Chapter 1

The Realm of Violence

An Overview

Salman Akhtar and Shawn Blue

Even though Sigmund Freud (1893) attributed it to an un-named English writer, he deserves the credit for popularizing the saying that "the man who first flung a word of abuse at his enemy instead of a spear was the founder of civilization" (p. 36). Regardless of its original source, the dictum does capture something of great beauty and meaning. The interpolation of thought and language between emotion and action is one of the cardinal achievements of humanity. Indeed, the common basis of human experience is constituted not only by a shared anatomy, physiognomy, and motivational substrate but also by a set of many other variables. These include "the capacity for thought and thinking, the acquisition of language, barriers against murder and incest, group affiliation, and the generative elaboration of myths and rituals" (Akhtar, 2003, pp. 131–132). The acquisition and sustenance of such "humanity," however, depends upon the individual's growing up and continuing to live in an "average expectable environment" (Hartmann, 1939) though constitutional givens also contribute to the achievement. An implication of this proposal is that if and when such hard-wired proclivities contain levels of anxiety and aggression that are difficult to "tame" and if and when the environment during formative years of childhood is unreliable, frustrating, and violating, then acquisition of "humanity" is tenuous and vulnerable to regression. Under such circumstances, thought becomes disordered, language regresses, prohibitions of murder and incest are weakened, and affect rapidly translates into action. Human propensity for violence, especially in its intense, cruel, and sustained form, is often the most devastating accompaniment of such malevolent transformation.

We select such violence as our focus in this contribution. Addressing both the origins and consequences of violence, we will divide our discourse in two major sections: "Antecedents, Settings, and Consequences," and "Remedies

and Interventions." *In the first section,* we will tackle the occurrence of violence in (i) domestic, (ii) criminal, (iii) clinical, and (iv) political realms; in addition, we will address a category which, for the lack of a better term, can only be labelled (v) random violence. *In the second section*, we will delineate ameliorative strategies in (i) social, and (ii) clinical realms. We remain cognizant of potential overlaps in our categories just as we are aware that violence can be physical and mental as well as self-directed and other-directed. The schematic organization of our contribution is in the service of didactic clarity and by no means reflects oblivion to the concept of "over-determination" (Freud, 1895) and the "principle of multiple function" (Waelder, 1936).

ANTECEDENTS, SETTINGS, AND CONSEQUENCES

The setting in which violence takes place, the variables that propel its occurrence, and the results it leads to differ considerably. The accoutrements of brutality are myriad, the victims of many stripes, and the consequences range from transient humiliation through reactive fear and rage to life-long psychic damage. The following passages elucidate some of the scenarios involved in violence.

Domestic Violence

While we employ the commonplace expression, "domestic violence," we remain aware that it carries a certain heteronormative bias of prioritizing heterosexual relationships and marriage. McHugh and Frieze (2006) have especially highlighted how the terms "wife abuse" and "domestic violence" do not adequately or appropriately explain all situations in which violence occurs, such as in cases of same sex relationships and unmarried dating relationships. Although new terms have emerged to compensate for historical biases, (i.e., "dating violence" and "lesbian battering"), the term "intimate partner violence" is now increasingly used to address the violence that occurs in romantic relationships. Intimate partner violence includes psychological, physical, and sexual behaviors of a violent, stalking, and controlling nature. Perpetrators of such violence utilize domination, intimidation, and coercion (Dasgupta, 2002; Dutton and Goodman, 2005; Pence and Paymar, 1993) as well as isolation, surveillance, and jealousy. Often psychological and emotional abuse occurs before physical abuse. The emotionally abusive behaviors can involve constant criticism, intellectual and moral domination, and humiliation as well as manifold attempts to undermine one's confidence. Sexual coercion also constitutes a form of intimate partner violence. This can range from lascivious talk to forced sexual activities to refusal to use contraception

and protection. Over time, the severity and frequency of violence increases within the relationship.

Stewart and Vigod (2017) utilized an ecological framework adapted by the World Health Organization (WHO) to classify risk factors for intimate partner violence into four areas: (i) *individual risk factors,* which include a history of child abuse, emotional disorders, violence, alcohol and substance use, limited education and intelligence, younger and older age, low income level, medical illness or physical disability, recent migration, sexual and ethnic minority and indigenous status; (ii) *relationship risk factors,* which include marital conflict, alcohol and substance use, exposure to parental violence, history of child abuse, poor parenting behaviors, low socioeconomic status, friendships with individuals who utilize violence, limited education, need for over-control, poor attitudes toward women, and constant need for additional sexual partners; (iii) *community risk factors*, which include poverty, high crime, unemployment, high mobility, lack of social cohesion, and inadequate ameliorative resources; (iv) *social risk factors*, which include the normalization of intimate partner violence (e.g., by joking about it), cultural acceptance of such violence, and the overall prevalence of gender inequality.

Stewart and Vigod (2017) acknowledge the multiple consequences of intimate partner violence on couples, families, social community, health system, and economy. Individuals experiencing violence in an intimate relationship are affected in both their physical and emotional health. Emotional effects include depression, anxiety, and posttraumatic stress disorder, as well as the vulnerability to develop risky behaviors (i.e., poor eating and sexual practices, alcohol, drug, and cigarette abuse). Other psychological consequences include emotional detachment, antisocial behavior, low self-esteem, difficulty trusting others, sleep disruption, self-harm, and suicidality (Stewart and Vigod, 2017; Zolotor, Denham and Weil, 2009). Physical effects of intimate partner violence include sexually transmitted diseases, brain, organ and dental injury, blindness/deafness, burns, lacerations and contusions, and death (Stewart and Vigod, 2017; Zolotor, Denham and Weil, 2009). Chronic conditions such as gastrointestinal disorders, cardiovascular disease, joint disease, bladder and kidney infections, migraines, headaches and asthma (Stewart and Vigod, 2017; Zolotor, Denham and Weil, 2009) can worsen. Infertility, miscarriage, and unintended pregnancies can also result (Stewart and Vigod, 2017; Zolotor, Denham and Weil, 2009). Pregnant women subject to violence often obtain prenatal care late or not at all, and often have premature babies or those with low-birth weight and vulnerability leading to perinatal death.

