student in the head with a brick, at age 12 stabbed a fellow gang member, and at age 16 used a knife to lacerate someone's stomach. His biological father engaged in violent behavior with his mother and other women, and was killed in a fight with a girlfriend. Mr. D. characterized his mother as having a "bad temper," and stated that she would often let a variety of transgressions pass before beating the children severely with relatively little provocation. All four of Mr. D.'s half-brothers have a tendency to engage in impulsive and violent behavior, and a maternal uncle is incarcerated for murder. As an adult, Mr. D. has engaged in frequent violent behavior toward girlfriends and wives, which contributed to his three divorces after marriages of 5.5 years, 5 months, and 6 years, respectively. In addition to physical assaults, he has destroyed furniture and other property using hammers and knives. Mr. D. was a patient on a psychiatric unit for 2.5 months at the age of 26, after having made three suicide attempts during a 2-week period, which included cutting his wrists, running his car into a utility pole, and taking an overdose of pills. A recent suicide attempt also involved an overdose of pills. Episodes of violent behavior involving his significant other have included choking, hitting, biting, arm twisting, and hair pulling, in addition to verbal abuse. Episodes of violence have begun with Mr. D. experiencing a sad mood, racing thoughts, and feelings of being out of control, trapped, and fidgety. Physical concomitants have included rapid respiration, sweating, shaking, and pacing. Vomiting has often preceded episodes of violence, as have sleep disruptions and obsessive thoughts. Mr. D. fulfilled criteria for the DSM-III-R diagnoses of alcohol, cannabis and cocaine dependence, stimulant and hallucinogen abuse, depression concurrent with alcohol dependence, paranoid personality disorder, and borderline personality disorder.

Discussion

A number of characteristics are common to all of these patients. Three of them had been exposed to family violence growing up. All four reported feeling trapped, threatened, insecure, rejected, or criticized immediately before losing control and becoming violent. Somatic changes, including increased motor activity, palpitations, shaking, sweating, and hyperventilation, typically preceded or accompanied the aggression. Once in this state of heightened arousal, virtually anything the partner said or did could result in an explosion of rage and physical violence. While alcohol and/or drugs were frequently abused, they did not always account for the violence.

Most abusive interactions began with a verbal component that included cursing, and using insulting or demeaning language. This escalated into a physical confrontation characterized by hair pulling, hitting, punching, slapping, and/or choking. For one of the patients, the violence ended only when he saw blood. The others generally felt a sense of release and fatigue, which lead to a cessation of the physical assault. Following the violent behavior, each individual reported feeling extreme guilt that was intensified by the realization that the psychological effect of their behavior on the other person was irreversible.

The complexity of the characteristics exhibited by these patients underscores the difficulty in incorporating the constellation of symptoms present in individuals who initiate domestic violence into a single diagnostic category. Therefore, we propose that at least four diagnostic categories need to be considered when characterizing individuals who initiate domestic violence. First, the diagnosis of panic disorder needs to be explored given the large number of symptoms described by these patients (*e.g.*, palpitations, agitation, and feeling out of control) which are also characteristics of panic disorder. Second, it is possible that repeated exposure to emotionally charged episodes of domestic violence during

childhood could lead to a form of posttraumatic stress syndrome. Aggressive behavior could subsequently be triggered when the individual feels threatened or trapped. Third, these individuals react in a way that is out of proportion to any environmental stressor, suggesting an impulse control problem, possibly related to intermittent explosive disorder. Finally, the emotional lability and self-injurious behavior exhibited by these patients could be associated with one of the personality disorders, such as borderline or antisocial personality disorder.

Conclusions

Domestic violence is a major societal problem affecting all socioeconomic classes. Characterizing individuals who initiate such violence, both psychologically and biologically, is a necessary step in developing effective therapeutic interventions. Future studies are needed to explore relationships between neurotransmitter functions and behaviors exhibited by homogenous groups of spouse and/or child abusers.

References

American Psychiatric Association (1987) *Diagnostic and statistical manual of mental disorders* (3rd ed, rev). Washington, DC: Author.

Hornung CA, McCullough BC, Sugimoto T (1981) Status relationships in marriage: Risk factors in spouse abuse. *J Marriage Fam* 43(3):675–692.

Island D, Letelier P (1991) *Men who beat the men who love them: Battered gay men and domestic violence*. Binghamton, NY: Haworth.

Murphy JE (1989) Date abuse and forced intercourse among college students. In MA Pirog-Good, JE Stets (Eds), *Violence in dating relationships: Emerging social issues*. New York: Praeger.

Renzetti CM (1992) *Violent betrayal: Partner abuse in lesbian relationships*. Newbury Park, CA: Sage.

