Family Functioning in Suicidal Inpatients With Intimate Partner Violence

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Background: Intimate partner violence (IPV) is commonly bidirectional with both partners perpetrating and being victims of aggressive behaviors. In these couples, family dysfunction is reported across a broad range of family functions: communication, intimacy, problem solving, expression or control of anger, and designation of relationship roles. This study reports on the perceived family functioning of suicidal inpatients.

Method: In this descriptive, cross-sectional study of adult suicidal inpatients, participants completed assessments of recent IPV and family functioning. Recruited patients were between 18 and 65 years of age and English fluent, had suicidal ideation, and were living with an intimate partner for at least the past 6 months. Intimate partner violence was assessed using the Conflict Tactics Scale-Revised, and family functioning was measured using the McMaster Family Assessment Device. The study was conducted from August 2004 through February 2005.

Results: In 110 inpatients with suicidal ideation and IPV, family functioning was perceived as poor across many domains, although patients did report family strengths. Gender differences were not found in the overall prevalence of IPV, but when the sample was divided into good and poor family functioning, women with poorer family functioning reported more psychological abuse by a partner. For both genders, physical and psychological victimization was associated with poorer family functioning.

Conclusion: Among psychiatric inpatients with suicidal ideation, IPV occurred in relationships characterized by general dysfunction. Poorer general family functioning was associated with the perception of victimization for both genders. The high prevalence of bidirectional IPV highlights the need for the development of couples treatment for this population of suicidal psychiatric inpatients.

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Intimate partner violence (IPV) is identified in multiple settings from the general practitioner's office[1,2] to inpatient psychiatric units.[3] It is important to recognize that IPV is no longer considered primarily a situation with a male batterer and a female victim. Many community and clinical studies have found that IPV is often bidirectional, where each partner is both an aggressor and a victim of IPV. The U.S. National Comorbidity Survey revealed rates of violence of 6.5% for females and 5.5% for males.[4] A meta-analysis of 82 studies including both community and clinical samples found that more women than men reported physical aggression in their relationships.[5] In an outpatient sample of couples seeking marital therapy, 64% of wives and 61% of husbands were classified as aggressive.[6] In 272 engaged couples, both women (44%) and men (31%) reported physical violence toward their partners.[7]

Intimate partner violence is associated with individual psychopathology, with rates of 54% to 68% for major depressive disorders and rates of 50% to 75% for posttraumatic stress disorder in female victims,[8,9] and excessive alcohol use.[10–14] Women arrested for IPV have high rates of posttraumatic stress disorder, depression, generalized anxiety disorder, panic disorder, substance use disorders, borderline personality disorder, and antisocial personality disorder.[15]

Intimate partner violence is also associated with family pathology. A brief review of the current literature of family dysfunction and IPV follows. Included are the results of a previous study examining family functioning across many dimensions,[3] which was carried out by the authors. In this previous study, high rates of IPV were associated with poor family functioning.[3] The current study describes a subsequent analysis of this same sample of inpatients. The current analysis provides in-depth information about the relationship between IPV and family functioning.

PROBLEM SOLVING

Male perpetrators show poorer problem-solving behavior in both community samples[16] and court-referred samples[17,18] Court-referred male batterers also blame and show contempt for their partners during problem-solving

discussions.[19] However, problem-solving skills vary with the topic being discussed in that when couples discussed low-conflict situations, the use of effective skills exceeded the use of ineffective skills, but when the couples discussed high-conflict problems, ineffective skills exceeded effective skills.[20]

AFFECTIVE RESPONSIVENESS AND BEHAVIOR CONTROL

A meta-analysis of studies of male batterers found these men to have higher levels of anger and hostility compared with nonviolent men, even after accounting for relationship distress.[21] Higher trait anger and poorer anger control are also found in community samples of maritally violent men and matched controls.[16,22] In Boyle and Vivian's study,[16] spouse-specific anger/hostility, low problem-solving ability, and relationship discord were significant predictors of violence.