Unfortunately, many women tend to remain in chronically violent relationships due to economic concerns (Bowker, 1983; Browne and Williams, 1989), fear of disapproval from loved others (Dobash and Dobash, 1979; Frieze, 1979; Walker, 1979), learned helplessness (Walker, 1979; 1983;

1984), loss of identity (Chandler, 1986), emotional connection with abusing partner (Browne, 1987; Dutton and Painter, 1981; Walker, 1983), lack of access to helpful community resources (Gondolf and Fisher, 1988; Sullivan, Basta, Tan and Davidson, 1992), and fear of retaliation such as threats of being kidnapped or having children taken (Ridington, 1978; Stahly, 1996). This is evidenced by the fact that violence tends to escalate following a separation and divorce (Coker, Smith, McKeown and King, 2000) even resulting in death (Browne, 1987; Jones, 1981; Pagelow, 1981).

Same sex romantic relationships are no different in this regard (Greenwood, Relf, Huang, Pollack, Canchola and Cantania, 2002; Island and Letellier, 1991; Renzetti, 1989; 1992; Turell, 2000; Waldner-Haugrud, Gratch and Magruder, 1997). Influences such as power differential, victim-blaming, and the battered partner's hapless attempts to change the perpetrator's behavior (Brown, 2008; Elliott, 1996; Walsh, 1996) are also found in homosexual couples. Such couples can experience conflicts related to safe sex practices (Heintz and Melendez, 2006), their varying extents of internalized homophobia and transphobia (Greenwood et al., 2002), and the stress related to their being a minority (Balsam and Szymanski, 2005). An additional problem in the setting of violent homosexual couples is that the criminal justice system gets influenced by the perpetrator's sex and the couple's sexual orientation (Connolly, Huzurbazar and Routh-McGee, 2000; Island and Letellier, 1991; Letellier, 1996; Renzetti, 1989; Renzetti, 1992). Even the police are less likely to make arrests or enforce protection orders (Connolly et al., 2000; Renzetti, 1989) or intervene in situations of intimate partner violence (Renzetti, 1989). As a result, gay and lesbian couples who experience intimate partner violence might not receive the similar protection as heterosexual relationships. However, Seelau and Seelau (2005) found that gender and not sexual orientation determined how individuals witnessing an altercation would respond. Heterosexual relationships where males were the perpetrators were found to be more serious regarding threat of injury than heterosexual relationships with female perpetrators and gay and lesbian couples.

Child abuse often co-occurs in situations of intimate partner violence (Zolotor, Denham and Weil, 2009). Intimate partner violence also increases the potential of accidental injuries of children, either being held by parents during a violent altercation or when a child intercedes to end the altercation (Bair-Merritt, 2010). Children experiencing parental intimate partner violence often develop depression, anxiety, and posttraumatic stress disorder. They can also experience developmental delays and physical problems, including sleeping and eating disruption. Interpersonal problems including separation anxiety, aggressive behaviors, fearfulness, and hypervigilance can also occur and so do lowered self-esteem, school failure, substance abuse, and risky sexual practices. Such children attend less regular checkup visits and

obtain less immunizations and are more likely to utilize emergency department services. Often their psychic lives are marred forever.

Criminal Violence

Here it is important to distinguish between affective violence and predatory violence (McEllistrem, 2004). Affective violence is defined by a presence of anger and fear and is the result of a perceived threat. It is often impulsive, reactionary, and emotional. Predatory violence lacks acute emotionality and perceived imminent threat. It is premeditated. A study of mass murderers and serial killers has accumulated several relevant characteristics (Melroy, Hempel, Gray, Mohandie, Shiva and Richards, 2004). A majority of adults and adolescents were portrayed as loners and tended to spend a great deal of time alone and not interacting with others. A good percentage of adults were preoccupied with weapons or war, had a history of violence (usually involving a female romantic partner), suffered from psychiatric illness (paranoid schizophrenia, delusional disorder, or major depression), or had severe personality disorders (narcissistic, antisocial, paranoid, and schizoid), often left threatening messages, were facing a triggering event, and had multiple weapons at their disposal.

Hate crimes refer to violence inflicted on individuals based on prejudicial beliefs on race, religion, sexual orientation, or ethnicity. Such violence does not only impact the individual but influences the individual's entire social status group, as well as society as a whole. Hate violence when compared to criminal violence includes an excessive level of destructiveness and multiple offenders (Downey and Stage, 1999), as well as increased psychological trauma (Sullaway, 2004). Studying the experience of hate violence, it appears that the occurrence of hate violence results in the victims' feeling powerless and mistrustful (Bard and Sangrey, 1986). Researching hate violence specifically in lesbian, gay, and bisexual individuals revealed greater psychological distress (Herek, Gillis and Cogan, 2000). As a result of hate violence, gay, lesbian, and bisexual individuals tended to perceive the world and people as unsafe and experienced feelings of powerlessness and vulnerability (Garnets, Herek and Levy, 1990). Levin and McDevitt (1995) and McDevitt, Levin and Bennett (2002) classified perpetrators of hate violence into four categories: (i) *thrill motivated offenders* who engage in violence to seek the right to brag and to be accepted by peers, (ii) *defensive offenders* who view other individuals different than themselves as a danger to their way of life, (iii) *mission offenders* who hold a supremacist belief system and, (iv) *retaliatory offenders* who have a desire to right a perceived wrong to their social group. Often the perpetrators of hate crimes show all four characteristics.

