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THE PROS AND CONS OF THE LEARNED HELPLESSNESS CONSTRUCT
AND THE BATTERED WOMAN SYNDROME:
A CRITICAL ANALYSIS AND POSSIBLE REFORMULATION

BY

LUCILLE ANDREOZZI STERN

A DISSERTATION IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY IN
PSYCHOLOGY

UNIVERSITY OF RHODE ISLAND

2004

Doctor of Philosophy Dissertation

Of

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2004

Abstract

Two prevailing, contrasting theories, learned helplessness and health psychogenesis, have been proposed to describe and explain the battered woman's experience and response to domestic violence. This research examined the status (scientific adequacy) of each theory's database to determine where the preponderance of evidence lies.

The investigator articulated nine factors that differentiate the two theories. Trained independent raters then rated study outcomes as falling into one of three categories: pro-learned helplessness, pro-health psychogenesis, or supportive of both theories. Studies of two research samples (shelter and community) were identified and assessed (rated) along four methodological dimensions (sample, instrumentation, statistical analysis, and hypothesis testing). Each was assigned a total design quality score, and the studies were then divided into three groups according to the overall level of design quality (high, medium, low). A table was then created that exhibited the overall picture of design quality by outcome (the theory supported by the study).

The research relevant to each theory appeared to be roughly equal in overall design quality. The majority of

the research evidence appeared to support the pro-health psychogenesis theory. However, the difference between the percentage of evidence that supported psychogenesis versus learned helplessness was modest (16 studies, or 55%; 10 studies, or 34%). It may be argued that a theory that appears to be validated (correct) approximately 50% of the time (health psychogenesis) or approximately one-third of the time (learned helplessness) does not reflect a strong or well-articulated theory. One would expect that a theory's predictions would, at least, be greater than chance.

These results suggest that rather than trying to determine which of the two theories is better, a more fruitful approach might be to develop an integrated theory that draws on the strongest elements of each. The dissertation concludes with a number of suggestions regarding how research and clinical practice might begin this process.

Acknowledgements

I would like to acknowledge the following individuals for their significant contribution to my personal and professional development: Dr. David Faust, major professor, for his insight, patience, and intellectual challenge; Dr. Charles Collyer and Dr. Dominic Valentino for their insight and intellectual perspectives; Dr. Grace Frenzel for her warm, thoughtful feedback and careful guidance; Dr. Diane Horm for her generous support. I would also like to acknowledge Dr. James Campbell for helping me to grow as a grounded, innovative therapist.

I would like to thank the staff of the University of Rhode Island Counseling Center for their collective support over the past two years. I am especially grateful to Dr. Brian Howard, who generously helped with the last minute details of this manuscript.

I would like to express my deep gratitude to my family and closest friends for their help, encouragement, and understanding throughout my life and the doctoral process—my father, John H. Andreozzi; and mother, Madeline Andreozzi; my uncle, Dante Pompa; my grandmother, Gilda Pompa; and the friends who create for me a spiritual circle that uplifts me with their love,

support and belief in me, including Eileen Roche, Mary Gregory, Peggy Leason, Elizabeth Gricus, Carol Schilling, and Laurie and Tomas Carlson. I especially owe heartfelt gratitude to my son, Lyle Benjamin Stern, who participated with me in this long and mysterious process, always seeing the fun and wonder in it.

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CHAPTER I

**Wife Abuse, Child Witnesses, and Family Violence:
Background, Definitions, Description of the Problem,
And Purpose of this Research**

As an evolving science, explanatory theory, treatment paradigm, and perspective on social intervention and change, the field of family violence stands at a developmental crossroads. A growing research base, drawn from a variety of national family violence surveys, clearly documents domestic violence as an important health problem requiring serious and immediate attention. In its third decade of research and theory building, the field is multifaceted, interdisciplinary, and complex, characterized by a variety of prominent viewpoints and a number of fundamental, hotly debated controversies.

The study of family violence encompasses a range of subdomains, including elder, child, interpartner, and wife abuse. This rapidly growing field faces a crisis of ideas in the form of major, competing explanatory theories. The current lack of consensus among family violence experts flows from debate over major

methodological issues and multiple, simultaneous, at times competitive, conceptual lenses: psychological, sociological, feminist, and family systems. Major controversies cut across all forms of family violence with special implications for women and children.

Core dilemmas involve:

- definitions, measurement, and scope of the problem;
- root causes and explanatory theories;
- dynamics of family violence;
- the relationship between types and levels of abuse, or the underlying continuity-discontinuity question: Do low levels of physical violence progress incrementally to higher levels, or are low/mild and high/severe levels of physical violence qualitatively distinct in form and type, each with different causes?;
- the intergenerational transmission hypothesis, or risk and intervention focus;
- treatment method: separate therapy or concurrent treatments of perpetrator and survivor; and

- the relevance, validity, and social consequences of the constructs of learned helplessness and the battered woman syndrome (BWS).

This dissertation focused on the wife abuse family violence subcategory, its effects on women and children, and the strengths and competencies characteristic of the survivor-process.

Scope and Nature of the Problem

Wife Abuse

The following statistics highlight the prevalence and pervasiveness of domestic violence and paint a disturbing profile of the lives and experiences of women and children living with family violence. Jones (1996), citing national statistics, underscored the general rise in rates of violent acts against women in our society. She stated, "A few years ago the FBI reported that in the United States a man beat a woman every eighteen seconds. By 1989 the figure was fifteen seconds. Now [in 1992] it's twelve (p. 2)."

Although these statistics reflect the general increase in men's violence toward women, the statistics

on violence directed toward women and children inside the family are even more alarming. Notions of "marriage" and "family" are usually associated with intimacy and interpersonal safety. O'Leary, Barling, Arias, Rosenbaum, Malone, and Tyree (1989), in their longitudinal analysis, reported that one out of every three marriages experienced marital violence and nearly half of all dating/marital relationships experienced some form of interpartner aggression.

According to Straus and Gelles' 1985 National Family Violence Resurvey, reported in their book *Physical Violence in American Families* (1990), one out of every eight women is hit by her husband each year. In addition, over the course of marriage, about one in four American couples experience husband-to-wife violence. Hansen and Harway (1993) stated that the nature of the assaults included physical injuries such as: fractures, chronic back injuries, torn ligaments, dislocations, ruptured eardrums, broken teeth, lacerations, and stab wounds.

As Straus and Gelles (1990) demonstrated, the actual rates of assault and injury may, in fact, be double the reported rates, given the "virtual certainty" that

respondents were not always completely candid in reporting violent incidents. As research evidence has suggested (e.g., Bowker, 1986; Hansen & Harway, 1993), this reticence may be partially a function of shame and humiliation. Most women seemingly would be loath to admit abuse and victimization at the hands of a spouse or partner who promised to "love, honor and cherish" them and the children of the marriage. Whereas guilt is about doing and remorse over actual transgressions, shame is about being and the broken bonds of attachment.

Crime victims have typically reported reluctance in reliving the painful details of the assault (Straus & Gelles, 1990). Battered women and children who are victims of intimate crime often feel betrayed by the intimacy associated with the crime and their close relationship with the perpetrator. Studies conducted in Texas (Teske & Parker, 1983) and Kentucky (Schulman, 1979), have indicated that as much as 91% of spousal or intimate violence may never be reported to the police.

Two contrasting theories have evolved for describing, explaining, and conceptualizing the behavior, experience, and recovery process of battered women and children. Learned helplessness theory has framed the survivor process in terms of psychological dysfunction

and a personal deficit model of treatment, intervention, and change. The alternative health psychogenesis theory has framed the survivor experience in terms of personal strengths and has taken a competency-based view of the survivor process, rejecting the learned helplessness explanatory theory.

This dissertation investigated the pros and cons surrounding learned helplessness and the battered woman syndrome (BWS) as major explanatory theories and practical treatment models. Specific theoretical issues examined and research questions addressed included:

- How prevalent is this syndrome among samples of battered women survivors?
- Is BWS more accurately viewed as a summary term that describes a social or a psychological problem?
- Does the label and category of BWS homogenize, stereotype, and further victimize the diverse samples of women studied to date, casting their experience into a negative and abnormal light?

These theoretical issues have major implications for levels and types of intervention.

This dissertation focused on battered women and their children in the stage of recovery when the male

batterer has been separated from the home and family environment. This stage was chosen for two reasons: it provided a clear delineation or turning point in the family's recovery, and it also represented the point of entry for the preponderance of current research. The family form under study involved the battered woman and her children as a newly transformed and transforming family unit. This family developmental stage involved differentiation in the service of forming new attachments, structural arrangements, and renegotiated personal, interpersonal, and system boundaries.

Family Violence and its Effects on Children

Children are also physical and emotional casualties of family violence. They are drawn into the ritualized cycles of family conflict and aggression in many direct and indirect ways. When a woman is battered and she makes the crucial decision to seek help, undertaking what is often the long legal and psychological road to freedom, her children automatically join in the journey. In Canada, based on an analysis of intake data, MacLeod (1987) reported that 70% of battered women seeking shelters brought children with them, with 17% of the

women bringing three or more children. Therefore, children are immersed in the crisis and abrupt transitions of the abuse experience.

The effects of witnessing abuse and accommodating to sudden changes in family life circumstances can affect children in many ways. MacLeod's (1987) statistics have shown that large numbers of children often witness and are embroiled in family violence. Children of family violence can become the targets not only of physical but psychological abuse. Violence does not always take the form of physical aggression and physical injury to others, although this is often the case when family abuse escalates and becomes overt.

As a number of researchers have indicated (e.g., Jaffe, Wolfe, and Wilson, 1990; Peled and Davis, 1995), there are other equally damaging, subtle forms of violence that take their toll on children:

- a parent's inability to see a child for who the child is;
- a parent's blind indifference to a child's aspirations and accomplishments;
- an overwrought parent's inability to be emotionally accessible or an emotional support to their child;

- a parent's discouragement;
- or worse, a parent's steady, deprecating criticism and emotional rejection of a child that can profoundly effect a child's mind, spirit, imagination, empathy, and expectations for his or her future. Such forms of abuse or neglect can exert a significant effect on child development (discussed in detail in Chapter 7).

The Effects of Witnessing Family Violence

Even when children escape direct physical abuse (e.g., are not hit), they often suffer, as true trauma victims do, by what they witness and experience. Research (Arnold, 1990; Azar, 1991; Azar, Barnes, & Twentyman, 1988) has indicated that children are usually present during incidents of family violence, that is, instances of physical and verbal abuse directed at one spouse by another. Jaffe, Wolfe, and Wilson (1990) estimated that three to four million children per year witness interparental violence. Carlson (1984) estimated that 3.3 million children between the ages of three and 17 witnessed, or directly experienced, family violence.

Social learning theory, exemplified by Bandura's (1986) social cognition theory and research on modeling behavior, has strongly suggested that children absorb and

acquire models of behavior through vicarious as well as observational modes of learning. Children can learn the lessons of aggression by absorbing and internalizing violent models: as they watch and witness what occurs, as they overhear the sounds of angry physical and emotional confrontation from behind closed doors, or from their beds at night.

In this paradoxical form of observed aggression, the experience can be more potent and compelling for several reasons. Most obviously, the child often feels that she or he cannot do anything about the violence; the child perceives her- or himself as a helpless and disabled witness. Children who are involved aggressively with the abusive parent (e.g., rescuing or protecting the abused parent) are at least doing something, however destructive and inappropriate those actions might be. The child is not ready emotionally to handle this kind of power, power that the child was given by default. The child who witnesses someone hurting someone else has the added emotional burden of not perceiving him or herself as able to help, to act, or effectively intervene. In not being able to stop people from getting hurt, the child can have his or her very notion of personal competence and self-efficacy stripped away.

Research on childhood stress and family violence (Arnold, 1990; Carlson, 1984; Deblinger, McLeer, Atkins, Ralphe, & Foa, 1988) has suggested that being a witness to one parent's brutality toward the other, to be reduced to a helpless onlooker, can be, in itself, a traumatic and disturbing experience. To over-hear the violence, to have it take place outside of the child's plain view and real powers of cognitive integration, can be additionally destructive and troubling. When events are not seen, they can become more terrifying, as children's imaginations are left to fill in the details. When such ambiguity about potentially terrifying events exists, their impact and magnitude may be magnified. This is the poignant situation for many children immersed in family violence, dysfunction, and cycles of abuse.

Common themes frequently expressed by children of family violence, reported in the research and clinical literatures (Arnold, 1990; Azar, Barnes, & Twentyman, 1988; Jaffe, Wolfe, & Wilson, 1990; Leeder, 1994; Wolfe, Jaffe, Wilson, & Zak, 1985), have included scenes of psychological and actual aggression. These involved internalized representations as well as overt scenes that showed some form of symbolic or actual violence against mind, body, relationships, and self-integrity. In

effect, the child is denied important access and affirmation--not being seen, known, heard, and found by those the child cares about and assumes care about him or her (Andreozzi, 1996). Chapter 7 will provide a detailed analysis of research on the effects of family violence on children and the role of the male batterer in the family violence clinical-research equation. The implications of this research will shed additional light on the major controversies characteristic of current research on family violence and battered women.

**Wife Assault and the Battered Woman's
Response to Violence: A Psychological or Sociological
Problem?**

A major controversy at the center of the science, theory building, treatment imperatives, and level of social intervention in the field of wife abuse and family violence has revolved around perspectives on three main issues.

- The definitions and root causes of abuse, specifically the mental status or level of psychopathology associated with men who batter.

- The consequences or cumulative effects of violence on women and children survivors, including alternative conceptualizations of the degree of psychological health/dysfunction, type and quality of coping strategies, and overall level of functioning and adjustment of battered women.
- The appropriate focus of treatment and intervention.

The essence of this controversy may be reduced to the differences observed between the two main, essentially opposing viewpoints that have evolved concerning conceptualizations of battered women. Each has taken a considerably different stance on the role and significance of learned helplessness as an explanatory theory for understanding and treating the problem of family violence. Prevailing perspectives on the battered woman may be divided into two categories: primarily psychological or sociological views and definitions of the problem.

The major distinction between psychological and sociological viewpoints has revolved around the position taken on learned helplessness theory, related constructs, and hypotheses. Researchers, theorists, and therapists in the field of family violence have been largely split in

terms of the effects of wife battering, with different implications for treatment. Each model projected a different recovery process, diagnostic expectation, and treatment emphasis and plan. The two prevailing viewpoints included a psychologically oriented, clinical pro-learned helplessness position and a sociologically oriented, health psychogenesis growth model.

Both models evolved simultaneously, each reflecting the findings of two different concurrent research camps. Although it was commonly believed that the learned helplessness model preceded the health psychogenesis model, they were contemporaneous theories. This common historical misimpression was partly due to the widespread popularity and publicity surrounding learned helplessness. In the past two decades this theory overshadowed the scientific merits of an equally plausible health psychogenesis theory. The historical development of each theory occurred as follows.

Learned Helplessness

In the late 1970s, Lenore Walker conducted a three-year qualitative, retrospective study of battered women (N = 403). These women, primarily residents of the Rocky Mountain region, comprised a self-selected sample. In-depth interviews with battered women were conducted to

explore their psychological responses to violence. In an attempt to explain why battered women remained in intolerable relationships, Walker hypothesized and tested two theories -- learned helplessness and a tension-reduction cycle theory of violence. Focusing on "leaving the relationship" as the critical variable associated with effective coping strategies, Walker (1984) attempted to explain why battered women remained in abusive relationships.

Walker reasoned that leaving the relationship was essentially the single most positive outcome, synonymous with self-care, self-protection, and healthy, adaptive self-assertion. To explain why women stayed, she adopted and applied Seligman's (Abramson, Seligman, & Teasdale, 1978; Seligman, 1975; Seligman & Maier, 1967) reformulated learned helplessness theory to the behavioral response patterns and thought process of battered women. She concluded that battered women remained in abusive relationships because they relied on and developed ineffective coping strategies, the outgrowth of chronic abuse. Her research generated a great deal of public attention and her proposed theory took hold, having a far-reaching influence on prevailing treatment models, grass root women's advocacy programs,

and the popularization of clinical profiles of battered women.

As a consequence of Walker's published research and learned helplessness theory, battered women were mainly seen as having cognitive, motivational, and affective deficits. Similar to the research of cognitive attribution theorists (Abramson, Seligman, & Teasdale, 1978; Hiroto, 1974; Seligman, 1975; Seligman & Maier, 1967), Walker's theory was constructed on the hypothesis that non-contingent outcomes (e.g., a person's perceived inability either to predict or control events) led to depression. She asserted that these deficits caused battered women to be passive, dependent, and unrealistic in their life choices and appraisal of their relationships. Descriptions of their survivor experience emphasized their anxiety, lack of effective coping strategies and failure to actively seek outside help.

Thus, battered women became a clinical population unable to solve problems, unwilling to seek help or follow through, and unrealistically bonded to the abuser, denying their own outrage as a means of self-protection and defense. As a result of the prevailing learned helplessness view, battered women, as a group of mental health clients and family violence survivors, were mainly

seen as suffering from a stress response syndrome. Symptoms included anxiety, depression, agitation, denial, emotional lability, and extreme passivity. Learned helplessness supported a psychological, internalized, developmental or genetic, and predominantly clinical model. Walker (1983) wrote, "Events which occurred in childhood, as well as in the relationship, interact with the violence and effect the woman's current state" (p.32).

Health Psychogenesis

However, a separate body of research evidence was emerging in support of a different, if not completely contradictory, view of battered women and their survivor process. This literature arose primarily from sociological research and, in part, in direct response to growing questions about the adequacy of the learned helplessness theory. For example, in the domain of problem solving, as Hotaling and Sugarman's (1986) review of research suggested, battered women were not necessarily "deficient or inadequate as hypothesized in the learned helplessness theory." Research on battered women's problem-solving behaviors will be more fully explored in Chapters 5 and 6 of this dissertation.

Similarly, the notion that unrealistic expectations of the abusive relationship guided battered women's behavior has also been challenged. The learned helplessness theory has presupposed impaired cognitive functioning and serious perceptual distortions as a function of abuse. Consequently, the phenomenon of why women remained with their abusers has been attributed to acquired psychological dysfunction. Women were thought to remain because they were unrealistic about the help that is available to them. In contrast, Gondolf's (1988b) research has shown that battered women made numerous attempts to stop the violence and displayed a wide range of active, help-seeking behaviors.

Bowker (1983a, 1993) has also shown that battered women were effective long-term planners and that they stayed for sound, practical reasons. Her research, which involved a national sample of over 1,000 battered women, suggested that battered women remained until it was safe and advantageous for them to leave. A growing number of researchers (Bowker, 1983a, 1983b, 1993; Dobash & Dobash, 1979; Okun, 1986) have shown that these women's actions were purposeful and planned, active and not passive. This viewpoint, grounded in a competency-based health psychogenesis theory, adopted from Bowker's (1993)

descriptive term, presents a sociological, normative view of the battered woman's experience and behavior framed within the cultural context of broader "women's issues."

The health psychogenesis theory has proposed a social, rather than a psychological, definition of and solution for the problems of wife abuse, treatment, and recovery. This dissertation critically examined both sides of the research controversy surrounding learned helplessness and a competency-based concept of treatment and recovery.

CHAPTER II

Major Explanatory Theories of Family Violence:**Frames of Reference for Understanding the Abuse Dynamic**

Properly conceptualizing the learned helplessness-health psychogenesis controversy, for purposes of research evaluation, required an in-depth analysis of the broad array of family violence and wife abuse literature. Diverse theoretical frameworks have been proposed to describe and explain the causes and transactional features of family violence. Theories have been developed to explain both the batterer's and the battered woman's experience, account for intergenerational transmission (Egeland, 1993), and identify the appropriate method and level of intervention. Major explanatory theories have reflected a broad range of social science perspectives. These perspectives can be thought of as three points of access and analysis, arranged along a continuum.

At one end of the continuum, we find individually oriented theories that focus primarily on the psychology of self, alternating attention between the perpetrator's and victims' personality patterns, attributes, and

traits. Here, attention is focused on the extent to which victim-prone and violence-prone personalities aid in our understanding of the abuse dynamic. At the other end of the continuum, we find sociological theories that take a broad social systems and sociocultural perspective on the abuse experience.

Falling midway between individualistic and systemic perspectives, interactional and psychosocial theories examine the abuse experience at the juncture where individual personality and situational or transactional process views merge in a dynamic self-system theory of the causes, course, and consequences of family abuse. These theories have focused on the interplay of perpetrator and victim in the oscillating patterns and predictable cycles of family violence associated with assaults on battered women and children.

Examples of four overviews or frameworks of major explanatory theories of family violence include Hansen and Harway (1993), Browne (1989), Viano (1992), and Gelles and Straus (1979). Reflecting a feminist-constructivist view, Hansen and Harway (1993) described psychoanalytic, social learning, social psychological, family systems, feminist, and sociological theories. Drawing upon a naturalistic or ethnographic approach,

Browne (1989) organized explanatory theories into a similar framework that included the psychiatric/psychopathic, special victim, psychological, psychosocial, and social/environmental. Viano (1992) offered a more sociological or socioculturally oriented framework that included social biological, social learning, exchange, resource, social conflict, patriarchal, ecological, evolutionary, culture of violence, and general systems theories.

Gelles and Straus (1979) provided an alternative classification and organization of major explanatory theories of family violence. They grouped 15 theories into three main categories: intraindividual, social psychological, and sociocultural. Intraindividual theories included psychopathology and substance abuse (alcohol and drugs). Social psychological theories included explanatory models, ranging from frustration-aggression and social learning, to exchange and attribution theories. Briefly, frustration-aggression theory has asserted that conflict evokes frustration and, hence, the motivation to aggress against others. Social learning theory has emphasized the importance of socialization and learned behavior through modeling and imitation. Social exchange theory has drawn attention to

the "quid pro quo" nature and expectations often implicit in relationships. Attribution theory has attempted to explain behavior in terms of situational factors or inferred dispositional qualities or both. Sociocultural theories included functional, culture of violence, structural, general systems, conflict, and resource. Sociocultural theories have applied variants of general systems theory to the understanding of behavior.

When analyzing the broad range of explanatory theories, one can choose from among three basic perspectives. One perspective has focused intensively, and almost exclusively, on the inner world of self, personality development, individual behavior, and pathology. These have comprised the predominantly psychiatric and psychological theories of family violence. Another group of theories has examined and emphasized the interplay of personality, societal, and situational variables and attributes. These theories are representative of social psychological explanatory models, and equally weigh individual and social perspectives. Yet another group of theories has focused almost exclusively on sociological variables, social structure, and organization. This third group of theories has favored a broad social systems approach.

The array of theories briefly described offers explanatory frameworks that run the gamut from a micro- to macro-level view of the etiology, development, and treatment of family violence. Accordingly, the evaluation and analysis of major explanatory theories of family violence presented in this dissertation was organized into three broad categories: the individual, self in relation to system, and system.

**The Individual Psychological View of Wife Battering:
Personality, Psychology, and Psychopathology**

A growing body of clinical and research evidence has focused mainly on the personality of the batterer and the battered woman or victim. Researchers have attempted to develop profiles or personality patterns of victims and batterers. The emphasis has been placed on the documentation of identifiable clusters of personality traits that differentiated the batterer and victim from non-clinical populations. Personality research in this area has largely been directed toward evidence of psychopathology, personal coping deficits, or predisposition to inflict or submit to violence.

Battered Women

Our approach to the treatment of the battered woman starts with a diagnostic label, from which treatment plans flow. However, diagnostic categories can become a two-edged sword; their initial pro-treatment purpose can unwittingly contribute to the problem. Diagnostic categories, often required for the battered woman to obtain treatment or help, can cast her experience in a dysfunctional or pathological light. Traditional psychiatric diagnostic categories have suggested deficiencies primarily within the individual. Typical diagnostic labels attributed to the abused woman seeking help have included "posttraumatic stress disorder," "depression," and "borderline personality disorder."

For example, Hansen and Harway (1993) criticized the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), for using a woman who tolerates an abusive marriage as an illustration of "Dependent Personality Disorder". The DSM-III-R appendix also offered a description of Self-Defeating Personality Disorder (SDPD) as a newly proposed diagnostic category. Hansen and Harway stated:

Some of the diagnostic criteria for SDPD are as follows: a persistent pattern of self-defeating

behavior, including choosing people and situations leading to disappointment and failure; rejecting attempts of others to help; inciting anger or rejecting responses from others and then feeling hurt, defeated, or humiliated; failing to accomplish tasks crucial to personal objectives despite the ability to do so; and engaging in self-sacrifice unsolicited by the recipients of the sacrifice.

(p. 30)

The point that they and Caplan (1991) made is that diagnostic categories such as SDPD cast the traditional socialization and normative experience of women and feminine behaviors into a pejorative and pathological light.

Theories regarding the presence of pathology in the battered woman's behavior and experience primarily emanated from the psychoanalytic perspective (Rosenblum & Harlow, 1963). According to psychoanalytic theory, personality is shaped by critical events in early childhood and fixed early in life. Rooted in drive theory, psychoanalytic writers have focused on the human tendency in personality formation either to contain or express aggressive or violent impulses. Hence,

individuals are seen as either inflicting or submitting to violence and aggression. Psychoanalytic perspectives have often characterized battered women as showing insufficient coping skills, ego-deficits, and characterological weaknesses or flaws.

When these deficiencies reach a certain level, they translate into psychiatric disorders. Consistent with the psychoanalytic emphasis on pathology, Hansen and Harway (1993) have cited theorists in the psychoanalytic camp such as Blum (1982); Snell, Rosenwald, and Robey (1964); and Whitehurst (1974). Such theorists have described the battered woman as "having a basic need to provoke violence, as displaying passive hostility that contributes to the violence, and as having a masochistic motivation that promotes further violence" (pp. 30-31). This psychoanalytic, pathology-focused approach has essentially blamed the battered woman and sought root causes in her personality formation, thereby motivating her provocative behavior.

