emerged is a frightening one. Clearly, family violence is a major public health concern and requires a community response.

As with most health care issues, clinical demands and frustrations precede the scientific explorations, and family violence has followed this pattern. Particularly evident over the years has been the frustration of emergency room personnel as physical injuries from family violence have dramatically escalated, and police, medics, and others have brought victims by the thousands for emerging care. Many have literally been saved from "death's door," while others have not been so lucky. Even those "saved" often return to the precarious environment from whence they came, only to repeat their journeys to the emergency facilities, much to the disgust and ongoing frustration of the health care, criminal justice, and social service systems. Further, while emergency medicine has become a certified medical specialty, emergency room personnel are still ill-prepared to deal with the emotional and psychological impact of family violence. Emergency rooms also function as social service agencies after 5:00 pm and on weekends, when most agencies are closed and victims of violence gravitate to emergency rooms for psychological as well as physical attention. Whether emergency room staff are prepared or not, they must deal on a round-the-clock basis with all aspects of interpersonal violence.

Priority Populations

Harborview Medical Center, founded in 1877, is a 340-bed tertiary care teaching hospital affiliated with the University of Washington in Seattle. From its inception, Harborview has served the indigent medically ill of King County. Its priority populations, announced by the Board of Trustees in 1984, are persons in the King County jail; mentally ill patients, particularly those treated involuntarily; persons with sexually transmitted diseases; substance abusers; indigent patients without third-party coverage; non-English-speaking poor; trauma patients; burn patients; and those requiring specialized emergency care (victims/perpetrators of violence).

Harborview Medical Center is also the major emergency facility in Seattle, King County, and the Pacific Northwest. Most medical, psychiatric, and psychosocial emergencies are brought to Harborview's Emergency Trauma Center (ETC). Specific county commitments with the Division of Human Services, including the Involuntary Treatment System (ITS) and the Division of Alcohol Services (DAS), bring the acutely disturbed psychiatric patient and the excessively intoxicated patient for care. In addition, because Harborview is a designated regional trauma center for the Pacific Northwest,

it provides care to the majority of multiply injured patients in Seattle and surrounding environs, including the states of Washington, Alaska, Montana, and Idaho (referred to as the WAMI region). Annual traffic through the ETC averages 40,000 visits in a city and county with a combined population of 1.3 million.

It was from this clinical experience, coupled with an interest and commitment to help as well as to prevent, that the Harborview Medical Center project on interpersonal violence developed. The results of violence are most frequently treated in hospital emergency rooms. Thus, the emergency room has a unique opportunity to identify, intervene, assess, and treat interpersonal violence. The emergency room provides access to a population that often is too frightened or ashamed to seek assistance from traditional social work agencies; these patients seek the anonymity of a large, busy, often impersonal health facility (Clement, J., unpublished paper, 1985).

The Social Work program in the emergency room began in 1971. One of the goals was to evaluate needs of the emergency room population and to develop programs sensitive and responsive to those needs. In the next decade a series of problem areas were identified and clinical protocols for intervention initiated. The Social Work Director and the Medical Director of the emergency room wanted very much to provide services to victims of violence and provide leadership in the area of interpersonal violence throughout the city, county, and state. The goal was to define the health problems of a patient not just by the presenting symptom but by the primary diagnosis. This meant that a women's broken arm may need to be explored as a case of domestic assault, that a seizure or pancreatitis may indicate a need to explore the patient's alcohol use, or that a straight wrist laceration might require exploration as a suicide attempt.

Six Different Protocols

The clinical protocols established a standardized model of detection, assessment, and intervention specifically for victims of interpersonal violence. They now include the Child Abuse Protocol, the Adult Abuse Protocol (wife battering, spouse battering, partner battering), the Sexual Assault Protocols (including incest victims, male and female), and the Elder Abuse Protocol. The Grief Reaction Protocol addresses services to family members of suicide and homicide victims. The Psychiatric Evaluation Protocol provides services to patients with a psychiatric illness or alcoholism who have been violent or who have the potential for violence and are "at risk." The beginning of the intervention process is dictated by "criteria for involve-

ment" by the social worker. It remains imperative that the criteria be as broad as possible, rather than include only those persons who are clearly identified as victims (Clement, J., unpublished paper, 1985). This initial approach is the key to detection of all problems of family violence and sets the scene for early intervention and prevention.

(For additional information on the Social Work program in the emergency room, the reader is referred to "Social Work in the Emergency Room," Clement, J. and Klingbeil, K. in *Health and Social Work*, November, 1981 and "Emergency Room Intervention: Detection, Assessment, and Treatment" by Klingbeil, K. and Boyd, V. in *Battered Women and Their Families*, Springer Publications, 1984.)

This paper presents a comprehensive model for handling interpersonal violence in a hospital emergency room. The goal is to recognize, detect, assess, and treat all forms of violence against persons. This model, while initially established in a hospital-based emergency room, is applicable and replicable in other settings as well. Special focus is on tertiary and secondary prevention; however, the model does address primary prevention of interpersonal violence as an overall but often elusive goal. Complementary to the model is the necessity to consider allocations of personnel, including support staff, other budgetary considerations, and space allocation.