Spitzer RL, Williams JBW, Gibbon M, First MB (1990a) *Structured Clinical Interview for DSM-III-R—Patient edition (SCID-P), Version 1.0*. Washington, DC: American Psychiatric Press.

Spitzer RL, Williams JBW, Gibbon M, First MB (1990b) *Structured Clinical Interview for DSM-III-R—Personality disorders (SCID-II), Version 1.0*. Washington, DC: American Psychiatric Press.

Straus MA (1979) Measuring intrafamily conflict and violence: The Conflict Tactics (CT) Scales. *J Marriage Fam* 41(1):75–88.

Straus MA, Gelles RJ (1990a) Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys. In MA Straus, RJ Gelles (Eds), *Physical violence in American families* (pp. 113-131). New Brunswick: Transaction Press.

Straus MA, Gelles RJ (1990b) How violent are American families? Estimates from the National Family Violence Resurvey and other studies. In MA Straus, RJ Gelles (Eds), *Physical violence in American families* (pp. 95-112). New Brunswick: Transaction Press.

Doris A. Bitler, Ph.D.[1,2]
Markku Linnoila, M.D., Ph.D.[3]
David T. George, M.D.[1]

[1] Laboratory of Clinical Studies, National Institute on Alcohol Abuse and Alcoholism, Bethesda, Maryland. Send reprint requests to Dr. George at National Institute on Alcohol Abuse and Alcoholism, Building 10-3B19, 9000 Rockville Pike, Bethesda, Maryland 20892.

[2] Office of the Dean, College of Arts and Sciences, George Mason University, Fairfax, Virginia.

[3] Scientific Director, National Institute on Alcohol Abuse and Alcoholism, Bethesda, Maryland.

The Polysomnographic Effects of Clonidine on Sleep Disorders in Posttraumatic Stress Disorder: A Pilot Study with Cambodian Patients

Sleep disorders and nightmares are major symptoms of posttraumatic stress disorder (PTSD). Difficulty falling or staying asleep is one of the arousal criteria, and recurrent disturbing dreams of the traumatic events are included in the re-experiencing criteria of PTSD in DSM-III-R.

The attempts to characterize, by polysomnographic recordings, the sleep and dream disturbances in PTSD have led to contradictory findings (Ross et al., 1989). One study of Vietnam veterans (Kramer and Kinney, 1988) and another of Yom Kippur War veterans (Lavie et al., 1979) reported long rapid eye movement (REM) latencies, but another study found shortened REM latencies (Greenburg et al., 1972). The reoccurrence of some nightmares in non-REM sleep has been reported, but contradictory findings have also been found (Ross et al., 1989). In a recent thorough review of the psychobiology of PTSD, Charney et al. (1993) suggested that insomnia is part of a generalized increased arousal associated with increased CNS nonadrenergic tone. Clonidine, a presynaptic alpha^2-agonist, has been used to treat hypertension for 20 years, and in psychiatry it has been used for opiate and alcohol withdrawal, smoking cessation, and control of anxiety (El-Mallahk, 1992). In a sleep study, a single morning dose of clonidine produced sedation in waking subjects and marked REM suppression in sleeping subjects (Carskadon et al., 1989). Based on the ability of clonidine to block CNS nonadrenergic effects, our Indochinese clinic at Oregon Health Sciences University has used clonidine extensively to treat Cambodians, 90% of whom suffer from PTSD (Kinzie et al., 1990). In a prospective study of clonidine on nine patients, nightmares lessened in seven and complete recovery from insomnia occurred in five (Kinzie and Leung, 1989). The goal of this pilot, nonblind study was to characterize by all-night polysomnograph (PSG) recordings the sleep of four Cambodians who had been severely traumatized. This study provides the only information, to our knowledge, of polysomnographic recordings of PTSD in non-Western patients. A second goal was to determine the clinical effects of clonidine on the disorder.

Methods

The four Cambodian women in this study all had applied for treatment in the Indochinese clinic for symptoms related to depression and posttraumatic stress disorder. All of the patients were women who had children living with them and were between the ages of 29 and 46. All had undergone severe traumatic experiences from 1975 to 1979, under the Pol Pot regime in Cambodia. All had 4 years of forced labor, had been starved, had witnessed murders, and had immediate family members killed. Currently, all four were refugees in the United States and were very symptomatic, with marked re-experiencing, startle reaction, irritability, and marked avoidance behavior. Nightmares were reported between nightly and three nights a week, and all reported very disturbed sleep, averaging 3 to 4 hours of sleep a night with frequent awakenings. All qualified for a (DSM-III-R) diagnosis of chronic posttraumatic stress disorder and major depressive disorder.