Hotaling and Sugarman (1986) identified 52 case-comparison studies involving 333 measurements of approximately 97 potential risk markers of husband-to-wife violence. Their comprehensive review effectively demonstrated the lack of research support for a number of

widely held hypotheses about the victim-prone personality of battered women and causal theories about husband-to-wife violence. Only one of the 42 risk markers associated with battered women emerged as a consistent risk factor across studies: witnessing violence between parents/caregivers in the woman's family of origin. Their study found no evidence to support a demographic or personality profile that would predispose a woman to be at a significantly higher risk of intimate victimization. Hotaling and Sugarman wrote:

With the exception of exposure to parental violence in childhood, no risk marker consistently discriminates victims of husband violence from nonvictims. Identifying female victims of violence is not possible if only her characteristics are considered. There is no evidence that the statuses a woman occupies, the roles she performs, the behavior she engages in, her demographic profile, or her personality characteristics consistently influence her chances of intimate victimization. (p. 118)

The import of their article has suggested that the popular view of battered women's research may not auger

well for theoretical models of victimization that focus on characteristics of victims. As a review of the evidence has indicated, the research literature (e.g., Bowker, 1983a, 1986; Gondolf, 1988b) has strongly supported the converse: that battered women consistently demonstrated positive coping skills, ego strengths, resourcefulness, and often ingenious powers of survival.

Men Who Batter

Prior to the mid-1980s, there was a concerted effort to view the batterers' behavior as an outgrowth of normal male socialization. As Vaselle-Augenstein and Ehrlich (1992) described, ironically, the majority view that prevailed until the mid-1980s (e.g., Back et al., 1982; Bograd, 1984; Dutton, 1988; Gelles & Cornell, 1983; Walker, 1981) asserted that pathology was present in only between 10-20% of all male batterers. In this period, clinical and research attention in relation to the batterer primarily focused on the social and environmental concomitants or "triggers" of abuse. Specifically, research examined the causative role played by non-personality factors such as alcohol and drug abuse, unemployment and other sociological factors, including widespread cultural approval of violence, and sex role stereotyping.

According to Vaselle-Augenstein and Ehrlich (1992), the tendency to view the batterer as normal and consequently de-emphasize pathology has stemmed primarily from four pragmatic objections arising from feminist quarters. First, feminists have argued that to focus on the batterer's psychopathology diverts attention from and clouds the larger issue, namely, the pervasive culture of violence that we live in and that tolerates misogynous behaviors and attitudes.

Second, when the batterer is viewed as pathological, most feminists have contended that he will evade or will be spared the full measure of legal and moral responsibility for his actions. His psychiatric label will afford him more favorable treatment and an advantaged position in the criminal justice system, family courts and custody issues. In essence, a psychiatric diagnosis will excuse or minimize his conscious responsibility and further weaken the battered woman's legal, social, and moral quest for equity and justice.

A third objection has involved the following "logic": To label the batterer as dysfunctional and to include him within the psychiatric population is to place him in a minority of individuals within our general

population and, thus, to infer that wife battering is rare, whereas, in fact, it is not. Fourth, politically motivated feminist researchers and activists have expressed concern that to focus on the batterer's psychopathology will only divert public policy makers and growing public awareness from the crucial issue, the need to stop domestic violence.

Contrary to these objections, Tolman and Bennett (1990) and Vaselle-Augenstein and Ehrlich (1992) reviewed a growing body of clinical and research evidence which suggested that personality problems and serious psychopathology were present more than occasionally among male batterers. Research has shown that various characteristics differentiated batterers from nonbatterers, including dependence, anxiety, low self-esteem, depression, paranoia, dissociation, poor impulse control, antisocial tendencies, and hostility toward women. As Vaselle-Augenstein and Ehrlich stated, "Although psychopathology may not be present in all cases, there is pathology in many men who batter" (p. 139). Based on their comprehensive review of research on men who batter, Tolman and Bennett (1990) stated: "Although woman abuse is not limited to men with personality problems or other identifiable psychological

problems, such men do seem to constitute a large proportion of the identified treatment population, especially those men with concurrent alcohol problems" (p. 89). Tolman and Bennett stressed the interaction of alcohol and substance abuse as an important mediating variable and disinhibitor in the male batterer's violence-prone profile.

Based on his review of the evidence, O'Leary (1993) also concluded that the preponderance of men who batter showed evidence of personality disorders. He observed, "There seems to be little question that physically abusive men who attend programs for containment of violence are significantly different from men who are maritally discordant but not physically abusive" (p. 25). O'Leary went further, adding that, "These men are not simply products of a social system that fosters attitudes that promulgate the domination of women" (p. 25).

In their comprehensive analysis of risk markers in husband-to-wife violence, Hotaling and Sugarman (1986) also examined the consistency and prevalence of significant abuser characteristics across studies. Three risk markers in particular displayed a consistent pattern of findings across studies: the use of violence toward children, sexual aggression toward women, and witnessing

parental violence as a child or adolescent. The preponderance of findings on risk markers in the direction of abuser characteristics as predictors of husband-to-wife violence led Hotaling and Sugarman to conclude that:

The search for characteristics of women that contribute to their own victimization appears futile. There is no consistent evidence, after 15 years [in 1986] of search, that any behaviors, attitudes, demographic characteristics, or personality traits can predict what types of women will become victimized by husband or male partner violence. Characteristics of men with whom she is involved in intimate relationships may be a better predictor of a woman's odds of being victimized by violence. (p. 120)

In summary, cumulative research evidence has underscored the emergence of a psychopathology-dominated profile of the male abuser.

Children of Family Violence

Although clinical evidence has suggested that family violence damages the psychological adjustment and behavioral competence of children, these and other issues

have yet to be adequately examined, tested, or clarified through formal research. There is an overall paucity of research on the effects of family violence on children. Findings are primarily derived from shelter samples. Beyond the general statement that abuse adversely affects child development, more refined questions have remained largely unanswered.

Clinical and research literature on battered women and family violence (Leeder, 1994; Peled & Davis, 1995; Jaffe, Wolfe, & Wilson, 1990), as well as on abusive parenting and child maltreatment (Arnold, 1990; Azar, 1991; Azar, Barnes, & Twentyman, 1988; Deblinger, McLeer, Atkins, Ralphe, & Foa, 1988) have indicated that children who witness or experience family violence are more likely to live in family environments that intentionally or unintentionally do not meet their developmental needs. These children are more likely to have the normal cycle of development interrupted and their basic developmental needs ignored or inadequately met.

Research on children at risk and on developmental resiliency (Peled & Davis, 1995; Jaffe, Wolfe, & Wilson, 1990) has identified variables that differentiated developmental outcomes in relation to the abuse experience. The developmental prognosis appeared to be

the most negative for children who experienced severe and chronic abuse; who became the direct targets of the batterer's sexual or physical abuse; who had fewer, if any, emotional supports or outlets outside the family; who showed low identification with both parents; and who had no substitute parental role models to emulate. These were the children who were left to fend for themselves, without nurturance and guidance in hostile, indifferent, and neglectful environments.

Children who witness family violence also tend to suffer child abuse, as there is an association between wife battering and child abuse. Hughes (1982) and Straus, Gelles, and Steinmetz (1980) estimated that 30-60% of families experiencing interspousal violence also showed incidents of parental physical or sexual child abuse. In their sample of 1,000 battered women, Bowker, Arbitell, and McFerron (1988) found that approximately 70% of the wife batterers also physically abused their children. The affects of abuse have been documented in the many disturbing behavioral symptoms and interpersonal sequelae children display (Berman, 1993; Peled & Davis, 1995). Children who live in violent homes were found to be less likely to achieve academically; displayed impaired life-skills, and lower social competence; were more impulsive

and distracted; were less empathetic; showed inappropriate affect or incongruent emotional responses; were anxious and hyper-vigilant; were depressed and angry; and reported more somatic complaints. In effect, the growing research data on children of family violence has revealed a general clinical profile: These are children who have nightmares, show exaggerated startle responses, are sad and withdrawn, are agitated and irritable, and are reluctant to trust.

Social Psychological View of Wife Battering

As noted, the psychological perspective, which localized the problem within the individual, occupied one end of the continuum. The social psychological perspective, occupied the central or midpoint on the continuum. The social psychological viewpoint emphasized the interaction between self and system, focusing on the patterned ways individuals think, feel, and behave in social situations. Behavior is viewed as situationally mediated. Primary explanatory theories of family violence, drawn from the social psychological perspective, have included social learning theory and the

concepts of learned helplessness, traumatic bonding, and the cycle of violence.

Social learning theory has generally asserted that behavior is the outgrowth of modeling (Bandura, 1986): the consistent internalization of learned behaviors, including aggression. The theory generally postulated that men who batter their wives originally experienced or observed violence in their families of origin, saw that violence was rewarded, and continued to use violence as a means of interpersonal problem solving. Similarly, as some research has shown and the theory of learned helplessness contended, the battered woman's response was also the byproduct of learning. Battered women have often reported experiencing or witnessing violence and abuse in their families of origin. Therefore, they have been socially conditioned to tolerate violence and have come to expect violence in their adult relationships. For both the batterer and battered woman, violence has been learned in the context of family patterns.

Learned Helplessness and Depression

The concept of "learned helplessness," derived from Martin Seligman's (Seligman & Maier, 1967; Seligman, 1975) extensive laboratory research, has been adopted to explain the battered woman's passivity and ostensibly

nonresponsive behavior in the face of violence. Seligman originally coined this term to describe the phenomenon in which experience with uncontrollable events created passive behavior in response to a subsequent threat to well being. Using non-contingent reinforcement, he conditioned dogs to react passively (i.e., no attempt to escape) to adverse stimuli (i.e., pain/punishment), disrupting an association between behavior and expected outcome. In one experiment, Seligman and Maier (1967) showed that dogs that had not been subjected to uncontrollable electric shocks learned quickly to avoid the subsequent shocks. However, dogs repeatedly exposed to non-contingent electric shocks failed to escape from additional electric shocks even when escape was readily apparent--crossing over a barrier into a compartment where no shocks were delivered. Similarly, Hiroto (1974) found that human subjects exposed to inescapable loud bursts of noise failed to protect themselves in a later situation where the noise could, in fact, be easily avoided.

Findings derived from these studies and replications led Seligman to conclude that both animals and humans, when exposed to an uncontrollable event, learn that control is not possible and, therefore, stopped trying to

exert control over outcomes. Seligman's original experiments were designed to learn more about exogenous depressions by producing them situationally in the laboratory setting. Furthermore, as experiments investigating the relationship between learned helplessness and depression have shown (Abramson, Seligman, & Teasdale, 1978), many non-depressed individuals, when exposed to uncontrollable aversive events, developed depressive symptoms such as discouragement, pessimism, and passivity or lack of initiative. This led Seligman to conclude that depression is a form of learned helplessness resulting from the experience of uncontrollable events. Seligman's experiments appeared to be successful in training dogs to submit and in immobilizing their motivations to escape. Seligman was able to disrupt the connection, or causal link, between precipitating event, strategies to intervene, and the expected outcome.

However, Seligman's findings in relation to depression generated controversy that, in the advent of cognitive psychology, eventually led to a reformulation and refinement of his original conception (Brehm & Kassin, 1993; Gondolf, 1988b). As Gondolf (1988b) has described, earlier versions of Seligman's learned

helplessness reflected the assumptions of behaviorist conditioning; however, later versions reflected the cognitive shift toward the role of individual expectations and attributions that mediate the development of learned helplessness. For example, as Abramson and colleagues (1978) asserted, perceiving a lack of control in one situation was not necessarily sufficient to produce learned helplessness in another situation. Hence, the concept of learned helplessness began to undergo modifications and, much like the concept of self-efficacy, has come to represent a multidimensional construct that is less global than situation-specific.

The role of causal attributions--an individual's explanatory theory for what caused the initial lack of control -- was central to Abramson's (1978) theory of learned helplessness. She refined the concept of "learned helplessness" by focusing attention on the interaction of individual perceptions and personal context. Her reformulated theory considered three aspects or classes of attributions in evaluating the likelihood of learned helplessness. Attributions were classified as stable or unstable, global or specific, and internal or external. This reformulated theory held that

individuals high on stable and global causal attributions are more likely to view future life events as uncontrollable. Individuals high on internal causal attributions are more likely to show low self-esteem. Individuals high on all three--stable, global, and internal causal attributions--are more susceptible to depressive episodes.

Learned Helplessness and the Battered Woman Syndrome

Lenore Walker (1978, 1979, 1984, 1993) adopted Seligman's theoretical conception of learned helplessness to explain why battered women in her research sample found it difficult to escape the battering relationship. She likened the symptoms she described in the "battered woman syndrome" to the emotional upset, phobias, and sleep disturbances found in the laboratory research on learned helplessness. She hypothesized that the non-contingent nature of the battered woman's "attempts to control the violence" eventually produced learned helplessness and depression. Walker reasoned that if a woman is to escape the battering relationship, then she must overcome the tendency toward learned helplessness by adopting proactive survival techniques. They included: "Becoming angry rather than depressed and self-blaming; active rather than passive; and more realistic about the

likelihood of the relationship continuing on its aversive course rather than improving" (p. 87).

The Abuse Dynamic, Traumatic Bonding, and the Cycle of Violence Theory

What makes the battered woman stay in an abusive relationship? Why does she persist so long in a relationship that, in addition to its severe punitive qualities, appears depleted of any obvious reward or benefit? Several explanatory concepts, closely allied to learned helplessness, have been proposed. These have included the concept of traumatic bonding and the predictable, self-reinforcing cycle of violence. Dutton and Painter (1993) and Painter and Dutton (1985) described traumatic bonding as, "strong emotional ties that develop between two people when one person intermittently harasses, beats, threatens, abuses or intimidates the other" (p. 364). The abused woman's experience has been likened to that of other trauma victims, and the relationship between the battered woman and her abuser has been compared to hostage and captor. Batterers have been described as terrorists in their own homes, and the battered woman's experience as comparable to the Stockholm Syndrome (Rawlings, Allen, Graham, & Peters, 1994). The Stockholm Syndrome has been compared

to the experience of prisoners of war, that is, when captives identify with and consequently surrender their will and freedom of thought to their captors.

Traumatic bonding has been described as deriving its power and tenacity from intermittent reinforcement. Learning theorists, such as Bandura (1986) and Barnett and LaViolette (1993) have amply documented that random reinforcement often produces highly persistent, and difficult to extinguish behaviors. As Hansen and Harway (1993) have emphasized, "Many studies have demonstrated that intermittent patterns of maltreatment create strong bonds in humans and other animals...[This phenomenon] leads the battered woman to ignore the problem or distort its meaning to that of an aberration in the relationship" (p.33).

How is intermittent reinforcement manifested in the lives of battered women? The powerful motivation, or conditioned response to stay, is thought to be a function of the intermittent cycles of violence. Working from a tension-reduction hypothesis, Lenore Walker (1984) proposed a recurring cycle of violence characterized by three distinct phases: tension building, acute battering phase, and loving contrition. The tension-building phase is characterized by a gradual escalation of tension shown

in the form of discrete acts such as name-calling. Friction increases as the batterer begins to express dissatisfaction and hostility; however, at this point, the dissatisfaction is moderate and not at a crisis level.

In response to the tension-building signals, the battered woman typically attempts to placate or calm the batterer, or to do whatever she cannot to aggravate him further. She tries not to respond to his anger and uses general anger reduction techniques. In this phase of the cycle, the batterer's tension builds toward the release of aggression whereas, simultaneously, as a counter-measure, the battered woman works to reduce anger. Often she succeeds temporarily in forestalling the violent episode she anticipates and manages to contain the batterer's escalating behavior. This temporary stay provides one form of intermittent reinforcement for the battered woman; she believes she can control events. This unrealistic sense of reclaimed influence or false hope about positive change occurring in the batterer and abusive relationship has been termed "learned hopefulness" (Barnett & LaViolett, 1993; Gondof, 1988b).

However, despite the battered woman's best efforts, the tension continues to build. Eventually, the tension

reaches its threshold and the battered woman is no longer able to contain the batterer's angry response pattern. Next, according to Walker's (1984) cycle theory of violence, a provocative and dangerous phase ensues. This phase is characterized by a sequence of distance regulation moves in which the battered woman, sensing the increased agitation of the batterer combined with growing awareness of her non-contingency response-to-outcome reality, now withdraws from the batterer. In other words, the battered woman is denied the connection between action and consequences; her actions are met with random, unpredictable responses. Perceiving her withdrawal and possibly interpreting it as abandonment, the batterer presses toward her physically and emotionally. He pursues her oppressively.

Interpreting her distance perhaps as rejection, combined with his need for tension relief, he chooses a relatively trivial event and erupts explosively. The uncontrolled discharge of pent up aggression comprises the acute battering phase. This traumatic event shakes the woman's fundamental sense of safety, self-worth, and continuity of a world of predictable cause and effect. She now perceives events as unstable, random, dangerous, and out of control. She does not know if whatever action

she takes will have the anticipated, normal, predictable outcome. In the acute battering phase, the woman usually sustains physical and emotional injuries, and outside intervention may occur.

In the third phase, described by Walker (1984) as the "honeymoon" or "loving, contrite phase," the batterer may apologize and may try to win back the battered woman's affections. During this phase, it is presumably this "loving behavior" that reduces the aversive arousal and reinforces maintenance of the relationship. The loving phase stands in sharp contrast to the prior phase. The aftermath of the acute battering incident phase is one of extreme aversive arousal coupled with dissociative feelings of disbelief and self-blame.

This last, tension-free phase provides considerable relief from, and reinforcement for, the battered woman's posttraumatic reactions. However, in contrast to Lenore Walker's conception of this phase in the abuse cycle, Dobash and Dobash's (1984) data suggested that after the first battering incident, few batterers expressed contrition. The intermittent reinforcement in this phase appears to be often simply characterized by the absence of tension and violence. This moratorium may more aptly be described as providing temporary respite for battered

women and children instead of the hope and positive experiences that maintain relationships.

The Sociological and Sociocultural Perspectives on Wife Battering

The third point on the continuum is occupied by the sociological, sociocultural, and feminist perspectives, which have focused on the largest unit of analysis, social organization and family structure. These orientations have viewed the impact of society on the family. The analysis begins from a macrosystem perspective, examining the impact of social forces on the family as an institution. Sociologists, exemplified by Gelles (1993) and Straus (1990), have typically approached the problems of family violence from either of two perspectives: Subcultural theory and theories of family organization. Subcultural theory has subscribed to the premise that certain cultural and ethnic subgroups tacitly approve or positively sanction wife battering. Theories of family organization have viewed the family as a primarily conflict-ridden unit, a system characterized by high levels of potential interpersonal violence. In this light, sociological theory has often viewed the

family as an incubator of potential violence, an intimate biopsychosocial system where tensions run high and conflict is inevitable.

Bowker's (1993) research has offered an alternative viewpoint and explanation of the battered woman's behavior that goes beyond learned helplessness and the concept of traumatic bonding. She has asserted that battered women stay in abusive relationships not out of psychological paralysis but for very sound, practical reasons and other real, compelling fears. She has conceptualized the battered woman's problems as largely social, not psychological. Her research, involving a national sample of 1,000 battered women, provided a dramatically different profile of the reasons and thought processes guiding these women's behavior.

Based on intensive, in-depth interviews with battered women survivors, Bowker (1993) identified a broad range of pragmatic, sociologically oriented reasons that explain what often appears like paradoxical, counterproductive behavior. Bowker found that these women often formulated realistic appraisals of their life options, actively and continuously sought help and, in effect, attempted to make long-term, strategically timed plans to leave the abusive relationship.

Feminist theory (exemplified by such individuals as Dutton-Douglas & Walker, 1988; Hansen & Harway, 1993; Leeder, 1994; and Yllo, 1993), which is closely allied to a sociological perspective, has focused on the power inequities inherent in family structure, marriage, and traditional sex role stereotyping and gender socialization. Feminists have contended that the traditional family structure perpetuates institutionalized sexism. They have argued that the power differential created by the male-female traditional marital relationship, in itself, makes a woman vulnerable and subordinate. Marriage makes women passive and dependent on male providers; girls, unlike boys, are socialized to submit.

In effect, these conditions create the environmental vulnerabilities that make any woman susceptible to the power dynamics of abuse. Feminist theory has drawn heavily on the interactionist view of individual perceptions and sociocultural contexts. Feminist theory has sought root causes in gender as a social category of experience. This perspective has essentially comprised a social constructivist view of power, control, intimate relationships, and the family. Feminist theory of domestic violence homogenized the experience in such a

way that the battering aspect of family life is regarded as normative and sociological, rather than individualistic and psychological.

The feminist perspective has evolved from a social action orientation. For feminists, the most fundamental insight into domestic violence, viewed primarily as a social and political problem, has rested in a fuller understanding of the dynamics of gender and power. Feminists have directed the focus of intervention at patriarchal ideology and the basic structure of society within which individuals and interpersonal relationships are embedded. To date, they have drawn the broadest definition of wife or partner abuse, including in their descriptions physical, emotional, symbolic, and economic deprivation and control. Utilizing a social constructivist viewpoint, feminist theory has questioned and addressed philosophical (French, Teays, & Purdy, 1998) as well as epistemological issues (Boulanger, 1990). From a feminist perspective, domestic violence has become synonymous with coercion and the social control of women that is personal and institutional, symbolic and material (Yllo, 1993).

A Family Therapy/Social Systems View

Wife abuse and family violence have become highly problematic issues for family therapists who have subscribed to general systems theory, particularly because of the many difficulties inherent in reconciling abhorrent individual behavior with systems thinking. Family therapists have typically conceptualized and treated presenting problems as relational, a function of mutual complementary processes, predicated on circular causality. The attempt of such a therapist to resolve the practical issue of assigning individual responsibility has become problematic: incompatible with the conceptual requirements of general systems theory.

General systems theory has purported to be blame free; neutral; and, thus, unencumbered in the complexities of moral judgments. It does not "see" the individual, but rather is focused on system process. Furthermore, it has asserted that a system is greater than the sums of its parts and that no one element or person within the system can control the remainder of the system. This has led family therapists to maintain a systems view of mutually escalating processes in the abuse dynamic. From this viewpoint, to a lesser or greater extent, everyone in the family system is viewed

as creating, contributing to, and maintaining the violence. No one person is totally culpable; however, as evidenced in the literature, victim-prone conceptions of the battered woman also emanate from systems views of family violence.

Consider, for example, Pittman's (1987) widely endorsed clinical assertions. His viewpoint perhaps best encapsulated the family therapy-general systems theory epistemological dilemma. Pittman, a noted family therapist, has contended that battered women who remained in abusive marriages displayed "somewhat more distinctive" psychopathology than their husbands. In addition, he has characterized these women as feigning weakness, refusing help, manipulating guilt, and capitalizing on their one-down position in the relationship in order to control the marriage. Viewing battered women as active participants and sources of psychopathology, he wrote:

They expect to be mistreated, probably have been prior to this marriage, and were usually perfectly aware that the man they were marrying had a low tolerance for frustration and became violent when frustrated...She [the battered wife] seems to believe she deserves this treatment,

and she cringes along, acting pitiful and inept, accepting the violence and taking care of the man who beats her. These women can frustrate their would-be rescuers. They are chronic victims, suffering and making everyone else feel guilty because they suffer. They determinedly refuse to acknowledge that they have any power, that they can positively or negatively influence what happens to them. They insist that they deserve the beatings, but that they can't help doing whatever it is they do that makes them so deserving of beatings, and they can't leave the situation or change it.

But they beg for help. (P. 289-290)

Pittman's excerpt serves as another vivid example of victim blaming viewpoints found in the professional literature. This systems theorist clinical explanation has helped to perpetuate the misconception that battered women choose or invite their victimhood, or are, on some level, deserving of, gratified by, or responsible for the violence and abuse.

With the exception of feminist family therapy (e.g., Bograd, 1984; Hansen & Harway, 1993; Leeder, 1994; Yllo, 1993) that has attempted to combine systems theory with

an activist, political stance, family therapy (e.g., Pinsof & Wynn, 1995; Sprenkle, 2002) generally has focused primarily on system level views of etiology, explanation, and intervention. Minuchin (1984) has aptly characterized this viewpoint when he suggested that to separate a family, or individual behavior, from its context is akin to "studying the dynamics of swimming by examining a fish in a frying pan" (p. 34). In the true systems spirit, he explained that an understanding and treatment of family violence "requires a frame that is semi permeable, so that the blood and tears flow in and out of the picture" (p. 34). As both quotes from Minuchin have illustrated, the fundamental issue is epistemological. Minuchin's (1974, 1984) research, combined with findings of other family therapists (e.g., Pinsof & Wynn, 1995; Sprenkle, 2002) provided evidence for the multidimensional nature of perception and the importance of system integrity. Hence, family therapy has adopted an epistemological position emanating almost exclusively from "context." In effect, the family therapist's way of knowing has derived from consideration of interpersonal connections, relationships, and interactions.

The source of this epistemological concern may be traced directly to Bateson and his concept of "epistemological error." As Dell (1986) has written, for Bateson the world was "mindlike, systemic, cybernetic," organized according to circular causality. From this perspective, a family theorist would argue that all social and ecological systems are circularly organized, interconnected, and arranged into larger and larger systems. Therefore, in a framework built on pure systems thinking, unilateral control would appear contradictory, implausible, or completely impossible.

However, Dell (1986) continued to argue in favor of an important distinction between circular and lineal causality that provided a sensible way out of this epistemological dilemma. In a world that is theoretically organized into increasingly larger circles of mutual influence, he contended that there is also a place for practical lineal interventions. As Dell has suggested, we can describe and intervene lineally and explain systemically. If we ascribe different functions at different levels (descriptive and explanatory), then we remain faithful to a general systems viewpoint and sidestep the epistemological error.

Feminist family therapists such as Bograd (1984, 1988) have advanced this position by separating out and distinguishing between the elegance of general systems theory (principles of pure system process) and the pragmatics of assigning moral, individual responsibility. On practical grounds, in the day-to-day realities of clinical practice and lineal interventions, we can hold the male batterer responsible for his violence, intimidation, and control. On theoretical grounds, we can move beyond the family unit borders, enlarging the system in question to encompass society or our sociocultural system. Accordingly, feminist-oriented family therapy can accommodate linear and circular causality: The male batterer is descriptively (lineally) assigned moral responsibility, while the system under study (circular causality) becomes society and the gender socialization process, per se.

The two frames of reference and associated bodies of research under study in this dissertation represented two points on the domestic violence theoretical continuum. Learned helplessness embodied an interactional, psychosocial view; health psychogenesis expressed a primarily sociological perspective. This dissertation has undertaken an appraisal of the outcome research evidence

supporting both theories to determine where the preponderance of evidence lies. Chapter 3 identifies and defines the methodological criteria and research plan (steps and procedures) used in the outcome analysis.