When couples were videotaped in their homes during periods of conflict, physically aggressive couples had different patterns of expression of anger compared with nonviolent couples.[23] Angry behavior in one partner increased the display of angry behavior in the other partner, and physically aggressive couples displayed rigid, highly contingent behavioral patterns that were stronger and longer lasting than those of the control couples. Control couples demonstrated some of the same negative behavior patterns but were able to exit these negative interaction cycles quickly.[23]

COMMUNICATION

Couples often identify communication as a greater problem in their marriage than physical aggression.[24] Poor communication skills in the husbands predicted husband to wife violence in a community sample of violent married men.[25] However, poor communication skills in the wives did not correlate significantly with their husbands' violence. Violent men offer less competent social responses compared with nonviolent men when asked to solve vignettes[17] and show less facilitative and more aversive behavior.[26] Violent distressed men report less mutually constructive communication, more mutual blame, and more mutual avoidance and withholding compared with nondistressed nonviolent men recruited from the community.[18]

ROLES

For both male and female college students, dissatisfaction with the level of power in dating relationships predicts dating violence.[27] Likewise, a power discrepancy in a marriage in which the husband is subordinate is a risk factor for husband to wife violence.[25] In this study, the wife's educational advantage was related to the husband's lower perception of his own decision-making power and to greater violence.[25]

INTIMACY/AFFECTIVE INVOLVEMENT

The degree of closeness between couples can be described in their attachment styles (secure, anxious, or dismissive). A dismissive style describes those with a discomfort of closeness. Anxious attachment styles are predictive for women being victims of IPV.[28] Anxiously attached women in combination with men with a dismissive attachment style have a 9-fold increase in IPV. In this study, insecure attachment was found in 56% of women and 20% of men, and a dismissive style was found in 49% of men and 22% of women.[28] Husbands may express ambivalence about closeness[29] and use a demand withdrawal pattern to regulate intimacy.[18,25] Relationships characterized by hostility and detachment have greatest physical aggression, and hostile detached couples are more likely to have conflictual families and children with behavior problems than hostile or conflict-engaging couples.[30]

These descriptions provide a great deal of descriptive information about different aspects of the functioning of the couple's relationship but do not give information about the relationship as a whole, specifically about the general functioning of a couple. These studies do not identify whether weaknesses or problems are circumscribed or if they extend throughout the relationship. These studies provide no information about family strengths. The current cross-sectional study assessed the totality of family functioning and also reported on family strengths. The current study reflects a further analysis of a sample of inpatients who described IPV and suicidality.

METHOD

Eligible patients were aged 18 to 65 years, had lived with a romantic partner for at least the previous 6 months, and were admitted to an acute inpatient psychiatric unit with a chief complaint of suicidal ideation. This chief complaint allowed a large number of patients to be sampled. Subjects were approached at least 24 hours after admission. Patients who were psychotic or non-English speaking were not eligible for the study. After providing informed consent, all patients completed a demographic questionnaire and the following self-report assessment measures. The study was conducted from August 2004 through February 2005.

Instruments

The demographic questionnaire gathered information regarding age, gender, years of education, ethnicity, income, length of current relationship, length of time living

together, number of children, and number of charges for domestic violence brought against the subject and/or the subject's relationship partner.

Relationship aggression was assessed with the Conflict Tactics Scale-Revised (CTS2).[31] This 78-item scale measures the behavior of both the respondent and the respondent's partner. The CTS2 contains 5 subscales: negotiation, psychological aggression, physical assault, sexual coercion, and injury. Subscales may be further divided to distinguish between "minor" and "severe" items. In the present study, we distinguish between minor and severe violence only for the physical assault subscale, since physical violence was the primary focus of the study and is the scale in which severe items are most often differentiated in the literature. For each item on the CTS2, respondents rate their own behavior and their partner's behavior on a 7-point frequency scale (never, once, twice, 3–5 times, 6–10 times, 11–20 times, over 20 times). The CTS2 is scored by summing the frequency of the behaviors in the past year reported on each subscale. Sample items from the psychological aggression subscale include "I did something to spite my partner" and "I destroyed something belonging to my partner." Sample items from the physical assault subscale include "I pushed my partner" (minor violence) and "I choked my partner" (severe violence). A sample item from the sexual coercion subscale is "I used force to make my partner have sex," and a sample item from the injury subscale is "My partner went to a doctor because of a fight with me." The CTS2 demonstrates adequate reliability and validity.