These are the steps for development of the comprehensive model.

1. Policy Statement

The first step is the clear articulation of a policy statement sanctioned by the governing board or executive body of the institution. This is critical for any program in interpersonal and family violence. Myths and personal judgments continue to cloud the detection of violence between relatives, friends, acquaintances, or strangers. A policy statement demonstrates commitment, sets priorities of staff time and resources, and requires the administration, through the budgetary process, to allocate monies to an interpersonal violence program.

Institutional commitment to a policy of non-violence is a major step toward primary prevention and is as important to staff as to clientele.

This is an example of a policy statement:

"Harborview Medical Center (Faculty, Staff, Departments) acknowledges a responsibility in the tertiary, secondary, and primary prevention of violence. This includes the detection, assessment, and diagnosis of all aspects of interpersonal violence, the identification of high risk individuals and

groups, and the development of resource networks and/or primary preventive efforts as resources permit.

"The policy addresses two major areas:

A. Intra-Family Violence

1. Spouse battering
2. Wife battering
3. Marital rape
4. Child abuse
5. Incest (child sexual abuse)
6. Sibling abuse
7. Elder abuse
8. Abuse of parents by children

B. Extra-Family Violence

All forms of violent acts against another person not related in an intimate situation.

"Suicide attempts (and homicides) are frequently present in the above categories and require the use of the Psychiatric Protocol for assessment purposes. The interventions may differ, but sensitive and nonjudgmental assessment and diagnosis is imperative. It is important to note that the major difference between A. (Intra-Family) and B. (Extra-Family) is in the definition of the relationship: *i.e.*, violence occurring in the context or absence of intimacy."

The appointment of a hospital-wide committee on interpersonal violence is detailed in Step 3 (see below), but could be included as part of a policy statement.

2. Background/Justification Data

After the policy statement comes the justification of the program, with appropriate background and substantiating information. This includes information on specific problems, such as child abuse, wife battering, suicide attempts, etc. This second step also requires a definition of terminology, including the kinds of abuse and the distinction between abuse and battering. Abuse occurs in the physical, psychological, sexual, and environmental contexts. Additionally, there should be a statement of philosophy, principles, and the identification of high risk individuals or groups by critical identifiers for diagnostic purposes.

Thus, step two addresses the following key areas:

A. problem statement
B. definition of terms
C. philosophy
D. principles: standards of practice

E. magnitude of the problems — statistics
F. demographics, if applicable
G. behavioral characteristics or descriptions
H. identification of high risk individuals/groups
I. bibliography and references

This second step clearly articulates the justification and philosophy for a violence program in the emergency room. In other words, anyone reading Step 2 would understand the extent of the problem, the need for intervention, methods of intervention, etc.

Philosophy is important to any program, particularly one where there are varying opinions and myths that prohibit appropriate diagnosis and intervention. A comprehensive philosophy should include a statement on non-violence as a way of life — that violence is not justified in any relationship except in self-defense. Additionally, it should address the continuum of violence, from child abuse to elder abuse. It should clearly address prevention and lay the groundwork for education of client and professional.

Definitions can be relatively simple: for example, ". . . family violence is defined as behavior toward a family member that would evoke legal action if directed toward a stranger." ("Family Violence Principles of Intervention and Prevention," Jean Goodwin, M.D., *Hospital and Community Psychiatry*, Oct. 1985). Or family violence includes any act of force or coercion against another person without his or her permission.

Additional philosophical statements can deal with treatment strategies, advocacy, community resource building, and networking.

3. Procedures

The third step in this model is the development of specific, recommended approaches to various problem areas in interpersonal violence. Obviously the emergency room would have quite specific and detailed protocols pertaining to interpersonal violence, while other departments in the hospital might not. All departments, however, should have written procedures in concert with the overall hospital policy. As an example, a nursing department policy/procedural statement might address staff development and inservice training in support of the overall hospital violence policy.

The third step would include protocols, if the department is involved in "hands on" tertiary care. Otherwise, a statement of how department policies mesh with hospital policy will suffice.

A sub-step is the development of literature, including brochures and pamphlets on community resources as handouts to patients and their fam-

ilies. Copies of regulations and/or the law should also be available, either attached to a specific protocol or referred to in a department procedure. Both brochures and copies of appropriate laws might be included in the patient's admission packet, but would in any case be available in the emergency room as handouts.

An overall multidisciplinary hospital committee on interpersonal violence should be established. This committee could assure continued attention to protocols, referrals, resources, and resource allocation (including staff time, and budget). The committee should review hospital policy and update it as needed. Additionally, the committee could focus on political issues in the community, including public policy issues, statewide as well as local funding issues, and environmental trends. Secondary and primary prevention involve activities well beyond direct service, such as advocacy and testimony regarding proposed legislation. A hospital committee can provide leadership through legislative action. An interdisciplinary or multidisciplinary hospital committee can advance staff training on various levels, such as employee orientations to "Violence Rounds," a major educational pathway.