CHAPTER III

Method

This dissertation had two objectives: to explore the research database (i.e., scientific adequacy) of the learned helplessness theory, and to compare and contrast these findings with the accrued research database supportive of the competency-based, health psychogenesis survivor-process theory of battered women and children. A comprehensive review and analysis of major conceptual issues, research problems, and findings on battered women and children was undertaken. This involved examination of the extant research on both sides of the learned helplessness/health psychogenesis debate. This chapter describes the methodology used to examine and compare the research outcomes. The research procedures and steps are described below.

Samples

1. Major national surveys on battered women, children, and family violence were analyzed to determine the adequacy of the databases and to identify major

conceptual and methodological controversies such as the intergenerational transmission hypothesis.

2. The substantive research on battered women was grouped (subdivided) and analyzed, for purposes of outcome evaluation, into two sample types: non-random shelter studies and non-random community studies. First, results were analyzed and reported separately regarding findings and study characteristics (methodological adequacy) for each sample type.

3. The separate research literatures on battered women and children were also analyzed and evaluated. This dissertation attempted to examine the extent to which these literatures could be interwoven to form an integrated view that incorporated the independent findings on women and children into a family unit or systems level profile. Of interest was whether the status of both literatures permitted integration, and whether it was possible to formulate links joining the recoveries and phenomenological experiences of women and children, either as a treatment unit or as a methodological and/or transactional unit of analysis.

However, if it was determined that no systems level research (or only a limited body of research) evidence was found on women and children's joint recovery process,

then the following alternative conceptual framework of outcome analysis was proposed: the application of family developmental stage theory to construct a hypothetical family profile. If both options proved to be unproductive, then a third alternative was to report the data on women and children as parallel profiles on two independent sets of findings.

4. In keeping with a systems level perspective, research on the male batterer was also examined. Specific attention was focused on the controversy over ascribing and localizing psychopathology within the male batterer. This involved the reconciliation of the individual-systems interface question or individual psychopathology versus general systems theory.

Procedures:

Categorizing and Evaluating the Research Data

The research evaluation plan suggested three possible outcomes, each with its own secondary set of issues, research questions, and position on the learned helplessness/health psychogenesis controversy. Each outcome in this categorization schema offered a different perspective on the concepts and research variables of

competence, survival, and recovery of battered women. The categories were defined as follows:

A Pro-learned Helplessness Position

The majority of research data was found to support the learned helplessness theory and premises: that the behavior of battered women reflected cognitive, motivational, and affective distortions. Chronic abuse resulted in psychological disturbance requiring clinical intervention. Battered women developed and displayed learned helplessness, depression, and ineffective coping strategies.

A Pro-health Psychogenesis Position

The majority of data were found to support the health psychogenesis theory and premises: that the behavior of battered women reflected effective problem solving skills, accurate perceptions, and adequate positive motivation. Battered women were psychologically healthy, proactive, competent, and emotionally strong.

A Modified Pro-learned Helplessness/Pro-health Psychogenesis Position

Equally substantive data were found to support aspects of both learned helplessness and health psychogenesis theories and their underlying premises. It was proposed that such an outcome suggested two branching

sub-outcomes or subcategories of experience: that battered women either displayed learned helplessness and the "battered woman syndrome," or a relatively symptom free, healthy response. This modified outcome, in turn, suggested that other kinds of hybrid outcomes were also possible. For example, the data were found to support the following outcome interpretations: (a) neither theory was well supported by its respective research databases, (b) one theory's research database was found to be more consistent, stronger, and scientifically adequate than the other, or (c) the research data appeared to support different concepts/assumptions associated with each theory, leading to the proposed integration of aspects of both theories.

Measures

This dissertation attempted to critically examine both sides of the clinical-research controversy surrounding learned helplessness/health psychogenesis. The following four methodological criteria (research design dimensions) were used to evaluate the status (scientific adequacy) and findings of each theory's research database. These criteria were derived from a

review and analysis of texts/perspectives (Campbell & Stanley, 1962; Hersen & Barlow, 1976; Huck, Cormier, & Bounds, 1974; Keppel, 1991; Kerlinger, 1964; Isaac & Michael, 1976; MacDonald, 1985; Riecken & Boruch, 1974; Tabachnick & Fidell, 1989) on social science research design and evaluation. In addition to identifying critical social science dimensions to consider in evaluating level of design quality, a second rationale influenced criteria selection, that is, the nature of the subject under study and its implications for application. Treatment plans typically follow from theories of battered women and abuse. Hence, the following methodological criteria were not only selected because they generally reflected important social science methodological dimensions but, because they also appeared well suited to practical intervention questions/issues with regard to battered women and children. Four dimensions or categories of research design quality (criteria) were used to evaluate the research databases:

1. Sample, sampling procedures, and power. Is the preponderance of the data drawn from shelter or community samples? Are the samples randomly selected or are they comprised of non-random samples of convenience? Is the sample large enough to permit trustworthy inferences? Do

the data purporting to support each theory allow a power analysis and, if so, what does that analysis show?

2. Instrumentation. Are the methods used for data gathering adequate to support the conclusions drawn? Are the specific tools (survey, questionnaire, interview protocol, psychological tests, etc.) reliable and valid? For example, does a study base its findings on its own research instrument/questionnaire? Does the study use another study's instrument or replicate another study's classification/scoring system? Are original instruments used in conjunction with standardized, well established instruments? Does the study reflect findings derived from multiple data sources and perspectives (e.g., self-report, objective ratings), combining subjective and objective vantage points and multiple criterion measures?

3. Statistical analysis. Is the statistical approach appropriate and adequate, given the nature of the research evidence and quality of the research design?

4. Hypothesis testing. Does the study explore general issues or broad research questions (no formal hypotheses stated)? Are the research hypotheses clearly stated; however, appear too general, or not directly or specifically related to the core concepts/research questions posed by the theory under investigation? Or, do

the majority of the study's assertions rely on post hoc analyses, or expo-facto reasoning? Does the study test formal hypotheses and make clear predictions germane to core concepts of the theory examined?

The four dimensions were selected to address the issue of corroboration, at the extent to which research evidence supports core components of the theory.

A Stepwise Plan for Outcome Appraisal

The followings series of steps were implemented in order to evaluate the quality and outcome of each theory's respective research data.

1. The major network of core studies (i.e. most prominent and frequently referred to studies in the literature) were identified. These studies formed the basis for analysis in this investigation. At the observational, single study level, the shelter and community studies were reviewed, described, and analyzed in relation to sample (size, composition, procedures), instrumentation, hypotheses, and reported findings in the areas of spousal and child abuse. The characteristics pertinent to each study were abstracted (identified and listed) by this investigator. Study characteristics and

findings were then reported separately for each study in the shelter and community samples. The results are reported in Tables 5.1 and 6.1 respectively.

2. A four-category method of evaluation was devised to provide a quantification (rating) of methodological adequacy. The rating system reflected the methodological criteria described above. Hence, each study was rated on and assigned a numerical value in four areas: sample, instrumentation, statistical procedures, and hypothesis testing. These relatively straightforward ratings based on study characteristics were identified, organized, and assigned a rating (per dimension) by this investigator.

3. Next, each study was assigned an overall rating or Total Design Quality Score (TDQS). This rating represented the sum of the numerical values assigned to the study across the four research dimensions (sample, instrumentation, appropriate statistics, and hypothesis testing). The scale definitions, coding system, and scoring rationale are presented in Chapter 5. The results of these analyses are reported in Tables 5.2 and 6.2, and are discussed separately in the sections on shelter and community samples.

4. The individual studies were also analyzed along an outcome dimension. This outcome dimension was based

on the study's findings. Accordingly, study outcomes were assigned by independent raters to one of four categories: "pro-health psychogenesis," "pro-learned helplessness", "both" (equally supportive of both theories), or "not directly applicable" (NDA), that is, findings did not pertain to either theory.

5. To safeguard against investigator bias, raters were trained, and a test of interrater reliability was applied to outcome categorization and assessment. Three raters (two undergraduate students in psychology at the University of Rhode Island, and one master's level mental health clinician) were trained (two, 2-hour group workshops) in the core concepts and assumptions of learned helplessness and health psychogenesis. (The basis of the training is outlined in the nine core concepts presented in Figures 5.2 and 5.3). The two undergraduate raters were then presented with individual study findings for shelter and community samples. They independently rated study outcomes. When disagreement between the two undergraduate raters occurred, the third graduate level rater (clinician) served as a tie-breaker. The results of these outcome ratings are discussed in the sections on "Corroboration" for shelter and community samples.

6. Because a simple outcome categorization appeared to be an insufficient measure, the decision was made to qualify each study's outcome rating by the study's overall level of design quality (high, medium, or low), using the study's assigned TDQS. Therefore, a study's outcome was considered more "significant" when it fell within the high design quality level. Tables 5.3 and 6.3, presented in Chapters 5 and 6, organized studies by level of design quality by outcome, or which theory the study's results (i.e., majority of findings) supported.

7. The initial step in the design quality by outcome analysis focused on shelter and community samples separately. Next, the design quality-by-outcome findings were integrated across shelter and community samples. Table 8.1 was organized to present the outcome data in a different light. This analysis combined shelter and community samples for an overall research sample, crossing level of design quality by type of outcome. Outcome evaluation involved consideration (interaction) of methodological adequacy and substantive outcome.

In Chapter 4, consistent with the first research objective, the results on findings derived from national probability surveys of domestic violence are analyzed and described.

CHAPTER IV

Results:

National Random Surveys of Domestic Violence

This chapter addresses the broader questions of prevalence and measurement in the area of family violence. The focus is on national statistics regarding the experience of battered women and children. Table 4.1, which is to be discussed, summarizes major national surveys: their sample sizes, instrumentation, and major findings on partner violence and child abuse.

Battered Women:

National Probability Surveys

But what do we actually know about battered women? The knowledge we have of battered women, including their experience of and response to family violence, is primarily derived from three sources: randomized, national probability surveys of the general population, which are used to draw inferences about battered women's experiences; non-random shelter samples; and volunteer,

self-selected community samples. Table 4.1, in this chapter, and Tables 5.1 and 6.1, in Chapters 5 and 6, identify major studies and highlight significant statistical as well as clinical findings across these three broad research areas and populations. Table 4.1 focuses on findings obtained across national surveys; Table 5.1 describes studies on shelter samples; and Table 6.1 summarizes research based on volunteer community samples. The majority of what is known and attributed to battered women has been derived from non-random samples and in the case of shelter samples, has often represented the worst case scenarios--the most severe forms of abuse and incidence of chronic violence.

Large scale national surveys have highlighted the prevalence of interpartner as well as wife assault across a range of categories of violence severity. Such random surveys have detailed the frequency of violence in marriages. Although battered women were not specifically examined in these studies, the broad statistics the studies provided about "violence against women" permitted inferences about the battered group.

The data pool on the reported incidence of family violence has been derived from a number of independent research studies. These included Gelles and Straus's

1975 First National Family Violence Survey (random sample of 2,143 families) and 1985 National Family Violence Resurvey (random sample of 6,002 families), cited in Straus and Gelles (1990); and the 1977-1978 National Crime Victimization Survey (random sample of 60,000 households), cited in Gaquin (1977-1978). In 1992, the Bureau of Justice Statistics revised the National Crime Victimization Survey's protocol to specifically and directly address violence between intimates. All three national surveys have provided strong evidence regarding the critical nature and life-threatening implications of family violence.

One important point should be noted: In contrast to the other two surveys cited above, the National Crime Survey reported considerably lower rates of family violence. Upon closer examination, the discrepancy in reported rates appeared to reflect methodological artifact. As Hansen and Harway (1993) observed, the National Crime Survey was presented to respondents "as a study of crime," whereas other national surveys were presented as "studies of family problems." In describing the methodological reasons that accounted for discrepancies in survey outcomes, Hansen and Harway have called attention to the broader social psychological

problems inherent in family violence: "Most people do not think of family violence as a crime, thus fewer incidents of domestic battery may have been reported" (p. 2).

Statistical Overview

Consider the following statistics that have underscored the prevalence and pervasiveness of domestic violence and have presented a disturbing profile of the lives and experiences of women and children living with family violence. Jones (1996) highlighted the societal rise in rates of violent acts against women. She stated that, prior to 1989, the FBI reported that a man beat a woman every eighteen seconds in the United States; by 1989, the figure rose to every fifteen seconds; by 1992, the rate was every twelve seconds.

Although these statistics have reflected and, in some respects, paralleled the general increase in men's violence toward women, the statistics on violence directed toward women and children inside the family have appeared more alarming, given the context of intimacy and interpersonal safety associated with the notion of "marriage" and "family." O'Leary, Barling, Arias, Rosenbaum, Malone, and Tyree (1989), in their longitudinal analysis, reported that one out of every three marriages experienced marital violence and nearly

half of all dating/marital relationships experienced some form of inter-partner aggression.

According to Straus and Gelles's 1985 National Family Violence Resurvey, reported in their book *Physical Violence in American Families* (1990), one out of every eight, or 6.25 million, women are hit by their husbands each year. Three out of every one hundred, or 1.8 million, women are severely assaulted by their husbands each year. The nature of the physical assaults have ranged from fractures (usually to the nose and jaw), chronic back injuries, torn ligaments, dislocations, ruptured eardrums, broken teeth, and lacerations, to stab and gunshot wounds. Other researchers (Barnette & LaViolette, 1993; Hansen & Harway, 1993; Leeder, 1994; Pagelow, 1981; Stark & Flitcraft, 1996) have catalogued similar injuries and documented similar violence rates. Brown and Hendricks (1998) further corroborated this point. They stated "more than 50% of all couples experienced at least one assaultive incident during the course of their relationship, with women experiencing more than ten times the number of violent incidents than men" (p. 123). Emphasizing the serious nature of assaults, they further stated: "39% of all violent encounters involved the wife being punched with a fist,

kicked, bitten, or attacked with a knife or gun" (p. 123).

Interpreting the Reported Controversial Data on Husband to Wife and Wife to Husband Violence

An overview of national statistics on the incidence of domestic violence is incomplete without a brief discussion and explication of similarly reported rates of wife-to-husband violence. These findings, derived from Straus and Gelles's (1990) national survey research, have raised issues regarding the bidirectional nature of marital violence, a view that has implicated women as being as aggressive or violent as men. Because such a view has far reaching, real-life ramifications for the victims of domestic violence, several qualifying remarks are offered to prevent a misinterpretation of the data.

Recent debate and heated criticism arising from feminist-based research quarters have challenged the nature of the controversial findings generated by Straus and Gelles's reported rates of wife-to-husband violence. Straus and Gelles have reported findings on the incidence of wife-to-husband violence that equal, mirror, and, when examined on face value, slightly exceed husband-to-wife violence. Straus and Gelles found that 124 per 1000, or 6.8 million, women committed some act of aggression

(slapped, pushed, shoved, etc.), and that 48 of 1000, or 2.6 million, women engaged in forms of serious violence (kicked, punched, bit, etc.).

Criticisms raised by feminists have revolved around the possible psychological and political misapplication of these data. For example, feminists have expressed concern that such data will be used to "blame the victim," disparage the victim's character, discredit the merits or worthiness of the "cause" for equity between genders, and slow or ultimately forestall legal, social, and political progress for survivors of domestic violence. As many feminist researchers, and as Straus and Gelles (1990) themselves aptly pointed out, the consequences and meaning of these findings must be judged in their context. Feminists have argued that, usually, women's acts of aggression occur in response to or in defense against a husband's violent assault. Women's violence is largely reactive and self-protective. Thus, feminists have contended that violence rates must be judged in terms of directionality; whether the aggressive action is an initiating act or a reaction to or defense against assault.

In addition, considering the typical physical disparity in size and strength between men and women,

women are no match for men in an aggressive interchange. As Browne (1989) suggested, because men are physically stronger and larger than their wives, with more social and economic resources at their disposal, the physical and social consequences of marital violence are usually limited and relatively less severe when men are the victims. Accordingly, violence rates need to be assessed in terms of outcome; for example, in terms of the severity of inflicted injury. Obviously, women typically inflict less serious bodily injury than men. When the outcomes of husband-to-wife and wife-to-husband violence were compared, based on medical and police reports, women fared much more poorly, sustaining more severe and serious physical injury (Dobash & Dobash, 1979; Hansen & Harway, 1993).

Returning to data obtained in National Crime surveys, Barnett and LaViolette (1993) have called attention to Schwartz's (1987) findings. Schwartz analyzed National Crime survey information from 1973 to 1982, focusing on gender and injury in spousal abuse, and found that: Of the abuse reported, 94% of the victims were women and 95% of the recorded injury cases sustained (involving medical treatment) were women. In light of these consequences, Gelles and Cornell (1990) concluded,

"Data from studies of households where the police intervened in domestic violence clearly indicated that men are rarely the victims of 'battery'.... When injury is considered, marital violence is primarily a problem of victimized women" (p. 82).

As Straus and Gelles (1990) stated, "For a typical American woman, her home is the location where there is the most serious risk of assault. The rates of husband-to-wife assault...are many times the female victimization rate outside the family" (p. 19). Straus and Gelles reported that the rate of being assaulted at home, when compared to assaults outside the home, was much higher, as shown by homicide rates. Homicide statistics have shown that women are seldom murder victims outside the family. According to Plass and Straus (1987), 21% of stranger homicide victims were women, whereas women comprised 76% of spouse murder victims. Women were far more likely to be victims of murderous assault inside their family than at the hands of an unknown assailant on the street. As Gelles and Straus (1988) stated:

The cruel irony of staying home because one fears violence in the streets is that the real danger of personal attack is in the home.

Offenders are not strangers, climbing through

windows, but loved ones, family members. You are more likely to be physically assaulted, beaten, and killed in your own home at the hands of a loved one than any place else, or by anyone else in our society. (p. 18)

Table 4.1 presents the sample size, method of instrumentation or data collection, and salient findings on partner violence and child abuse across major national probability surveys. When comparing findings across studies with those derived from the National Crime Victimization Survey, Table 4.1 vividly illustrates the problem of definition, description, and reporting in both the measurement of family violence and the reluctance to acknowledge intimate violence in the general population. Table 4.1 highlights the prevalence of wife battering in our society. This Table provided a national and normative view of domestic violence and served as a baseline and backdrop for assessing the demographics and research data on non-random shelter and community samples.

Table 4.1: National Probability Samples

Study Name/ Researchers/ Date	<u>N</u>	Instrumentation	Findings: Partner Violence	Findings: Child Abuse
National Family Violence Survey by Straus, Gelles, & Steinmetz 1975-1976*	2143 households 1146= 2 parent useholds with children	one-hour in home, face to face interview, CTS	Husband-to-Wife -Overall Violence= 121 per 1000 couples, -Severe Violence= 38 per 1000 couples	-Overall Violence: 630 per 1000 children, -Severe Violence: 140 per 1000 children, -Very Severe Violence: 36 per 1000 children
National Family Violence Resurvey by Straus & Gelles 1985	6002 households ***	Random digit dialing, 35 minute telephone interview, CTS & questions on directionality of violence and resulting injury	Husband-to-Wife: -Overall Violence= 113 per 1000 couples -Severe Violence= 30 per 1000 couples**	-Overall Violence: 620 per 1000 children -Severe Violence: 107 per 1000 children -Very Severe Violence: 19 per 1000 children
National Crime Victimization Survey- US Department of Justice, Gaquin 1973-75	60,000 households	7 face to face interviews per household; 6 month intervals -structured, 3-part interview (household, person, incident)	Husband-to-Wife: 2.2 per 1000 Marital Violence: 3.9 per 1000 -out of 26.4 per 1000, assault= 3.9, spouse abuse (for women)	not analyzed in Gaquin

*determined by period of time covered in survey questions vs. actual time study conducted

** comparisons between 1975 and 1985 based on unweighted samples

*** N broken down as follows; 4032= national probability sample proportionate to distribution of US households, 3520=couples married or cohabiting, 1428= 2-parent households with children: the 1985 study is also a larger, more dependable sample size

Scope, Definition, and Measurement of Family Violence:

Impact on Battered Women

Definitions, Levels, and Types of Family Violence

The collective body of clinical and research evidence has illustrated that the concept of "family violence" is multifaceted and complex. An understanding of family violence is intimately tied to and embedded in the more general construct of and research on aggression. The research on aggression is discussed, at this juncture, because it sheds light on a number of methodological (i.e., definition of terms and measurement) dilemmas characteristic of research on battered women. Violence toward women represents one form or variant of family violence and a subset of a more general cluster of behaviors and intentions that we label as "aggression." Drawing upon research in the area of aggression, "aggression" may be broadly defined as any action or intent designed to inflict harm (physical or psychological) on another.

Herek (1992), who investigated the role and relationship of aggression in the context of hate crimes, amplified the definition of aggression to include words or actions intended to harm or intimidate an individual.

Behaviors falling within this broad definition of "aggression" ranged from obvious violent acts such as assault, rape and murder, to property crimes motivated by animosity, and more subtle forms of psychological terror and fear such as threats of violence and intimidation. Extending this definition and the understanding of aggression further, Bandura's (1986) conceptualization set the parameters for assessing acts of aggression beyond the "act" or "consequences" of the aggressive act itself, to a consideration of the broader frame of reference or context within which the aggressive act was committed. For Bandura, the context of the aggressive act represented the by-product of and, therefore, must be evaluated in terms of the interaction between social-structural variables and the self, including such psychological processes as subjective judgment. In emphasizing wide-spread cultural "cues" and the concept of "disinhibition", Bandura argued that predictive rules about the perception of aggressive behavior encompassed more than the behavior per se, to include social as well as self (cognitively and affectively mediated) factors.

Aggression toward women in our society is deeply embedded in the ethos of our culture. Aggressive acts are often tacitly and overtly approved or fostered by our

social structure. Our tolerance of aggression is often so pervasive and its manifestations so ubiquitous, that people can become inured or desensitized to its effects. The above discussion of varying concepts and research perspectives on "violence" was intended to highlight the definitional and, by inference, measurement dilemmas inherent in research on wife abuse.

Problems with the scope and definition of aggression and, hence, types of family violence (where to set our margins and draw the definitional lines) has stemmed from our cultural ambivalence about the merits and limits of aggression. Acts of aggression toward women are often positively, although tacitly, sanctioned, approved, minimized, or ignored on many intersecting levels: personal, interpersonal, systemic, community, societal, symbolic, and, ultimately, cultural.

Browne (1989) stated that such societal and cultural ambivalence toward justified and unjustified aggression has confounded most attempts to deal with the pervading problem of family violence. He contended that it is the task of law and social policy to discriminate between what comprises "normal" socially acceptable violence and unacceptable, "abusive" violence in the family. He attributed the discrepancies (wide variations) in

reporting incidents of domestic violence to the lack of consensus, or the ambiguity, surrounding the definition of what constitutes abuse. Gelles and Straus (1979) offered a purposefully broad definition of spouse abuse as "any act carried out with the intention of or perceived as having the intention of physically harming another person" (p. 554).

The problem of comparing rates of partner abuse across representative and non-random samples of convenience has evolved, in part, from the breadth and ambiguity of definitions applied. For example, in their First and Second National Family Violence Surveys, Straus and Gelles (1986, 1990), using the Conflict Tactics Scale (CTS), relied on a definition that considered physical and verbal expressions of interpartner violence. They defined the reported violence in overt behavioral terms and physical acts of injury. In contrast, Stark and Flitcraft (1996) employed a more sweeping definition, including both physical and emotional injury. Consider their definition: "Battering describes the dynamics of partner assault as a pattern of coercive control. Battering encompassed the range of behaviors employed to hurt, intimidate, coerce, isolate, control, or humiliate a partner" (p. 161). As Gelles (1997), Flitcraft (1977),

and Stark and Flitcraft (1996) noted, the tension between definitions, lies in the difference between academic research and social service goals. They have contended that the dictates of academic research required more restricted, behaviorally anchored definitions, whereas human service guided definitions incorporated psychological and emotional violence. Accordingly, for the present research, the organization and analysis for both representative and non-random studies included findings on physical and emotional violence.

An initial step in this research involved review and analysis of major national probability surveys on battered women, children, and family violence. The objective was to provide an overview of the scope and nature of the problem, identify major conceptual and methodological controversies, and determine the adequacy of the respective databases for learned helplessness and health psychogenesis theories. The findings on national probability surveys have formed the normative background against which specific findings on battered women were analyzed.

The Relationship between Physical and Emotional Abuse

Family violence takes many forms. There are overt acts of physical assault and aggression, the obvious

brutality and injury that we associate with the typical image of spousal abuse and family violence. There are also subtle and insidious kinds of psychological abuse that take the form of verbal and emotional battering, degradation, ridicule, intimidation, control, and shame. Emotional abuse pervades the lives of many women who experience domestic violence, whereas episodes of physical abuse punctuate it periodically in the often predictable patterns of the abuse cycle. Emotional battering has been identified in the abuse dynamic. A number of researchers have provided evidence to support this point.

Follingstad, Rutledge, Berg, Hause, and Polek (1990) examined the link between emotional and physical abuse in the intimate relationships of battered women. Emotional abuse was divided into six categories: threats of abuse, ridicule, jealousy, threats to change marriage, restriction, and damage to property. Of the 234 battered women who comprised the research sample, 229 (98%) of the subjects reported having experienced at least one episode of emotional abuse, and 72% reported experiencing at least four types of emotional abuse. Ridicule was the most common form of emotional abuse; however, threats of abuse, jealousy, and restriction were also reported by a

large percentage of subjects. Approximately 159 women (68%) reported that emotional abuse had a more severe and devastating impact than physical abuse and, when evaluating the severity of different kinds of emotional abuse, 45% of the battered women rated ridicule and verbal harassment as the most painful and worst types of emotional abuse.

The results of Follingstad et al.'s study have shown that, regardless of the severity and extent of the physical abuse, the women overwhelmingly experienced the emotional aspect of the abuse as more painful and detrimental. As Walker's research (1984) has demonstrated, verbal or emotional battering often superseded physical battering as a more powerful, coercive technique of intimidation and control. Emotional abuse has been experienced by battered women as more detrimental than physical violence.

