Psychodynamic Aspects of Violence

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The natural tendency of the physician is to seek to understand human discomfort or human deviation by focusing upon individual variation. Such an approach serves us well in treating diseased individuals and may also provide us with important perspectives on certain social problems. In dealing with the complexities of human violence, however, focusing upon the individual alone provides us with little information of explanatory value, and it is necessary to adopt a more complex systems-oriented approach. The psychodynamics of violence must be understood in terms of the manner in which given individuals adapt to varying environmental situations. Physicians do not usually concern themselves greatly with the environment in which a given dysfunction develops. But in studying violence, such concern is critical.

It is possible to create environments in which almost anybody will be violent (for example, wartime), and it is possible to create environments in which hardly anyone will be violent. All of this means that the physician who is to work with violent people must keep at least two perspectives in mind at the same time. On the one hand, he must constantly be examining the natures of forces in the patient's environment which are conducive to violence. At the same time, he must constantly be searching for answers to the question of why some individuals are more prone to be violent in these environments than others. The latter task is a little more familiar to most physicians than the former. It is particularly familiar when we can find situations in which violent behavior seems inappropriate, unreasonable and maladaptive to the environment in which it occurs, and we can focus upon the individual as the causative agent in a violent act.

Obviously, there are many aspects of the current American environment which are conducive to violence. These are probably familiar to most of you, but it will be useful to consider briefly some of the more general socio-political hypotheses that have been put forth to explain the rise of violence in recent decades. The following general factors have at one time or another been considered to be critical:

(1) A widespread sense of rootlessness and lack of community within the society. With great upward mobility and easy access to travel, few of us are able satisfactorily to integrate our lives into a stable community. Few people are able to benefit from the support and value systems of the extended family. This situation both increases overall levels of stress which may push people towards violence and decreases the power of control mechanisms which may restrain violence.

(2) Value systems within the society have been changing at a rapid rate, leading to much conflict between generations, sexes and races. All of these factors make for a diminished cohesiveness of the family unit, which in the past could serve as a force that controlled violent behavior.

(3) The rapid rate of change has left us very uncertain about the future. People tend increasingly to live in the present, and they are wary of committing themselves to life styles based on the promise of future gratifications. This condition leads to a sense of immediacy and demandingness which may be expressed in violent action.

(4) An economic and political situation which makes it difficult for young people to

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assume a responsible role in society for many years and prolongs their dependency upon their parents or upon social agencies. The young are the most prone to violence. When their social status is poorly defined and their sources of gratification are limited, their society will be subjected to more violence.

(5) Greater awareness of oppressiveness in the world and greater awareness of the dishonesty and hypocrisy which often characterize authority in our society. This awareness is brought to us largely by electronic media. Television makes us more aware of and perhaps more frustrated by disturbing things that are happening in our world. It also exposes the weakness of many of our leaders and erodes the controlling aspect of authority.

(6) The presence of powerful media reinforcement to violent behavior. There have been many who have argued persuasively that the large exposure to violence that we all receive through the media, particularly television, simply teaches us to be more violent people.

(7) An easy accessibility to weapons which allow for lethal rather than simply cathartic expression of angry feelings. If most of us fought only with our hands, we would terminate the struggle once the antagonist was subdued or repentant. Guns and knives kill impersonally and do not give us time to change our minds.

(8) The easy availability of drugs, particularly alcohol, which interfere with control mechanisms that ordinarily prevent us from expressing violent impulses.

The above listed factors are descriptions of forces which influence all members of our society. Other stresses such as poverty and racism are important but less general factors in creating violence. If one lives in a society in which the rewards of success are visible and allegedly available to all, but is at the same time denied legitimate ways of gaining these rewards, one is more likely to seek illegitimate and, perhaps, violent means of being rewarded. Poverty and racism also create ghettos, which are dominated by despair and a ruthless struggle for survival. These conditions encourage sub-cultures which teach violence and condone or actually reward it.

Many of the social stresses which I have listed exert a direct influence upon the family. When roles are not clearly defined, when values are in a state of rapid change and where community support is not present, the family cannot teach gratifying non-violent behaviors nor can it exercise restraint on violent impulses. If the family must also deal with the burdens of poverty or racism, it may also become a battleground in which social as well as personal frustrations are expressed. Much of the violence which plagues our society originates within families, particularly families which view themselves as oppressed by society.