4. Protocols

The fourth step includes the development of specific clinical protocols for use in the emergency room. The clinical protocols include:

- A) Adult Abuse Protocol
- B) Child Abuse Protocol
- C) Sexual Assault Protocol
- D) Incest Protocol
- E) Elder Abuse Protocol
- F) Psychiatric Evaluation Protocol
- G) Alcohol Protocol
- H) Grief Reaction Protocol

Protocols should convey a clear commitment to exemplary, non-judgmental patient care. (See Klingbeil, K. and Boyd, V., *Battered Women and Their Families*, Springer Publishers, 1984). This is especially important for standardizing a level of care regardless of previous staff training.

The protocols should include all laws that apply to crimes of violence, reporting requirements, and victim compensation, if applicable.

5. Resource Management

Step 5 calls for the establishment of a resource "bank" or network of community agencies to which victims, families, and perpetrators may be referred. This can involve the development of new programs within the hospital and/or community as needs arise and are identified. This important

step extends the boundaries of the hospital into the community and develops an effective "safety net" for patient care. Conversely, the community comes into the hospital.

Resources can be identified in a number of ways but should include the following:

- — Criminal justice system for reporting and investigative purposes, as well as treatment planning.
- — Social service system for victims, perpetrators, and children; includes mental health, alcohol, resources, and self-help. Crisis to long-term care facilities should be identified.
- — Advocacy and legislative groups, including national professional organizations, such as AMA, APA, APsyA, NASW, ANA, and statewide organizations.
- — Religious community
- — Welfare agencies
- — Health care system
- — Educational community

6. Organizational Component

The sixth step concerns the organization of an interpersonal violence program. Specific areas are as follows:

A. Population served
B. Practice and Standards by Discipline
C. Supervision — Peer Review Leadership
D. Knowledge and Skills
E. Protocols — Clinical Aspects
F. Program Development
G. Administrative Structure and Staffing
H. Demographics and Community Trends for the Future
I. Budget

Extra-Family Violence

So far the focus has been on intra-family violence issues. Now let's turn to extra-family violence. To the six steps delineated above we would add the identification of high risk populations in regard to extra-family violence.

The identification of high risk individuals or groups seen in the emergency room is important in secondary prevention. Clinical impressions tell us that many individuals, particularly those involved in extra-family vio-

lence episodes, have previously been seen at hospital and health care settings. To identify these individuals and to intervene prior to a violent act is the purpose of secondary prevention.

These are some of the high risk categories:

1. Psychiatric diagnosis such as depression
2. Alcohol diagnosis (including DWI) and substance abuse
3. Behaviors associated with loss, grief, death
4. Isolation
5. Lack of support system
6. Homelessness
7. Previous history of assault/suicidal behavior
8. Chronic unemployment
9. Presence or use of weapons, previous arrest for crime, etc.
10. Runaway
11. Single auto accidents
12. Psychosomatic complaints

This is a list of "red-flag" antisocial and delinquent behaviors. These categories are important to early case finding and early intervention, since these patients most frequently show up in the emergency room. Their identification would be followed by the use of screening devices, such as violence scales and/or inventories which are particularly useful to an emergency room staff. Many scales and inventories in the trauma literature can be adapted for interpersonal violence behaviors. Emergency room staff could apply such scales to individual patients and hopefully begin to predict the level of lethality in future violent episodes.

Summary

This paper illustrates the steps in a comprehensive model for the identification, assessment, and treatment of victims of violence in a hospital setting. A crucial step is the use of clinical protocols which specifically detail the detection, assessment, intervention, and referral procedures.

Various hospitals in the country have moved ahead to develop family violence programs in their emergency rooms and outpatient clinics. Few programs in hospitals have also included extra-family violence.

Once the extra-family violence groups can be identified through protocols such as the psychiatric assessment or alcohol protocol, both assessment and early intervention techniques can be addressed. Assessment and primary diagnosis are imperative to early intervention. Strategies must be developed to identify patients-at-risk and to promote listening, caring, and helping

for this highly vulnerable population. Education of staff is essential. Programs need to be developed that reach out to these people, who frequently do not seek help in the early stages of trouble. Networking with social agencies must be accomplished. Attention should be given to tracking systems, since this population frequently "shops" for care (but confidentiality issues must also be addressed).

It is clear, however, that much can be done to reduce violence in our society without massive new resources. We must begin with the idea that an approach found successful in intra-family violence can be adapted for extra-family violence, too. Protocols can be developed, modified, and expanded. Protocols also lend themselves to audit and quality assurance accountability.

Every hospital in this country should have a policy and procedural manual on interpersonal violence. Lack of attention to this critical area can mean more health care dollars poorly spent and many lives needlessly lost.