Despite the physical injuries that women suffered at the hands of their abusive partners, research by Walker (1984) and others (e.g., Follingstad, et al., 1990) consistently has shown that battered women experienced verbal humiliation and emotional abuse as the worst kind of battering. Emotional battering has been identified as the main tactic the abuser uses to isolate, dominate,

demean, and confuse family members. Like physical abuse, emotional abuse forms part of the hostile traumatic bond that keeps the violence a carefully guarded secret; unites family members in a community of fear and silence; and keeps the "victim" mystified and enveloped by inexplicable self-recrimination and shame. The overwhelming consensus of formal researchers on the power and pain of emotional abuse is that, for abused women, physical injuries heal much more quickly than the emotional traumas and hurts they experience.

The Relationship between Verbal and Physical Aggression

A controversy central to problems of definition, measurement, and prediction in the field of family violence has revolved around the continuity-discontinuity question: the relationship between different levels and types of violence. For example, is the relationship between different types of violence a qualitative or quantitative one? Are violent actions arranged along a continuum that gradually builds (increases) from lesser to more violent behavior? In effect, does violent behavior escalate (progress) with verbal and milder forms of physical aggression necessarily leading to more severe assault, as the abuser becomes more desensitized to the effects of violence and as his tolerance threshold for

aggression-release increases? Or, instead, do verbal and physical aggression stem from two qualitatively different phenomena, rather than representing simply two different levels of aggression, each with a different threshold?

Longitudinal and national survey research, investigating the relationship of verbal aggression to physical abuse, has demonstrated a direct link between the levels of verbal and physical aggression, and that verbal aggression often functioned as an antecedent to physical abuse. Research consistently has shown that the more husbands and wives are verbally aggressive toward each other, the higher the rates of physical aggression (Straus, 1974a, 1974b). Studies (Straus, 1974a, 1974b; Straus, Gelles, & Steinmetz, 1980) have demonstrated that individuals who engage in verbal aggression toward their spouses are more likely to engage in physical violence. As Bowker (1983a, 1983b) observed, research has shown a positive association between verbal and physical aggression in direct opposition to leveling, catharsis, and ventilation theories of verbal aggression. Further, Murphy's (1987) longitudinal study corroborated the general finding that verbal aggression functions as a "precipitant" to physical aggression.

Straus and Smith (1990) explained these findings in terms of the counterproductive effects that verbal aggression has on conflict resolution. They argued that verbal aggression does not constructively address the underlying sources of marital tension. Instead, verbal aggression engenders increased animosity, further exacerbating family tension and causing the original sources of marital conflict to cycle and recycle repeatedly throughout the marital relationship and to remain unresolved. Similar, parallel research findings have been reported regarding the relationship between verbal aggression and child abuse. For example, Straus and Smith (1990) reported that parents who were either verbally aggressive toward the referent child or toward each other displayed higher rates of child abuse. As Bowker (1983a) emphasized, national surveys of family violence, combined with data from clinical observation and studies of other specialized populations, consistently support three important findings:

- (a) wife battering is a common (rather than an atypical or deviant) event;
- (b) the incidence, severity, and frequency of violent assaults by men against women can have serious

damaging consequences, creating a significant social problem; and

- (c) wife battering can lead to and is frequently associated with child abuse, as child witnesses also become targets of physical and emotional assault.

In Chapter 5, which follows, results on non-random shelter samples are discussed. Chapter 6 reports findings on non-random community samples. Both Chapters 5 and 6 offer parallel investigations on shelter and community sample outcomes. The integration of these findings forms the foundation and point of departure for research outcome evaluation discussed in Chapters 7 and 8.

CHAPTER V

Results:**Analysis of Non-random Shelter Samples**

First, data on shelter samples are organized in a table that describes salient study characteristics (sample, instrumentation, hypotheses) and presents major research findings. In Table 5.2, each study is rated across four dimensions, including sample, instrumentation, appropriate statistics, and hypothesis testing. Each study in Table 5.2 was assigned a summary score of Total Design Quality (TDQS). Table 5.3 organizes the data from a different perspective: studies are grouped according to design quality, and the dimension of outcome is added.

Progressing from Tables 5.1 and 5.2, Table 5.3 crosses level of design quality or TDQS by outcome category: whether a study's findings supported learned helplessness or health psychogenesis, or both. The analyses with shelter samples, the topic of this chapter, were repeated with community samples in Chapter 6. These parallel analyses were compared, combined, and integrated into an overall view on outcome and formed the basis for

the learned helplessness-health psychogenesis research outcome evaluation on learned helplessness-health psychogenesis discussed in Chapter 8.

Battered Women:

Non-random Shelter Samples

In Chapter 3 a number of methodological criteria were identified to evaluate the respective research databases for learned helplessness and psychogenesis. As Table 5.1 indicates, eight out of the overall 17 studies represented shelter samples exclusively, with the nine remaining studies reflecting shelter and community combinations. Of these nine studies, Back, Post, and D'Arcy (1982), and Gellen, Hoffman, Jones, and Stone (1984) involved, respectively, psychiatric battered-nonbattered group comparisons and consecutive admissions to a residential treatment program with self-selected, matched community controls.

Finn (1985) and the three interrelated Follingstad and associates studies (1990, 1991, 1992) either combined spousal abuse program participants with shelter samples or drew upon a variety of participant sources, including shelters, women's prisons, emergency rooms and social

support groups. Claerhout, Elder, and Janes' (1982) two-step study involved a shelter sample for instrument development, The Family Problem Questionnaire, followed by a test of the instrument based on a community battered-nonbattered group comparison. Pagelow's (1981) study reflected a very small proportion of community representation: 91% shelter residents, 9% non-shelter volunteers. Launius and Lindquist (1988) used a two-group comparison to study learned helplessness, locus of control, and passivity. They recruited a shelter sample ($n=22$) and a community sample ($n=23$).

Table 5.1: Non-random Shelter [and Shelter/Community] Samples

Researchers/ Date/ Geographical Location	N	Hypotheses/ Issues Studied	Instrumentation	Findings: Women
<p>Labell, 1976-1978 Florida</p>	<p>N=512 512 women residing in shelters; economically disadvantaged (682 children) racial mix: 22%= white, 76.8%= black, 1.2%= other</p>	<p>personal characteristics of battered women & perpetrators a) history of violence, b) substance abuse, c) helpseeking behavior, d) decision to leave</p>	<p>written questionnaires variables derived from intake-departure forms: demographics, history of violence, contributing factors, self-help motivation</p>	<p>33.4% of women, history of childhood violence 68% of perpetrators, abused or witnessed childhood violence [N=297] 7.8% of women, drinking problem [N=255] 72% of perpetrators, drinking problem [N=364] 6.4% of women, drug abuse [N=249] 28.2% of perpetrators, drug abuse [N=255] 72% of women sought help from other sources [N= 399] 74.2% of women separated from mate one to ten or more times Women healthier than abusers: less childhood violence and substance abuse</p>

Table 5.1 (Continued)

<p>Schillinger,** 1988* Southwest</p>	<p>N=11 11 current or previous shelter residents; referred or self-selected volunteers. All women currently or previously involved in welfare system; economically disadvantaged racial mix: 9= Caucasian, 2= Hispanic</p>	<p>a) childhood history of physical violence, b) women's psychological mental health & decision-making process, c) effects of social services on women, d) therapy dependency</p>	<p>face to face, unstructured/ semi-structured interview varying from one to four hours in length, across a variety of settings</p>	<p>Most women experienced or observed physical violence in families of origin Majority of women, price of independence is welfare or agency dependence; "agencization" Women's behavior, rational instead of characterologically weak Anger toward patriarchal welfare bureaucracy Majority anticipated long term therapy to correct personal deficits</p>
<p>Mills,** 1982 Southeast</p>	<p>N=10 10 current or previous shelter residents, all recently left batterer, range of socioeconomic & education backgrounds, no information available on racial/ economic distribution</p>	<p>women who have left the abusive relationship Post-hoc analysis: 5 Stage Theory of Coping</p>	<p>face to face, open-ended interview schedule; schedule not always followed setting varied: shelter, home, work interview length varied, 1 to 2 hours 4 issues: 1) current living situation & self-image, 2) violent relationships; views of self, important</p>	<p>Entering a violent relationship coincides with factors of vulnerability, current life crisis or life change, and heightened desire for intimacy. Vulnerability contemporaneous with relationship, not long standing, childhood precursor</p>

Table 5.1 (Continued)

			<p>influences, & thoughts/ perceptions of violence, 3) life prior to violence & self-image vis-à-vis the violence, 4) importance of other relationships & history of other violent encounters</p>	<p>Managing the violence: A) primary strategy of protecting oneself from harm is placating the husband; B) justifying maintaining relationship, 3 coping strategies; a) minimizing seriousness of violence, b) focusing on other aspects of life; competencies and strengths, c) defining the husband as victim; woman- strong, batterer- weak and dependent; transforms batterer's deviant behavior from "bad" to "sick" (and in need of help) Experiencing a loss of self: loss of social identities & the observing self/ insights Re-evaluating the Relationship: decision to leave is both emotional and cognitive</p>
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Table 5.1 (Continued)

				Restructuring the Self: Survivor identity determined by the nature of the experiences, resources, and lack of isolation at time of leaving batterer (4 Survivors, 3 Victims, 3 Confused)
Snyder & Scheer, 1981* Detroit, MI	N=74 74 women, brief residents in shelter over a 6 month period racial mix: 36%= white, 64%= black	factors predictive of the actual disposition of a woman after a brief shelter residence utility & maximum effectiveness of shelter services	extensive questionnaire divided into 6 parts: 1) intake data/ referral & reasons for admission; 2) sociodemographics; 3) history of domestic violence, current & childhood family; 4) current medical status & psychological distress; 5) discharge summary, length of stay, utilization of services; 6) 6-10 week follow-up data, current living arrangements & status of physical abuse	on admission, 14%, intention to return to abuser; by discharge, 33%, intention to return; at follow-up, 55%, living with abuser significant group differences between "IN"s & "OUT"s on 6 variables: 1) reasons for seeking admission (short term separation vs. counseling as a means of reconciliation), 2) relationship to batterer (married or cohabiting), 3) length of marriage, 4) previous separations, 5) religious affiliation, 6)

Table 5.1 (Continued)

				<p>length of stay at shelter</p> <p>3 most significant predictors of women's return to batterers: 1) length of marriage, longer vs. shorter = -.670 (standardized weight), $p < .01$; 2) previous separations, yes vs. no = -.504 (standardized weight), $p < .01$; 3) religious affiliation, Catholic = .477 (standardized weight), $p < .01$</p> <p>no significant group differences between severity of physical violence and number of children with decision to leave or remain in abusive relationship</p> <p>no significant group differences between "IN"s & "OUT"s</p> <p>sociodemographics or nature and severity of</p>
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Table 5.1 (Continued)

				<p>physical abuse significant discrepancy/ inconsistency between women's intentions regarding abuser at shelter admission and their actual follow-up behavior</p> <p>DFA improved the accuracy of prediction from a 52% rate of accuracy using base rate alone to an 80% rate of accuracy using discriminant function coefficients</p>
<p>Okun, 1978-1980 Michigan- Ann Arbor area shelter & Ypsilanti batterers' counseling</p>	<p>N=419 300 women & 119 male batterers, for an overall sample consisting of an independent man-woman sample and a small dependent man-woman/partner sample (21%, or 25 of 119 batterers) economic distribution: 73.3%= homemakers, 22%= full time employed, 4%= part time employed, .7%= laid off &</p>	<p>1) Comparison of the Samples to the General Population; 2) Concordance between Victims' & Assailants' Report; 3) Factors relating to the termination or resumption of Cohabitation between the Battered Woman & Batterer; 4) Predictors of the magnitude of woman abuse; hypothesized higher levels of violence for longer</p>	<p>a 47 variable in-depth intake form for women SAFE House intake forms - a 41 variable analysis of male batterers' counseling file data - male batterers' counseling files objective divorce records use of CRT, a version of Straus' CTS, & also Gelles' violence indices/ scales</p>	<p>An overrepresentation of unemployed women & women on welfare in the shelter sample compared to the general Michigan population No significant differences between shelter sample (31.4% of N=242) & general population (28%; Straus, et al.) on experiencing childhood conjugal</p>

Table 5.1 (Continued)

	<p>collecting unemployment; 30% on welfare; 74-78% are economically disadvantaged racial mix: 79.3%= white, 16.7%= black, 2%= Asian, 2%= Hispanic</p>	<p>relationship, previous estrangement more severe violence, physical self-defense met with escalation of violence, no racial differences in severity of violence 5) Predictors of outcome of batterers' counseling</p>		<p>parental violence Low level of concordance between counseling client & partner on quantity, frequency & severity of violence; elapsed time since first assault; whether batterer assaulted partner during pregnancy, was a child abuser, or alcoholic No statistical association between outcomes of relationship and the women's experiences as abused or nonabused children Of the 33 couples where the woman produced more income than her batterer, 54.5% immediately terminated vs. 27.7% immediately terminating among couples where the batterer produced an equal or greater income. Eventual termination was 57.6% for woman</p>
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Table 5.1 (Continued)

				<p>main income earner vs. 39.1% for the rest; financial independence, an objective factor</p> <p>Women with 1 or no previous separations half as likely to terminate immediately as women with 2 or more: 23% vs. 44.6%+</p> <p>Women who terminated experienced more recent separations than women who resumed relationship (immediate = 10.6 months vs. 20.2 months & eventual = 11.2 months vs. 20.9 months)+</p> <p>Women who terminated averaged significantly longer prior separations than women who resumed relationship (immediate = 124 days vs. 63 days & eventual = 114 days vs. 63 days) +</p> <p>Significantly more severe average</p>
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Table 5.1 (Continued)

				worst assaults of shelter women by former or active alcohol abusers/ male batterers ($t=3.89$, $df=233$, $p<.0001$) +
Frisch & MacKenzie, 1991* Waco & Austin, TX	N=46 46 women; 23 chronically abused(CA), 23 formerly abused(FA) economically disadvantaged (\$10-15,000) racial mix: 78.2%= white, 15.2%= black, 6.5%= Hispanic	Compared "INS" & "OUTS"; the decision process involved in why some women leave and some stay in abusive relationships Factors helping/ hindering women in leaving the abuser Cognitive explanations: cost-benefit, Learned Helplessness, & self-efficacy theories Studied physical violence	a series of self-report measures administered in randomized order: Attitudes Toward Women Scale- Short Form (Spence, Helmreich & Stapp, 1973); Coopersmith Self-Esteem Inventory- Adult Form (1975); Internal-Powerful Other-Chance Scale- Chance Subscale (Levenson, 1979); Information Questionnaire (Frisch & MacKenzie, 1986); Dysfunctional Attitude Scale- Form A (Weissman, 1979); Social Avoidance & Distress Scale (Watson & Friend, 1969); Assertion Inventory- Discomfort Scale (Gambrill & Richey, 1975)	significant main effects for abuse history; CA vs. FA; Wilks' lambda = .222; $F(18,23) = 3.30$, $p<.01$ significant post-hoc univariate analyses: a) CAs, 1) more traditional views on women's roles; 2) lower self esteem; 3) felt more controlled by outside forces; b) CAs, 1) less likely to be employed; 2) less educated; 3) less likely to feel they had contributed to the violence; c) series of exploratory t-tests: CAs, 1) tended to agree more with others; 2) dependency; 3) inability to "make it"; 4) belief that

Table 5.1 (Continued)

				<p>"good outweighs the bad" in relationship; 5) responsible for keeping family together</p>
<p>Aguirre, 1980 Texas: Dallas, Houston, Austin, San Antonio, El Paso, San Marcos</p>	<p>N=312 312 women across 15 shelters only women married/residing with husband prior to shelter admission</p>	<p>4 Gelles-based Hypotheses: women more likely to separate from abusive husbands who: 1) make greater number of decisions during shelter stay, 2) use greater number of shelter services, 3) have more positive evaluation of shelter, 4) have abusive husbands not in counseling. 4 antecedents & 4 functional covariates: a) previous experiences with violence, b) number of injuries experienced, c) issues experienced during batterings, d) economic dependence on husband, and a) number of shelter services used, b) number of decisions made during shelter stay, c) extent to which shelters deemed</p>	<p>Survey of Residents of Family Violence Centers (SRFVC): 1) sociodemographics, 2) dimensions of the battering, 3) previous experiences with domestic violence, 4) use & evaluation of shelter services</p>	<p>Husband sole source of income- 15.7% of women intended to separate vs. 84.3% intended to remain Husband not sole source of income- 82.3% of women intended to separate vs. 17.7% intended to remain Strength of relationship between husband being sole source of income and woman's decision to separate or not is reflected in the -1.46 beta coefficient, Chi square=44.3, p=.0001</p>

Table 5.1 (Continued)

		<p>useful, d) whether batterer in counseling</p>		
<p>Gondolf,*** 1984-1985 Texas</p>	<p>N=6612 6612 women across 50 Texas shelters, over an 18 month period excluded duplicate & incomplete questionnaires, & women under 16 & those not physically abused (1/3 classified as non-residents at 5 Texas formal non-residential programs) economically disadvantaged racial mix: 57%= white, 15%= black, 29%= Hispanic</p>	<p>1) Survivor Hypothesis: A) battered women increase helpseeking (from formal and informal sources) in face of increased violence (wife abuse, child abuse and batterer's antisocial behavior), B) survivor may experience anxiety/ uncertainty over leaving the batterer like lack of options know-how and finances. As a result, the battered woman may actively attempt to change the batterer instead of leaving, C) inadequate or piecemeal helpgiving leaves the woman little alternative but to return, D) inadequacy of help sources may be attributed to a kind of Learned Helplessness experienced in community services</p>	<p>intake & exit forms 84 question interview: woman's background at intake, abuse within 3 days of intake, helpseeking at exit evaluated physical & verbal abuse, used CTS</p>	<p>Considerable active helpseeking behavior: 1) 71%= previously left home, 64%= contacted shelter or lawyer, 54%= called police at least once, 19%= took legal action against batterer 2) DFA shows: batterer in counseling (-.57), own transportation (.50), child care (.49), and own income (.31) are the most influential predictors of shelter outcome 3a) Tested Survivor Model, revised no-arrest model, & Learned Helplessness model Survivor model most adequate: goodness-of-fit = .986; adjusted goodness-of-fit = .950; y coefficient = .934; x coefficient = .998</p>

Table 5.1 (Continued)

		3) Predicted that the Survivor model would be superior to the Learned Helplessness model		<p>Additionally coefficient of determination for SEM = .729</p> <p>b) Revised no-arrest model, substitutes "batterer's response to abuse" for "batterer's antisocial behavior." Model equivalent to survivor model; AGFI=.847</p> <p>c) Learned Helplessness model, substitutes "abused as a child" for "batterer's antisocial behavior." Model would not converge; non-significant findings</p>
<p>Pagelow, *** 1976/1981* Florida & California</p>	<p>N=350 350 women; 91% shelter residents, 9% non-shelterees a range of working class - economically disadvantaged women with somewhat of an overrepresentation of the middle-class racial mix: 77.9%= white, 14.1%= black, 3.7%=</p>	<p>Tests the empirical basis of Gelles' hypotheses: 1) Less severe and less frequent the violence, the more a battered woman remains in an abusive relationship, 2) more a woman experienced physical parental violence/child abuse, the more</p>	<p>A variety of measures & data sources: 1) in-depth, audiotaped interviews, 2) unobtrusive observation, 3) participant observation in discussion groups, 4) records analysis, 5) 114-item survey questionnaire: a) Personal Data, b)</p>	<p>1) severity & frequency of violence did not influence decision to leave 2) no support for the relationship between experiencing violence in childhood & decision to leave in fact, women who</p>

Table 5.1 (Continued)

	<p>Hispanic, .9%= Oriental, 3.4%= combination of American Indian- Puerto Rican- biracial- Near Eastern immigrants</p>	<p>likely the woman will remain in the abusive relationship, 3) fewer resources and less power she has, the more likely she is to remain Hypothesis tested: the fewer the resources, the more negative the institutional response, and the more intense the traditional ideology of battered women, the more likely they are to remain in the abusive relationship and less likely to perform acts that significantly alter the situation in a positive direction</p>	<p>Data Regarding Spouse, c) Nature of Injuries, d) Community Response key variables included: a) resources, b) institutional response, c) traditional ideology, d) secondary battering cohabitation (length of time cohabiting after battering began)</p>	<p>experienced greater parental abuse were more likely to stay in relationship a shorter period of time 3) resources (education, occupation, income) DID influence decision to leave [weak negative relationship on regression analysis of extent of childhood violence & length of stay, with an R² of .015; F= 3.9; p<.05]</p>
<p>Gellen, Hoffman, Jones & Stone, † 1984* South Florida</p>	<p>N=20 10 Residential Treatment women; 10 matched, non- abused, community controls economic status: primarily middle class racial mix: 80%= white, 10%= black, 10%= Hispanic</p>	<p>Abused women will show a large number of characteristics associated with personality disorder and that the obtained MMPI personality profile would differ significantly from non-abused controls Abuse defined as marital or partner physical abuse</p>	<p>MMPI= Minnesota Multiphasic Personality Inventory administered orally</p>	<p>1) A highly significant difference (p<.005) was found on 8 of the 10 clinical scales: Hs, D, Hy, Pd, Pa, Pt, Sc, Si 2) Significant differences between proportion of abused & non-abused women noted on Hy, D & Pd scales</p>
<p>Back, Post & D'Arcy, †</p>	<p>N=116</p>	<p>Predicted that</p>	<p>MMPI scores upon</p>	<p>1) 50% of battered</p>

Table 5.1 (Continued)

<p>1975-1978 Colorado</p>	<p>116 women admitted to psychiatric hospital: 30= history of battering by partners, 62= no history of physical abuse, 24 excluded for insufficient information on relationships with men education: nonbattered women more highly educated than battered employment: few women had substantial independent incomes</p>	<p>battered women: 1) have experienced greater incidence of childhood physical abuse; 2) are likely to be disadvantaged in terms of education and financial status; 3) have greater difficulties with child rearing; 4) greater incidence of alcohol and drug abuse; 5) higher incidence of suicidal behavior; 6) higher incidence of somatic disorders</p>	<p>admission intake interview data hospital records discharge diagnoses: personality, thought & affective disorders</p>	<p>women reported history of childhood physical abuse vs. 22% of non-battered women ($\chi^2= 10.37, p<.01$) 3) 33% of battered women relinquished custody of one or more children vs. 7% of non-battered women ($\chi^2= 6.57, p<.05$) 5) 77% of battered women attempted suicide vs. 45% of non-battered women ($\chi^2= 8.12, p<.01$) [all findings are based on the non-age matched group]</p>
<p>Finn,*** 1985* Southern city</p>	<p>N=56 56 self or court/ social service referred women who sought help for marital violence through a spouse abuse program education: 24%= less than 12 years, 40%= graduated high school, 36%= had some college economic distribution: 52.6%= unemployed, 42.1%= employed, 5.3%=</p>	<p>1) based on general stress theory & theory of Learned Helplessness, battered women experience a variety of environmental and interpersonal stressors; 2) accordingly, battered women use fewer active problem-solving coping strategies than the general population; specifically battered women would be lower</p>	<p>women participating in spousal abuse programs or admitted to shelters completed intake forms on: demographics; a stress scale on common spousal abuse stressors (money, work, children, relatives, physical illness, jealousy, sexual relationship, deciding who's boss, settling arguments, & alcohol/ drug use; & the F-Copes</p>	<p>1) more than half the women reported experiencing all the stressors but physical illness 2) 4 of the hypotheses regarding differences in the use of coping strategies between battered women & the general population were confirmed: Battered Women use less Social Support</p>

Table 5.1 (Continued)

	<p>employed part time; low to lower middle socioeconomic status racial mix: 54.4%= white, 45.6%= black</p>	<p>on Acquiring social support, Reframing, Seeking spiritual support, & Mobilizing the family to acquire and accept help; and higher on Passive appraisal. Therefore, degree of stress would be positively associated with Passive Appraisal and negatively associated with the other 4 coping dimensions</p>	<p>(McCubbin, Larsen & Olson, 1982) scale = a 29 item instrument based on family stress theory (integrating family resources & meaning-perception factors): 1) Acquiring social support & family's active problem-solving methods; 2) Reframing or family's capacity to redefine stressful event to make more manageable; 3) Seeking spiritual support; 4) Mobilizing the family to acquire & accept help; 5) Passive appraisal or acceptance of problematic issues, minimizing reactivity</p>	<p>($t=8.49, p<.05$); Reframing ($t=6.91, p<.05$); Spiritual Support ($t=3.61, p<.05$); & utilized Passive Appraisal more ($t=5.68, p<.05$) Degree of stress was not significantly, positively associated with Passive Appraisal 3) Significant inverse relationship between degree of stress &: Reframing ($r= -.32, p<.01$); Mobilizing to Acquire & Accept Help ($r=-.33, p<.01$); Seeking Spiritual Support ($r=-.20, p<.08$); Passive Appraisal ($r=-.21, p<.08$); & Seeking Social Support ($r=.01, p<.46$)</p>
<p>Follingstad, Hause, Rutledge & Polek,+ 1992* South Carolina</p>	<p>N=234 234 women drawn from a variety of sources: shelters, social support groups, physicians, women's</p>	<p>1) frequency and severity of physical incidents were expected to increase over time; 2a) long term and</p>	<p>a 2 1/2 hour structural telephone or face to face interview structured format obtained objective</p>	<p>1a) a significant increase in frequency of abuse occurred over the first 5 years [ANOVA: $F(5,171)=$</p>

Table 5.1 (Continued)