There is no scientific proof of any of the socio-political hypotheses of violence. Nevertheless, I believe that any effective effort to prevent violence would require drastic changes in our total environment. The amount of actual prevention we can obtain by focusing upon individuals is minimal. There are only two strategies for preventing violence that might work, and both involve changes in the environment. We could drastically alter the nature of our society by changing the factors I have listed, or we could add additional sanctions and restraints to our social system. The first alternative would mean revolutionary change. The second alternative is unwelcome, but we accept it out of desperation and pragmatism.

Our current criminology literature reflects our society's attempts to deal with violence not by changing people and not by changing oppressive institutions, but by making minor changes in laws and practices. Disillusionment with the possibility of predicting and preventing violence in individuals and desperation over the usefulness of rehabilitation has led most criminologists to advocate greater use of punishment as a deterrent and greater police protection and carefulness upon the part of victims as a means of avoiding situations in which violence might occur. Whether the new criminology (actually a very old criminology) will help us is debatable, but the renaissance of a system of justice

founded mostly upon deterrence is a clear by-product of our frustration.

It is important that physicians understand the intensity of the current negativism among criminologists towards individualized approaches to the violent offender. It has been correctly pointed out that physicians are incapable of predicting violent behavior in a given individual with sufficient precision so as to make a preventative disposition both legal and ethical. There is disturbingly little evidence that efforts to rehabilitate offenders help. Emphasis on rehabilitation through psychiatric treatment has been drastically diminished, and it is a rare violent offender these days who is privileged to receive psychiatric treatment. Whatever knowledge we have of individual variation which makes some people more susceptible to violent behavior is primarily being utilized to help the court in making legal decisions as to the disposition of violent offenders. To put this another way, psychiatrists these days are more than welcome to make judgments as to the competency or responsibility of the Hearsts, Moores and Frommes of the world. There are few institutionalized settings, however, in which they are willing or able to treat those people.

The physician must also appreciate that many people in our society are antagonistic to scientific efforts even to study individual causes of violence. They fear that individual-oriented explanations of violence will distract us from considering the social causes of violence and that blame will be ascribed to deviant individuals rather than to an oppressive society. They view research into biological and psychological causes of violence as efforts to strengthen an oppressive *status quo* and have militantly (and sometimes successfully) sought to curb such research.

With full awareness that neither our society nor our criminologists are impressed by psychodynamic or individualistic theories of violence, and with considerable humility as to our capacity to help society, we can approach the question, "What factors make some people more prone to violence in environments which are relatively benign and in which the overwhelming majority of people would never be violent?" In looking at this questions, we are on relatively safe professional grounds. We may never get to the point at which we can predict that a given person in a given situation will definitely be violent. But we can at least expand our knowledge so that we are in a better position to know which people are more likely to be in need of and responsive to our interventions, and we can also refine the effectiveness of our interventions.

In taking a relatively individual-oriented approach to the psychodynamics of violence, it is still impossible to avoid looking at the environment in which violence occurs. The manner in which that environment is perceived, both by the treator and by the patient, is critical. The physician who is not aware of socio-political variables is always at risk of assuming that the environment in which the violent behavior took place was benign when it actually was not. The first thing we must do in understanding why an individual seems to have responded inappropriately to a benign environment is to check our own perceptions of that environment. This requires that we be at least knowledgeable as to socio-political conditions. If we can use this knowledge in an unbiased fashion to convince ourselves that the patient is indeed responding unreasonably to a relatively benign environment, we can begin to assume that the problem resides in the patient. Either his perception of the environment is distorted because of some biological or learning disability, or his willingness or ability to restrain violent behavior is diminished by virtue of some biological or psychological cause.

It would be helpful if we could develop unified theories or models for explaining how some people become more susceptible to violent behavior than others. Unfortunately, this is difficult to do. Several years ago, I hypothesized that criminal actions, particularly those that one could view as unreasonable, were a response to a feeling of helplessness engendered by a perception, real or distorted, that one could do nothing to change an oppressive situation and yet could not possibly adapt to it by changing something about himself. The violent or criminal act was then viewed as the only adaptation available for

avoiding helplessness and for sustaining organismic integrity. This conceptual framework, which was largely based on psychoanalytic concepts of the unconscious, had only limited usefulness. It required detailed elaboration of how different individuals came to learn and experience a sense of helplessness. It was of no value whatsoever in explaining the behavior of those who enjoy or profit from violence.