We assessed family functioning with the McMaster Family Assessment Device (FAD),[32] which assesses 6 dimensions of family functioning (problem solving, communication, behavior control, affective involvement, affective responsiveness, and roles) and also includes a general functioning subscale. The FAD has been tested for reliability and validity.[33] We chose this measure because it is easy to administer and assesses a broad range of family functioning.

Table 1. T Tests Comparing CTS2 Variables and Good Versus Poor General Family Functioning (GRF) for Women (N = 66)

CTS2 Variable	Good GRF,[a] Mean (SD)	Poor GRF,[b] Mean (SD)	t (df)
Psychological abuse by respondent	18.20 (21.5)	32.90 (31.3)	–2.24 (62)*
Psychological abuse by partner	11.72 (15.6)	30.16 (26.8)	–3.44 (60)**
Physical assault by respondent	11.88 (10.7)	33.69 (40.8)	–3.20 (46)***
Physical assault by partner	17.84 (16.0)	32.34 (26.0)	–2.70 (61)***
Sexual coercion by respondent	2.32 (6.9)	5.15 (13.5)	–1.10 (60)
Sexual coercion by partner	2.48 (7.0)	7.64 (18.0)	–1.60 (53)
Injury caused by partner	0.60 (1.4)	5.46 (12.2)	–2.46 (40)*
Injury caused by respondent	1.24 (3.9)	4.78 (13.7)	–1.50 (48)

[a]Score on McMaster Family Assessment Device < 2.00.
[b]Score on McMaster Family Assessment Device ≥ 2.00.
*p < .05.
**p < .001.
*** p < .01.
Abbreviation: CTS2 = Conflict Tactics Scale-Revised.

Table 2. T Tests Comparing CTS2 Variables and Good Versus Poor General Family Functioning (GRF) for Men (N = 44).

CTS2 Variable	Good GRF,[a] Mean (SD)	Poor GRF,[b] Mean (SD)	t (df)
Psychological abuse by respondent	10.25 (12.2)	20.14 (27.8)	–1.58 (39)
Psychological abuse by partner	9.36 (13.4)	6.00 (22.5)	–1.15 (30)
Physical assault by respondent	15.09 (15.1)	24.77 (24.8)	–1.52 (29)
Physical assault by partner	13.27 (10.9)	23.20 (19.8)	–2.01 (33)*
Sexual coercion by respondent	2.92 (7.5)	3.87 (9.8)	–0.34 (26)
Sexual coercion by partner	2.17 (7.2)	1.72 (3.1)	0.21 (13)
Injury caused by partner	0.00 (0)	5.42 (11.2)	–2.69 (30)**
Injury caused by respondent	0.167 (0.38)	5.73 (12.0)	–2.54 (29)*

[a]Score on McMaster Family Assessment Device < 2.00.
[b]Score on McMaster Family Assessment Device ≥ 2.00.
*p < .05.
**p < .01.
Abbreviation: CTS2 = Conflict Tactics Scale-Revised.

RESULTS

The sample consisted of 44 male patients and 66 female patients. The male patients were 42.5 years of age; had 12.6 years of education, 2.5 children, and a median yearly income of $23,000; and were predominantly white. The female patients were 40.9 years of age; had 13.5 years of education, 2.2 children, and a median yearly income of $10,000; and were predominantly white. The mean length of relationships was 15 years for both genders. Principal diagnoses by chart review for both genders included major depressive disorder and depressive disorder not otherwise specified (50%); mood disorders, including bipolar disorder and mood disorder not otherwise specified (26%); substance abuse and dependence disorders (15%); and a miscellaneous group (9%). About 90% reported severe IPV perpetration and victimization in their relationships in the past year with no gender difference (all p values > .05). When FAD scores for family functioning were compared by gender, there were no significant differences for general family functioning on any of the FAD subscales.