Interdisciplinary Interventions Applicable to Prevention of Interpersonal Violence and Homicide in Black Youth

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Monday morning, October 28, 1985

Interpersonal violence and its most devastating outcome, homicide, are endemic in urban black areas with low socio-economic indicators. Those who are most affected are young and male. Homicide is the leading cause of death for black men ages 15-24 years at a rate of 72.5 for every 100,000[1] and for black men ages 25-44 years at a rate of 125 for every 100,000.[2] These rates are 7-12 times higher than homocide rates for the general population.[3]

Non-fatal interpersonal violence occurs at rates that are at least a magnitude higher than homicide and likely represents an even greater overall cost to society. There is less adequate data on non-fatal interpersonal violence. Emergency room and school data are the best sources of rates for non-fatal interpersonal violence. However, these rates are underestimations because, as we know, many episodes of interpersonal violence are neither treated in emergency rooms nor do they occur in schools.

The Northeastern Ohio Trauma Study measured the incidence of cause-specific trauma by collecting emergency room data for the year 1977. The study reported an assault rate of 862 per 100,000 population. The overrepresentation of urban blacks of lower socio-economic status was demonstrated in this study as well. The incidence rate for assault in the urban black neighborhood was over twice the total incidence rate and up to six times the lowest neighborhood rate.[4]

School-based data are equally compelling. During the 1969-70 school year, Seattle Public Schools had four assaultive injuries per 1,000 students.[5] In the U.S. generally there are approximately 75,000 assaultive injuries to teachers a year at a rate of 35 per 1,000.[6] A November 1983 publication from the Boston Commission for Safe Schools[7] reported a survey of four public high schools revealing that 50 percent of the teachers and 38 percent of the students reported being victims of a school-based crime during the year. The overrepresentation of urban black students was evident in this

report as well. Black students were suspended at the rate of 17 per 100, compared to a rate of 8 per 100 for white students. A large number of the suspensions (30 percent) are for interpersonal violence.

Weapon-carrying behavior was also reported in this Boston survey. Seventeen percent of the girls and 37 percent of the boys reported bringing a weapon to school at some point during the school year.

Socio-economic factors are thought to account for this overrepresentation of blacks among homicide victims. In a recent Atlanta study data that was corrected for socio-economic status, using the number of people per square foot of housing, no longer showed a racial bias.[8] Urban black adolescents are overrepresented among the poor with unemployment rates of 40-60 percent[9] and are overrepresented among the victims of fatal and non-fatal violence.

The severity and urgency of the problem for urban black communities dictates the need for appropriate and effective prevention strategies. The possibilities for such prevention strategies were greatly enhanced by the recent conceptualization of interpersonal violence as a public health problem.

Traditionally violence was viewed as only a law enforcement problem which limited both the professional expertise and the variety of institutions involved. The traditional public health model attributes occurrence of disease to complicated interactions between the environment, the pathogen (the agent that is responsible for the disease), and the host (the individual with the disease). The traditional public health model has been applied to unintentional injuries. The application of the model to violence prevention offers a particular challenge because of the intentional nature of violence-related injuries.

The public health interventions applied to other problems that have been most successful are those that have manipulated the environment and have had little dependence on changes in human behavior. Yet, when applied to intentional injury, environmental manipulations can be expected to be less effective. For example, a safety lock on the trigger of a handgun could be expected to prevent handgun-related accidents; but this intervention could not be expected to have that same effect on intentional shootings.

Altering the host (victim) and the pathogen (assailant) in this case to prevent interpersonal violence and homicide is dependent on changing human behavior, which is more difficult than altering the environment. The goal in such manipulations is to make the host more resistant to the disease, and the pathogen less virulent. Preventing interpersonal violence in urban young black men requires an appreciation of the distinct similarities between the victim and the assailant, as demonstrated by Ruth

Dennis, Ph.D.[10] Her work compares three groups of black men ages 18-34 who were 1) incarcerated homicide perpetrators; 2) victims of serious assault (knife and gun wounds); and 3) randomly selected non-institutionalized black men found through household sampling. Social and psychological profiles of each participant were done and the three groups were then compared.

The victim and perpetrator groups were similar to each other; they were distinguishable from the control group in that they had less education, had experienced more juvenile detentions, were more likely to carry a gun, and were more likely to have been in jail before. In addition to having similar characteristics distinct from the control group, these two groups had more participants exchange roles (victim vs. perpetrator) during the study. Because of this role exchange and the similarities between victim and perpetrator, when the public health model is applied to interpersonal violence the host and the pathogen become equal, and prevention strategies designed to make the individual less likely to be involved in violence are applicable to both.

These strategies designed to raise an individual's threshold for violence are predominantly education and behavior modification techniques. Teaching conflict resolution and using role play to practice alternatives to violence are such strategies.

The tenuous application of the host, pathogen, and environment disease model is not the most significant gain from the conceptualization of interpersonal violence as a public health problem. Perhaps the most significant gain is the potential application of a multi-institutional and interdisciplinary model which has been applied to other public health initiatives. The national campaign to reduce smoking is an example of such an initiative. The media, health care institutions, public schools, job sites, health fairs, and county fairs become the source of education, information, and incentives. Product labeling and advertisement restrictions are a part of the effort. This approach is applicable to interpersonal violence prevention as well when it is understood as a public health problem. Health education programs like the one I teach are only a piece of the total picture.