The frustration aggression models developed by Dollard and others are based on the assumption that aggressive or violent behavior is a general response to frustration. This model does not help us understand those who enjoy or profit from violence. Its explanatory powers are also limited. Unless supplemented by other theories, it does not provide us with a basis for understanding individual responses to frustration. The variations in frustration which any of us can tolerate before becoming aggressive must be influenced by constitutional factors, by our perception of the frustrating events, and by previous learning experiences in dealing with frustrating situations.

There are also limits to the usefulness of socio-psychological theories of violent behavior. Social psychologists have presented us with a great deal of laboratory information suggesting that people who are exposed to violent situations, such as watching violence on television, will behave more violently. This data seems to validate a sociological hypothesis of violence, but it does not help much with the question of individual variation. Almost all of our children watch television, but only some of them become violent.

Confronted with the limited usefulness of theory in this complex area, most behavioral scientists have taken a more empirical approach and have focused upon biological and psychological factors that seem to be correlated with violent behavior. Here we are forced to rely almost entirely upon retrospective studies. We can take a group of violent people, examine them, and determine that a high percentage of this group will have some unusual biological trait, will show some unusual behavioral trait, or will have been exposed to certain unusual environmental situations in early life. We can demonstrate that these traits or conditions occur more frequently in the lives of those who are violent than in the lives of those who are not. We are not able, however, to say that any one of these traits or conditions is a necessary or sufficient cause of violence. The presence of each trait or condition merely increases the probability of violence. At present, our research lacks the degree of specificity that would enable us to comment upon the degree of such probability.

I do not mean to imply that literature is not rich in describing the psychodynamics of individual violent offenders. Given enough time to study a case, psychiatrists and others have been able to put together eloquent and probably accurate descriptions of how some individuals with or without deficits experience certain situations in their childhood which influence their subsequent learning in a manner which makes them violence-prone even in benign situations. These case studies may be extremely useful to the courts in making decision as to the proper disposition of the offender, and they may even be useful in subsequent efforts to treat the individual offender. The problem is that the insights derived from these individuals may be cynically viewed as a form of art. They may be aesthetically pleasing, but they have little practical value to the society or to the practicing physician.

The best we can do at present is to continue to elaborate our knowledge of the linkages between certain traits and conditions and violent behavior. One group of variables which have long intrigued criminologists are those related to biological deficits.

Biological deficits can increase propensity to violence by causing the individual to misperceive the environment or by compromising his control mechanisms. Research in this area has thus far been primitive, but because of the high rate of abnormal electroencephalograms among violent individuals, we have good reason to suspect that some brain dysfunction may be a factor in their behavior. The episodic dyscontrol syndrome has already been discussed here and I will not elaborate upon it. Hypotheses as

to violent people having an additional Y chromosome have been interesting, but current evidence indicates that the X-Y-Y chromosomal configuration is not disproprotionately associated with violence. One area of biological dysfunction which has not been sufficiently explored is that relating to minor inborn learning deficits. Patients with various types of dyslexia are likely to experience repeated failures during school which may diminish their self-esteem, force them to search for illegitimate means of gratification, and put them into environments where violence is easily learned. The biological deficit in such cases may be one factor which helps elicit a chain of responses which ultimately increases the probability of violence. Those of us who view schizophrenia as a disease with biological determinants are also concerned that the presence of this psychosis may predispose one to violence. More about this will be said later.

In studying murderers, rapists and child abusers, a number of events and behaviors have been described as having a high correlation with violence. The most important events relate to experiences in early childhood. Consistently, there is a higher incidence of parental deprivation and physical brutalization as a child in those who become violent as opposed to those who do not. The incidence of parental brutalization is especially high in murderers. In Frazier's studies, the element of brutality was accompanied by powerful efforts to shame and humiliate the child. The violence prone individual can also be seen as having developed a number of behavioral patterns which are maladaptive. Among the most important of these are:

(1) A failure to develop a clear-cut sexual identity. Most sex offenders and some murderers are heavily preoccupied with issues relating to their sex roles. Many have latent or overt homosexual conflicts.

(2) A limitation of social contacts with peers. In the history of many violent people, one can find a tendency towards "aloneness." Retrospectively, it is quite common to discover that the violent person was always "different," "out of it" and schizoidal.

(3) The presence in male offenders of an inordinate preoccupation with masculinity and maintaining a reputation which is compatible with masculine stereotypes. In Hans Toch's studies of violent men, violence was often elicited by situations in which masculinity was threatened or in which the violent person felt driven to protect a super-masculine reputation.