	<p>prisons, emergency rooms & newspaper/ radio announcements 26%= short term abuse vs. 74%= long term abuse 89%= "OUTS" vs. 11%= "INS" racial mix: 81%= white, 17%= black, 2%= Oriental</p>	<p>"OUT" women were expected to be more likely to recognize signs of impending violence than short term and "IN" women, 2b) short term and "OUT" women more active in their responses once they recognized physical force likely to occur, 2c1) short term and "IN" women receive more positive response, 2c2) for ST and "IN" women partners more contrite, 2d1) short term and "OUT" women would threaten batterer with consequences, 2d2) ST and "OUT" women would form an action plan (leave mate or seek outside intervention); 3) short term and "OUT" women will view reason abuse stopped as function of own actions, not outside intervention; 4a) mates of long term women predicted to be more remorseful, offer</p>	<p>facts in addition to belief/ attitudinal factors content areas: demographics, relationship history & quality, specific chronological history of abuse (types, frequency, severity) modified CTS, events surrounding abuse incidents, changes over time in abuse pattern (first, second, third, typical, worst), physical & psychological symptoms, frequency of types of emotional abuse (6 categories), beliefs about abuse & physical force in relationships, beliefs about sex roles (Spence, Helmreich & Stapp's sex role inventory), beliefs about assertiveness (Rathus Assertiveness Scale)</p>	<p>4.88, $p < .0002$]; increases in abuse were established in an 18 month time period from onset of abuse and then remained relatively stable; 1b) frequency of abuse over time, as reported = 61%- increased, 15.4%- fluctuated, 14.8%- stayed the same, 8.9%- decreased; 1c) ANOVA conducted on battered women was highly significant [F(2,173)=5.58, $p < .004$], paired t-tests indicated significant increases in how many different types of force occurred from first to third [t(174)=3.46, $p < .0007$] & second to third incidents [t(174)=3.47, $p < .0007$] suggesting early increase even in number of violent types of force toward</p>
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Table 5.1 (Continued)

		<p>more promises, and express more positive aspects of relationship; 4b) mates of "IN"s predicted to be more remorseful, offer more promises, and express more positive aspects of relationship; 5) long term women expected to be more active early on but become less active as time progressed</p>		<p>battered women 2a) no significant differences in long term vs. short term women in recognizing impending violence 2b) ST vs. LT women did not differ in their level of activity; LT women showed a more active response during the third incident, once they thought force might occur [F(1,178)=3.69, p<.05]; 2d1) LT & ST women did not differ significantly in their strategies for threatening consequences after abuse incidents; 2d2) ST women were more likely to have a plan after early incidents than LT women [plan after first incident - F(11,178)=14.56, p<.0002; plan after third incident- F(11,143)=8.44, p<.004]; LT & ST</p>
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Table 5.1 (Continued)

				<p>women also differed significantly in content of plan: ST women more likely to threaten outside intervention or reciprocate violence (36.3% vs. 12.2%),</p> <p>first incident: $\chi^2 = 5.10, p < .02$; second incident: $\chi^2 = 8.59, p < .01$; third incident: $\chi^2 = 7.76, p < .02$;</p> <p>LT women more likely to threaten change in marriage (87.8% vs. 63% ST); 2d3) comparable MANOVAs on "IN" vs. "OUT" women revealed findings consistent with LT vs. ST women cited above; first incident for "IN"s vs. "OUT"s, both groups considered altering the marriage most frequently ($\chi^2 = 7.60, p < .05$)-- "OUT"s considered reciprocating violence & "IN"s considered outside intervention; third</p>
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Table 5.1 (Continued)

				<p>incident - "OUT"s thought threats would worsen situation vs. "IN"s felt they didn't know what to do ($\chi^2= 12.89, p<.005$)</p> <p>3) the vast preponderance of ST women believed abuse ended due to their own actions and sanctions on the man (73.6%)</p> <p>4a1,4a2,4a3) men's remorse, promises, and positive relationship effects were nonsignificant factors for ST vs. LT women across all three incidents</p> <p>4b) significant effect for "INS" vs. "OUTs" in second and third incidents</p> <p>[$F(3,196)= 4.25, p<.002$ & $F(3,176)= 2.96, p<.03$]</p> <p>4b1) "INs" were more likely to think men were more remorseful after second and third incidents</p> <p>4b2) trends across</p>
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Table 5.1 (Continued)

				<p>all three incidents for men to have made promises to "INs" more than "OUTs"</p> <p>4b3) positive effects were more likely to follow abuse in second and third incidents for "INs"</p> <p>[F(1,198)= 8.93, p<.003 & F(1,178)= 7.78, p<.005]</p> <p>5) Long-term consistent pattern of response: Those LT women who typically reacted more assertively or aggressively were more likely to have been active in responses to the first 3 incidents [F(4,165)= 6.10, p<.0001; F(4,160)= 8.36, p<.001; F(4,159)= 12.57, p<.0001]</p> <p>Similarly, more active early responses to the awareness that abuse likely to occur in first 3 incidents related to more active</p>
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Table 5.1 (Continued)

				<p>typical responses later in the relationship, suggesting the consistency of response</p> <p>[F(4,163)= 2.08, p<.08; F(4,157)= 4.60, p<.001; F(4,156)= 6.56, p<.0001]</p>
<p>Follingstad, Brennan, Hause, Polek & Rutledge, 1991* South Carolina</p>	<p>N=234 234 women drawn from a variety of sources: shelters, social support groups, physicians, women's prisons, emergency rooms & newspaper/ radio announcements 26%= short term abuse vs. 74%= long term abuse 89%= "OUTS" vs. 11%= "INS" racial mix: 81%= white, 17%= black, 2%= Oriental</p>	<p>more severe symptoms in battered women associated with high frequency and severity of abuse, inability to predict or control abuse, and having few social supports</p>	<p>a 2 1/2 hour structural telephone or face to face interview structured format obtained objective facts in addition to belief/ attitudinal factors content areas: demographics, relationship history & quality, specific chronological history of abuse (types, frequency, severity) modified CTS, events surrounding abuse incidents, changes over time in abuse pattern (first, second, third, typical, worst), physical & psychological symptoms, frequency</p>	<p>predictive factors differentiating women with many symptoms (MS) & women with few symptoms (FS): most severe type of force differentiated MS vs. FS women accounting for 7% of overall 23% significant regression variance. Frequency of physical abuse during first 6 months contributing 3.8% of variance associated with more psychological & physical symptoms, accounting for 3.5% of variance.</p>

Table 5.1 (Continued)

			of types of emotional abuse (6 categories), beliefs about abuse & physical force in relationships, beliefs about sex roles (Spence, Helmreich & Stapp's sex role inventory), beliefs about assertiveness (Rathus Assertiveness Scale)	Controllability, non-significant Frequency of emotional abuse non-significant Social support variables were found to be non-significant. Physical health along 5 life stages: "childhood" & "life prior to involvement" healthier than "during abuse" [t(225)= -12.79, p<.0001; t(225)= -12.88, p<.0001], & healthier than "after abuse" [t(225)= -3.60, p<.0004]. Emotional health: "childhood" healthier than all stages except "after abuse" [t(225)= -1.92, p<.05; t(225)= -3.59, p<.0004; t(225)= -21.08, p<.0001; t(225)= -.73, p= n.s.]
Follingstad, Rutledge, Berg, Hause & Polek,*** 1990* South Carolina	N=234 234 women drawn from a variety of sources: shelters, social support groups,	greater emotional abuse related to more symptoms and short term women would exhibit fewer effects	a 2 1/2 hour structural telephone or face to face interview structured format	99% of women in study experienced emotional abuse. Presence of ridicule & threats

Table 5.1 (Continued)

	<p>physicians, women's prisons, emergency rooms & newspaper/ radio announcements 26%= short term abuse vs. 74%= long term abuse 89%= "OUTS" vs. 11%= "INS" racial mix: 81%= white, 17%= black, 2%= Oriental</p>	<p>than long term women</p>	<p>obtained objective facts in addition to belief/ attitudinal factors content areas: demographics, relationship history & quality, specific chronological history of abuse (types, frequency, severity) modified CTS, events surrounding abuse incidents, changes over time in abuse pattern (first, second, third, typical, worst), physical & psychological symptoms, frequency of types of emotional abuse (6 categories), beliefs about abuse & physical force in relationships, beliefs about sex roles (Spence, Helmreich & Stapp's sex role inventory), beliefs about assertiveness (Rathus Assertiveness Scale)</p>	<p>of changing relationship were more likely to be present for women feeling that emotional abuse was worse [F(1,219)= 8.75, p<.003; F(1,219)= 15.75, p<.0001]. None of the emotional abuse types were related to the severity & frequency of physical abuse. ST women reported being more physically & emotionally healthy during abusive period than LT women</p>
<p>Launius & Lindquist, 1988* Orange County, CA</p>	<p>N=55 N=22 battered women residing in a shelter who had been living with the batterer at</p>	<p>Investigated learned helplessness, external locus of control, and passivity.</p>	<p>Written administration of questionnaire: Learned helplessness measured using two</p>	<p>1) battered women displayed poorer problem solving skills: spent less time on tasks and</p>

Table 5.1 (Continued)

	<p>least 1 year N=23 community women living in a nonabusive relationship at least 1 year Education=</p>	<p>Predicted: 1) battered women would identify fewer behavior options in problem solving tasks and show less motivation to perform on these tasks than nonbattered women 2) battered women more likely to have external locus of control than nonbattered women and that external locus of control correlates with learned helplessness and problem solving 3) battered women would be more passive than nonbattered women and that passivity correlates with learned helplessness</p>	<p>situational problem solving tasks designed for study Problem solving: 1) ability to generate behavior options and 2) motivation to perform problem solving tasks Unit of analysis equation= number of options produced in time designated for task Measured locus of control: Rotter (1966) Internal- External Scale (internal vs. external locus of control) Passivity assessed on two measures: Personal Assertion Analysis (Hedlund and Lindquist, 1984) Passivity: current behavior vs. personality traits Personal Relationship Inventory (modified from Rosenbaum and O'Leary, 1981; Curley and O'Leary, 1980) Passivity: level of assertiveness scores</p>	<p>generated fewer behavior options [battered vs. nonbattered group difference: time= F(1,44)=13.06, p<.01; options= F(1,44)=4.35, p<.05] 2) no significant group differences on external locus of control (between battered and nonbattered groups and standardization sample) (M=8.17, 7.70, 7.75) Battered and nonbattered women displayed a general internal locus of control as compared to standardized sample (M=14.83, 15.3, 8.42) 3) no significant differences on general passivity between battered and nonbattered women on PAA significant differences between battered and nonbattered women on more passivity and less</p>
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Table 5.1 (Continued)

				assertiveness on PRA [F(1,44)=33.93, p<.01; F(1,44)=11.01, p<.01]
Claerhout, Elder & Janes,*** 1982* West Virginia	N=64 30 abused women: for instrument development 34 community women: 14= battered, 20= non- battered (for battered- non battered group comparison) low income, rural all Caucasian	Problem solving strategies/ alternatives for battered women and non battered women	developed original instrument/ questionnaire (Family Problem Questionnaire)= 6 problem situations , each generating 5 open-ended responses (problem-solving alternatives) either rated as effective, ineffective (avoidant, dependent, inappropriate/ aggressive) or unscorable	Battered women generated less effective strategies/ alternatives than non-battered women (6.2 vs. 14.7: F= 19.2, p<.001) Battered women produced more avoidant & dependent responses than non-battered women: avoidant= 3.2 vs. 1.2 (x), F=4.6, p<.05 dependent= 2.8 vs. 1.3 (x), F=5.4, p<.05

* (A) unless asterisked, the date is the actual time of the study; (B) asterisk indicates date of research publication

** indicates current and former shelter resident samples

*** indicates combined shelter resident and community samples (no designation) indicates current shelter resident sample indicates combined sample of residential treatment women with nonabused controls, or a psychiatric hospital sample of battered and nonbattered women

The first step in a critical analysis of the research on either side of the learned helplessness-health psychogenesis debate required the development of a coding system to transform the qualitative information on studies into quantitative values. A four-category evaluation system was devised based on methodological criteria. The basic rule of thumb was straightforward: the use of well-accepted methodological principles in the sociological and psychological sciences.

The dimensions and corresponding coding system (assignment of numerical values) reflected what this investigator, in consultation with the recommendations of social science researchers in the family violence domain (e.g., personal communications with Willian Doherty, Ph.D., 2000; John Wideman, Ph.D., 1999; David Kantor, Ph.D., 2002) determined to represent consensus in the field regarding design adequacy. The development of a Total Design Quality Score (TDQS) involved a review and analysis of possible methods of evaluation. The decision was made to adopt a direct method of summing across dimensions. In addition, as observation of Figure 5.1 indicated, two dimensions, specifically, sample size and instrumentation, reflected sub-score values of 5 and 4, respectively. In contrast, the remaining two dimensions,

appropriate statistics and hypothesis testing, reflected sub-score values with a maximum of 3. The decision was made to differentiate sample size into a five-level rating scale because of the relationship of sample size to power, that is, small ns are typically characteristic of psychological research. Lack of adequate power in relation to sample size may, in effect, obfuscate the quality of results, contributing to a poor or inadequate test of research hypotheses. In contrast, increased power provides the potential for increased accuracy. This rationale was used to support the emphasis on sample size and the assignment of a five-point scale.

Instrumentation was divided into a four-level rating scale because of the crucial role "quality of measurement" plays in the integrity of research findings and overall outcome. The dimensions, definitions, and codes or numerical values assigned for (a) purposes of rating the research adequacy of individual shelter and community studies, and (b) the rationale for the assignment of a total design quality score per study are presented in Figure 5.1.

Although the TDQ is comprised of four sub-categories, each with a different range, the decision was made to sum across scores for several reasons. Although

scores were summed, there is an obvious implied weighting in the organization of assigned sub-categories. Sample size has the greatest number of values (a total of 5 points), suggesting it had a greater import for overall design quality. The emphasis on sample size related directly to the issue of power, and also the fact that large samples are the exception in psychology, in general, and particularly in clinical and experimental research in the study of battered women. However, most published research employs appropriate designs and statistics relative to the research hypothesis as well as instrumentation.

Sample Size, Sample Composition, Sampling Procedures, and Power

One salient set of methodological criteria related to sample size, sample composition, sampling procedures, and the important question of power. To permit quantitative analysis, the issues of sample size and power were divided into five levels. Single or multiple group studies with sample sizes of 29 or less were assigned a numerical value of 1. Single or multiple group studies with Ns of 30 to 69 were assigned a value of 2. Single or multiple group studies with group Ns of 70 to 99 were assigned a value of 3. Single or multiple group

studies with Ns of 100 to 249 were assigned a value of 4. Single or multiple group studies with sample sizes of 250 or greater were assigned a value of 5. Accordingly, as Table 5.1 depicts, in about 56% of the studies the sample sizes were relatively small (i.e., below 100 participants), with the remaining 44% of the studies reflecting larger ns of 100 or more, ranging from 116 to as large as 6,612. It should be noted that a total sample size of 18, rather than 17 (the actual number of studies in Table 5.1), was due to the fact that Claerhout, Elder, and Janes (1982) conducted a two-step study, using two separate samples. (See figure below).

Sample Size:

- 1= a single or multiple group study with Ns of 29 or less.
- 2= a single or multiple group study with Ns of 30-69.
- 3= a single or multiple group study with Ns of 70-99.
- 4= a single or multiple group study with Ns of 100-249.
- 5= a single or multiple group study with Ns of 250 and above.

Instrumentation:

- 1= used own measurement/questionnaire.
- 2= used original questionnaire and/or replicated another study's protocol, or scoring/classification system.
- 3= combined own measurement/questionnaire(s) with well established, standardized instrumentation, or used well established, standardized instrumentation, alone.
- 4= used multiple data sources (e.g., self-report, objective ratings) and a range of perspectives (subjective/objective) in conjunction with standardized instruments.

Appropriate Statistics:

- 1= qualitative findings (e.g., reported in anecdotal or narrative form).
- 2= descriptive, non-inferential statistics (percentages, etc.).
- 3= findings derived from univariate/multivariate statistical methods (i.e., tests of statistical significance, probability, and inference).

Hypothesis Testing:

- 1= general issues, no formal hypotheses stated.
- 2= post hoc analysis after data collection, or hypotheses tested were neither central nor germane to core concepts/assumptions of either theory.
- 3= clear predictions made, formal hypotheses tested, germane to the core concepts and/or assumptions of either theory.

Total design quality score (TDQS) equals the sum of the values across the four design quality dimensions. TDQS range is from 4 to 15. Low design quality equals a score of 4-7; Medium/Average design quality equals a score of 8-11; High design quality equals a score of 12-15.

Figure 5.1: Design Quality Scoring System

For purposes of evaluation (i.e., findings reported in Tables 5.1 and 6.1), sample composition was divided into three sub-areas: racial and ethnic distribution, educational background, and socioeconomic representativeness. Of the 14 studies that reported racial composition, eight (Follingstad, Brennan, Hause, Polek, & Rutledge, 1991; Follingstad, Hause, Rutledge, & Polek, 1992; Follingstad, Rutledge, Berg, Hause, & Polek, 1990; Frisch & MacKenzie, 1991; Gellen, Hoffman, Jones, & Stone, 1984; Okun, 1986; Pagelow, 1981; Schillinger, 1988) reflected a normative, racially representative distribution (approximately 80:20 Caucasian/non-Caucasian). Three studies (Finn, 1985; Gondolf, 1988b; Snyder & Scheer, 1981) approximated an evenly divided Caucasian/non-Caucasian distribution, with the three remaining studies (Claerhout, Elder, and Janes, 1982; Labell, 1979; Launius and Lindquist, 1988) representing predominantly special populations, either almost exclusively Caucasian or African American.

Only four out of the 17 studies cited in Table 5.1 reported data on educational background. Of these four studies, two (Finn, 1985; Mills, 1985) reported a broad range of educational levels, with the remaining two studies (Back, Post, & D'Arcy, 1982; Launius & Lindquist,

1988) slightly skewed in the direction of more educated women. Approximately 41% of the studies that reported economic distribution (Back, Post, & D'Arcy, 1982; Frisch & MacKenzie, 1991; Gondolf, 1988b; Labell, 1979; Launius & Lindquist, 1988; Okun, 1986; Schillinger, 1988) focused on economically disadvantaged women. Launius and Lindquist (1988) presented a special case in which the average income of their shelter sample fell between \$10,000 and \$20,000, or at a more economically disadvantaged level than their community sample with an average income of between \$20,000 and \$30,000.

The remaining studies primarily addressed the following socioeconomic statuses: low income, rural (Claerhout, Elder, & Janes, 1982); low to low-middle class (Finn, 1985); middle class (Gellen, Hoffman, Jones, & Stone, 1984); range of socioeconomic statuses with an overrepresentation of middle class (Pagelow, 1981); and a broad range of socioeconomic backgrounds (Mills, 1985). If one combines the studies involving low income, rural and low to low-middle class individuals with the seven studies involving economically disadvantaged individuals, the total percentage of economically disadvantaged samples increased to 53%. This suggested that half of the research findings reported in Table 5.1 represented

economically impoverished or disadvantaged women residing in emergency shelters.

When socioeconomic status in the community sample cited in Table 6.1 is later examined, it will be seen that a similar finding holds. The principle sampling procedures across all 17 studies involved referrals, self-selected volunteers and/or non-random consecutive shelter resident or hospital admissions. Table 5.2 presents the quantitative values assigned by dimension to each study and also provides a TDQS. These numerical ratings are described in this section and will be referred to in the following sections on the analysis of shelter sample research.

Instrumentation

The criterion of Instrumentation addressed two basic questions: Were the methods used for data gathering adequate to support the conclusions drawn? To what extent were the specific tools reliable and valid? The research reported in Table 5.1 was organized and evaluated according to a four-level rating scale. Studies that used their own measurement/questionnaire only were assigned a numerical value of 1. Studies that used their own instrument in conjunction with use/replication of another study's instrument and/or

scoring/classification system were assigned a value of 2. A numerical value of 3 was assigned to those studies that used their own measurement/questionnaire(s) with standardized instrumentation, or standardized instrumentation alone. Studies that used multiple data sources and perspectives (subjective/self-report, direct observation/objective ratings) in conjunction with well established standardized instruments were assigned a value of 4. Level Four was reserved for studies which employed a multi-method, multiple perspective approach to the research problem of wife battering, incorporating a variety of data sources and range of vantage points on the abuse/recovery process.

Almost 30% (29.4%) of the studies used their own original instruments. The majority of the studies, approximately 52.9%, used a combination of original and well established standardized measures. Only 17.6% of the studies employed an approach using multiple measures and multiple data sources. The five studies that solely used original instrumentation included Aguirre (1985), Labell (1979), Mills (1985), Schillinger (1988), and Snyder and Scheer (1981). The nine studies, which combined original and standardized instrumentation, included: Claerhout, Elder, and Janes (1982); Finn (1985); Follingstad, et al.

(1990, 1991, 1992); Frisch and MacKenzie (1991); Gellen, Hoffman, Jones, and Stone (1984); Gondolf (1988b); and Launius and Lindquist (1988). Level four was used by Back, Post, and D'Arcy (1982); Okun (1986); and Pagelow (1981).

Table 5.2: Shelter Studies:
Design Quality Ratings

Study	Sample Size	Instrumentation	Appropriate Statistics	Hypothesis Testing	Total
Labell	5	1	2	3	11
Schillinger	1	1	1	1	4
Mills	1	1	1	2	5
Snyder, Et al.	3	1	3	3	10
Okun	4	4	3	3	14
Frisch, et al.	2	3	3	3	11
Aguirre	5	1	3	3	12
Gondolf	5	3	3	3	14
Pagelow	4	4	3	3	14
Gellen, Et al.	1	3	3	3	10
Back, et al.	3	4	3	3	13
Finn	2	3	3	3	11
Follingstad, et al. (1990)	4	3	3	3	13
Follingstad, et al. (1991)	4	3	3	3	13
Follingstad, et al. (1992)	4	3	3	3	13
Launius, Et al.	2	3	3	3	11
Claerhout, Et al.	3	3	3	1	10

The primary data gathering methods used across most studies, which fell into level one or two, involved written questionnaires and/or in-depth structured/unstructured face-to-face interviews with battered women. In these studies, information was

obtained almost exclusively in shelter, hospital, or residential treatment intake or exit settings. Variables on outcome, demographics, or descriptive data on battered women (backgrounds, relationships, and violence histories), and their beliefs, attitudes, and perceptions were derived from original protocols. When original instrumentation was combined with standard measures, data sources included objective records (divorce, medical), the use of DSM-IV diagnostic categories, and/or use of other standardized measures such as Gelles' Conflict Tactics Scale (CTS) and violence indexes/scales or inventories (e.g., Attitudes Toward Women Scale - Short Form [Spence, Helmreich, and Stapp, 1973], Coopersmith Self-Esteem Inventory - Adult Form [Coopersmith, 1981]). Two studies (Back et al., 1982; Gellen et al., 1984) used the MMPI. The use of multiple data sources included unobtrusive observation or participant observation in discussion groups. Unfortunately, only one study included outcome follow-up data (Snyder and Scheer, 1981).

Design Quality and Statistical Analysis

Three criteria were applied to evaluate design quality and overall statistical analysis. These criteria reflected a three-level scoring system. Level one

included qualitative findings based on exploratory data, involving anecdotal, life-history narrative. Level two studies relied on and reported only descriptive (non-inferential) analysis. Level three studies employed univariate or multivariate methods, probability assumptions, control group comparisons, tests of statistical significance, and inference. Two studies (Schillinger, 1988; Mills, 1985) were categorized as exploratory, falling into level one. Only one study (Labell, 1979) employed descriptive statistics exclusively. The remaining 14 studies (Aguirre, 1985; Back et al., 1982; Claerhout et al., 1982; Finn, 1985; Follingstad et al., 1990, 1991, 1992; Frisch & MacKenzie, 1991; Gellen et al., 1984; Gondolf, 1988b; Launius & Lindquist, 1988; Okun, 1986; Pagelow, 1981; and Snyder & Scheer, 1981), which fell into level three, used a range of evaluation methods, including discriminate function, one-way fixed ANOVAs/MANOVAs, factor analysis, structural equation modeling, cluster analysis, and multiple regression. In effect, 82.4% of the shelter studies used inferential methods.

The data in Table 5.1 were also examined from another perspective. The studies were grouped according to their general type and research intent, that is,

subdivided into either group differences or correlational analysis. Group differences were further sub-categorized into research that examined differences between "Ins" and "Outs" (women who remained in or left abusive relationships) or normative and abused sample comparisons. Applying this framework, eight studies (Aguirre, 1985; Follingstad, et al., 1990, 1991, 1992; Frisch & MacKenzie, 1991; Gondolf, 1988; Okun, 1986; Snyder & Scheer, 1981) evaluated "In"- "Out" differences among battered women, five studies (Back, et al., 1982; Claerhout, et al., 1982; Gellen, et al., 1984; Launius & Lindquist, 1988; Okun, 1986) addressed abused-nonabused differences, and five studies employed correlational analysis (Finn, 1985; Follingstad, et al., 1990, 1991, 1992; Pagelow, 1981). Three of the 17 studies (Labell, 1979; Mills, 1985; Schillinger, 1988) were excluded from this reorganization of the data because their hypothesis testing methodology was primarily exploratory. Additionally, the total was 18 studies in this tally because four studies were counted twice. These studies either doubly addressed the group difference issue or combined group difference hypothesis testing with correlational analysis.

Corroboration

Table 5.1 summarized individual studies and described/identified major findings. Table 5.2 provided quantification (ratings) for individual studies. In Table 5.2, each study was assigned a numerical value per methodological dimension as well as a TDQS. In Figure 5.1, which defined and outlined methodological dimensions, the rationale was provided for computing the TDQS as well as a system for coding studies along a range of high, medium, and low design quality. Table 5.3 has built on these findings and also added the dimension of outcome. This table crossed levels of design quality (high, medium, low) by outcome (pro-learned helplessness, pro-health psychogenesis, "both").

Outcome was determined by applying a three-fold rule: a) if all or a majority of the findings supported learned helplessness concepts, then the study was categorized as pro-learned helplessness; b) if all or a majority of the findings supported health psychogenesis concepts, then the study was categorized as pro-health psychogenesis; and c) if an equal number of findings supported learned helplessness and health psychogenesis, then the study was categorized as falling in the outcome "both." The term "majority" was applied as follows: When

the findings within an individual study were counted or tallied to determine with which camp, learned helplessness or health psychogenesis, the preponderance of evidence rested, at least two-thirds of the research findings had to support one or the other designated outcome. Studies designated as "not directly applicable" (NDA) were eliminated from the results reported on outcome. Similarly, when findings within an individual study were determined to be "not directly applicable", these findings were not considered (counted or tallied) in evaluating (categorizing) the study's outcome (i.e., pro-learned helplessness, pro-health psychogenesis, or "both").