Although the majority of sexual violence occurs within intimate relationships, sexual violence and coercion can also occur with non-intimate partners. Verbal coercion used to obtain nonconsensual sex can include the utilization of blackmail, trickery, and threats. Sexual violence in the form of rape can be experienced when the individual is "ego-compromised" either through sleep, alcohol and/or drugs. Latane and Darley (1970) studied the patterns of how bystanders respond in times of emergencies and what motivates individuals to not intervene. As a result of their work, they created a five-step model of the process in which individuals intervene during a crisis as a bystander (Burn, 2009; Latane and Darley, 1970). The steps of this model include the individual noticing the event is occurring and then making the interpretation that an intervention is needed. The individual then makes a decision to take responsibility, makes a decision of how to help and finally takes some action to intervene in the situation.

Dating violence and sexual assault have both been identified as gender-based categories of violence. Compared to the typical experience of multiple occasions of violence that can occur in intimate partner violence, sexual assault usually occurs in a singular situation. In recent years, there has been study of sexual assault on college campuses due to the growing pattern of sexual violence that occurs in these settings. Also, the culture that exists on college campuses is argued to be influential in the prevalence of sexually violent behaviors. There is a body of research that identified college students hold belief of myths related to rape and hold biases related to individuals who experience sexual violence (Banyard, 2008; Burn, 2009; McMahon, 2010; Suarez and Gadalla, 2010). McMahon and Banyard (2012) offered Kelly's (1987) and Stout and McPhail's (1998) continuum of sexual violence as a model to explain the existence of the sexual culture on college campuses. This continuum utilizes feminist principles to describe the totality of sexually violent acts resulting from issues related to power and control. The continuum involves a range of acts that differ in levels of severity but all ultimately are connected in some way to each other (Kelly, 1987, 1989; Leidig, 1992; McMahon and Banyard, 2012; Osborne, 1995; Stout, 1991). Based on this continuum, sexual assault, rape, and criminally sexual behaviors would be defined as sexual violence (Stout and McPhail, 1998) and form the severest types of sexual violence with language, visual and media images, pornography, and harassment of a sexual nature falling on the other end of the spectrum. Whereas behaviors on the severe end of the spectrum are understood as criminal with associated enforceable laws and legal guidelines if they are perpetrated, behaviors on the other end of the continuum are seen as common and are not readily perceived of as negative and as damaging (McMahon and Banyard, 2012; Stout, 1991). However, these behaviors are seen to add to the systematic process of violence toward woman (Brownmiller, 1975; McMahon

and Banyard, 2012; Sanday, 2007; Schwartz and Dekeseredy, 1997) which create a *rape supportive culture* (Buchwald, 1993; McMahon and Banyard, 2012; Sanday, 1981). All of the behaviors and acts on the continuum are viewed as some form of sexual violence and as detrimental to the healthy respect of women. The utility of bystander interventions is seen in the opportunity it allows for utilization at various points on the continuum. In addition, it provides a set of interventions that can be directed at the multiple sexually violent behaviors along the continuum (McMahon and Banyard, 2012).

Studying the effect of sexual violence on military women during their terms of service, it was found that these women reported poor health status when compared to military women who hadn't experienced sexual violence (Sadler, Booth, Nielson and Doebbeling, 2000). In fact, the emotional and physical effects of experiencing sexual violence evolved into similar health profiles of individuals diagnosed with major chronic illnesses. Results also showed differences related to physical and sexual violence. Those who experienced physical violence endorsed concerns related to their physical health status; however, those who reported experiencing sexual violence described both poor physical and emotional health as well as educational and economic deficits. Sadler et al. (2000) suggested that the finding of the chronicity and severity of health status as a result of physical and sexual violence could be due to the repeated exposure to violence during military service. These researchers also noted that obstetrician-gynecologists could be valuable resources to recognize the medical outcomes of sexual and physical violence of women.

Political Violence

Political praxis in democratic societies rests upon translating a value-driven social vision into enforceable governmental policies. This is accomplished by garnering public support for the cause, convincing the electorate, and negotiating with the members of the elected opposition. With rare exceptions, the process and discourse skirts breakthrough of primitive affects. Under different circumstances, the scenario turns more emotionally charged, cognitively biased, and replete with vituperative exchanges. This tends to happen when the democracy is being mocked by those in authority, when the democracy is a façade for theocracy, or when the government turns into a puppet for autocratic and dictatorial elected representatives. Worse developments occur when two nations are in conflict or when the very definition of a nation is perverted by the exclusive domination of one of its groups over the over. All sorts of conflicts then arise which can range from popular uprisings, freedom movements, terrorism, and civil war. And, here begins a huge linguistic, conceptual, and political conundrum. Take a look at the following four points.

