Prevalence and Severity of Intimate Partner Violence and Associations With Family Functioning and Alcohol Abuse in Psychiatric Inpatients With Suicidal Intent

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Background: Many medical settings have conducted screenings for domestic violence, but no study has assessed the prevalence and frequency of intimate partner violence (IPV) within the acute psychiatric inpatient population.

Method: This descriptive, cross-sectional study was conducted in adult inpatient acute care units at a psychiatric hospital. Participants completed questionnaire-based assessments of recent and lifetime history of IPV, family functioning, and alcohol use. Recruited patients were aged between 18 and 65 years, were English-fluent and literate, had suicidal ideation, and had been living with an intimate partner for at least the past 6 months. Acutely psychotic patients and patients who were too agitated to complete the questionnaires were excluded. 110 patients completed the assessments. Interpersonal violence was assessed using the Revised Conflict Tactics Scale (CTS2), family functioning was measured using the Family Assessment Device, and alcohol use was assessed with the Alcohol Use Disorders Identification Test. Data were gathered from August 2004 through February 2005.

Results: Over 90% of suicidal inpatients reported IPV perpetration and victimization in their relationships in the past year, with the overwhelming majority reporting severe IPV. Male and female patients did not differ significantly on any CTS2 violence perpetration or victimization subscale (all p values >.05). Poor family functioning predicted physical violence victimization in both male and female suicidal inpatients, even after controlling for alcohol use and demographic characteristics.

Conclusion: Psychiatric inpatients with suicidal ideation or intent would benefit from screening for IPV. Information about IPV and treatment options should be made available to psychiatric inpatients with suicidal intent. Attention to the family functioning of these patients is recommended.

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Intimate partner violence (IPV) is a serious problem in the United States, with over half of women and one third of men murdered in the United States being killed by their domestic partners.[1] The prevalence rates of IPV in clinical samples depend on the site of the studies. Current IPV is reported by 20.2% of women in primary care settings,[2] 4.9% of women and 3.0% of men in family practice,[3] 21% of women in obstetrics/gynecology,[4] 17% of women in community pediatric clinics,[5] and 19% of women and 20% of men in emergency medicine.[6] Among female alcoholics seeking couples therapy, two thirds reported victimization by their male partners, and two thirds reported engaging in violence toward their male partners.[7] We found no studies regarding IPV from general psychiatric inpatient settings.

Many health problems are associated with IPV, such as unwanted pregnancy and long-term physical and mental problems, including depression, posttraumatic stress disorder, somatization, suicide, and substance abuse.[8–10] Women are 7 to 14 times more likely than men to suffer severe physical injury from an assault by an intimate partner[11] and experience more fear toward their abuser than men.[12] In addition, women are more likely than men to be severely injured, hospitalized, or killed by an abuser.[13,14] Women are more likely to be hospitalized with any diagnosis in the year before they file a protective order[15] and to self-report poorer health and morbidity compared with

male victims of physical IPV.[3] Attempted suicide is common in female victims,[16–18] with 35% to 40% reporting multiple attempts.[19] Female victims often suffer from major depressive disorder, with rates of 54% to 68%, and posttraumatic stress disorder, with rates of 50% to 75%,[20,21] and women's use of violence is related to global distress in the form of depressive symptoms and life stressors.[22] Alcohol use is frequently associated with IPV, with rates of 45% for men and 20% for women.[23] Alcohol and drug problems are common in female victims,[24] and both female victims and female perpetrators of IPV report excessive alcohol use.[25–27] Lastly, infants whose mothers report IPV are at risk for disruptive attachment disorders,[28] and children who witness IPV are at risk for developmental delay, school failure, psychiatric disorders, and violence against others.[29] As can be seen, there is a dearth of studies of male victims of IPV.