The Black Adolescent

Designing violence prevention strategies that are effective with urban black adolescents of lower socio-economic status requires an understanding of adolescence, of issues of race, and of poverty. I will not review all the theories of adolescent development under the impact of race or poverty as

such, though I will offer a general outline of these issues as applicable to the development of violent behavior.

Adolescence is that period of dynamic physical and psychosocial maturation which is the transition from childhood to adulthood. The physical changes are the growth and development of puberty. The psychosocial changes include both cognitive maturation from concrete to abstract thinking and the mastering of specific developmental tasks. These are the major developmental tasks:

1) Individuation from family with the development of same-sex and opposite-sex relationships outside the family.
2) Adjustment to the physical changes of puberty with the development of a healthy sexual identity.
3) Development of a moral character and a personal value system.
4) Preparation for future work and responsibility.

Failure to accomplish these tasks can result in significant dysfunction for the adolescent, which can impair him as an adult. The tasks are accomplished simultaneously and are the major requisites for healthy adulthood. The experience of poverty and of racism can significantly hinder the accomplishment of these essential tasks. The development of a healthy self-identity requires a sense of self-esteem and a healthy racial identity, both of which can be undermined by poverty and racism. Preparing for future work and responsibility is a meaningness enterprise, when unemployment rates are astonishingly high. Developing a sense of moral character and a functional personal value system is also not easy, when television and the street are the main sources of values.

What Is "Normal?"

One of the most difficult problems facing service providers for adolescents is that of defining normal behavior. Normal behavior for adolescents includes a variety of experimental behaviors which at other developmental stages would be abnormal. Defining normal is even more difficult in cases where there is a subcultural experience. Claude Brown in his literary work *Manchild in the Promised Land* describes such an experience:

> "Throughout my childhood in Harlem, nothing was more strongly impressed upon me than the fact that you had to fight and that you should fight. Everybody would accept it if a person was scared to fight, but not if he was so scared that he didn't fight."

The example clearly illustrates the dilemma. How much fighting is too much? When is it problematic? Many would agree that violence in self-

defense is appropriate; yet, if a homicide results, would running not have been a better response? On the other hand, in a violent world, is it not healthier to defend oneself rather than be beaten or harassed?

Narcissism and Sexual Identity

There are several characteristics of adolescence which make a teenager more prone to violence. One such characteristic is narcissism. Narcissism helps the adolescent make the transition from family to the outside world. Yet, this narcissism is also responsible for the extreme self-conscious feelings of adolescents which make them extremely vulnerable to embarrassment. The adolescent feels that he is always in the limelight and on center stage. He is particularly sensitive to verbal attack, and it is nearly impossible for him to minimize or ignore embarrassing phenomena. Another adolescent characteristic that predisposes to violence is the transient stage of extreme sexual identity, or "macho." Establishing a healthy sexual identity requires transient stages of extreme femininity for girls and macho for boys. Macho is often synonymous with violent. The image of a coward is a deadly one for a male adolescent in this stage.

Peer pressure has been labeled the single most important determinant of adolescent behavior.[11] This vulnerability to peer pressure, a normal part of adolescence, facilitates the accomplishment of several of the developmental tasks; yet, it is a characteristic of adolescence which enhances the predisposition for violence. If fighting is the expectation of peers, as illustrated in Claude Brown's quote, then an adolescent is often unable to disregard those expectations.

Erikson[12] describes a societal moratorium from responsibility that is necessary during adolescence to allow the requisite experimental behavior to occur without compromise of future options. Thus, the adolescent is able to experiment with a variety of roles without making a commitment. There is debate as to whether this moratorium occurs at all, yet many agree that in the situation of poverty, it does not. The poor adolescent struggles with developmental tasks without the protection of a societal moratorium.

The black adolescent has to develop healthy racial identity, in addition to the listed developmental tasks. Contact with racism results in anger that appears to contribute to the overrepresentation of black youth in interpersonal violence. Psychologist Ramsey Lewis used "free floating anger" to describe anger not generated by a specific individual or event but from global factors such as racism and limited employment options.[13] This anger is the excess baggage that an individual brings to an encounter that lowers

his threshold for directed anger and violence. This concept is helpful in that it attempts to account for the environmental and socio-economic factors and not label the individual as deficient. The anger is normal and appropriate. Violence prevention is therefore designed to achieve a healthier response to anger, not to eliminate the anger itself.

Violence prevention programs which are appropriate for adolescents developmentally and which have a realistic cultural context can be expected to be effective. Developmentally appropriate programs utilize peers in education and counseling and reflect an understanding of the stages of adolescent development. The cultural context has to acknowledge the violence, racism, and classism that many such adolescents experience.