- *First*, even though jettisoned in popular discourse, the word "terrorism" originated in connection with state-sponsored suppression of dissent. The word entered the English lexicon in 1795, when it referred to the governmental suppression of defiance by pumping fear in the arteries of its subjects. The term was derived from the French Revolutionary statesman Maximilien de Robespierre's Reign of Terror (1785–1794). From then on, the world has witnessed many horrific examples of such "terrorism from above," including the purges of Joseph Stalin (1878–1953), the Holocaust of Adolf Hitler (1889–1945), the killing fields of the regime of Pol Pot (1925–1993), and the torture chambers of August Pinochét (1915–2006). Arguably, the illegitimate and brutal invasion of Iraq by George W. Bush (1946–present) can also form an example of "terrorism from above." On a lesser scale, the assassination of nearly 30,000 Haitians by François Duvalier (1907–1971), the ruthless persecution of ethnic minorities in Uganda by Idi Amin (1925–2003), and the stunning atrocities by Hissène Habrè (1942–present) in Chad during the 1980s can also qualify as "terrorism from above." Yet, both the professional and popular coverage of terrorism gives far more attention to the "terrorism from below," that is, the mayhem let loose by comparably small groups of people who, for real or imaginary reasons, consider themselves humiliated and disenfranchised. Another point to remember is that "terrorism from below" is the weapon of the weaker party in the conflict; it has two choices: either surrender and accept defeat or to devise home-made means to fight one's enemy. The decision to take the latter route is less ideological and more tactical—maximum benefits to be accrued from minimum resources.
- *Second*, the designation "terrorist" is not a self-earned medal of identity. It is assigned to one by others who might be driven by politico-economic expedience and narrow self-interests. Thus, the British, at different eras in their history, have regarded George Washington (1732–1799), Subhash Chandra Bose (1897–1945), and Menachem Begin (1913–1992) as terrorists, while the respective American, Indian, and Israeli followers of these leaders upheld them to be great freedom-fighters. Moreover, someone labelled "terrorist" one day can be celebrated as an "outstanding contributor to world peace" the next day. In 1987, the United States held that Nelson Mandela's (1918–2013) African National Congress was one of the world's "most notorious terrorist groups" (Chomsky, 2003, p. 190), but six years later celebrated his receiving the Nobel Peace Prize. The leader of the Palestine Liberation Organization, Yasser Arafat (1929–2004), was long held to be a terrorist by the United States and Israel but later in his political career was awarded the 1994 Nobel Prize for Peace. More recently, Narendra Modi (1950–present), leader of the right-wing Hindu fundamentalist BJP (Bhartiya Janata Party), was barred entry into the United States for

being a terrorist. Upon becoming India's prime minister, however, Modi was not only allowed travel to the United States, but was feted with great fanfare by President Barack Obama in June 2016. Who is and who is not a terrorist (and what is and what is not a terrorist act) thus comes to lie in the proverbial eye of the beholder, and how clear and far-sighted is such eye's vision is not easy to tell.

- *Third,* while most "terrorist attacks" of today are traceable to Muslim groups of this or that stripe, the politico-religious violence subsumed under the label of "terrorism" is not exclusive to any religion. One does not have to invoke the Crusades (the intermittent religious military campaigns from 1096–1291), which Pope Urban II declared to be the will of God, in order to illustrate this point. The warring Protestants and Catholics of Ireland, the Tamil Tigers of Sri Lanka, the Khalistan secessionists and Maoist Naxalites of India, and the Basque separatists of Spain give testimony to the deployment of terrorist tactics by Christian, Hindus, and Sikhs alike. And, as none other than the Israeli prime minister Benjamin Netanyahu (1949-present) has acknowledged, "there are also acts of terror committed by Jews" (cited in *Israelam*, December 23, 2015). Moreover, history tells us that the practice of suicidal terrorism—reflexively equated with today's Muslims—goes quite far back and elements of it can be found in the tactics of the 1st-century Jewish Zealots and Sicarri, the 11th-century Ismaili Assassins of Northern Iran, and the 20th-century Japanese Kamikazes. Such practices were given the contemporary form of suicide bombing by the Tamil Tigers, a Marxist-Leninist Hindu group of Sri Lanka, and only later adopted by Muslim terrorists of the Middle East. In fact, the prime minister of India, Rajiv Gandhi (1944–1991), was killed by a Hindu woman suicide bomber of this group.
- *Fourth*, the gamut of violence subsumed under "terrorism" varies greatly. It ranges from the savagery of lone actors (e.g., Timothy McVeigh of Oklahoma City bombing; Nidal Hasan, who killed thirteen and injured thirty people at the Fort Hood, Texas, military base; Baruch Goldstein who, in 1994, showered bullets on Muslim Palestinians praying in a mosque, killing twenty-nine worshippers and wounding another 125; and Dylann Roof, the white supremacist who recently killed nine African American people in a mass shooting at a South Carolina Bible study), through the nefarious rampage of gangs (e.g., Beider-Meinhoff in Germany) to the mass violence caused by the political right (e.g., Ku Klux Klan in the United States of the 1950s) or the political left (e.g., the Shining Path Guerillas of Peru, the Naxalites of India) or by religious zealots (e.g., Boko Haram of Nigeria). Thus, all "terrorist attacks" are not the same. There are different kinds, different degrees, different motivations, and different results involved here.

The ground becomes more murky when we try to distinguish "terrorism" from "war." The tongue-in-cheek quip that a cult is a small religion and a religion is a big cult comes to our aid here. Terrorism is weak and poor peoples' war and war is powerful and rich peoples' terrorism. The former justify their aggression by pointing to their being oppressed. The latter regard theirs as necessary self-protection; they label their actions as "counterterrorism." The powerful blame the weak for brutalizing civilians while ignoring their own massacre of innocents; their victims are invariably "insurgents" and "militants." What gets overlooked in all this mayhem is that few wars are "justified wars" (e.g., protecting innocents, right intentions, last resort; see Elshtain, 2002) and that "war against terrorism" only begets "terrorism against war." The cycle of violence thus repeats.