Suggested possible mediators between IPV and suicidal ideation are mental health disorders and stressful life events.[30] As shown above, for women, high rates of psychiatric illness are associated with IPV, and an accumulation of risk factors including childhood victimization and victimization in adulthood leads to an increased risk of suicidal behavior.[31,32] Female victims are also more likely than male victims to have numerous and/or severe negative life events, a history of child maltreatment, high levels of psychological distress and depression, hopelessness about the future, and alcohol and drug problems.[31]

A third possible mediating factor between IPV and suicidal intent is alcohol abuse/dependence, especially for male perpetrators of violence.[33] Violence is also shown to decrease after successful couples-based alcoholism treatment for male patients who are perpetrators of IPV.[34] Childhood physical abuse and impulsivity have been identified as risk factors for both alcohol problems and IPV.[35] A fourth possible mediating factor is family dysfunction. The overall functioning of families with IPV has not been studied. Several individual dimensions of family functioning have been examined; for example, couples who report hostility and detachment also report verbal and physical aggression,[36] and violent couples are more likely than nonviolent couples to engage in blaming and to show contempt during problem-solving discussions.[37] Violent distressed husbands also report that they desire high levels of closeness with a spouse but express ambivalence about closeness.[38] However, more than one dysfunctional dimension of family functioning may determine the level of violence in a family. Thus, it is important to assess couples across a number of family dimensions rather than to focus on only 1 aspect of the relationship.

There are several gaps in our knowledge about IPV. What is the prevalence of IPV among psychiatric inpatients? Do levels of IPV predict suicidal intent? What psychiatric illnesses are related to IPV and suicidal intent? Is there an association between family functioning and levels of IPV? The objectives of this study, therefore, were to assess the prevalence and severity of IPV in the psychiatric inpatient setting for patients who have suicidal ideation and to identify the associations with family functioning and alcohol abuse.

METHOD

Eligible patients aged 18 to 65 years who were English-fluent and literate and who had lived with a romantic partner for at least the previous 6 months and were admitted with a chief complaint of suicidal ideation or behavior were approached at least 24 hours after admission. All patients completed a demographics questionnaire and self-report assessment measures. Acutely psychotic patients and patients who were too agitated to complete the questionnaires were excluded. Data were gathered from August 2004 through February 2005.

Instruments

The demographics questionnaire gathered information regarding age, gender, gender of partner, 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.

Suicidal ideation was assessed with the Beck Scale for Suicide Ideation (BSS).[39,40] The BSS is a self-report 19-item scale preceded by 5 screening items. The BSS and its screening items are intended to assess the respondent's thoughts, plans, and intent to commit suicide. All items are rated on a 3-point scale (0–2). No specific cutoff scores exist to classify severity or guide patient management. Increasing scores reflect greater suicide risk.

Relationship aggression was assessed with the Revised Conflict Tactics Scale (CTS2).[41] The CTS2, based on the original Conflict Tactics Scale,[42] is the most widely used scale for assessing partner violence.[41] This 78-item scale, which measures the behavior of both the respondent and the respondent's partner, 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 scale include "I pushed my partner" (minor violence) and "I choked my partner" (severe violence). A sample item from the sexual coercion scale is "I used force to make my partner have sex," and a sample item from the injury scale is "My partner went to a doctor because of a fight with me." The CTS2 demonstrates adequate reliability and validity.[41]

We assessed relationship and family functioning with the Short Marital Adjustment Test (SMAT)[43] and the Family Assessment Device (FAD).[44] The SMAT is a standard measure of marital adjustment. It consists of 15 items regarding various aspects of the participant's relationship, has high reliability, and differentiates between well-adjusted and maladjusted couples. The convergent validity of the SMAT has been established.[45] Scores below 100 are generally considered to be indicative of marital distress. We chose this measure because it is a valid, brief self-report instrument and is frequently used in other studies.[46,47]

The FAD assesses 6 dimensions of family functioning: problem solving, communication, behavior control, affective involvement, affective responsiveness, and roles. It also has a general functioning scale. The FAD has been tested for reliability and validity.[48] We chose this measure because it is easy to administer and assesses a broad range of family life.