(4) The presence of a repeated lack of success throughout life which is rationalized by projecting the blame upon others. Here, I am not considering those individuals who have realistically been denied success because of social constraints. I am talking about people who have had opportunities, but who have repeatedly failed and have developed a pattern of viewing their lowly status in life as the responsibility of others.

There are certain other specific constellations of behavior that can be associated with violence. The well-known triad of fire-setting, enuresis, and cruelty to animals and children often heralds violent behavior as an adult.

Psychological studies have also uncovered some relatively common characteristics in sexual offenders and child abusers. Sex offenders, in general, tend to fear direct and consenting contact with an adult partner of the opposite sex. They may suffer from feelings of inadequacy and concern regarding their sexual identity. Sometimes they have a history of having encountered a great deal of seductiveness as well as brutality on the part of their parents during early childhood. Child abusers are sometimes described as extremely passive, dependent people who were exposed to a great deal of deprivation and cruelty from their own parents. It is alleged that the child abuser often identifies the abused child as the resented parent.

One of the most interesting, but least explored, aspects of individual violence relates to the events in the patient's life in the period shortly preceding the offense and the patient's behavior during this same period. The most common situation related to violence in families is that in which a loved one threatens to leave or arouses feelings of

possessiveness and jealousy by showing interest in another partner. Most murders in the United States are usually responses to direct fears of losing a loved one. Any event that diminishes self-esteem in a drastic manner can also be critical. Such events can involve not only the fear of losing a loved one but also the fear of other kinds of loss of status, prestige, and security. A severe "put-down" in which the offender's masculinity is threatened often precedes a violent act.

The patient's behavior in the pre-violent environment may also provide some clues to impending violence. In one study of murderers, it was noted that there was an increase in illness behavior, both physical and psychiatric, shortly before the offense. Impotence and sexual preoccupation during this period was common. Violence is frequently associated with abuse of a drug, sometimes for months preceding the offense. (Recent studies have shown that the use of alcohol, amphetamines and secobarbital frequently precedes violent acts. Psychodelics, on the other hand, are not regularly associated with violence.) It is also likely that many offenders are experiencing a profound depression during this period. In various studies, as many as 18% to 33% of men charged with homicide have successfully completed suicide.

In considering the events and conditions which precede the violent act, we must again be aware of the critical influence of the environment. Changes in the individual's circumstances are often beyond his control. Environmental events are also highly unpredictable. A given murder, for example, might not have happened unless the murderer happened to go to a certain tavern where his wife's paramour was drinking, unless the murderer was drunk, unless he was distressed by having been humiliated by his wife that day, and unless weapons were readily accessible.

The relationship of mental illness to violence should be elaborated. One critical question here is exactly what we are going to call a mental illness. If we call sociopathy a mental illness but use as one of the criteria for its diagnosis, the finding of incarceration or criminality, we will find many sociopaths in prison and a high association between sociopathy and violence. If more stringent criteria of sociopathy are employed, however, the association between the sociopathic disorder and violence is not powerful. There is also a clear-cut association between alcohol abuse and violence, and if alcoholism is viewed as a disease, it will also have a high association with violence. The most intriguing association between illness and violence, however, is found when we examine the psychoses. Studies of the arrest rates of ex-mental patients up to the early part of the 1960's indicated that these populations (largely made up of psychotic patients) actually had fewer arrests for violent and non-violent crimes than the rest of our population. Later studies during the 1960's came up with somewhat different results. Ex-mental patients had slightly higher rates than control groups for some crimes such as rape and robbery, but lower rates for other violent crimes. More recently, Zitrin *et al.*, in reviewing the arrest rates of patients discharged from Bellevue Hospital in New York City, found that mental patients had quite similar arrest rates to a control group for crimes of murder and robbery and markedly higher arrest rates for aggravated assault, burglary and rape. In the case of rape, ex-mental patients were arrested with twice the frequency of other dwellers in the Bellevue catchment area.

A final study on which I wish to report is still unpublished. This is a survey of the arrest records of patients discharged from Dorothea Dix Hospital in 1969. The research was part of a doctoral thesis by Dr. James Mullen and was supported by NIMH funds. I was a consultant to Dr. Mullen in this research. Mullen found that ex-mental patients had five times the arrest rate of other individuals from the same catchment area and committed five times as many violent crimes. There were many alcoholics in this series, but the rates of violent crimes for ex-psychotic patients were even higher than those of the group as a whole.

