

Violence in Our Society

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Violent interactions between parent and child, and between spouses, occur at a high rate in the United States. In response to this situation, several federal agencies are involved in various research projects whose goal is a better understanding of the roots of violence. Among these agencies are the Division of Injury Epidemiology and Control (Centers for Disease Control), the Office of Minority Health (Department of Health and Human Services), and the Antisocial and Violent Behavior Branch (National Institute of Mental Health).

Let me begin by citing two indicators of violence in our central societal institution. In 1985, violent interactions between parents and children occurred in the United States at an overall rate of 620 instances of violence per 1,000 children. Of every 620 incidents, 19 were "severe"—that is, they entailed kicking, biting, or hitting with the fist or using or threatening to use a gun or knife. An additional 97 incidents involved hitting and trying to hit with another instrument. During the same year, violent interactions between spouses occurred at a rate of 113 per 1,000 couples, with nearly one quarter of these instances involving severe violence. In any given year, attacks by husbands on wives result in more injuries among women which require medical treatment than rapes,

muggings, and automobile accidents combined.

While my discussion does not focus on violence in the family, one cannot dissociate the family from the larger society. That we adhere to the ideal of the family as a source of nurturance while so often resigning ourselves to its reality as a site of violence may not in itself define our society as an excessively violent one, but it does underscore the extent to which we accept violence as a medium of personal interaction. In fact, ours is a violent society. I needn't recite the entire litany:

More than 24,000 homicides each year, distributed unevenly throughout our society. The likelihood of being a homicide victim is one in 21 for adult black males in contrast to a probability of one in 131 for all males in the United States; for young adult black men, homicide is the leading cause of death
27,000 suicides reported annually, some 5,000 of which are completed by adolescents and young adults

171,000 rapes reported in the course of a year
The tremendous impact of self-directed violence—alcoholism, primarily, and drug abuse—on the nation's morbidity, mortality, and general health status

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The fascination with violence that is evident in so much of our arts, our media, our recreations, from professional sports to video games, and the influences of this fascination on the development of propensities toward violence, particularly among the young.

Violence and Public Health

As a society, we are not newly aware of the extent to which violence and the threat of violence permeates and, thus, rules all of our lives. Since the 1960s, particularly, extensive attention has been directed to the issue of violence from numerous vantage points: the social, the cultural, the legal, the biomedical and psychological, the familial, and the geopolitical. All of these perspectives are useful and necessary, but the disparateness, combined with the credibility of each, has tended to undermine the possibility of appreciating, not to mention studying, the problem in a coherent fashion.

In the landmark report, *Promoting Health/Preventing Disease—Objectives for the Nation*, issued by the office of the Surgeon General of the U.S. Public Health Service in 1980, the reduction and prevention of violence was designated as one of 15 pressing health priorities of the nation. The designation of violence as a threat to the public health of the nation and its persuasive articulation over the past five years of the public health paradigm by Surgeon General Koop do not promise easy answers to the multitude of questions surrounding the etiology, distribution, expression, effects, or prevention of violence. The designation does, however, through the host-pathogen-environment model, offer a framework for organizing the di-

verse approaches to and array of factors that are involved in the phenomenon of violence. The strength of the model is that, *by definition*, it requires and facilitates the involvement of multiple perspectives and social institutions. In his presentation of the Public Health Service report, the then Surgeon General Julius Richmond noted that the tasks required the efforts not only of the health community, but also of those in education, industry, labor, community organizations, and other settings.

Time does not permit an exhaustive listing of the mechanisms available within the federal government, or even within the Public Health Service, for our conduct of a public health assault on violence. I might single out, however, a few key loci of activity.

One is the Division of Injury Epidemiology and Control at the Centers for Disease Control. This division, established in 1983 as the Violence Epidemiology Branch under the direction of Dr. Mark Rosenberg, and more recently headed by Dr. Lucy Davidson, has enhanced significantly the quality of data upon which research and related intervention strategies are based.

Another key site of activity is the Office of Minority Health in the Department of Health and Human Services, under the direction of Dr. Herbert Nickens, who has designated violence as a special priority of that Office. Among the specific aims of the Office are public education to increase awareness of the unconscionable impact of violence on the nation's minority populations, the stimulation of research, and development of preventive strategies.

A third, and I believe [and would, even if I had not held my National Institute of Mental Health (NIMH) position] critical and productive, program is the Antisocial and Violent Behavior Branch at NIMH. This program, headed by Dr. Saleem Shah since its inception as the Center for Studies of Crime and Delinquency in 1966, has been a tremendously productive wellspring of research into violence and, particularly, the individual bases of violent behavior. Dr. Shah has advised me that all of the contributors to this special issue have had affiliations with the NIMH program: as research grantees, recipients of research training fellowships, members of initial review groups, and, in the case of Dr. Layton McCurdy, as a member of the National Advisory Mental Health Council.

In 1986, the Antisocial and Violent Behavior Branch funded a total of 32 projects, with a total cost of slightly more than \$5 million. The research portfolio encompasses: (1) childhood aggression; (2) domestic violence (the data on family violence which I cited earlier are provided by Murray Straus and Richard Gelles, both longtime grantees of the program); (3) rape and sexual assault; and (4) the issue of violence and danger-

ousness within the broader context of law and mental health.

Although the Antisocial and Violent Behavior Branch is the nucleus of our activities, research and related activities pertinent to the issue of violence are found throughout the NIMH program. Basic behavioral research, neurobiological studies of aggression, and treatment are all germane, as is the work of various units involving national leadership and demonstration activities targeted to such populations as young adults with chronic mental illness and the homeless who are mentally ill. The Surgeon General's Workgroup on Violence and Public Health categorically includes homeless women under the rubric of elder abuse, given the high vulnerability of this group to violence.

Despite the obvious and necessary multidisciplinary nature of a public health approach to the study and prevention of violence, there is concern that, in our enthusiasm over the evident and potential yield of neuroscientific investigations into the bases of behavior, the study of violence might succumb to a reductionistic, exclusively biological/biochemical orientation. I believe the likelihood of this is diminishing, but we must remain vigilant.