Follingstad et al.'s study (1992) provides an example of the application of the outcome categorization procedure. This study tested five hypotheses and reported 17 separate results. The first three results corresponding to hypothesis one dealt primarily with force, frequency, and severity of abuse. These results were designated "NDA" because they did not address concepts of learned helplessness or health psychogenesis. The remaining 14 results, across hypotheses two through five, were analyzed individually and then categorized as falling into either the learned helplessness or health

psychogenesis camp. Figures 5.2 and 5.3 outline the nine core concepts and basic assumptions of learned helplessness and health psychogenesis, respectively. Each result was assessed against these criteria. For example, result five (2b) in the Follingstad et al. (1992) study, described in Table 5.1, indicated that there was no significant difference between long-term and short-term women in their level of activity. This result was regarded as supporting a health psychogenesis view of battered women's proactive behavior. On the other hand, result nine (2d2) provided research evidence that short-term women were more likely to have a plan than long-term women after early incidents of abuse. This result supported a learned helplessness view of the battered woman's cognitive confusion or lack of intentional assertive action. In all, this study's results broke down as follows: three NDA, which were excluded from the outcome analysis, and 14 results to be considered. Of the 14 results, ten supported the health psychogenesis position; and four, the learned helplessness position. Or, 71% of the results supported health psychogenesis and 29% of the reported research findings supported learned helplessness. Thus, applying the two-thirds decision

rule, this study's outcome was coded in favor of health psychogenesis.

Stated more simply, Follingstad et al.'s study reported a total of 17 findings. Three findings (NDA) were eliminated from the outcome analysis. Of the 14 remaining research findings for outcome analysis, 10 findings supported health psychogenesis and four findings supported learned helplessness. Accordingly, this study was coded as supporting health psychogenesis. Table 5.3, which reports study outcomes, formed the basis for the following discussion and later outcome analyses in Chapter 8.

Figures 5.2 and 5.3 represent this investigators synthesis of salient concepts that are central to each theory (learned helplessness theory and the health psychogenesis theory) and also highlight major differences between them. In order to rate studies (and also because a set of core concepts for each theory were not found in the literature), it was necessary for this investigator to develop Figures 5.2 and 5.3. Figures 5.2 and 5.3 provided the basis for interrater reliability or agreement on the determination of the outcomes of individual studies. Overall, the analysis of shelter samples yielded a 94% (16 out of 17 studies) interrater

agreement between the two trained undergraduate raters. Using a third independent rater (master's level clinician) as a tie breaker, the one remaining study in question (Mills, 1985) was designated as a health psychogenesis outcome. Figures 5.1 and 5.2 provided the basis for training raters in the core concepts and assumptions of each theory.

Of the 17 studies cited in Table 5.1, two studies were categorized as "both". This left 15 studies for outcome determination. Overall, nine, or 60%, of the studies in Table 5.3 supported core concepts of the health psychogenesis theory. These studies portrayed battered women as active helpseekers (Gondolf, 1988; Labell, 1979); reality-based problem solvers whose decisions to remain with abusers involved external circumstances, including economic, occupational, and educational disadvantages (Aguirre, 1985; Gondolf, 1988; Okun, 1986; Pagelow, 1981) and psychologically competent survivors who were often the victims of "agencization" (Follingstad, et al., 1991, 1992; Mills, 1985; Schillinger, 1988). The nine studies that supported the basic assumptions underlying the health psychogenesis theory were predominantly of high design quality (6, high quality; 1, medium quality; 2, low quality).

- 1 - Battered women do not develop adequate self-protection skills in childhood, resulting in adult vulnerability to physical and sexual abuse. The theory is predicated on a developmental, genetic view of childhood susceptibility or psychological risk markers that predispose the women to the violence in the abuse dynamic.
- 2 - Battered women adhere to traditional sex role ideations.
- 3 - Battered women are poor problem solvers. They demonstrate ineffective coping strategies, cognitive impairments, and behavioral and motivational deficits.
- 4 - Battered women employ negative self-attributions. They blame themselves and/or exonerate, excuse and forgive the abuser.
- 5 - Battered women are viewed as passive, anxious, and socially isolated; women who are immobilized and unable to actively seek help for themselves.
- 6 - Battered women demonstrate low self-esteem. Their self-esteem steadily and progressively declines as the abuse continues.
- 7 - The victim and abuser are both viewed as caught up in an emotionally dysfunctional relationship; both exhibit cognitive, motivational, and psychological deficits.
- 8 - The hallmark of a woman's mental health is defined by the single outcome criteria that she leaves her abuser. Conversely, the fact that she stays is viewed as strong evidence in favor of the learned helplessness phenomena and the woman's inadequate and impaired psychological coping strategies.
- 9 - This theory proposes a social-psychological model of the abuse dynamic. It incorporates concepts of social learning theory, intermittent contingency behavioral reinforcement, and a tension building/tension reduction hypothesis. The abuse is attributed to interpersonal and intrapsychic factors of the abuser and the abuse victim.

Figure 5.2: Core Concepts and Assumptions of Learned Helplessness

- 1 - A core concept of normality or prior mental health of battered women is predicated in this theory. The timeline for the abuse dynamic does not begin in a precursor childhood but in the actual first incident when a woman is hit.
- 2 - As a group, battered women demonstrate fewer adherences to traditional sex role ideations than the norm.
- 3 - Battered women are effective problem solvers. They are cognitively realistic and devise effective behavioral, safety, and self-help plans.
- 4 - Battered women are less likely to blame themselves but instead blame the abuser. They do not believe the abusers contrition and are cognizant that the abuse will continue.
- 5 - Battered women are viewed as active help seekers in contrast to being compliant, passive, or help-resistant.
- 6 - On average, battered women show a higher sense of self-esteem and self worth than counseling controls. Their self-esteem does not portray a linear progressive self-decline, but rather is seen as curvilinear. The women's self-esteem is initially depressed by battering but when all seems hopeless, without any external stimulus for the change, a spark of innate health ignites growth in the personalities of these women. The U-shaped curve of self-esteem bottoms out and gradually battered women become stronger, accelerating their personal growth until they successfully end the violence in their lives.
- 7 - Battered women are healthy whereas the male batterer is more emotionally unhealthy, substance dependent, or pathological.
- 8 - The staying/leaving criterion is not viewed as the defining factor determining a battered woman's health or psychological dysfunction. Battered women who stay in relationships are viewed as remaining for valid and realistic reasons, not because they are helpless and psychologically impaired. They are viewed as practical, realistic, long-term planners who wisely assess the safety/danger index in the act of leaving the violent and unstable abuser.
- 9 - This theory proposes external social factors as the precipitators that create and maintain the abuse dynamic: for example, social isolation, economic dependence and disadvantage, and "agencization" or lack of appropriate responses on the part of the helping professions. This theory adopts a sociological view.

Figure 5.3: Core Concepts and Assumptions of Health
Psychogenesis

Of the 17 studies cited in Table 5.1, two studies were categorized as "both". This left 15 studies for outcome determination. Overall, nine, or 60%, of the studies in Table 5.3 supported core concepts of the health psychogenesis theory. These studies portrayed battered women as active helpseekers (Gondolf, 1988; Labell, 1979); reality-based problem solvers whose decisions to remain with abusers involved external circumstances, including economic, occupational, and educational disadvantages (Aguirre, 1985; Gondolf, 1988; Okun, 1986; Pagelow, 1981) and psychologically competent survivors who were often the victims of "agencization" (Follingstad, et al., 1991, 1992; Mills, 1985; Schillinger, 1988). The nine studies that supported the basic assumptions underlying the health psychogenesis theory were predominantly of high design quality (6, high quality; 1, medium quality; 2, low quality). In contrast, six studies, or 40%, were found to support several core concepts of learned helplessness. Back, Post, and D'Arcy's (1982) study indicated that battered women, compared to nonbattered women, reported a higher incidence of childhood physical violence, thereby supporting concepts relating to childhood vulnerability.

Table 5.3: Shelter Studies:
Design Quality by Outcome (N=17)

High

Author	Pro Learned Helplessness	Pro Health Psychogenesis	Both
Okun (1986)		X	
Frisch & MacKenzie (1991)			X
Aguirre (1985)		X	
Gondolf (1988)		X	
Pagelow (1981)		X	
Back, et al. (1982)	X		
Follingstad, et al. (1992)		X	
Follingstad, et al. (1991)		X	
Follingstad, et al. (1990)			X

Medium

Labell (1979)		X	
Snyder & Scheer (1981)	X		
Gellen, et al. (1984)	X		
Claerhout, et al. (1982)	X		
Finn (1985)	X		
Launius & Lindquist (1988)	X		

Low

Schillinger (1988)		X	
Mills (1985)		X	

similarly, battered women were found to have higher, clinically elevated MMPI personality profile scores than nonabused women (Gellen et al., 1984). Claerhout et al. (1982); Finn (1985); Launius and Lindquist (1988); and Snyder and Scheer (1981) provided findings that suggested battered women employed less effective coping strategies and perceived fewer alternatives, supporting the relationship between increased stress and decreased coping strategies characteristic of learned helplessness. The six pro-learned helplessness studies reflected a different design quality breakdown. In contrast to the six high, one medium, and two low design quality tally for the pro health-psychogenesis, only one study in the learned helplessness camp was rated as high, with the five remaining studies falling in the medium design quality category.

The remaining two studies (Follingstad, et al., 1990; Frisch & MacKenzie, 1991) were more accurately categorized as "both" because they equally supported the core concepts of each theory. Chapter 6 reports the results on research findings derived from non-random community samples following the same methods outlined in this chapter.

CHAPTER VI

Results:**Analysis of the Non-random Community Samples**

This chapter examines the research dimensions and outcomes of non-random community samples. The same set of tables and types of research criteria described in Chapter 5 were used to evaluate community study outcomes. Table 6.1 describes samples, hypotheses, instrumentation, and findings for each community study. Building on this data, Table 6.2 transformed study results and outcomes into quantitative values (ratings). Community sample studies were rated and assigned a numerical value corresponding to level of methodological adequacy per dimension (sample, instrumentation, appropriate statistics, hypothesis testing), with these ratings combined to form a Total Design Quality Score (TDQS). Table 6.3 has condensed the data further by crossing categories of design quality (high, medium, low) by outcome (pro-learned helplessness, pro-health psychogenesis, "both") across studies.

Battered Women:**Non-random Community Studies**

Of the 14 studies in Table 6.1, six samples, including Hilberman and Munson (1978), Rounsaville, (1978), Stark and Flitcraft (1981,1996), and the two studies by McLeer and Anwar (1989), were drawn from medical contexts; three samples, including two studies by Bowker (1983a) and one study by Walker (1984), represented local or national community volunteers; two samples (Cascardi & O'Leary, 1992; Rhodes, 1992) reflected domestic violence programs; two samples (Rhodes, 1992; Rounsaville, 1978) involved community mental health programs; one sample combined shelter and community volunteers (Campbell, Miller, Cardwell, & Belknap, 1994), and one sample (Launius & Jensen, 1987) involved an undergraduate university community. The total number of 15 studies reflected the fact that two studies were counted twice (Rhodes, 1992; Rounsaville, 1978) because of a split sample.

Participants were obtained through a variety of sources--newspaper or television advertisements, national woman's magazine solicitations, and social service referrals. Similar to the studies outlined in Table 5.1,

Table 6.1 also reflects non-random samples of convenience.

Sample Size, Sample Composition, Sampling Procedure, and Power

In Table 6.1, nine studies, including Campbell, et al., (1994); Kuhl, (1985); Walker (1984); two studies by McLeer and Anwar (1989); two studies by Stark and Flitcraft (1981, 1996); and two studies by Bowker (1983a), or 64%, of the studies reported sample sizes at or above 100, falling into categories four and five, with the remaining five studies (Cascardi & O'Leary, 1992; Hilberman & Munson, 1978; Launius & Jensen, 1987; Rhodes, 1992; Rounsaville, 1978), or 36%, falling into categories two and three, with sample sizes below 100. This finding indicated a somewhat greater frequency of category two samples in the community studies than the shelter studies (64% vs. 44%).

Of the twelve studies that reported racial and ethnic distribution, five of the studies (Campbell, et al., 1994; Kuhl, 1985; Rhodes, 1992; Rounsaville, 1978; Walker, 1984) were racially representative. The remaining seven studies depicted a range of special populations, including four studies that were almost exclusively Caucasian, with one study representing a

Caucasian college student sample (Launius & Jensen, 1987), and three Caucasian community samples, including two studies by Bowker (1983a) and one study by Cascardi and O'Leary (1992); two studies by McLeer and Anwar (1989) reflecting Black inner city samples; and one study (Hilberman & Munson, 1978) involving predominantly Black tenant farmers and mill families. Of interest, the shelter samples reported in Table 5.1 appeared to be more racially representative than the community samples in Table 6.1.

Table 6.1: Non-random Community Samples

Researchers/ Date/ Geographical Location	N	Hypotheses/ Issues Studied	Instrumentation	Findings
<p>Stark & Flitcraft, 1996*, New Haven, CT</p>	<p>N=481 Initial n= 520 women who sought help for medical injury at a major urban emergency room during a 1 month time period n= 481 women with complete case records</p>	<ul style="list-style-type: none"> - identifying frequency of domestic violence injuries - chronicity of abuse - discrepancy/ congruence between institutional vs. true prevalence - psychosocial & psychiatric problems of battered women: whether problems precede or are the result of domestic violence (battered-nonbattered group comparison on suicide attempts, alcohol abuse, drug abuse, psychiatric emergency service, community mental health centers, State mental hospital, psychosocial labels) 	<p>medical/ social service/ psychiatric records examined each episode of injury, classifying women as: positive, probable, suggestive, or reasonable negative</p>	<ul style="list-style-type: none"> -episode/ sample visit: physicians identified 14 positive battered women (2.8%), and Stark & Flitcraft added 72 probable and suggestive (15%) full trauma history: 9.6% positive, 15.4% probable and suggestive (+) -number of injuries/ woman: positive= 6.35, probable= 6.26, suggestive= 3.08, negative= 1.83 (+) - of 1400 injuries in the study month, 75 (5%) were identified as positive and 340 (24%) were identified as probable or suggestive for a total of 30% directly associated with abuse (+) - prior to first episode of at-risk injury, battered and nonbattered women show no differences in psychosocial profiles following reported

Table 6.1 (Continued)

				<p>episode of domestic violence, battered women's risk of suicide attempt was 8 times greater, drug abuse was 6 times greater, rate of alcohol abuse was 15 times greater, and rate of hospitalization in state mental hospitals was 14 times greater</p>
<p>Stark & Flitcraft, 1977-78 New Haven, CT</p>	<p>N=116 n= all children referred to the Hospital Dart Committee during the one year of the study (July 1977- June 1978) n= 116 mothers</p>	<p>- significance of battering in families experiencing child abuse -identity of perpetrators - whether mothers who were battered came disproportionately from problem homes -whether current dispositions responded appropriately to family situation</p>	<p>Children's Dart Committee reports and mother's medical records matched and mother classified according to trauma history and risk classification: positive, probable, suggestive, negative (see above). Complete records include medical records, family background notes & Dart Committee reports</p>	<p>battering was the typical context for child abuse, not maternal deficits: 29 women were positive (25%), 18 were probable (16%), 5 were suggestive (4%), and 58 were negative (50%) (+) -for families of battered women, father was more than 3 times more likely to be child's abuser than of nonbattered women; 50% of children of at-risk women were abused by male batterer (+) -battered mothers were less likely to have family disorganization than nonbattered women (e.g. Alcoholism= 12% vs. 19%, Violence= 17%</p>

Table 6.1 (Continued)

				<p>vs. 16%, Suicide Attempts= 10% vs. 11%, Incest= 2% vs. 6%, & Chaotic family= 23% vs. 19%</p> <p>-response of child abuse system was ineffective and at times punitive: of all children, 1/3 removed from home in which mother was battered</p>
<p>Rhodes, 1992* Pasadena, CA</p>	<p>N=92 n= 46 battered women n=46 nonbattered women without history of sexual abuse/ childhood incest drawn from community outpatient domestic violence and counseling clinic representative racial sample socioeconomic and ethnic mix of clients similar</p>	<p>Personality profiles and psychopathology in survivors of domestic violence: - expected that battered women would have a higher mean score on scale 4, Psychopathic Deviate scale, due to childhood sexual abuse - examine the implications of an elevated MMPI-Psychopathic Deviate score for battered women</p>	<p>MMPI: Psychiatric Deviate scale & Harris- Lingo's subscale & MMPI-2</p>	<p>battered women scored higher than nonbattered women on 4 of 5 Harris subscales: Harris-Lingo's battered vs. non battered group mean subscale score difference on, Pd1, Family Discord (x= 69.11, x= 57.39, p<.001); Pd2, Authority Problems (x=55.63, x=45.59, p<.001), significantly elevated but not in the clinical sense; Pd3, Social Imperturbability (x= 48.52, x= 43.98, p<.05); Pd4a, Social Alienation (x=57.93, x= 52.00, p<.01); no difference on Pd4b, Self-Alienation</p>

Table 6.1 (Continued)

				-elevated scores, group mean differences on Psychopathic Deviance raise issues of social pathology vs. psychopathology in context of battered women
Launius & Jensen, 1987*, Baton Rouge, LA	n= 57 volunteer women college students: 19 Battered, 19 Counseling, 19 . Controls white, middle class	examined the relationship of emotional distress (depression & anxiety) on problem-solving skills for battered and nonbattered using both abusive and non-abusive problem situations -predicted that battered women would generate fewer total options & fewer total effective options & select fewer effective options for use. If battered women display a general problem-solving deficit unrelated to distressed mood or cognitive deficiencies, predicted no significant group differences on depression, anxiety	Beck Depression Inventory (BDI), State-Trait Anxiety Inventory- Form Y (STAI) [Spielberger, Gorsuch, Lushene, Vagg & Jacobs], Revised Beta Examination: Beta II (Beta) [Kellogg & Morton], 6 interpersonal problem-solving situations: 3 general problem-solving situations selected from the Interpersonal Problem Assessment Technique- Adult Form (IPSAT) [Getter & Nowinski], and 3 abuse problem-solving situations selected from Claerhout, Elder & Janes	significant between group differences on BDI: Counseling group more depressed [mildly depressed: $F(2,56)=11.05, p<.01$] significant between group differences on STAI: Counseling group more anxious [State scale- $F(2,56)=5.74, p<.01$; Trait scale- $F(2,56)=6.79, p<.01$] Problem-solving Scores (Interrater reliability= .87): 2x3x6 ANOVA (problem type x group x problem) significant main effect for group on total number of options generated [$F(2,56)=5.28, p<.01$]: battered women generated significantly fewer options per problem; no significant

Table 6.1 (Continued)

		or intelligence measures		<p>main effects for problem type or individual problems. ANCOVA indicated significant between group differences on each of the dependent measures, after controlling for effects of BDI & STAI scores. Duncan's Multiple Range Test: Battered women generated fewer total options (M=16.93) than Counseling (M=19.20); Battered women generated fewer total effective options (M=6.57) than Control & Counseling (M=8.14 & 8.35, respectively); Battered women less likely to select an effective option (M=3.50, 4.38, 4.44, respectively) Problem-solving deficits statistically significant after controlling for depression and anxiety</p>
Cascardi & O'Leary, 1992*, Nassau County, NY	n= 33 women who sought therapeutic assistance from the Nassau County Coalition Against	assessed the incidence and magnitude of depressive	Self-report psychological assessment including: Modified	A- 70% of women scored greater than 14 on the BDI, with 52% of these women scoring greater

Table 6.1 (Continued)

	<p>Domestic Violence: primarily white, Catholic, married, unemployed women sample represent severely battered women (20+ episodes of battering)</p>	<p>symptomatology and poor self-esteem 1- as frequency, severity, and consequences of physical aggression increased, depressive symptomatology would increase and self-esteem would decrease predicted that self-esteem and depressive symptomatology would each contribute uniquely to the reported battering experience assessed the degree of self-blame in battered women and the association of blame attributions to the psychological characteristics assessed, length of abuse, and degree of battering 2- self-blame would be greater for attributions about beginning relationship violence vs. violence in general 3- as the length of</p>	<p>Conflict tactics Scale (MCTS) [Neidig & Friedman modified from Straus], Beck Depression Inventory (BDI), Rosenberg Self-Esteem Scale (RSE), an open-ended Injury Index, & a blame scale</p>	<p>than 20, reflecting a severe level of depressive symptomatology 1- self-esteem contributed more unique variance to battering than depressive symptomatology B- self-esteem accounted for 32% unique variance whereas depressive symptomatology accounted for 5% unique variance to physical aggression battering had its greatest influence on self-esteem 2- 12% blamed themselves for violence in general, and 18% blamed themselves for the first episode of violence 3 & 4- neither self-blame nor partner blame were significantly correlated with depressive symptomatology, self-esteem, length of abuse, or frequency and severity of physical</p>
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Table 6.1 (Continued)

		<p>abuse increased, self-blame would decrease</p> <p>4- self-blame would be positively correlated with depressive symptomatology and poor self-esteem, and that partner blame would be positively correlated with frequency and severity of violence</p>		aggression
<p>Kuhl, 1985*, WA</p>	<p>n= 115 women who sought treatment from one of 12 domestic violence programs during a six month period</p> <p>racial mix: 70%= white, 4%= black, 8%= Native American, 2%= Asian American, 3%= Hispanic, 6%= mixed heritage & 7%= unreported</p>	<p>tested for a positive relationship between severity of abuse and the following:</p> <p>1- all 33 need scores on the ACL, 2- Masculinity, 3- Femininity, 4- Abatement, 5- Intraception, 6- Nurturance, and 7- Succorance</p>	<p>2 hour interview using the Domestic Violence Assessment Form (DVAF) [Kuhl] and Gough's Adjective Check List (ACL)</p>	<p>1- high positive association found for Total Number of Adjectives Checked with pushed or shoved (.71), Number of Unfavorable Items Checked with pushed or shoved (1.00), and Succorance with slapped six plus times (.71), high negative association found for Intraception with pushed or shoved (-.72)</p> <p>2- Not supported: Abused women do not appear to have a strong masculine identification</p> <p>3- moderate positive</p>

Table 6.1 (Continued)

				<p>association between sexual abuse and Femininity</p> <p>4- no support for severity of abuse and Abatement: abused women did not seem to have a strong need to express feelings of inferiority through self-criticism, guilt or social impotence</p> <p>5- Not supported</p> <p>6- Not supported</p> <p>7- high positive association with being slapped six or more times and Succorance (.71): women who were slapped six or more times appeared to feel inadequate in coping with stress and crises and appear to need to avoid confrontation and tend to retreat into fantasy</p>
<p>McLeer & Anwar, 1976, PA</p>	<p>n= 359 women: every fourth case of female trauma from 1976 at the Medical College of Pennsylvania (MCP) primarily lower socioeconomic, Black population from inner</p>	<p>identify battered women, replication and use of Stark & Flitcraft's 4 category system: positive, probable, suggestive, negative</p>	<p>Stark & Flitcraft's methodology: 4 category classification system retrospective record review</p>	<p>positive= 5.6%, probable= 10.9%, suggestive= 9.2%</p>

Table 6.1 (Continued)

	city. Emergency department			
McLeer & Anwar, 1977, PA	n= 412 women: every fourth case of female trauma from 1977 at MCP primarily lower socioeconomic, Black population from inner city Emergency department	1- whether use of a protocol with direct questions about whether injuries were caused by battering, the percentage of battered women identified could be increased	Stark & Flitcraft's' methodology: 4 category classification system and interview protocol	positive increased from 5.6% to 30% with use of protocol relationship between age and battering: 42% of female traumas in the 18-20 age range were battered, 35% in the 21-30 age range, and 18% in the 61+ age range
Hilberman & Munson, 1977-78*, NC	n=60: 40 black & 20 white mill and tenant farm families in isolated rural areas referred by medical staff of rural health clinic for psychiatric evaluation high rate of unemployment, poverty level incomes, severe stresses of coping with basic survival needs	the role of physical abuse in symptom formation and anxiety	mothers' narrative, pediatric clinic charts and/or direct conversation or dialogue	debilitating psychological and somatic effects of chronic physical and mental abuse -over half of sample had a past psychiatric history: classic depression, manic-depression, schizophrenic, alcoholic, severely character-disordered, and hospitalized with violence and psychotic behavior
Rounsaville, 1978*, New Haven, CT	n=31: 17 from ER & 14 from the Connecticut Mental Health Center self-selected wide range of sociodemographics	comparison of evidence supporting sociological and psychological theories of wife-beating	two hour open-ended & structured interview use of Center for Epidemiological Studies Depression	Psychological findings: 1: syndrome of depressive, "learned helplessness" is a critical, paralyzing factor - CES-D report

Table 6.1 (Continued)

			<p>Scale (CES-D) (Comstock & Heising, Radloff), Social Adjustment Scale (Weissman & Bothwell), and Recent Life Events Scale (RLES) (Holmes & Rahe)</p>	<p>found 80% complained of a substantial level of depression, with 20% reporting a level comparable to hospitalized patients, and when correlated with symptom assessment, found 53% warranted a diagnosis of depression 2: alternating dependent and counter-dependent, passive-aggressive behavior Sociological findings: 1: found that only 25% had specific exposure to inter-family violence in childhood 2: presence of severe current social stress - average number of stressful events on the RLES was 3.8 with 36% experiencing 2 events or fewer, 19% experiencing 3 and 55% experiencing 4 or more in the past 6 months, this level is somewhat higher than the average of 1.69, reported by Paykel (1969), for depressed adults & .59</p>
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Table 6.1 (Continued)

				for normal controls. Found that 75% experienced some major life problem in the previous year of the abusive relationship 3: status inconsistency - found that 61% of the women in sample have superiority in either job skills or education
Campbell, Miller, Cardwell & Belknap, 1994 Midwest & Mideast	N at T2 = 114. Longitudinal study: original N = 193: 97 battered and 96 nonbattered women education: mean educational level = high school 1/3 economically poor racially/culturally heterogeneous (41% primarily African American - 59% Caucasian)	hypothesized that based on the learned helplessness theory, depression, self-esteem, self-care agency, relationship control, relationship duration, and education at T1 expected to predict whether or not women were being battered 2-3 years later	At T1 and T2 in-depth interview and standardized written questionnaire BDI (Beck, 1972): enduring vs. transitory depression Tennessee Self-Concept Scale (TCSC) (Fitts, 1972): self-esteem SCL-90 (Campbell, 1989; Derogotis, 1977): physical symptoms of stress and grief Denyes Self-Care Agency Instrument (DSCAI) (Denyes, 1990): woman's ability to take care of her own health interview included	Battered women more competent and active than predicted: childhood exposure to violence as victim or witness not predictive of continued abuse witness: $x^2 = .541, p = .46, df = 1$; victim: $x^2 = .191, p = .66, df = 1$; minimum statistics: $x^2 = .002, p = .96, df = 1$ non-significant function obtained [F(df=3,96)=1.68, $p > 1.17$]: failure of problem-solving ability, depression, low self-esteem, physical symptoms of stress, child abuse,