Of course, one cannot end this discussion of politically motivated terrorism without mentioning the assassination of great leaders. In the United States alone, such brutality includes the murder of Abraham Lincoln (1865), John F. Kennedy (1963), Malcolm X (1965), Martin Luther King, Jr. (1968), and Robert Kennedy (1968). But, the pattern extends to other geopolitical locales as well. India, Bangladesh, Egypt, Israel, Egypt, and Pakistan have witnessed the politically motivated murders of Gandhi (1948), Sheikh Mujib-ur-Rahman (1975), Anwar el-Sadat (1981), Yitzhak Rabin (1995), and Benazir Bhutto (2007), respectively. In most such circumstances, an intricate blend of ontogenetically determined rage, actual or imagined threats to one's group identity, and autohypnosis with political overtones drive the violent action. The attempted killing of Ronald Regan (1981) was, however, an exception and had surprisingly little actual or imaginary basis: it was related to the malignant erotomania of a single individual.

Clinical Violence

Psychiatrists and emergency medicine physicians have a higher risk of experiencing violence and nurses, pharmacists, therapists and social workers also have a high risk of experiencing violence, with nursing staff having the greatest risk (Morrison, Lantos and Levinson, 1998). Front desk staff and receptionists in psychiatric clinics also have a greater risk of experiencing violence (Privitera, Weisman, Cerulli and Groman, 2005). Several factors also have been associated with a higher chance of patient violence (Madden, Lion and Penna, 1976; Foust and Rhee, 1993; Dubin, 1981), including physician inexperience, urban location, intoxication, and emotional conditions such as psychosis, delirium, schizophrenia, and alcohol and drug use (Madden, Lion and Penna, 1976; Foust and Rhee, 1993; Dubin, 1981; Iozzino, Ferrari, Large, Nielssen and de Girolamo, 2015; Madden and Lion, 1976). In outpatient settings,

borderline, antisocial, and paranoid patients are more prone to violent acting-out.

It appears that experiencing the consequences of violence by patients is similar to experiencing a crime or a natural disaster (Erdos and Hughes, 2001). Although it appears that the majority of cases of violence include verbal threats and injuries, there are a significant number of situations that result in workplace deaths. Health professionals who experience violence have associated symptoms of fear, anxiety, anger, self-blame, and issues related to confidence (Lanza, 1996; Morrison, Lantos and Levinson, 1998), as well as posttraumatic stress disorder, guilt and shame (Nolan, Dallender, Soares, Thomsen and Arnetz, 1996). Many individuals experience symptoms of posttraumatic stress disorder, especially startle response, sleep disruptions, bodily tension, and soreness (Erdos and Hughes, 2001). Experiencing violence can cause considerable conflict for mental health professionals: they have a desire to help others but do not want to be physically injured in the process. In addition, health-care professionals tend to underreport the occurrence of violence due to the experience of shame (Harris, 1989), the perception that the occurrence is an isolated situation or they believe they have some responsibility in the violent occurrence (Morrison, Lantos and Levinson, 1998) or that it is part of their job (Harris, 1989). Violent situations are often experienced in psychiatry residency settings (Fink, Shroyer and Dubin, 1991; Madden, Lion and Penna, 1976; Rueve and Welton, 2008; Whitman, Armao and Dent, 1976), with the highest occurrence in emergency departments, prisons, and state hospital forensic units (Madden et al., 1976).

Morrison et al. (1998) suggest that violence is initiated by patients for several reasons. Patients might utilize violence as a means of communication during situations of conflict. In addition, patients might have dissatisfaction with their medical or psychiatric care or treatment progress. Furthermore, patients might perceive physicians as being similar to parents and will have unconditional acceptance of inappropriate behaviors. Patients might utilize violence as a mechanism to control situations of perceived powerlessness of medical crises. Finally, patients describe experiencing trauma when being secluded, restrained, and medicated against their will and engage in reactive violence (Olofsson and Jacobsson, 2001; Daffern, Mayer and Martin, 2006).

Violence also occurs with nonpatients, including family members, caretakers, and acquaintances (Morrison et al., 1998). In addition, other incidents of violence are associated with former employees, supervisors, in situations of theft and personal or domestic disputes (Bachman, 1996; Feldmann, Holt and Hellard, 1997; Morrison et al., 1998).

There are a number of costs related to violence in the health-care system. Medical costs due to time away from work and counseling services lead to financial loss incurred by the health-care institution (Campbell et al., 2011;

Morrison, Lantos and Levinson, 1998). Mental health staff and employees experience a decrease in job satisfaction as well as a desire to leave or resign from the organization (Sofield and Salmond, 2003). Other outcomes of violence in the workplace include staff turnover (Owen, Tarantello and Jones, 1998), time away from work, medical errors, injury claims (Ito, Eisen, Sederer, Yamada and Tachimoro, 2001; Roche, Diers, Duffield and Catling-Paull, 2009), and lowered quality of patient care (Campbell et al., 2011).

Random Violence

That a category of "random violence" forced itself upon our didactic stream of thought is itself a sad commentary on the state of affairs in our nation. We say this because while occasional outbursts of such violence might occur elsewhere, the phenomenon of "random violence" seems quintessentially American. The instances we have in mind for this group of violent acts share the following characteristics: (i) it is entirely unexpected, (ii) the victims are totally innocent, (iii) it is not restricted to crime-ridden areas but can pop up in utterly serene and bucolic settings, and (iv) its perpetrator has no personal or political axe to grind. The following five incidences illustrate such violence, though more examples can be readily given:

- *The April 20, 1999, Columbine massacre*: Seventeen-year-old Dylan Klebold and eighteen-year-old Eric Harris shot and killed thirteen people and wounded twenty-three others before killing themselves at Columbine High School, outside of Littleton, Colorado. The tragedy is among the worst mass shootings in US history.
- *The 2002, Washington DC area sniper killings*: The perpetrators—seventeen-year-old Lee Boyd Malvo and the much older John Allen Mohammad—acted from long distance and had little emotional involvement with their victims. In avoiding "intimacy" with their victims, they differed from ordinary serial killers. In lacking political motivation, they differed from terrorists. Theirs was a strange case which nonetheless brought enormous terror to the region where they operated.
- *The July 20, 2002, mass killing in the theater*: Twenty-year-old James Holmes shot and killed twelve people and injured seventy others in a theater at a midnight show in Aurora, Colorado. He had rigged his apartment with explosives; however, he was caught. He pleaded "not guilty by reason of insanity." He was convicted of twenty-four counts of first-degree murder, 140 counts of attempted first-degree murder, and one count of possessing explosives in July 2015. In August 2015, he was sentenced to life in prison without the possibility of parole: he was given twelve life sentences

(one for every person he killed), and 3,318 years for the attempted murders of those he wounded and for rigging his apartment with explosives.