Further analysis included separating the sample by good and poor family functioning and examining gender differences. Women with poor family functioning reported being victims of more psychological abuse and injury, as well as perpetrating more physical assault and injury, than women reporting good family functioning (Table 1). Men with poor family functioning reported being victims of physical assault and injury, as well as perpetrating more injury, than men reporting good family functioning (Table 2). Correlations between the CTS2

subscales of physical and psychological abuse and the FAD general functioning subscale were significant for both genders, mostly as victims of abuse rather than as perpetrators (Tables 3 and 4).

Intimate partner violence and family dysfunction across family functioning dimensions are strongly correlated. Overall, men reported family difficulties in all areas of functioning, with the highest number of men reporting difficulties with emotional or affective involvement. Women reported difficulties in all areas of family functioning, with the highest number of women reporting difficulties in the area of roles. This dimension measures the ability of the couple to carry out daily practical tasks as well as meet the emotional needs of nurturance and support of all family members. Several of the questions ask about feeling overburdened or perceived inequality in the allocation of responsibilities. When individual FAD questions were examined, both men and women reported similar levels of unhealthy and healthy family functioning for many items (Table 5).

Intimacy difficulties were perceived by the greatest percentage of male suicidal inpatients as the most dysfunctional aspect of family functioning, but both men (70%) and women (66%) agreed that it was difficult to talk to each other about tender feelings. Difficulty in the area of roles was the most common complaint by the female respondents, although both genders reported that family tasks do not get spread around enough (men: 65.9%, women: 72.3%). Only 60% of the women agreed "each of us has particular duties and responsibilities" compared with 86% of the men. However, no particular dimension of family functioning or aspect of IPV stood out, and the experience of the men and women was remarkably similar.

Table 3. Correlations Between FAD Subscales and CTS2 for Suicidal Male Inpatients (N = 44)

	CTS2			
	Psychological Abuse		Physical Abuse	
FAD Subscale	As Perpetrator	As Victim	As Perpetrator	As Victim
Problem solving	0.35*	0.30*	0.13	0.30*
Communication	0.17	0.25*	0.05	0.33**
Roles	0.25	0.42**	0.25	0.41**
Affective responsiveness	0.28	0.31*	0.30	0.37**
Affective involvement	0.13	0.36**	0.13	0.43**
Behavior control	0.08	0.31*	0.16	0.31*
General functioning	0.51**	0.38**	0.03	0.42**

*p < .05.
**p < .01.
Abbreviations: CTS2 = Conflict Tactics Scale-Revised, FAD = McMaster Family Assessment Device.

Table 4. Correlations Between FAD Subscales and CTS2 for Suicidal Female Inpatients (N = 66)

	CTS2			
	Psychological Abuse		Physical Abuse	
FAD Subscale	As Perpetrator	As Victim	As Perpetrator	As Victim
Problem solving	0.28	0.40*	0.20	0.19
Communication	0.18	0.31**	0.20	0.17
Roles	0.16	0.37*	0.23	0.28
Affective responsiveness	0.30	0.39*	0.31**	0.28
Affective involvement	0.15	0.48*	0.25	0.32**
Behavior control	0.03	0.33*	0.23	0.37*
General functioning	0.45*	0.49*	0.34	0.36*

*p < .01.
**p < .05.
Abbreviations: CTS2 = Conflict Tactics Scale-Revised, FAD = McMaster Family Assessment Device.

DISCUSSION

Poor general family functioning is correlated with IPV for both genders. No particular patterns of family dysfunction were found for men or women in this population of suicidal inpatients. There are 2 possible interpretations of these findings. In this sample of patients already impaired by thoughts of self-harm, general family functioning had deteriorated as a result of the patient's illness to the extent that violence had occurred in the relationship. It could also be interpreted that the violence in the relationship had resulted in the suicidality of the patients. The direction of the causality remains unknown. However, the fact that the violence was overwhelmingly bidirectional may favor the explanation that the poor marital relationship may have acted as a stressor in the patient's presentation.