Table 6.1 (Continued)

			relationship control, relationship duration, and child abuse	relationship control to discriminate between those battered and not at T2 fails to support learned helplessness
Bowker, 1980-1981, Milwaukee, WI	N= 146 battered women, who had ended the violence for one year prior to interview, from newspaper and television advertisements, social service referrals range of socioeconomic and educational backgrounds 134=Caucasian, 12=non-Caucasian	Issue: personal coping strategies and characteristics of the battering relationship Hypothesized that battered women were more competent and resourceful than passive and deficient	in-depth, 2-4 hour interviews conducted in university offices, churches/libraries, or own home a- differentiating variables (e.g. childhood violence, premarital violence, characteristics of battering relationship b- marital violence (frequency, length, severity, etc.) - modified version of CTS c- help-sources (helpseeking behavior) d- coping techniques e- strategies to combat violence - most and least effective f- cessation of violence	Battered women show positive personal strategies and sound reasoning: personal strategies: somewhat effective, short run: promising and threats, positive effect on batterer slightly more than half the time; talking and avoidance only effective in one third of the cases; counterviolence only effective in one fourth of cases; hiding - rarely; passive defense - almost never

Table 6.1 (Continued)

			g- advice toward battered women	
Bowker, 1980-1981, National	N= 1000 N= 854 from non-random survey through national woman's magazine, N=146 from Milwaukee study Primarily working/ middle class; high school/ college education; more than 9 out of 10 participants were Caucasian	battered women are not passive. Instead, they are active agents in trying to make their own environment safer Length of time remaining in relationship a function of batterer's intransigence/dominance and lack of social/institutional support, not the women's passivity	mailed written questionnaire and volunteered personal case histories	personal strategies: avoidance, most frequent, (591-10+ times, 480-20+ times); counterviolence, least frequent, (199, 10+ times) informal help sources- less effective effective formal help sources: women's groups (60%), battered women's shelters (56%), lawyers (50%), social service or counseling agencies (47%) rational reasons for staying: worse violence; harmful to children; retaliation against family and friends; starvation and homelessness; shame, failure, and public disgrace; loss of social identity
Walker, 1978-1981, Rocky Mountain Region	N=403 Primarily community, some shelter and incarcerated women (N=15) Education: 12%-less than high school,	1)- early social influence can predispose a woman to learned helplessness, accounting for the cognitive,	In-depth interview schedule with the following standard measures embedded: CES-D (Radloff, 1977), Locus of Control Scale	1)- "Ins" reached higher level of fear, anxiety, and depression at T2 (second battering incident) than "Outs". However, the curves for anger, disgust, and,

Table 6.1 (Continued)

	<p>25%-high school only, 40%-some college, 23%- college and post graduate Socioeconomics: 13%- low income, 35%- working, 45%-middle class, 10%-unemployed Racial distribution: 80%-Caucasian, 20%-non-Caucasian</p>	<p>motivational, and psychological deficits observed in battered women 2)- battering follows a three phase cycle of violence: tension- building, acute battering incident (tension reduction), contrition and state of quiescence</p>	<p>(Levenson, 1972), Attitudes Toward Women Scale (Spence, Helmreich, 1972), MMPI- Harris- Lingoes subscales variables included: family of origin/current demographics, relationship history and sex role socialization, self- esteem, life events locus of control attribution, perceptions and beliefs of battering experience, psychological functioning, medical history, psycho- physiological stress responses</p>	<p>hostility rose for both "Ins" and "Outs" but the level for "Outs" is higher at T3 (last battering incident), confirming learned helplessness in the women who remained 2)- in 65% of women reporting three battering incidents, evidence of tension building phase: in 58% of women, evidence of later contrition for first incident, tension building phase is 56% and 69% for later contrition by the last incident, 71% preceded by tension building, but only 42% followed by later contrition this confirms the Cycle of Violence hypothesis, also indicating that over time tension building becomes more common as contrition declines</p>
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Table 6.2: Community Studies:
Design Quality Ratings

Study	Sample Size	Instrumen- tation	Appropriate Statistics	Hypothesis Testing	Total
Stark, et al. (1996)	5	4	2	3	14
Stark, et al. (1977)	4	4	2	3	13
Rhodes	3	3	3	3	12
Launius, et al.	2	3	3	3	11
Cascardi, et al.	2	3	3	3	11
Kuhl	4	3	3	3	13
McLeer, et al. (1977)	5	2	2	3	12
McLeer, Et al. (1976)	5	2	2	3	12
Hilberman, et al.	2	1	1	1	5
Rounsaville	2	3	2	1	8
Campbell, et al.	4	3	2	3	12
Bowker (1983a)	4	3	3	3	13
Bowker (1983b)	5	3	3	3	14
Walker	5	3	3	2	13

Only eight of the 14 studies reported on educational background. Three studies (Bowker, 1983b; Launius & Jensen, 1987; Walker, 1984) reported educational levels as high school/college, with distribution skewed toward higher percentages of college educated women; one study (Bowker, 1983a) depicted a range of educational levels; two studies (Campbell, et al., 1994; Rounsaville, 1978) described a mean education level of high school; and one study (Hilberman & Munson, 1978) focused on women of educational deprivation.

Of the 14 studies, ten reported data on socioeconomics, falling into the following categories:

two studies (Launius & Jensen, 1987; Walker, 1984) involved middle class individuals predominantly; two studies by Bowker (1983a) represented a range of socioeconomic backgrounds; one study (Bowker, 1983b) focused on working class/middle class individuals; three studies, including the two studies by McLeer and Anwar (1989) and Rounsaville (1978), involved primarily lower socioeconomic class individuals; one study (Campbell, et al., 1994) reported one-third economically disadvantaged individuals with the remaining two-thirds representing the marginal working class; and the remaining study (Hilberman & Munson, 1978) reflected impoverishment or severe economic deprivation.

The community sample studies represented a somewhat higher proportion (60%) of economically disadvantaged women in contrast to the shelter samples (53%). The sampling procedures in the studies listed in Table 6.1 reflected similar methodologies identified in Table 5.1 on shelter samples. The samples were exclusively volunteer or self-selected. The data sources ranged from social service referrals, newspaper or magazine advertisements to emergency room hospital admissions and Community Mental Health programs.

As an adjunct to Table 6.1, Table 6.2 was constructed to present the methodological ratings assigned to the studies and also provide a TDQS. These numerical ratings provided the underpinnings for the subsequent text and basis for discussion throughout the following sections.

Instrumentation

In contrast to shelter samples, the community samples reflected a 21:79 split or slightly higher representation of multidimensional, multiple data source methods of measurement and instrumentation. One study (Hilberman & Munson, 1978), coded at level one, (using original instrumentation/scoring systems) and two studies (McLeer and Anwar, 1989), coded at level two, adopted a primarily medical (data source) access route to the exploration of the impact and effects of domestic violence.

For example, in one study, McLeer and Anwar (1989) replicated Stark and Flitcraft's (1981) four-category classification system (positive, probable, suggestive, reasonable negative) to identify the incidence of abuse presenting in an emergency hospital. McLeer and Anwar obtained a 5.6% positive identification rate. However, in their following study, when McLeer and Anwar (1989)

added their own 15 minute protocol that addressed trauma history and directly asked the women if they had been physically abused, the positive identification rate rose to 30.1%.

In a third study that investigated the psychological impact of physical abuse on symptom formation using informal narratives and treatment data, Hilberman and Munson (1978) found considerable evidence of depression, anxiety, self-directed aggression (e.g., suicide attempts), and psychosomatic complaints among battered women. Paralleling McLeer and Anwar's findings, Hilberman and Munson found that 56 of the 60 women were positively identified only when they were asked directly about the abuse. This highlighted two major dilemmas in the measurement and study of physical abuse: a) the widespread problem of underidentification of abuse victims and b) the myriad ways that chronic psychosomatic complaints may present as individual problems when, in fact, they mask chronic spousal abuse.

In focus and intent, the more methodologically sophisticated level three and four studies fell into three categories, addressing three broad issues. Of the eleven (level three and four) studies cited in Table 6.1, the two Stark and Flitcraft studies (1981, 1996), (coded

at level four), represented a medical perspective on abuse identification. Their first investigation (1981) underscored the discrepancy between institutional versus interview-focused identification of prevalence rates. Their second study (1996), which will be discussed in the section, "Battered Women and Children as a Family Unit" (see Chapter 7), focused on matched samples of abused children and their abused mothers, examining the co-occurrence of child abuse and battering in the same family context.

A second group of studies focused on the abuse dynamic and personality profiles of battered women. Rhodes (1992) investigated personality profiles of battered women and found that they demonstrated elevated scores on MMPI subscales such as Family Discord, Authority Problems, Social Imperturbability, and Social Alienation. Kuhl (1985) paired domestic violence assessment with personality needs of battered women as indicated on Gough's Adjective Check List. Her research suggested that the need structure of battered women was quite different than that usually described in the literature. For example, Kuhl's research raised serious doubt about the notion sometimes put forth of the masculine, efficient, aggressive woman who, presumably,

provokes her abuse. Instead, Kuhl found that most battered women were cautious, conflict avoidant, felt inadequate in coping with stress and trauma, and (feeling dissatisfied with their current status) often retreated into fantasy.

A third group of studies directly examined constructs central to health psychogenesis and learned helplessness theories. For example, Launius and Jensen (1987) conducted a three-group comparison of college students (battered, in counseling, control) to examine predicted differences on anxiety, depression, and problem-solving strategies. Cascardi and O'Leary (1992) tested basic assumptions regarding the relationship of depression, loss of self-esteem, and self-blame attribution to the frequency, severity, and consequences of abuse.

Building on their prior research, Campbell et al. (1994) directly examined core concepts of the learned helplessness theory in a longitudinal comparison of battered and nonbattered women. Using a battery of instruments and multiple regression methods, these researchers failed to find a statistically significant relationship between the presence/absence of learned helplessness variables and battered and nonbattered

women. Walker (1984), in her application of the learned helplessness theory to the context of battered women, examined between- and within-group differences among "Ins" and "Outs," battered women who remain or leave the abusive relationship. The battered woman's decision to leave the relationship was used as her principle outcome criterion to distinguish between learned helplessness (psychological deficits) versus healthy responses to the violence.

In contrast, Bowker (1983a, 1983b), the chief proponent of the health psychogenesis theory, examined the perceptions and rationale of battered women in a different way. In one study (1983a), she interviewed only those women who remained out of the abusive relationship for one year prior to her research. In her second national, non-random, survey (1983b), she documented the reasons battered women remained in abusive relationships and the nature of their help-seeking patterns. Her findings were quite different from Walker's in that she identified practical, realistic, socially sound reasons for women remaining in abusive relationships. Further, these reasons suggested such women were active, competent problem-solvers and planners. The comparison between Walker's and Bowker's

findings and diametrically different views is discussed in detail in the discussion section on research outcome evaluation. Rounsaville (1978) offered a descriptive analysis and assessment of psychological and sociological theories, providing supportive evidence for both viewpoints and the recommendation of adopting an integrated systems view.

Design Quality and Statistical Analysis

The same three-level system for assessing methodological adequacy (design quality and appropriate statistics) was applied to the community studies cited in Table 6.1. Regarding design quality, although the shelter sample reflected a greater proportion of level three studies (14 studies: 82%), community sample studies showed a more even split between level two (six studies: 43%) and level three (seven studies: 50%). In all, levels two and three combined make up 88% of the total shelter sample and 93% of the community samples. In the community samples, only one study (Hilberman & Munson, 1978) fell into level one, primarily involving exploratory data and anecdotal histories. Five studies fell into category two, providing descriptive levels of analysis. These studies employed such methods as description/classification (McLeer & Anwar, 1989; Stark &

Flitcraft, 1981, 1996) and theory evaluation (psychological versus sociological) on the basis of a multifactorial descriptive statistic method (Campbell, 1990; Rounsaville, 1978).

The remaining eight studies reflected more complex, multifaceted designs. Community level three studies employed an array of statistical procedures including ANOVAs/ANCOVAs/MANOVAs, multiple regression, factorial analysis, scale development and item correlation, and path analysis. Out of the total eight, level three studies, three studies used correlational techniques either exclusively or in conjunction with group differences methods. For example, Kuhl (1985) investigated the degree of association between domestic abuse items and scale scores on the Gough Adjective Check List, which measures the personality needs/structures of battered women. Cascardi and O'Leary (1992) examined the intercorrelation among measures of depression, self-esteem and self-blame attribution, for severely battered women. As part of her comprehensive analysis, in addition to emphasis on group differences, Walker (1984) used correctional methods extensively for scale and instrument development as well as to measure dimensions

of learned helplessness (childhood, current relationship, etc.).

Curiously, in contrast to 13, or 72%, of the studies in Table 5.1 on shelter samples that examined group differences ("Ins" versus "Outs" or battered versus nonbattered), of the community samples reported in Table 6.1 only five, or 33%, of the studies represented group differences designs. Campbell et al. (1994), Launius and Jensen (1987), and Rhodes (1992) explored battered-nonbattered group differences. Interestingly, Campbell et al.'s (1994) research represented the only longitudinal study that examined the differences between battered and nonbattered women on salient learned helplessness constructs (e.g., self-esteem, self-care agency, relationship control). Their study failed to support the elements of learned helplessness theory that it examined.

Walker (1984) and Bowker (1983b) investigated the perceptions, beliefs, and actions that presumably distinguished "Ins" and "Outs". Although the shelter sample appeared to reflect a more frequent use of the group differences model, the two group differences studies that launched the debate and controversy between the two competing models arose from community research.

These studies are the landmark research on health psychogenesis (Bowker, 1983a, 1983b) and learned helplessness (Walker, 1984). Of note, the overall tally in design quality analysis is 15 rather than 14, the actual number of samples cited in Table 6.1: One study (Walker, 1984) was counted twice because it employed both group differences and correlational models.

Table 6.3: Community Samples:
Design Quality by Outcome (N=14)

High

Author	Pro Learned Helplessness	Pro Health Psychogenesis	Both or NDA
Stark & Flitcraft (1996)		X	
Stark & Flitcraft (1977)		X	
Rhodes (1992)		X	
McLeer & Anwar (1989)			NDA
McLeer & Anwar (1989)			NDA
Kuhl (1985)	X		
Campbell, Miller, Cardwell & Belknap (1994)		X	
Bowker 1983a		X	
Bowker 1983b		X	
Walker 1984	X		

Medium

Launius & Jensen (1987)	X		
Cascardi & O'Leary (1992)		X	
Rounsaville (1978)			BOTH

Low

Hilberman & Munson (1977-78)	X		
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Corroboration

As previously described (see the section on Corroboration in Chapter 5), Tables 6.1, 6.2, and 6.3 build logically and cumulatively from qualitative to quantitative findings. Table 6.3 formed the basis for discussion in this section on the analysis of studies and also the upcoming outcome evaluation. Table 6.3 summarized TDQS and outcome results. In this section, results reported in Table 5.3 on shelter samples and Table 6.3 on community samples are compared.

In the shelter samples, nine studies, or 60%, supported the basic concepts of the health psychogenesis theory; six studies, or 40%, supported the learned helplessness theory; and two studies were labeled "not directly applicable" because they did not directly address core assumptions or constructs of either theory; and one study was labeled "both" because it supported each theory equally. The NDA studies were excluded from the analysis of outcome. In the community sample analysis, the results were quite similar. Seven studies, or 64%, supported health psychogenesis; four studies, or 36%, supported learned helplessness; two studies were labeled "not directly applicable" because they did not address any core assumptions of either theory; and one

study was labeled "both" because it examined both theories and found equal evidence to support each theory. Studies labeled NDA or "both" were excluded from the outcome analysis. Overall, seven studies supported the health psychogenesis theory.

Stark and Flitcraft's (1981, 1996) two studies supported the psychological health of battered women: prior to the first incident of violence, battered women's psychosocial histories were normal, and symptoms only developed after battering began. Additionally, information regarding battered women's family of origin did not support learned helplessness postulates about childhood susceptibility. Rhodes's (1992) study indicated that battered women obtained elevated scores on specific MMPI subscales. However, reported evidence of elevated scores on Psychopathic Deviance suggested the phenomenon of sociological pathology rather than psychological pathology in these women's lives.

Bowker (1983a) examined the perceptions, beliefs, attitudes, problem-solving strategies and help-seeking actions of battered women both in and out of the abusive relationship. Her profile of over 1000 battered women revealed a more positive picture: they displayed well-planned coping strategies, deliberate and competent

behavior, the capacity to persevere and pursue long-term goals in favor of less effective compulsive ones, and reality based reasons for their "waiting" behavior in their efforts to find the right time to leave.

Cascardi and O'Leary's (1992) study was also rated as pro-health psychogenesis. However, this study raises an interesting dilemma and will be used to illustrate how the decision was made to consider it supportive of the health psychogenesis theory. Although the findings were mixed, the weight of the evidence pointed more to a pro-health psychogenesis viewpoint. For example, results pertaining to two of the hypotheses supported health psychogenesis. Results pertaining to another hypothesis supported learned helplessness assumptions. As predicted by the learned helplessness theory, as the frequency, severity and consequences of physical aggression increased, depressive symptomatology increased, and self-esteem decreased.

However, supporting a health psychogenesis conception, only 12% of this sample of severely battered women blamed themselves as the cause of the violence. Neither self-blame nor partner-blame attribution significantly correlated with depressive symptomatology, self-esteem, length of abuse in relationship, or

frequency and severity of physical aggression. This portrayed battered women as not necessarily believing they were culpable and in some way responsible for bringing the violence on themselves, a cornerstone of the learned helplessness constellation of symptoms. Once again, Cascardi and O'Leary's (1992) study emphasized the importance of timing, that is, of when a measure of psychological dysfunction is obtained. These severely battered women were assessed after the battering had begun. For example, a measure of depression prior to the onset of abuse was not available.

Campbell (1989) designed an initial study to test the power of the theories of depression and learned helplessness and found relatively equal evidence supporting both theories. However, she noted problems with some aspects of the learned helplessness theory. In a more extensive, longitudinal study, using a larger sample of abused and nonabused women, Campbell et al. (1994) found little support for core concepts of learned helplessness theory, such as loss of self-esteem, depression, lack of self-care agency, and relationship control. Her research failed to find a difference between abused and nonabused women on these variables.

Four studies provided evidence in favor of learned helplessness. In investigating the relation between domestic violence assessment items and personality needs, as measured by Gough's Adjective Check List, Kuhl (1985) identified personality needs that closely approximated characteristics of women experiencing learned helplessness as a function of battering. Kuhl found these women to be cautious, conflict avoidant, unable to cope with traumatic stressors and, being dissatisfied with their current status, taking refuge in fantasy. Hilberman and Munson (1978), who studied chronically abused and impoverished women, reported a wide range of psychological distress concurrent with the abuse. The psychological sequelae included depression, manic-depression, schizophrenia, character disorder, and alcoholism. This is not to suggest that the abuse "caused" the psychological disorder, but rather to state these conditions were identified along with the presence of abuse in these women's lives (i.e., comorbid factors). Walker's (1984) research supported her own post hoc analysis. A retrospective examination of data, according to Walker's analysis, confirmed the learned helplessness theory as well as the Walker Cycle of Violence theory.

The Launius and Jensen (1987) study provided another vivid example of the difficulties in parsing out the evidence among findings. Consider the following description of this study and the rationale applied in determining outcome. Launius and Jensen compared three groups (Battered, Counseling, Controls) on measures of depression, anxiety, and problem solving. Contrary to the learned helplessness theory, the Counseling group, in contrast to Battered and Controls, obtained higher scores on the Beck Depression Inventory (Beck & Beamesderfer, 1974) and on a measure of anxiety. These two findings supported core concepts of the health psychogenesis theory.

However, battered women were also found to: (a) generate fewer options, (b) identify fewer effective options, and (c) choose fewer effective options. Collectively, this data supported a fourth finding: that these problem-solving deficits remained after controlling for the effects of depression and anxiety. In all, two of the findings supported health psychogenesis, whereas four of the findings supported learned helplessness, meeting the two-thirds decision rule in favor of learned helplessness. Of interest, the possible evidence of less effective problem-solving skills was gathered after the

onset of abuse. Although this suggested that abuse may debilitate a woman's perception of problem-solving options, it did not provide clear evidence that battered women were more impaired or less effective problem-solvers prior to the abuse.

In addition, the two McLeer and Anwar (1989) studies may be aptly characterized as "not directly applicable" because, while they touched on domestic violence issues and the battered woman's experience, they did not directly test any of the hypotheses or core constructs of either theory. The remaining study (Rounsaville, 1978) was categorized as "both" because it provided approximately equal evidence for key aspects of each theory. In effect, Rounsaville's research findings appeared to support assumptions underlying both theories and argued for the integration of salient features of each to yield a systems view of the battering experience.

Collectively, Tables 5.1 and 6.1 make two points clear: (a) that the preponderance of research, to date, has focused on that subcategory of women and children who have experienced the most severe and intense violence, who seek refuge in shelters, and who filter their perceptions and assessments through these experiences; and (b) that when community samples are used, maritally

distressed women in non-violent relationships usually serve as the comparison group. Hence, the research-derived view of battered women may be restrictive and narrow. Like any other heterogeneous group or population under study, battered women reflect a broader range and subcategories of experience. It stands to reason that we cannot predicate or expect "psychological dysfunction" among all battered women based on findings primarily drawn from self-selected, shelter or volunteer community samples. As Straus and Gelles (1990) wrote:

Studies based on "clinical" samples run the risk of what has been called the "clinical fallacy" because the information may not apply to families where the wife has been assaulted but the husband was not arrested or the wife did not seek help from a shelter for battered women. These are the overwhelming majority of cases...For example, the 1985 survey found that an arrest was made in only 1% of the cases involving assaults on wives. So research based on samples from police records or clients of safe houses, [such as Dobash & Dobash (1979)], leaves out 99% of all assaulted wives. (p.4)

However, Straus and Gelles (1990) have also made the point that the development of treatment programs for battered women based on epidemiological studies run the risk of what they term the "representative sample fallacy." This fallacy perpetuates the misassumption that large generic or normatively based probability samples carry more credence. A complete picture of the plight and experience of battered women should ideally combine findings derived from clinical and representative sampling research.

Walker's (1984) and Bowker's (1983a, 1983b) central work along with the other community and shelter studies cited in Tables 5.1 and 6.1 representing offshoots and partial replications (i.e., tests of core concepts) of either theory are discussed in the next chapter.

CHAPTER VII

Results:**Domestic Violence: Childhood Witnesses and Victims,
Mothers and Children as a Developing Family
Unit, and Male Batterers**

This chapter provides the research backdrop to the analysis of outcome presented in Chapter 8. In Chapters 4 through 6, the individual studies on battered women across national probability, non-random shelter, and non-random community samples were evaluated and examined methodologically. Three additional research objectives, described and discussed in the chapter on method, remain to be addressed. The first pertained to the quality of research evidence available on children who witnessed and experienced domestic violence.

The second objective related to a review and analysis of the separate literatures on battered women and children. The intent was to determine the extent to which these literatures could be interwoven to form an integrated view that incorporated the independent findings on women and children into a family unit or systems level profile. Of interest was whether the status

of both literatures permitted an integration, and whether it was possible to formulate links joining the recoveries and phenomenological experiences of women and children, either as a treatment unit or as a methodological/transactional unit of analysis.

The third objective revolved around the reconciliation of normative versus psychopathological views of the male batterer. This involved examination of the research on male batterer personality profiles. It addressed the question: To what extent is battering a socially prevalent and, therefore, normal (i.e., statistically normative) behavior, as opposed to an indicator and manifestation of pathology and character disorder in the male batterer? The results of the review and analysis of the research findings on children, the question of the integration of the separate literatures on battered women and children, and research on male batterers are presented in this chapter.

At this point, the question may arise: Why include research on children, mothers and children as a developing unit, and the male batterer? What relevance do these data and findings have to the task of research evaluation at hand? The rationale for including children, the transforming mother-child unit, and

research on the male batterer was that all three perspectives or family subcomponents are implicated in the core assumptions of both theories. Each theory (learned helplessness and health psychogenesis) makes predictions about the male batterer and the behavior of his victims. In order to evaluate the research evidence supporting each theory, the research picture needed, in some respects, to come full circle: starting with the battered woman, her children, and the male batterer, leading us back to the two differential views of battered women at the heart of each theory.

Children:

The Effects of Witnessing and Experiencing Family Violence

Children are also physical and emotional casualties of family violence. They are drawn into the ritualized cycles of family conflict and aggression in many direct and indirect ways. When a woman is battered and she makes the crucial decision to seek help, undertaking the long legal and psychological road to freedom, her children automatically join in the journey. Children are, therefore, immersed in the crisis and abrupt transitions

of the abuse experience. The effects of witnessing abuse and accommodating to the sudden changes in family life circumstances can affect children in many ways.

Moderating Variables, Gender Effects, and the Intergenerational Transmission Hypothesis

Peled and Davis (1995) identified, reviewed, and analyzed 18 studies on the effects of child witnessing of wife battering. The findings across studies indicated that children of battered women, on average, showed significantly greater adjustment problems; higher levels of externalizing behavior problems and internalizing problems; more temperament problems; less empathy; lower self-esteem; less social competence; more anxiety; and lower verbal, cognitive, and motor skills than comparison groups of children from non-violent homes.

As Peled and Davis and others (Hansen & Harway, 1993; Straus & Gelles, 1990) have indicated, the relationship between family violence and its effects on children is multidimensional and complex, mediated by a range of additional, intervening personal and situational factors. Mediating factors that have been investigated and shown to interact with the influence of family violence included severity of the violence witnessed; accompanying child abuse; gender, age and race of the

child; maternal stress (combination of maternal health, negative life events, and family disadvantage); child rearing practices; length of time exposed to the violence; and impact of shelter residence.