The problem of interpersonal violence among poor black adolescents has been long appreciated by frontline service providers, and despite an incomplete understanding of the causal factors, prevention and intervention programs have been developed with moderate success. The majority of these prevention programs are either based in a school or linked to a school because of the captive audience. Most are interdisciplinary and multi-institutional.

The Boston Curriculum

The Boston Youth Program is a comprehensive health care initiative for adolescents funded by the Robert Wood Foundation[13]. The health care services are hospital- or clinic-based and the health education/prevention services are school-based. A violence prevention curriculum developed for tenth-grade health students is one of the health education services. The Boston Youth Program curriculum on anger and violence has been instituted in four Boston high schools and one community agency setting. To date, approximately 500 students have received the curriculum. The curriculum is designed to

1) provide statistical information on adolescent violence and homicide;
2) present anger as a normal, potentially constructive emotion;
3) create an awareness in the students for alternatives to fighting by discussing the potential gains and losses from fighting;
4) have students analyze situations preceding a fight and practice avoiding fights by using role play and videotape;
5) create a classroom ethos which is non-violent and values violence prevention behavior.

The prevention curriculum is specifically aimed at raising the individual's threshold for violence, by creating a non-violent ethos within the classroom

and by extending his repertoire of responses to anger. It acknowledges the existence of societal and institutional violence and the existence of institutional racism. Students are not taught to become passive agents, but they are expected to claim anger and become intentional and creative about the responses to it.

Anger is presented as a normal, essential, and potentially constructive emotion. Creative alternatives to fighting are stressed. The classroom discussion during one session focuses on the good and bad results of fighting. The students list the results. The list of bad results is invariably longer than the good list; thus, the need for alternatives. This exercise emphasizes that fighting or not fighting is a choice and that the potential consequences are important to consider when making the choice.

Role-playing a fight is a unique part of the curriculum. During this session the students are asked to create a usual fight situation. The fight is videotaped and analyzed for the buildup or escalation phase, the role of the principal characters, and the role of the friends in the crowd. Videotaping the role-play is useful for discussions. Provocative behavior is labeled and alternative behavior is discussed. The focus of the discussions is the demonstration and reinforcement of preventive behavior.

The 10-session curriculum has been evaluated using pre- and post-testing in one of the high school settings.[15] This controlled study involved four tenth-grade health classes of 106 students (approximately one-third of the 10-grade enrollment for the school). Two classes were assigned to the experimental group, while the other two classes were the control. The violence prevention curriculum was presented to the experimental group, while the control students continued with the regular health curriculum. Both groups were evaluated by the same pre- and post-test instrument approximately 10 weeks apart. The instrument tested for both knowledge and attitudes about anger, violence, and homicide.

Higher Post-Test Scores

The experimental group had significantly higher post-test scores than the control group. There was no difference between the pre-test scores for the two groups. Knowledge scores accounted for more of the change than did the attitude scores, though the change in attitude was significant with $P<.01$. These differences in scores represent the effect of the Violence Prevention Curriculum.

Student questionnaires were used to evaluate the curriculum. Eighty-seven percent of the students enjoyed or very much enjoyed the unit.

Seventy-three percent of the students found it helpful with handling depression, and 63 percent found it helpful in handling anger.

This demonstration project shows that students can be receptive and enthusiastic about a curriculum on anger/homicide, and that a significant impact on both their attitudes and their knowledge can be accomplished. Further study must delineate the impact this curriculum has on behavior and the longevity of the impact. These preliminary results indicate that health education as a technique for violence prevention should be studied further and that no harm is apparent from the effort.

Recommendation

I believe that a health education initiative ought to be part of a national campaign to reduce interpersonal violence. Such an initiative could use a standardized version of our curriculum, replicated in a variety of high schools across the country. It would involve some teacher training and the production of new audiovisuals. If possible, some sort of nationwide, large-scale evaluation could be carried out, using pre- and post-testing for knowledge, attitudes, self-report of behavior, and self-concept. In addition, we would want to measure the longevity of the impact and the impact on behavior.

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This Epidemic of Family Violence

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Chief of Police, Minneapolis, Minnesota
Monday morning, October 28, 1985

In our society the family has been the traditional source of strength and stability. This sense of family was part of every immigrant group to these shores, from the first groups, the English and the Spanish colonists, to the most recent groups, such as the Central Americans and the Southeast Asians. But we are beginning to get an idea that not all families are strong and stable. In some, there may be abuse of one or another member, the wife or the children or an elderly parent. There may be incest. All these kinds of actions are crimes of violence. The outcomes involve pain and great personal distress. But these abuses and acts of violence against children also endanger society, since they are, in effect, acts that create tomorrow's adult criminal.

This is particularly and painfully evident among teenage women who become pregnant and have their babies, using them as a kind of ticket out of the house and into the adult world. They are "children having children," and a great many of them simply can't handle it. Already the reports are beginning to multiply of teenage mothers who have abused, severely beaten, and even killed their babies during periods of depression or anger or frustration. Of the babies that survive, many grow up to be the abusers and killers of tomorrow. And thus is born the generational cycle of family violence.