We used the Alcohol Use Disorders Identification Test (AUDIT)[49] to assess alcohol use/abuse. The AUDIT is a 10-item self-report instrument designed to screen for hazardous drinking. The AUDIT is considered superior to other alcohol screening instruments.[50] The AUDIT assesses quantity and frequency of drinking, drinking intensity, symptoms of dependence and tolerance, and alcohol-related negative consequences. Using the summed score on the AUDIT, a score of ≥ 8 suggests that the individual is drinking in a hazardous manner. The AUDIT has high internal consistency ($\alpha = 0.80$) and can reliably discriminate between patients with positive and negative alcohol drinking histories.[51,52]

Statistical Analysis

First, we reported demographic information and data regarding level of suicidality on the BSS for male and female patients in the sample. Subsequently, we reported the prevalence and frequency of past-year IPV on the CTS2 reported by male and female patients. We employed t tests to compare male and female patients' reports of frequency of IPV perpetration and victimization on each CTS2 subscale. Next, we described male and female patients' reports of their family functioning on the FAD and compared these scores with normative data collected from other samples. We conducted Pearson correlations to examine the relationship between general family functioning on the FAD and each CTS2 subscale. In addition, we reported sample data on the AUDIT and the SMAT, and we conducted Pearson correlations to examine the association between AUDIT scores, SMAT scores, and scores on each CTS2 subscale. Finally, we conducted multiple hierarchical regression analyses in which frequency of physical violence perpetration and victimization for male and female patients was the dependent variable and relevant demographic characteristics, AUDIT score, and FAD-general functioning were the independent variables.

RESULTS

Male patients (N = 44) had a mean (± SD) age of 42.5 (± 10.7) years, had completed 12.6 (± 3.0) years of education, had 2.5 (± 1.8) children, had a median yearly income of $23,000, and reported the following ethnic backgrounds: 89% Caucasian, 7% Hispanic, 2% American Indian, and 2% "other." Partners of the male patients were 87% Caucasian, 8% Hispanic, 3% African American, and 2% "other." Their mean length of relationship was 15.3 (± 9.7) years. Thirty-one percent of the male patients had previously been arrested or charged with a domestic violence offense. Male patients scored a mean of 19.0 (± 8.2) on the BSS.

Female patients (N = 66) had a mean age of 40.9 (± 9.7) years, had completed 13.5 (± 2.5) years of education, had 2.2 (± 1.8) children, and had a median yearly income of $10,000. They reported the following ethnic backgrounds: 95% Caucasian, 3% Hispanic, and 2% "other." Partners of the female patients were 96% Caucasian, 2% Hispanic, and 2% African American. Their mean length of relationship was 15.0 (± 10.7) years. Six percent of the female patients had previously been arrested or charged with a domestic violence offense; 2 female patients had been arrested once, 1 female patient had been arrested twice, and 1 female patient had been arrested 10 times. Female patients scored a mean of 18.7 (± 8.3) on the BSS.

Principal DSM-IV diagnoses 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 (25%), substance abuse disorders (16%) to a miscellaneous group that included posttraumatic stress disorder (9%). Axis II personality disorder or personality traits were recorded in 19% of patients.

The male patients reported a prevalence of 91% for male-to-partner physical violence and 93% for partner-to-male physical violence. Male patients reported a prevalence of 86% of severe male-to-partner physical violence and a prevalence of 88% of severe partner-to-male physical violence. The female patients reported a prevalence of 94% for female-to-partner physical violence and 92% for partner-to-female physical violence. Female patients

Table 1. Frequency and Prevalence of Behaviors on the Revised Conflict Tactics Scale (CTS2) for Inpatients (N = 110)[a,b]

	Male (N = 44)[c]		Female (N = 66)[d]	
CTS2 Variable	Frequency, Mean (SD)	Prevalence, %	Frequency, Mean (SD)	Prevalence, %
Respondent-to-partner				
Physical violence	22.7 (22.8)	91	26.7 (23.3)	94
Severe physical violence	8.6 (9.5)	86	11.2 (11.0)	91
Psychological abuse	17.2 (24.2)	86	23.0 (24.5)	86
Sexual abuse	3.7 (9.1)	32	5.7 (14.7)	28
Injury to partner	4.3 (10.0)	46	3.6 (9.7)	31
Partner-to-respondent				
Physical violence	21.2 (18.5)	93	25.4 (34.0)	92
Severe physical violence	8.8 (8.8)	88	12.1 (19.6)	86
Psychological abuse	14.3 (20.3)	83	27.5 (28.5)	92
Sexual abuse	2.1 (4.8)	29	4.0 (11.3)	19
Injury to respondent	4.5 (10.6)	39	3.4 (11.0)	32

[a]For each item on the CTS2, respondents rate their own behavior and their partner's behavior on a 7-point frequency scale (0 = never, 1 = once, 2 = twice, 3 = 3–5 times, 4 = 6–10 times, 5 = 11–20 times, 6 = over 20 times). Frequency of behaviors is scored by summing the behaviors in the past year reported on each subscale.
[b]Male and female patients did not differ on any CTS2 violence perpetration or victimization subscale (all p values > .05).
[c]Sample includes 2 homosexual men.
[d]Sample includes 5 lesbians.