- *The December 14, 2012, Sandy Hook massacre*: Twenty-year-old Adam Lanza fatally shot twenty elementary-school-aged children, six to seven years old, and six other school staff members at Sandy Hook Elementary School in Newtown, Connecticut. He had shot and killed his mother at home prior to coming to the school. He killed himself after the massacre. The tragedy is the deadliest mass shooting at either an elementary or high school, and the third deadliest shooting by a lone person in the United States.
- *The June 28, 2017, road rage killing*: Twenty-eight-year-old David Desper shot and killed eighteen-year-old Bianca Roberson while they both were attempting to merge into the same lane on Route 100 in Chester County in Pennsylvania. He shot her in the left side of her head while they were both driving. She was killed immediately and crashed her car into car into a ditch. He hid out for a few days then turned himself in.

As stated above, such mayhem happens unexpectedly, often in serene settings, and is directed at hapless and unsuspecting civilians, including children. "Random violence" is thus distinct from domestic violence which occurs in intimate relationships, political violence which arises from sociocultural grudges, clinical violence which emanates from psychopathology, and criminal violence which arises from disturbances of conscience and an admixture of need and greed. Just as these five kinds of violence have overlaps and distinctions, so do the ameliorative strategies to curtail this regrettable form of human behavior.

REMEDIES AND INTERVENTIONS

We will divide our comments on the multifaceted strategies to reduce violence into (i) community-based interventions, and (ii) clinical interventions. We do not take the manic route to thinking that all violence can be eliminated; the instinctual and socioeconomic vectors driving it are too deeply entrenched to be susceptible to complete elimination. Reduction, in fact considerable reduction, is, we believe, possible and that's what our proposals aim to achieve.

Community-Based Interventions

Major issues to consider in social strategies for amelioration of violence include targeting themes of power, control, and gender roles as well as governmental policies toward gun control. Preventive measures need to be

created, such as educational programs defining these issues and how they impact not only intimate relationships, but also relationships in general. Support, education, and counseling in the form of parenting behaviors and intimate interactions will also improve the relationship dynamics of romantic relationships and families. Since alcohol and drug use plays a major role in violent behavior, the provision of healthy and effective coping strategies as well as rehabilitation and treatment of alcohol/drug abuse will be important in addressing the influence of alcohol and drugs in the practice of violence. As recommended before, better screening and assessment of violence should be employed in all settings. Another issue that must be considered involves the pattern of silence that is pervasive in the culture of violence. Most likely due to the result of society's acceptance of violent behaviors, much of the existence of violence is hidden by a culture of silence. As society begins to take a clearer stand against the perpetuation of violence, the closer it will get to ending its occurrence. The culture of violence that exists within the military and during war was also investigated. Further acknowledgment needs to emphasize the traumatization and added violence that occurs within individuals in the military. Finally, issues related to sexism need to be acknowledged when describing the prevalence of violence. Acknowledging that violence also exists within same sex romantic relationships and with trans individuals is extremely important in addressing the violence that is experienced by all members of society.

Gun control continues to be a controversial topic in today's society. Yet due to the violence of mass shootings, murder, and injury that pervades society, gun control must be addressed in order to ensure a safer society. Not only does uncontrolled gun possession lead to death and injury, it also creates a culture of fear as well as grief. In addition, it disrupts one's sense of safety and stability especially in settings where safety is often perceived to be inherent (i.e., home, neighborhood, academic and religious institutions). It is imperative that gun control is taken more seriously in order to begin the end to violence that occurs within society. Rigidly clinging to the 2nd Amendment provision can cloak hostile intentions under the noble garment of patriotism. This needs re-visiting and revision.

Racism and sexism continue to plague society. The violence that occurs as a result of hate crimes illustrates the depth of prejudicial beliefs on behavior. Again, a continuum of severe behaviors as well as those behaviors that are less severe but also damaging applies to the process of racism and sexism that exists. In addition, societal acceptance of these behaviors or lack of intervention when these behaviors are witnessed only further perpetuates the existence of racism and sexism and also allows the expression of violence against individuals seen as different than mainstream society. Hate speech has become normalized in today's world and therefore, its consequences are

often overlooked. Allowing hate speech to exist provides permission for violence against whom one holds prejudicial beliefs.

Finally, by addressing the sexually ill-informed, biased, and misogynistic "norms," sexual violence on college campuses and in society at large can be controlled (Kelly, 1987; Stout and McPhail, 1998). Abolishing a rape or sexually violent supportive culture will begin to break down the factors that lead to sexual violence. In addition, bystander programs and interventions will encourage the greater society to intervene and explicitly acknowledge that sexual violence is inappropriate and detrimental. It is argued that this continuum model can also be applied to the case of intimate partner physical, sexual, and emotional violence. Within intimate partner violence there are a range of behaviors that constitute the violence that occurs within these relationships. Similar to the continuum of sexual violence, this proposed continuum would also involve behaviors that differ in severity but again are all connected to each other. Also, similar to the sexual violence continuum, this one would include the most severe forms of violence on one end of the spectrum (i.e., those punishable by law) with damaging forms of violence on the other end (i.e., jokes, comments, etc.). When these behaviors are seen as a systematic process, it becomes clear about the depth of change that needs to occur to demolish this pattern of behaviors.