Some people use the term "monsters" to describe these babies who grow up as sociopaths, a menace both to the community at large and to those immediately around them. But I submit that the real "monster" in our society may, in fact, be that teenage mother, who bears her child and raises it, but is incapable of giving it a decent, peaceful family life, a life enriched by mutual love and a mutual sense of responsibility. Instead, these are children bred in chaos and violence; and they, in turn, breed their own chaos and violence.

This development — or this revelation — of violence in the American family, and outward from the family into the community, has had a profound impact on women in our society. Once placed on a pedestal and virtually worshipped, the American woman has been pulled off that pedestal

to become the target of street predators: muggers, rapists, and "Johns." They prowl at night, a time which no longer can belong to a woman alone. The appetites of these predators are whetted and twisted by the pornography industry, which is now doing billions of dollars worth of business in every medium of communication, including telephone and cable television. Women are enlisted or forced to take part in this industry, beginning with prostitution. Most of the time, they are snared into the business as teenage runaways. They have usually fled the sexual exploitation that begins right in their own homes, where they are victimized by members or close friends of the family . . . by fathers, step-fathers, brothers, and "uncles," real or imagined. For too many girls, this victimization occurs before they are 12 years old. Once on the street, their flesh is bartered over and over again, for years, until they have no sense of who they are, who they could have been, or even who they might still be.

For women, the issue of control of their own bodies is critical, but it is not an issue only for the prostitute or for the sexually victimized woman. Among women with more socially acceptable careers or with families, the issue re-appears as the abortion issue or as the marital rape issue. As suggested by the title of the best-selling book on women's health, "Our Bodies, Our Selves," if a woman does not control her own body, how can she have control over her self-hood and her destiny? She can't. Once she loses control over access to her own body, the cycle of abuse and violence only gets worse. Prostitution escalates to disfigurement and rape, and assaults escalate to homicide, the ultimate and total denial of a woman's body and self.

"Mad as Hell"

But women are fighting back through the feminist movement and the drive for liberation. They are raising their own consciousness and the consciousness of others, too. They are "mad as hell and they aren't going to take it anymore" and they have vowed to "take back the night." Their enemies are rape and pornography, which imprison women in a hopeless cycle of abuse, degradation, victimization, and death. Dozens of new women's organizations have sprung up representing virtually every point across the spectrum of health and justice, of politics and society. New institutions, such as women's shelters, have become integral elements of the total human resources of a community.

A year ago, in September 1984, the Attorney General's Task Force on Family Violence published a report which gave strong support to any efforts

that could change the way police departments look at family violence. The Task Force said that violent acts within a family are still criminal acts and they must be treated as crimes. The victims must be protected and given justice. The perpetrators must be arrested. The report indicated — and I agree — that arrest is still our best leverage for correcting a situation, including bringing the perpetrator into some kind of treatment.

For a woman, the arrival of the police is the time when she must bite the bullet. She has to understand how our adversarial system of justice works in order to take full advantage of it. For centuries women have been raised to accept their fate as victims and therefore to think and act like victims. If they were abused, they were led to believe that they somehow "deserved" it. But those days have got to end for all women. And they, in turn, need understanding and compassion from the police and the courts. They need strong advocates. But no one is more powerful than a woman herself. The woman/victim must use the system, must file a complaint, and, the hardest part of all, she must come forward to testify.

Male Myths

For their part, the police and the criminal justice system must abandon their convenient myths of male authority and power and must begin to take seriously the woman who lodges a complaint against a batterer. Yes, the police are changing, but they are still not effective in countering the arguments and pleas of the batterer and the abuser. We've heard those arguments a million times: that a man's home is *his* castle, not hers; that she must've done something to deserve what she got; that she probably "had it coming to her;" that they always kiss and make up; and they'll have forgotten all about it by morning. Sure, she filed a complaint, but we'll hold off signing it and see if she works things out like the others usually do. And so on.

Today's police need to adopt policies which limit discretion to allow this kind of thinking, policies which compel the arrest of the perpetrator or, if there is no arrest, policies which require a report explaining exactly why. The same thing applies to prosecutors and the courts. They, too, must begin to treat this matter seriously, applying sanctions of every kind to change the dangerous behavior of the batterer or the abuser and to protect the life and health of the victim. Parole and probation officers must recognize domestic violence as a crime and, therefore, a violation of the terms of probation or parole. And we need a re-evaluation of existing law, with new provisions making it harder for the batterer to get away with threats

and intimidation. These and other psychological weapons can be as destructive to a woman as physical punishment itself.

The demonstration project in domestic abuse, which we conducted in Minneapolis, revealed several things. First, we learned how important it is for a woman victim to be helped very early in the process by a woman's advocate. If they can be helped through those first few hours of horror and trauma and confrontation, most women will then show the courage and the intelligence to get protection and justice. We also became true believers in the importance of the women's shelter. There had to be a secure place to run to, a place where a woman will be understood, a place that doesn't ask a lot of questions because all the questions have already been asked and answered by the people already there to take her in.