Table 2. Family Functioning for Suicidal Inpatients in Relationships as Measured With the Family Assessment Device[a]

		Male (N = 44)		Female (N = 66)	
Dimension	Normal	Mean (SD)	% Unhealthy	Mean (SD)	% Unhealthy
General functioning	≤ 2.00	2.39 (0.54)	79	2.31 (0.62)	68
Problem solving	≤ 2.20	2.26 (0.50)	49	2.35 (0.60)	51
Communication	≤ 2.20	2.42 (0.44)	77	2.39 (0.53)	68
Roles	≤ 2.30	2.49 (0.38)	77	2.55 (0.46)	72
Affective responsiveness	≤ 2.20	2.41 (0.51)	72	2.29 (0.68)	54
Affective involvement	≤ 2.10	2.46 (0.55)	81	2.41 (0.60)	66
Behavior control	≤ 1.90	2.17 (0.46)	65	2.03 (0.50)	59

[a]All mean scores for both men and women were unhealthy.

reported a prevalence of 91% of severe female-to-partner physical violence and a prevalence of 86% of severe partner-to-female physical violence. The prevalence and frequency of psychological abuse, physical abuse, sexual abuse, and injury perpetration and victimization are reported in Table 1. We used t tests to compare male and female patients on the frequency of IPV perpetration and victimization. Male and female patients did not differ on any CTS2 violence perpetration or victimization subscale (all p values > .05).

Family functioning was poor for both genders, with 79% of men reporting poor functioning (mean FAD-general functioning score = 2.39, SD = 0.54) and 68% of women reporting poor functioning (mean FAD-general functioning score = 2.31, SD = 0.62). Healthy functioning is indicated by a score of ≤ 2.00 on this scale.[48] In Table 2, the FAD scores for each gender are reported for comparison with the normal values for healthy family functioning. Men reported poorest family functioning in the areas of roles and affective involvement, and women reported the poorest family functioning in the area of roles.

Marital distress (i.e., score < 100 on the SMAT) was reported by 60% of the male patients (mean ± SD SMAT score = 84.6 ± 27.9) and 64% of the female patients (mean SMAT score = 85.6 ± 30.1). Bivariate correlations between the SMAT and the CTS2 subscales showed that in male patients, marital distress was correlated with injuries to the partner ($r = 0.34$, $p < .05$), but not correlated with the other CTS2 subscales. In female patients, marital distress was correlated with psychological abuse victimization ($r = 0.49$, $p < .001$), physical abuse perpetration ($r = 0.39$, $p < .01$), and sexual abuse victimization ($r = 0.29$, $p < .05$).

Harmful drinking (i.e., AUDIT score ≥ 8) was reported by 52% of the male patients (mean AUDIT score for sample = 11.4 ± 11.0) and 33% of the female patients (mean AUDIT score for sample = 7.2 ± 10.2). Male patients scored significantly higher on the AUDIT than female patients; $t = 2.05$, $df = 105$, $p < .05$. Bivariate correlations between FAD-general functioning scores, AUDIT scores, and scores on each CTS2 subscale are presented for male and female patients in Table 3.