Poor family functioning was associated with an increased perpetration and victimization through physical assault for both men and women. The CTS2 asks for responders to identify how many times an action occurred, e.g., "I pushed my partner" (minor violence) or "I choked my partner" (severe violence), but does not measure the severity of the action. Therefore, no comments can be made on the severity of the violence experienced by either gender. Women who reported poor family functioning experienced and perpetrated more psychological abuse compared with men. This current study did not assess whether the poor family functioning caused IPV or vice versa.

What keeps these couples together? The participants were in long-term relationships, with a mean length of relationship of 15 years for both men and women. Gottman and Levenson[34] stated that marital stability is sustained when there is a balance of 5 positive factors to 1 negative factor. Is it possible that couples with IPV also have strengths? Indeed, despite the fact that the global scores were poor, participants did score positively on several items. For example, the participants agreed "We have

Table 5. Agreement With Individual McMaster Family Assessment Device Items by Gender[a]

Item	Men, % (N = 44)	Women, % (N = 66)
Weaknesses		
Problem solving		
After our family tries to solve a problem, we usually discuss whether it worked or not	45.2	35.4
Communication		
It is difficult to talk to each other about tender feelings	69.7	66.1
We often don't say what we mean	64.3	47.6
Affective responsiveness		
Some of us just don't respond emotionally	56.1	67.7
Affective involvement		
You only get the interest of others when something is important to them	61.0	42.2
Behavior control		
You can easily get away with breaking the rules	51.3	43.6
General functioning		
Planning family activities is difficult because we misunderstand each other	62.8	50.0
We avoid discussion of our fears and concerns	61.9	58.4
Roles		
When you ask someone to do something, you have to check up that they did it	62.8	69.2
We sometimes run out of things we need	64.3	60.0
Family tasks don't get spread around enough	65.9	72.3
Strengths		
Problem solving		
We resolve most everyday problems around the house	74.4	60.4
We usually act on our decisions regarding problems	76.7	76.9
We try to think of different ways to solve problems	75.7	76.5
Communication		
We talk to people directly rather than through go-betweens	74.5	73.8
When we don't like what someone has done, we tell them	78.6	75.4
Roles		
Each of us has particular duties and responsibilities	86.0	60.0
There are rules about dangerous situations	87.8	67.6
Behavior control		
We know what to do in an emergency	71.5	81.6
We have rules about hitting people	85.6	87.6
There are rules about dangerous situations	87.8	67.6
General functioning		
In times of crisis, we can turn to each other for support	79.0	81.5

[a]Men and women score similarly on these questions.

rules about hitting people" (men: 85.6%, women: 87.6%). However, 50% said they "can easily get away with breaking the rules." The participants perceived strengths in problem solving, with over 75% stating that "We usually act on our decisions regarding problems" and "We try to think of different ways to solve problems." Regarding communication, the majority of participants stated that "We talk to people directly rather than through go-betweens" (men: 74.5%, women: 73.8%) and "When we don't like what someone has done, we tell them" (men: 78.6 %, women: 75.4%). Communication that is direct and clear is usually considered a strength; however, it could be associated with increased conflict and therefore with IPV.

There are 3 significant limitations to this study. First, the reports are perceptions of 1 partner about his or her relationship and therefore cannot be considered to reflect the relationship from both partners' viewpoint. Second, the sample consisted of suicidal inpatients and therefore cannot be generalized to other populations. Third, the population studied was predominately white, and results may not be valid for other ethnic and racial groups.

This analysis of family functioning in patients with suicidal ideation clarifies that gender differences in the perception of victimization are not prominent, that perpetration of victimization occurs equally for men and women, and that IPV is not related to any specific family dysfunction. Furthermore, these couples, who had been together for 15 years, did perceive strengths in their relationship. Further study and the development of treatment for poor family functioning that includes a specific focus on IPV should be considered for clinical populations, such as patients with depressive illnesses.

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