Alcohol and Drugs

We also learned never to underestimate the possible role of alcohol and drugs. Alcohol and drugs in a man's bloodstream will take the place of love and reasonableness and responsibility and the healthy fear of unknown consequences. And we learned that the best weapon in our arsenal is the weapon of arrest. Get the perpetrator out of the situation, release the victims — his wife, his children — from the prison of his terror. Dry him out. If he's got a chronic abuse problem, get him into treatment.

That's where the medical profession comes into play. The police can't do this job alone. We know that. The courts can't do the job alone. They know that. We need the help of people like the ones here at this Workshop . . . doctors, nurses, psychiatrists and psychologists, social workers, lawyers, counselors . . . you are the people who can step in and treat and prevent and protect. You are the ones who can help a woman and her children rebuild their lives. Otherwise, the cycle of violence in that family will continue to escalate. And finally someone will get killed. The death of the victim — spouse, child, or parent — is the ultimate "kick," the final degradation.

The new federal and state laws requiring the health and social service professions to report any actual and *suspected* cases of abuse have been a long time in coming. But now they're here, and I urge every member of those professions to obey those laws, to report what they may believe to be the abuse of a child or the victimization of any member of a family by any other member. Such acts are crimes. Report them.

Violence of all kinds is reaching epidemic proportions in our society. We've got to work together to fight back, because we will never have

enough police and judges and jails to stem the rising tide of violent crime. Prevention is the only answer. But prevention comes in a variety of forms:

- It involves treatment for physical and mental health.
- It involves helping a person break away from a dependence on alcohol and drugs.
- It involves social justice — better schools, safer housing, more jobs for disadvantaged youngsters.
- It involves controlling the instruments of violence, such as handguns. This may not be an issue that would ordinarily involve the Surgeon General; nevertheless, while we're here together focusing on violence, I must ask him to use whatever influence he may have to convince the President and other members of the Administration to work for the total outlawing of handguns.

More Research Needed

Finally, I want to encourage the people here and anyone else who hears of this Workshop, that this is an area that still needs a great deal of research. We have relatively few facts; what we have most are statistics, and those are mainly drawn from arrest records and court records. But we don't know enough about why domestic violence occurs or who the typical offenders and perpetrators are. Until we get a more substantial body of research data behind us, we're not going to be able to do an effective job of treatment and prevention. And by "we" I mean not only the police departments of our country, but also the courts and the hospitals and the family service agencies and the churches and all the different community agencies, public and private, that can provide a healthful, positive influence upon the course of American family life.

This Workshop is a very important undertaking by the Surgeon General and I commend him and the U.S. Public Health Service for having taken the initiative and doing it. I can assure you that this effort comes not a moment too soon.

Thank you.

Plenary Session IV

Recommendations of the Work Groups

Tuesday afternoon, October 29, 1985

ASSAULT AND HOMICIDE: EVALUATION AND TREATMENT

CHAIR: Fernando A. Guerra, MD, MPH
ADVISORY COMMITTEE MEMBER: David Nee
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Marlene A. Young, PhD

Members of this work group introduced their recommendations with the following preamble:

- Violence in the United States has become so pervasive that it can no longer be usefully viewed only as a problem of disparate acts by individual offenders. Violence is a public health problem because of the toll it exacts in injuries and deaths, especially among young people.

• Public health has continually redefined its role so as to address more effectively the changing needs of a changing nation. Public health now needs to accept the challenge presented to our country by violence and its consequences.

• Any solution to the problem of violence will require a total community effort, in which health care providers can play a special role. The emergency room is often the first contact a victim has with those professionally charged to provide health care. That encounter may determine how well a victim recovers from the emotional consequences of assault as well as from the physical trauma.

• The health care system must help victims recover emotionally as well as physically and must help prevent further violence. Too many victims are victimized again and again; providers must be alert to the special needs of those most at risk of becoming repeat victims.

• Our call is for a spirit in America that rejoices in our ethnic variety, a spirit that protects all of our people as our most important resource and legacy, and finally a spirit that no longer tolerates violence.

In the area of *Education* we recommend that . . .

. . . information about the particular needs of violence victims — actual or potential, direct or indirect — and their communities should be part of the education of any health professional who interacts with violence victims. (E-1)

. . . the Public Health Service should encourage schools of medicine, nursing, social work, osteopathy, and the allied health professions to offer more and better training in the treatment and management of victims of violence. (E-2)

. . . the Public Health Service and the health professions should encourage state licensure and national board certification authorities to include in their examinations questions related to violence as a health/mental health problem. (E-3)

. . . leaders in the fields of health and mental health should actively enlist the media, schools, and community agencies in educating the public about violence as a health problem. (E-4)

In the area of *Research* we recommend that . . .

. . . the Public Health Service should support improvements in the collection of data about direct and indirect victims of assault and homicide, since at present there is so little reliable data on the numbers and types of victims treated by the health care system. (R-1)