Table 3. Correlations Between the CTS2 (frequency of behavior), FAD-General Functioning, and AUDIT Scores for Suicidal Inpatients (N = 110)

	Male (N = 44)		Female (N = 66)	
CTS2 Variable	FAD-General Functioning	AUDIT	FAD-General Functioning	AUDIT
Respondent-to-partner				
Physical violence	0.33*	0.19	0.42**	0.11
Psychological abuse	0.51**	0.26	0.38**	–0.04
Sexual abuse	0.22	0.19	0.14	0.06
Injury to partner	0.42**	0.19	0.35**	–0.08
Partner-to-respondent				
Physical violence	0.34*	0.25	0.36**	0.05
Psychological abuse	0.45**	0.26	0.49***	0.06
Sexual abuse	–0.03	0.23	0.16	0.20
Injury to respondent	0.42**	0.13	0.31*	0.02

Abbreviations: AUDIT = Alcohol Use Disorders Identification Test, CTS2 = Revised Conflict Tactics Scale, FAD = Family Assessment Device.
*p < .05.
**p < .01.
***p < .001.

Finally, we were interested in the relative contributions of demographic characteristics, alcohol abuse, and general family functioning in the prediction of physical violence perpetration and victimization. To reduce the set of possible predictor variables, we examined bivariate correlations between a number of demographic characteristics (i.e., age, number of children, years of education, income, and length of relationship) and frequency of physical violence perpetration and victimization on the CTS2. Analyses were conducted separately for men and women. Demographic variables that correlated significantly with the dependent variables (CTS2 physical violence perpetration and victimization) were entered into hierarchical multiple regression analyses along with AUDIT score and FAD-general functioning score.

Age was the only demographic variable significantly correlated with male patients' perpetration of physical violence ($r = –0.36$, $p < .05$). Thus, multiple hierarchical regression analysis was conducted in which age, AUDIT score, and FAD-general functioning were the predictor variables and CTS2 physical violence perpetration was the dependent variable. This analysis was statistically significant ($R^2 = 0.28$, $p < .01$). Age ($\beta = –0.34$, $p < .05$) and FAD-general functioning ($\beta = 0.34$, $p < .05$) significantly predicted physical violence perpetration, but AUDIT score did not ($\beta = 0.12$, $p > .05$). Length of relationship was the only demographic variable significantly correlated with male patients' victimization of physical violence ($r = –0.35$, $p < .05$). Thus, multiple hierarchical regression analysis was conducted in which length of relationship, AUDIT score, and FAD-general functioning were the predictor variables and CTS2 physical violence victimization was the dependent variable. This analysis was statistically significant ($R^2 = 0.27$, $p < .05$). FAD-general functioning ($\beta = 0.38$, $p < .05$) significantly predicted physical violence victimization, but AUDIT score ($\beta = 0.12$, $p > .05$) and length of relationship ($\beta = –0.14$, $p > .05$) did not.

For female patients, age was the only demographic variable significantly correlated with perpetration of physical violence ($r = –0.30$, $p < .05$). Thus, multiple hierarchical regression analysis was conducted in which age, AUDIT score, and FAD-general functioning were the predictor variables and CTS2 physical violence perpetration was the dependent variable. This analysis was statistically significant ($R^2 = 0.22$, $p < .01$). FAD-general functioning score ($\beta = 0.38$, $p < .01$) significantly predicted physical violence perpetration, but AUDIT score ($\beta = –0.10$, $p > .05$) and age ($\beta = –0.20$, $p > .05$) did not. Years of education was the only demographic variable significantly correlated with female patients' victimization of physical violence ($r = –0.28$, $p < .05$). Thus, multiple hierarchical regression analysis was conducted in which education, AUDIT score, and FAD-general functioning score were the predictor variables and CTS2 physical violence victimization score was the dependent variable. This analysis was statistically significant ($R^2 = 0.18$, $p < .01$). FAD-general functioning score ($\beta = 0.40$, $p < .01$) significantly predicted physical violence victimization, but AUDIT score ($\beta = –0.12$, $p > .05$) and education ($\beta = –0.07$, $p > .05$) did not.

CONCLUSIONS

There is a very high prevalence of bidirectional IPV among suicidal inpatients, and the frequency of violence perpetration and victimization did not differ significantly for men and women. Prevalence rates of IPV of 91% for male suicidal patients and 94% for female suicidal patients are much higher than was expected based on the literature available. It is imperative that other acute psychiatric inpatient populations are assessed for IPV in order to understand whether the high prevalence rates are related to suicidality or to the high level of care (i.e., hospitalization). Meanwhile, it is strongly recommended that inpatient psychiatric units start to screen for IPV, provide education, and offer appropriate assessment and treatment.