Trying to account for these gradual changes over time in the frequency of arrest rates for violent crimes in ex-mental patients provides an intriguing exercise. There was some

difference in the methodologies involved in the various research projects, but such differences are not sufficient to account for the great differences in results. Zitrin makes the strong argument for considering the gradual increase in violence among ex-mental patients as being related to early discharge from mental hospitals and subsequent inadequate follow-up. It is true that most of the earlier studies which showed low rates of violence among the mentally ill were done on patients in the New York State Hospital system who tended to spend a long time in the hospital. In Mullen's findings, the highest rates of violence were within the first year after discharge, lending some support to the idea that early discharge may have its hazards.

There are still other ways to account for the changes in data. It is possible that more potentially violent people have in the last two decades been funneled into the mental health system rather than into the correctional system. This is a hypothesis that has not been thoroughly investigated. Another possibility worth considering is that something about the nature of treatment patients receive in mental hospitals irrespective of early discharge has changed and may account for changes in the post-discharge behavior of these patients. Given the trends in the use of psychotropic drugs during the years when these studies were done, it is quite likely that one would find a progressively greater proportion of individuals who received pharmacotherapy while in the hospital as we move towards more recent studies. Some of the earlier studies, which showed that ex-mental patients had lower arrest rates, were considering patients who had had no pharmacotherapy. In more recent studies, pharmacotherapy was the rule rather than the exception. One could formulate a variety of interesting hypotheses here. Perhaps there is something about controlling psychotic behavior with neuroleptic medication that leaves the individual quite susceptible to impulsive behavior once medication is stopped. Since we know that as many as 40% of psychotic people stop taking their drugs once they leave the hospital, it is conceivable that the process of being treated with neuroleptic medication and then discontinuing it may have some disruptive effect on the individual which is conducive to violence. It is also conceivable that to the extent that neuroleptic medication has made it easy to discharge patients earlier without use of other treatments such as psychotherapy, we may not only have put people out on the street too soon but also have put them there without adequate treatment. These are farfetched speculations, but they deserve investigation.

While it is critical that we continue to study violence and refine our capacity to predict its recurrence, it must be admitted that given our present state of knowledge, there is little role for the physician in the prevention or treatment of violence. Our science of prediction in this area is primitive. We can point out factors that are correlated with violence, but since violence is such a relatively rare event, we have been unable to develop a system for predicting occurrence without considerable overprediction. This means that if we utilize current knowledge to predict who will commit violence and then interfere in these individuals' lives in some coercive but therapeutic manner, we will be compromising the liberty of many who would never be violent. At the present time, unless the clinician is dealing with high risk groups who have a history of violence, our predictions are rarely good enough to justify involuntary intervention. The most the clinician can do is to try to detect those individuals that might have a high propensity towards violence and seek to persuade them to accept some type of preventative or rehabilitative service.

The behaviors the physician should consider in being alert to the possibilities of violence are the following:

(1) A history of past violent behavior. This is probably the best predictor of future violence.

(2) Threats of violence. These must be evaluated carefully to distinguish braggadocio from fantasy from intention.

(3) A history of parental deprivation, parental brutality, isolation during youth,

confused sexual identity, and poor adjustment in general. A triad of enuresis, fire-setting, and brutality to animals seen in young people is highly predictive of subsequent violence.

(4) Changes in behavior in the direction of physical and emotional instability and sexual dysfunction.

There are certain conditions in the patient's immediate environment which should alert the physician. These are:

(1) An increased use of stimulant drugs, barbiturates or alcohol.

(2) Recent family dissension, particularly family dissent which is characterized by the threat of separation of marital partners.

(3) Any social or interpersonal condition that diminishes the sense of social worth and esteem, particularly of male members of the family.

Except for some cases of episodic dyscontrol, which are seen quite rarely and which can be helped by prescribing anti-convulsants, there is no pharmacotherapy for violence. The usefulness of psychotherapy in preventing the occurrence of violence in violence-prone individuals or in rehabilitating violent individuals is unproven. Nevertheless, most clinicians feel that it has both some preventative and rehabilitative value. Family therapy, because it allows the clinician to intervene directly in the system which is so important in spawning violence, is often a treatment of choice. The mere communication of feelings between troubled family members may often prevent escalation of animosities. Helping family members relieve the stresses they so often put upon one another and teaching them to stop reinforcing behavior in one another that might favor violence will also be useful.