Clinical Interventions

Keeping in mind that our readership is mainly psychotherapists and psychoanalysts, we will focus on the management of rage, hate, and potential violence in outpatient clinical practices. We are aware that a considerable literature exists about the treatment of such tendencies (especially when associated with psychotic regression) in inpatient settings, and that this literature addresses the modalities of psychopharmacology, milieu therapy, behavior modification, and the use of seclusion and restraints. Both hospitalized patients and their caretakers need attention if one has to reduce the possibility of violent outbursts: (i) *patients* could be provided psychoeducation including verbal communication, conflict resolution, affect regulation, use of assertive behaviors, self-awareness of anger, and the ways to remove oneself from the triggering situation (Sheridan, Henrion, Robinson and Baxter, 1990). Anderson and West (2011) suggested that in the risk assessment of potentially violent patients one must consider the patient's awareness of the illness, the nature of the violence (i.e., result of psychosis), medication compliance, access to weapons, the level of structure and available support system in the patient's life (Anderson and West, 2011); (ii) *physicians* and other caretakers must pay attention to signs from patients that make them

experience fear of feel threatened (Morrison et al., 1998; Rice and Moore, 1991). Precautions that physicians can consider include maintenance of physical space between the office door and the violent person, keeping a violent person within sight, and the removal of items that could be utilized as weapons (Dubin, 1981; Morrison et al., 1998; Rice and Moore, 1991). Morrison et al. (1998) offer several interventions to consider when creating a violence prevention program. Health-care administration must commit to initiating a program that addresses violence through training, crisis management, debriefing, and surveillance programs. Training and education should be provided to all employees, including managers, supervisors, and security staff. Psychiatric residency programs should provide education and training regarding the assessment and management of violence (Antonius, Fuchs, Herbert et al., 2010) as well as self-protection (Anderson and West, 2011). Anderson and West (2011) also suggested that the administration of health-care settings should encourage the reporting of violent occurrences and provide support to employees who do report incidents. All this pertains to the inpatient setting.

In outpatient management of hateful and destructive tendencies, we take Kernberg's (1995) important work in this realm as our starting point. Approaching specific technical interventions to the treatment of individuals with intense hatred and potential for violence, he makes the following seven suggestions: (i) assess the realistic risks of unleashing destructive forces from within the patient and the possibility of their being contained by the patient's ego and the therapeutic frame; (ii) judiciously use various auxiliary measures, including a firm initial contract to structure the treatment in order to minimize risks to the patient, therapist, and others; (iii) diagnose secondary defenses against hatred and consistently interpret them, with full awareness that such interventions might shift a quiet psychopathic transference (involving deceptiveness, dishonesty, and deliberate withholding of information) to a more heated paranoid one; (iv) help the patient become aware of his pleasure in hatred, thus seeking to render it ego-syntonic; (v) interpret the patient's paranoid reaction including acknowledge the incompatible views of "reality" help by the patient and the therapist; (vi) identify, circumscribe, and tolerate such a "psychotic nucleus" in the transference before attempting to resolve it interpretively; and, (vii) interpret, in relatively traditional manner, the guilt-ridden depressive transferences that emerge after the resolution of paranoid transferences.

While emphasizing the necessity to discern defenses *against* hatred, Kernberg does not pay adequate attention to the alternate formulation, that is, the defensive functions *of* hatred (e.g., against dependent longings in the transference). The issue, we must emphasize, is not whether hatred in transference is an activation of an early victim-victimizer relationship (however distorted by

fantasy) or is itself a defense against "the dread to resourceless dependence" (Khan, 1972). It is not an either/or situation since "in the flow and flux of analytic material we are always in the world of 'both'/and'" (Wallerstein, 1983, p. 31).

Three other points need to be considered as one works with hateful and potentially violent patients. *First*, the function of "holding" (Winnicott, 1960; Lewin and Schulz, 1992) often plays a greater role in interpretive unmasking and reconstruction. *Second*, the patient's overt hatred and destructive fantasies (and acts) might be the manifestation of his unconscious hope that the analyst will survive such attacks and, in doing so, detoxify his relentless need for revenge. *Third*, a patient in the throes of intense hatred does not actually have a reasonable portion of his ego allied with the analyst. The patient is neither able nor receptive to the interpretive undertaking. "When deeply regressed, the patient cannot identify with the analyst or appreciate his point of view any more than the fetus or newly born can sympathize with the mother" (Winnicott, 1947, p. 202).

This brings up the clinical situation of "emotional flooding" (Volkan, 1976), whereby the patient gets so enraged during a clinical session that he seems to explode and become violent. According to Volkan, the first manifestation of such "flooding" is

> usually an accumulation of memories and fantasies (flooding in the ideational field) that support the same emotion. The patient can refer to these memories or fantasies only in a kind of "shorthand"—fragmentary sentences, or a single world. He may then begin stuttering and lose the power of intelligible speech altogether. It is impossible at this point to distinguish between flooding in the emotional, actional, or ideational field. The patient may scream and exhibit diffuse motor activity; he may seem to have lost his human identity . . . . Patients capable of reporting their experience of emotional flooding after the even usually indicate that strange perceptual changes took place. They underwent a "metamorphosis" during the experience, becoming monstrous and diabolical when signal affects were replaced by primal affects closely related to the aggressive drive (pp. 179, 183).