The relationship between IPV and suicidality is not direct. There was no correlation between the BSS scores and any of the CTS2 subscales for either male or female inpatients. Is suicidality therefore linked to IPV through psychiatric illness or through another mechanism? Several possible mechanisms or links were considered. First, we assessed alcohol use in this sample because the link between alcohol abuse and violence is well recognized. However, only half of the male patients and a third of the female patients reported harmful drinking, and harmful drinking scores did not significantly predict physical violence victimization. Thus, harmful drinking cannot be

considered the mechanism linking suicidality and IPV in this sample. Other possible links were also considered for this sample, for example, family functioning.

Family functioning did predict physical violence victimization in both men and women. In this sample, family functioning was unhealthy in 79% of men and 68% of women, suggesting a possible mechanism that might lead to IPV and suicidality. Indeed, poor family functioning was associated with higher levels of IPV, even after controlling for alcohol use and demographic characteristics. Family functioning was poor across all dimensions except for problem solving in men, which was perceived as poor by 49% of patients. Eighty-one percent of men scored in the unhealthy range in the area of affective involvement. Affective involvement measures how family members are involved with each other. There is a range of styles of involvement, from lack of involvement at one extreme to overinvolvement at the other extreme. The most effective and healthiest form of family functioning is empathic involvement. Thus, in this sample of male suicidal inpatients, intimacy difficulties were perceived as the most disturbed aspect of family life.

For women, the unhealthiest scores fell in the dimension of roles. This dimension measures the ability of the family to carry out daily practical tasks as well as meet the emotional needs of nurturance and support of all the family members. Thus, in this sample of female suicidal patients, difficulties in meeting daily needs, both practical and emotional, were perceived as the unhealthiest aspect of family functioning. It is important to emphasize that family functioning for suicidal inpatients with IPV was poor across almost all dimensions of functioning. Therefore, when studying IPV and the quality of intimate relationships, a broad assessment of family functioning is necessary.

Limitations to this study include the lack of partner participation to corroborate the reports of violence and the possibility of overendorsement of symptoms. It is possible that depressed mood could contribute to a negative interpretation of life events, thus increasing patients' reports of distress and IPV. Another limitation is the homogeneity of the sample, which was predominantly composed of Caucasian couples.

In summary, the high prevalence of IPV in suicidal psychiatric inpatients emphasizes the need for routine screening for IPV among these patients. Interestingly, the U.S. Preventive Services Task Force[53] stated that screening instruments for IPV have not been evaluated against measurable violence or health outcomes and that there is no evidence that screening in a health care setting reduces harm. The Task Force concluded that although the literature on family and intimate partner violence is extensive, few studies provide data on the detection and management of IPV to guide clinicians. However, the American Academy of Pediatrics,[54] the American College of Emergency Physicians,[55] and the American College of Obstetricians and Gynecologists[56] encourage screening of patients for domestic violence and appropriate referral. The American Academy of Family Physicians[57] also advocates for their physicians "to teach parenting and conflict resolution skills to promote respectful and peaceful personal relationships." Surprisingly, the American Psychiatric Association[58] does not discuss routine screening in its policy statement on domestic violence.

The results of this study strongly support the use of screening for psychiatric inpatients with suicidal intent. Information about IPV and various treatment options, including emergency contact numbers and how to access shelters and obtain restraining orders, should be made available to suicidal psychiatric inpatients. Physicians must make the effort to discuss IPV with their patients, both male and female. Women with a history of partner abuse report that when physicians ask about domestic violence in a compassionate manner, it helps them take their situation seriously and that validation from a health care provider has "planted a seed" for change.[59] Information on the dynamics of domestic violence and its screening, documentation, safety planning, referral, and legal aspects is available through the American Medical Women's Association Web site.[60] Finally, for couples who wish to improve their functioning, there may be merit in offering family treatment that focuses on assessing the family and improving the emotional life of the family.

Disclosure of off-label usage: The authors have determined that, to the best of their knowledge, no investigational information about pharmaceutical agents that is outside U.S. Food and Drug Administration–approved labeling has been presented in this article.

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