Such emotional outbursts are of little psychotherapeutic use. During them, the patient does not seem amenable to interpretive interventions; not enough observing ego is available to him. Their usefulness lies in their detoxifying effects over a long period of therapy and in their providing foci for proper, in-depth investigation during calmer times. While they are occurring, the therapist must avoid action in response. Although he must depart from "neutrality" (Hoffer, 1985) and the patient if that becomes necessary, in general, he should stay motionless and attentive, almost to the point of appearing unaffected by the storm. This is silently reassuring to the patient; a parent's non-anxious,

non-retaliatory resolve in face of a child's temper tantrum is a developmental counterpart to such "containment." Another intervention useful in such circumstances is simply to name the overwhelming emotion. Katan (1961) made this point when she said that "verbalization leads to an increase of the controlling function of the ego over affects and drives" (p. 185). At times, addressing the patient by his first name during the emotional outburst gives him a cognitive handle for restabilization. Thus, calmly absorbing the affective spill, naming the emotion, and gently providing small cognitive anchors are the methods by which the therapist can bring the emotional flooding under control.

CONCLUDING REMARKS

In this contribution, we have elucidated the forms, antecedents, and consequences of violence in four settings: (i) domestic, (ii) criminal, (iii) political, and (iv) clinical. We have also addressed the societal and psychotherapeutic strategies aimed at reducing rage, hate, and violence. While we have cast our net wide, certain areas still remain unaddressed. These include the incidence, frequency, nature, and intensity of violence across the variables of (i) gender, (ii) life span, and (iii) culture. These are vast topics themselves and all we can do here is to briefly touch upon them in the hope that our comments will whet the readers' appetite for further study.

As far as gender is concerned, it is widely accepted that males are more violent than females (Caesar, 1988; Talman and Bennett, 1990; Hamberger and Hastings, 1991; Sugarman and Frankel, 1996). They commit more brutal crimes and more murders. The same applies to self-directed aggression. Women attempt suicide more often but men, prone to greater violence and having more access to firearms, end up killing themselves more often than women. The reasons for such gender-biased difference in the frequency and degree of violence are biopsychosocial in nature. Higher levels of testosterone in males contribute to their greater muscular strength and agility. Therefore, males, from childhood onward, are more prone to be motorically active and to discharge emotions via action. Greater amounts of aggression are needed for the "boy's dis-identification with the mother" (Greenson, 1968), and for a male child to avoid merger anxiety, sustain separateness, and form an authentic identity. Aggressiveness in men, whether in the form of ruthless competitiveness or in physical activity leading to intimidation of peers, is often upheld by the culture-at-large. Most, if not all, of the "superheroes" are males. And, then there is the greater availability of socially approved channels (e.g., the rough and tough of certain sports, military, war) which allow male aggression to flourish while subtly and not-so-subtly discouraging

similar traits in women. Given all this, it is hardly surprising that men are more violent than women.

As far as the life span variable is concerned, violence can be seen at all ages though less so toward infancy and old age. At the beginning stage of life, neither motor coordination nor psychic agency are well established; this precludes outward displacement of aggression on the part of the infant. Moreover, the baby's existence is almost totally dependent upon caretakers and thus rage, even if it accrues, is mostly discharged upon itself. Later in childhood, violence, if it does erupt, takes the primitive forms of scratching and biting since access to more "sophisticated" tools of destructiveness (e.g., knives, guns) is limited. At the other end of life, too, one notices a certain diminution of violence. This is attributed to the overall decrease in the intensity of instinctual life, diminishing levels of hormones that contribute to aggressiveness, experience-caused "burn-out," and actual infirmity and growing weakness of the body. A paranoid worldview and cantankerous behavior might still prevail but physical discharge of aggression becomes less apparent.

Finally, there is the issue of cross-cultural variation in the prevalence of violence. While the tendency to be violent is hard-wired and ubiquitous, there does seem to be a difference in the degree and frequency of violent acts across cultures. Finer debates notwithstanding, a most convincing evidence for this assertion comes from the variability of murder rates across nations. With shame as patriotic American citizens, we acknowledge that ours is the worst nation in this regard. In 2016, the estimated murder rate in the United States was 5.3 murders per 100,000 people (Friedman, Grawert, and Cullen, 2017); this translates into approximately 17,000 individuals being killed in the span of those twelve months. Comparing this to the annual murder rates across the globe, reported in the 2015 statistics of the United Nations Office on Drugs and Crime, reveals considerable regional variations. The rate of murder is 1.58 per 100,000 in France (1017 murders per year), 1.36 per 100,000 in Israel (110 murders per year), 0.85 per 100,000 (682 murders per year) in Germany, 0.56 per 100,000 in the United Kingdom (594 murders per year), and 0.31 per 100,000 in Japan (395 murders per year), testifying to the implicit sociocultural foundations of overt aggression, destructiveness, fire-arm availability, and lethal violence. Hanging our head low, we admit that there is something quite "uncivilized" about our nation.

This brings us back full circle to where we started, namely at Freud's quoting an anonymous English author that the person who used a curse word instead of casting a spear was the founder of civilization. We find ourselves suddenly shame-faced, embarrassed, and timid. How can we report that our nation, the United States of America, has the highest murder rate in the world and the most firearm-related violence and yet declare itself to

be a civilized—if not the most civilized—country? But bowing our heads in shame is hardly productive. Thinking, conceptualizing, conducting scientific research, and social activism that lead to curtailment of the mayhem all around us are better strategies. In order to improve the reality, we first have to acknowledge it and have to anchor our socio-clinical praxis in it. In other words, the ending of our discourse is actually a beginning of further, deeper, and more productive work vis-à-vis violence and its eradication.