These studies of moderator variables (Hansen & Harway, 1993; Peled & Davis, 1995; Straus & Gelles, 1990) have yielded several preliminary findings. Children who witnessed woman battering and who were also physically or sexually abused showed more behavior problems. In addition, the more chronic and severe the abuse, the greater was the likelihood of long-lasting and pervasive effects. The more violent the home, the more likely children were to become involved in criminal behavior and the court system. The influence of abuse was also found to be more profound when the child was younger and developmentally unequipped or less prepared, on cognitive and emotional grounds, to process and integrate the traumatic events.

Research on gender as a mediating variable has yielded mixed results and appeared to reflect interaction between the age of the child and the onset and duration of the violence (Hinchey & Gavelek, 1982; Levine, 1975; Stark & Flitcraft, 1996). However, the handful of studies, to date, has suggested a preliminary sketch or

profile. The profile appeared to follow cultural norms associated with gender-based differences in socialization, a point that, in part, has confounded the capacity to draw clear inferences from research findings.

This qualification noted, research has suggested that boys tend to act out their sadness and rage and are prone to conduct disorders. Girls are more likely to internalize their sadness and anger, showing signs of dependency and clinging behavior, anxiety, self-doubt, and fear, turning the blame on themselves. As Leeder (1994) characterized it, girls anticipate that victimization is inevitable and that they should suffer silently. Stated simply, boys externalize their anger whereas girls internalize it. However, regardless of gender, children who witness and experience family violence are trauma victims. They are more depressed and are likely to develop anxiety and/or posttraumatic stress reactions.

Preliminary research evidence has also suggested that physical and emotional abuse may affect children differentially, dependent upon developmental level. To date, only a handful of studies have examined developmental differences. Hilberman and Munson (1978) performed one of the few conjoint studies on women and

children that documented developmental differences. Pre-school and young school children typically displayed somatic complaints, school phobias, enuresis, and insomnia. Older children manifested behavior patterns differentiated around gender lines. Hilberman and Munson stated:

Aggressive disruptive behavior, most usually fighting with siblings and schoolmates and temper tantrums when frustrated, was the most frequently reported cluster for male children. In contrast, female children continued to have an increasing array of somatic symptoms and were likely to become withdrawn, passive, clinging, and anxious, this pattern also occurring in a smaller number of males. (p.463)

Interestingly, they also found that of the 209 children studied, one-third displayed somatic, psychological, and behavioral problems.

A childhood immersed in emotional combat and chronic, unrelenting physical aggression appears to compromise the child's emotional outlook and interpersonal future. In exploring the intergenerational link and relationship between childhood violence and adult violence, Gelles and Straus (1988) reported that

between 18 and 70% of children who grew up in violent homes will "recreate" that violence in their adult families. The broad range in this statistical estimation requires further clarification.

Kaufman and Zigler (1987, 1993) reviewed three sources of research data, providing evidence on the intergenerational transmission hypothesis. These data included case studies on emergency room visits, human service agency records, and self-report studies. After a careful review of research, Kaufman and Zigler (1987, 1993) concluded that the most accurate estimate within this wide range is about a 30% rate of intergenerational transmission. Although a history of childhood family violence clearly does not necessarily make a child become an adult abuser, there is a definite relationship between the experience of abuse and its future effects on the child (Egeland, 1993). Gelles (1997) made this point evident by comparing the 30% rate of intergenerational transmission for children of domestic violence to the average reported rate of abusive violence, (1-3%) for the general population. These statistics have drawn attention to the effects of modeling, early childhood experiences, and the role of the male batterer in the overall research picture on domestic violence.

Protective Factors and Resilience

What protective factors can safeguard the child from a potential future as an abuser? What factors appear to account for those resilient children, the 70% who do not go on to abuse? What positive aspects within the violent, conflict-ridden family environment protect the child? In examining factors that contributed to the resiliency of children, Garmezy (1983) identified three major categories of protective influences: dispositional attitudes of the child (e.g., ability to cope with and adjust to new situations), support within the family system (e.g., good, stable relationship with one parent), and support figures outside the family system (e.g., available resources and positive role models, such as peers and relatives).

Research on the resiliency of childhood trauma survivors has shown that the presence of a nurturing, emotionally available and responsive parent--one who is sensitive to the child's age- and stage-appropriate developmental needs, with whom the child forms a genuinely close emotional bond, and with whom the child can identify--is a crucial factor determining the well-being and predicted resilience of children who witness family abuse. Pett (1982) defined a good relationship

with one parent as a relationship characterized by the absence of severe criticism and the presence of high warmth. In most instances, the nurturant and stabilizing parent in abusive homes is the mother. Battered women have frequently reported (Hansen & Harway, 1993; Leeder, 1994) placing the safety and well-being of their children before their own welfare and personal needs. In fact, as most studies of battered women have documented, battered women have often made their decision to leave their batterers when the violence escalated and was directed toward the children (Vaselle-Augenstein & Ehrlich, 1992).

The Study of Battered Women and Children as a Family Unit

Thirteen studies were identified that involved mothers and children. The majority of these studies measured the psychological distress of battered women and children in shelter settings in the immediate aftermath of battering. The picture that emerged was one of families in crisis, a point noted in the previous sections. The main purpose of examining the literatures on women and children and/or identifying conjoint mother-child studies was to determine the extent to which an integrated transactional view of battered women and children's experience exists. The outcome of this investigation revealed a paucity of research on the

phenomenology of mothers and children as a family unit undergoing transformation.

The 13 studies identified were subdivided into four groups: (a) the psychological adjustment of mothers and children in shelter settings (Christopoulous, Cohn, Shaw, Joyce, Sullivan-Hanson, Kraft & Emery, 1987; Hughes & Barad, 1983; Hughes, Parkinson, & Vargo, 1989; Wolfe, Jaffe, Wilson, & Zak, 1985), (b) developmental impact of abuse on children (Hinchey & Gavelek, 1982; Levine, 1975; O'Keefe, 1994; Stark & Flitcraft, 1996), (c) methodological research, or the effects of different data collection methods on the quality of valid outcomes (Kruttschnitt & Dornfeld, 1992), and (d) mother-child intervention programs (Gentry & Eaddy, 1980; Holden & Ritchie, 1991; Hughes, 1982; Peled & Edleson, 1992).

This fourth category of studies that focused on intervention programs more closely approximated efforts to achieve a systems viewpoint. However, the kinds of data collected (i.e., described in the research literature) did not capture the transactional dynamics of the mother-child family system in transition (defined in Chapters 2 and 3). Typically, the data on mothers and children have been treated and reported separately.

Mothers and children emerged as separate rather than integrated units of analysis.

The studies on mother-child psychological adjustment in shelter settings and the studies on the developmental impact of abuse on children reiterated the kinds of findings noted previously in the sections on children.

Consider the psychological adjustment studies:

Christopoulos et al. (1987), who investigated 40 shelter mothers and their children, found that the children displayed a one standard deviation elevation on the internalizing and externalizing scales of the Child Behavior Checklist (CBCL) developed by Achenbach (1981). Wolfe et al.'s (1985) study of 102 abused children and 96 controls examined maternal ratings. Children of battered women obtained significantly higher scores on behavioral problems and significantly lower scores on social competence. Of the 102 children witnessing family violence, 34% of the boys and 20% of the girls fell within the clinical range, as defined by the CBCL.

A salient factor mediating the impact of family violence on the identified child was level of maternal stress (Arnold, 1990). Hughes and Barad (1983) studied self-concept, level of anxiety, and psychological problems in 65 children (ages 2-12) residing with their

mothers in a shelter. The children were rated by mothers, teachers, and staff, and were found to display a below average self-concept score for the preschool age group, more aggressive behavior in school age shelter boys than girls, and a general tendency for mothers to rate their children more negatively than other observers.

Hughes et al. (1989) used measures of anxiety, depression, and behavior problems on the CBCL to investigate the psychological impact of family violence. Mothers and children aged 4-12 comprised three groups: comparison (N=66), witness (N=44), and abused/witness (N=40). The groups were compared across self-report assessment measures. Results of the mothers' and children's ratings of anxiety, depression, and behavioral problems indicated that the abused/witness children manifested significantly more disturbance than the two comparison groups, with witnesses showing moderate levels and comparisons showing the lowest level of psychological difficulty. These findings should be tempered by two considerations: the assessments were conducted in the midst of family crisis under emergency conditions, and the majority of the data were obtained primarily from the mother, presenting a more unidirectional versus transactional view.

In examining interparental violence and the ways children are at risk, Levine (1975) found that children experiencing family violence displayed an array of symptoms, including insomnia, anxiety, tics, aggressive behavior, truancy, and enuresis. In an urban hospital setting, Stark and Flitcraft (1996) matched and identified battered women and their abused children. They concluded that child abuse and wife battering often occurred simultaneously in a family violence context. In a similar developmentally focused study, Hinchey and Gavelek (1982) compared the empathic responses of children of mothers who were abused in contrast to those of nonabused mothers. They found the abused children to be less empathic and to display incongruent and inappropriate affect.

O'Keefe (1994) investigated 185 children between the ages of seven and 13 from 120 mothers living in a shelter residence. She focused on identification of risk and protective factors. The three main protective factors that were identified included: quality of mother-child relationship, child's high level of self-esteem, and school competence. These cumulative findings paralleled the clinical observations and symptomatology described in

the sections on the psychological experience of wife battering.

Methodological research and clinical intervention studies often overlapped in objectives. Kruttschnitt and Dornfeld (1992) assessed the accuracy and corroboration between youth reports and reports of abused mothers on the Conflict Tactics Scale or CTS (Strauss & Gelles, 1990). They found that the accuracy of youth reports appeared to be primarily influenced by the salience of the event and environmental context. The attempt to explain degree of congruence between mothers' and children's perceptions provided a first step toward a systems/transactional view.

The fourth group of studies, focusing on treatment intervention, simultaneously addressed transactional issues. For example, Hughes' (1982) intervention model attempted to teach parenting skills and interrupt the transgenerational cycle of violence; Gentry and Eaddy (1980) implemented a family systems group program involving battered women, children and perpetrators; and Peled and Edleson (1992) constructed a group program that drew upon interview data from child witnesses, battered women, perpetrators and group leaders.

One other study attempted a type of systems level analysis. Holden and Ritchie (1991) examined the relationship between marital discord, parental behavior, and child behavior. Based on maternal self-report and mother-child observations of 37 battered women and 37 comparison mothers and their children (ages 2-8), the only robust self-report differences found between the two groups of mothers were the level of stress and reports of inconsistency in parenting. In addition, the expected difference between the mothers' reports of the two groups of fathers was supported: abusive fathers were perceived as more violent and irritable. In the violent family, maternal stress and paternal irritability were the two significant predictors of child behavior problems, whereas in comparison families, only maternal stress was a reliable predictor.

However, none of these 13 studies provided a phenomenological or genuinely transactional view of the mother-children unit as a newly emerging family system. It appeared that the primary method of analysis involved studying battered women and children separately. Although they were undergoing the realities of an immediately felt and shared family crisis, their perceptions, beliefs, and experiences were treated as

individual and unrelated. This certainly points to a dearth of information on battered mothers and children as an evolving system in crisis. Based on a review of the literature, it appears that the study of family violence would benefit from transactional research models, given that mothers and children often experience the battering as a system or unit.

In addition, among the national studies on family violence reported in Table 4.1, only two of the three studies (Straus, Gelles, and Steinmetz, 1980; Straus & Gelles, 1990) gathered data on child abuse as a concomitant to wife-battering. In reviewing and analyzing the shelter sample studies, with the exception of one study (Labell, 1979) that simply reported an N for shelter children or data in the form of demographic statistics, no studies provided insight or information into children's shelter experience and immediate response to family violence, upheaval, and crisis.

A similar condition held when community samples were examined. Only two studies (Hilberman & Munson, 1978; Stark & Flitcraft, 1996) included data on children. Stark and Flitcraft documented the high association between wife battering and child abuse. Hilberman and Munson mainly enumerated the symptomatology or

psychological sequelae observed in children of domestic violence. Drawing on a medical context, they identified developmentally focused symptom patterns of responses.

However, that only three of the 31 combined pool of shelter and community studies reported on children's experiences underscored the paucity of information available and the critical research need to incorporate children more fully in the research/recovery process. Therefore, not only is there a genuine lack of a systems view of family recovery, but also the information available on children, per se, is scant and superficial, primarily symptom focused, or demographic and descriptive.

A systems perspective would appear advantageous in terms of assessment, treatment, and the general conceptualization of recovery for several important reasons. Wife battering and child abuse appear to be associated and, therefore, the nature of the problem under study is interpersonal. Research has indicated that a male batterer is likely to abuse his children and his wife. Wife battering occurs in a social context, warranting a systemic view rather than a primarily individualistic focus. One might argue that, if maternal stress and child behavior problems are linked, then it

follows that mothers' and children's recovery processes are also linked, and would benefit from a joint or systemic treatment/assessment approach.

In addition, when the male batterer voluntarily leaves or is removed from the home, mother and children constitute a new, evolving unit and system in transition—a family undergoing developmental changes. A family systems perspective may more fully address developmental changes on multiple simultaneous levels: individual/personal, interactional, family, and societal. A growing body of psychotherapy outcome research, comparing the treatment efficacy of individual versus family systems (ecological) approaches to troubled families and violent, conduct disordered youth (Pinsof & Wynn, 1995; Sprenkle, 2002) has provided strong evidence for adopting a family systems intervention model as the treatment of choice for violent behavior.

Family systems or ecological approaches, which target and intervene in the family and with violent youth (e.g., substance abusers, juvenile offenders, sexual offenders), have been found to reduce recidivism, school drop-out rates, and improve family and community relationships and patterns of interactions. The rationale proposed, supported by research findings, is as

follows: If the research on factors contributing to violent behavior (etiology) supports a multidimensional model of correlates and determinants, then the intervention model most suited for effective treatment (a finding borne out via outcome research) would also be expected to be a multidimensional, systemic approach.

Men who Batter:

A Brief Research Overview to Provide Perspective:

Normality or Pathology

Chapter 3 on Methodology identified as one research objective the reconciliation of the controversy over normative versus pathology driven views of male batterers. This objective addressed fundamental aspects of the individual-system interface question, or the issue of sociological versus intrapsychic pathology.

From Normative Views to Pathology Based Theory

The common areas under investigation documenting male batterer pathology fell into several behavior/trait clusters: (a) anxiety, dependency, and relationship ambivalence; (b) control, power, and lack of verbal assertiveness skills; (c) fear of intimacy and dissociative reactions; (d) poor impulse control, rage,

hostility, paranoia, and suspicion; and (e) lack of genuine empathy and remorse. Consider the following clinically emergent, research based personality profile.

An increasing number of major research studies have identified patterns of psychological disturbance in male batterers. These studies presented a convergence of findings derived across diverse assessment and treatment methods that supported the presence of psychopathology in male batterers. Current research (e.g., Hamberger & Hastings, 1986, 1991; Murphy, Meyer, & O'Leary, 1992; Vaselle-Augenstein & Ehrlich, 1992) has raised serious doubt about prior theoretical and research based normative views of the behavior of male batterers. This view essentially held that: because the incidence of wife assault was so pervasive, the phenomenon reflected broader, more general male socialization patterns; that any man was capable of battering; and that male batterers were for the most part normal, showing evidence of minimal psychological disturbance.

Dependency, Anxiety, and Ambivalence

Research and clinical practice (Vaselle-Augenstein & Ehrlich, 1992) has suggested that male batterers appeared to be more dependent on their partners. Because dependency on a woman evoked anxiety, batterers often

reported feeling ambivalent. They appeared to wish for and simultaneously fear intimacy. This ambivalence has caused them to report vacillating between wanting and needing a close relationship and fearing the intensity of such a relationship, along with the possible loss of control. Hence, batterers, as one might expect, have also reported difficulty maintaining and negotiating personal and interpersonal boundaries.

Research has corroborated these clinical conjectures. For example, often the initial battering incident has been reported to occur around a dependency issue, evoked by events such as the honeymoon, the wife's pregnancy, and birth of the first child (Hamberger & Hastings, 1991; Okun, 1986; Vaselle-Augenstein & Ehrlich, 1992; Walker, 1984). Research has suggested that relationship events (i.e. pregnancy, birth of first child) evoke the conflicting fears of engulfment and abandonment or alienation. Pregnancy has been found to raise issues of dependency and responsibility. Parenthood signals a shift and rearrangement in interpersonal boundaries in order to include a new family member.

Dependency is a two-sided coin. Batterers not only reported fearing the threat of emotional fusion but also fearing separation. For example, the batterer's behavior

and violent outbursts (Gondolf, 1985, 1988a) were often motivated by fear of abandonment, accounting for the increased risk and threat of violence that women experienced when they leave the batterer. Rounsaville (1978) found that 71% of the battered wives he studied reported that their husbands had threatened to commit suicide if they left. As Rounsaville's research showed, even five years after the divorce or separation, many of the male batterers were still following or harassing their former spouses/partners.

Need for Control, Lack of Verbal Assertiveness

Batterers appear to need to be more in control in their intimate relationships than nonbatterers. According to research (e.g., Allen, Calsyn, Fehrenbach, & Benton, 1989; Vaselle-Augenstein & Ehrlich, 1992), the need for control is also related to problems with dependency, adequacy, and self-perception of the skills needed to negotiate an intimate relationship. For example, the batterer's assaults have often been found to coincide with or were precipitated by a perceived challenge to his authority. However, researchers have also asserted that the dynamics around control are not clear-cut. Being in control does not necessarily or directly relate to power in relation to the batterer's

behavior and personality. The relationship has appeared, on closer examination, to be more complex. Research has suggested that batterers are perhaps best understood in relation to other aspects of their personality. Hence, Vaselle-Augenstein and Ehrlich (1992) concurred with Allen et al. (1989), who argued that batterers attempt to control "not out of a need to dominate, but rather because they feel inadequate in close relationships" (p.142).

The research reviewed by Vaselle-Augenstein and Ehrlich (1992) strongly suggested that men who batter do not show a significantly greater need for power in comparison to nonbatterers, but that they are significantly less verbally assertive. Men who batter were found to be significantly less verbally assertive than either happily married or unhappily married nonbatterers. Maiuro, Cahn, and Vitaliano (1986) further examined the "verbal assertion deficit" hypothesis. These researchers administered their Assertiveness and Aggression Inventory, an instrument that provides separate scales designed to assess the ability to refuse requests and the ability to initiate requests, to a clinical sample of male batterers (N=78) and a comparison group of nonviolent men (N=29).

Interestingly, Maiuro et al. (1986) found that batterers and nonbatterers did not differ significantly on the measure of refusal assertiveness; however, batterers were found to be significantly lower on the measure of request assertiveness. In addition, significant differences in anger and hostility were also found between groups, with a positive correlation between refusal behavior and overt anger/hostility. Conversely, a negative correlation was found between initiating/request behavior and covert anger/hostility, suggesting the presence of social skill deficits in male batterers. These authors concluded that, because batterers were also found to be more hostile than nonbatterers, batterers appeared to be able to defend their rights, whereas they had difficulty with the positive expression of needs. Accordingly, growing research evidence (Gondolf, 1985, 1988a; Okun, 1986) has suggested that the batterer's excessive need for control is associated with related emotional difficulties in intimate relationships. Thus, batterers often perceive their wives' assertiveness as personally damaging to them.

Problems of Intimacy and Dissociative Reactions

Research (Hastings & Hamberger, 1986; Okun, 1986) supported the well-documented clinical observation and seeming consensus that batterers have extreme difficulties with intimacy. Batterers have often reported simultaneously feeling both emotionally isolated and extremely dependent on their wives, to whom they tacitly assign the role of emotional arbiter (Dutton & Strachan, 1987; Gondolf, 1988a; Gondolf, 1988b). It is typical to find a relationship dynamic in which the batterer perceives himself as assigned the role of "reason" and perceives his wife as assigned the role of "emotional interpreter." The batterer, who is afraid of his feelings and must keep them at a distance, dissociates from affect. For him, his wife "holds" the feeling dimension of the relationship.

Further research (Dutton & Strachan, 1987; Goldstein & Rosenbaum, 1985; Neidig, Freidman, & Collins, 1986; Rosenbaum & O'Leary, 1981), comparing batterers to nonbatterers or normative population data, showed that men who batter displayed fewer ego strengths, lower self-esteem, and inadequate verbal assertiveness skills in the context of request behavior. Using spouse-specific assertiveness scores derived from responses on the

Thematic Apperception Test in relation to need for power, Dutton and Strachan (1987) compared male batterers (N=25), maritally conflicted non-assaultive men (N=25), and satisfactorily married controls (N=25). Although male batterers did not differ significantly from maritally discordant men on need for power (both obtaining higher scores than controls), a discriminant function analysis based on assertiveness and need for power scores correctly classified both the male batterers and maritally discordant men in 90% of the cases.

In alluding to the potential underestimation of pathology in male batterers as measured on standardized instruments, such as the Minnesota Multiphasic Personality Inventory (MMPI) and the Millon Clinical Multiaxial Inventory (MCMI), Tolman and Bennett (1990) raised an important methodological point. They contended that the failure to observe elevated mean scores on these instruments may be a function of the way the data are organized and interpreted. Reinforcing Hastings and Hamberger's (1986) position, Tolman and Bennett (1990) suggested that male batterers' psychopathology was undetected because its manifestation (in clinically elevated scores) occurred on different kinds of clusters of sub-scales, "distinctions that are missed when

researchers collapse subgroups to study general group differences" (p. 88). Instead, as data in their comprehensive review indicated, results of percentages of men who showed clinically elevated sub-scale scores on these instruments (MMPI and/or MCMI) revealed consistent patterns of psychopathology with strong treatment implications.

Evidence for the dissociative features of the batterer's personality was derived from two studies. Allen et al. (1989) tested a large sample of batterers on the Fundamental Interpersonal Relations Orientation (FIRO-B), a test that assesses the need to associate with people, have control over others, and experience emotional involvement with others. Batterers were compared with normative population data reported by other investigators. The resulting test profiles suggested that batterers have difficulty expressing affection, are uncomfortable around others, are cautious about initiating and developing close relationships, and are highly selective about whom they permit to get close.

Murphy et al. (1992) found that physically abusive men displayed more autonomous and expressive personality disturbance--patterns of affective dysregulation and antisocial tendencies--than maritally distressed

nonabusive men. When compared with controls, these abusive men displayed significantly different and more aberrant personality profile patterns.

Impulse Control, Hostility, and Suspicion

Growing research evidence has qualified the relatively rudimentary clinical understanding of impulse control and suggested two different interpretations of the dynamics of impulse control among men who batter. The impulse control of men who batter was found to be selective. Batterers were not uniformly disinhibited. As research indicated (Bernard & Bernard, 1983; Sonkin, Martin, & Walker, 1985), batterers often have awakened their victims from sleep in order to beat them; aimed their blows where the injuries or bruises will not show; and stopped before they kill their victims. Batterers also have shown impulse control when they choose not to assault superiors or coworkers who frustrate or oppose them.

Clinicians (e.g., Bograd, 1984; Leeder, 1994; Hansen & Harway, 1993) have contended that these findings suggest that the batterer may store up aggression until it can be discharged safely and selectively against weaker individuals. Battered women have frequently reported that assaults or attacks occurred around

ostensibly trivial incidents (e.g., an over-cooked or late meal, a misplaced or un-ironed shirt). Research has strongly suggested that batterers may deliberately create "crises"--"mountain out of molehill" confrontations--as an intentional or unwitting means of discharging pent up aggression (Gondolf, 1985, 1988a, 1988b; Okun, 1986; Stark & Flitcraft, 1996). Whether batterers are viewed as lacking in impulse control or, paradoxically, as compulsively rigid and over-controlling, clinical observation and formal research has shown that batterers have chronic problems with anger management and aggression.

The batterer's cycles of anger and aggression in intimate relationships have also been associated with his elevated levels of hostility and suspicion. The man who batters his wife has been shown to be coercive, possessive, jealous, and suspicious. This clinical observation has been documented repeatedly (Gondolf, 1988a; Maiuro, Cahn, Vitaliano, Wagner, & Zegree, 1988; Vaselle-Augenstein & Ehrlich, 1992).

Research has suggested that as a group, batterers not only have a felt need to be more in control in their relationships than nonbatterers, but also that they demonstrate more uncontrolled behavior in their

relationships. Based on their review of research, Vaselle-Augenstein and Ehrlich (1992) concluded that batterers displayed significantly poorer impulse control, as inferred from scores on the MMPI. Based on data from the Sixteen Personality Factors Questionnaire and the Psychological Screening Inventory, Schuerger and Reigle (1988) found similar evidence for impulsivity in a sample of batterers. Using the MMPI, Vaselle-Augenstein and Ehrlich (1992) found significantly higher scores for batterers in comparison to nonbatterers on a scale (i.e., Hypomania) that measures, among other things, mood instability.

In addition to personality test score batteries, research evidence has shown that batterers often have a history of violence and aggression. For example, Carlson (1990), Rounsaville (1978), and Sonkin et al. (1985) reported that between 44%-67% of batterers who were seen in treatment programs were found to have had previous violent relationships with women or to have been arrested previously for other crimes of violence, including assaulting other men. Batterers, on average, have shown less impulse control than non-batterers. For example, Vaselle-Augenstein and Ehrlich (1992) found significantly higher scores on the Paranoia scale of the MMPI for

batterers than for non-batterers. Such scores may reflect tendencies to over-perceive threat or to misinterpret others' behaviors as suspicious or conspiratorial, and creating the potential for acting out.

Similarly, Maiuro et al. (1988) found that batterers obtained significantly higher scores (that approximated the scores of men who were generally assaultive) than non-batterers on a measure of suspicion, derived from the MMPI. Typically, the batterer's suspicions revolved around his wife's sexuality and sexual behavior. As studies of battered women have documented, batterers were often convinced that their wives were having affairs or that their wives used sex to gain an advantage. For example, Gayford found (1975, 1994) that battered women respondents reported that beatings or violent episodes frequently erupted around the batterer's attempts to extract confessions of infidelities or extramarital affairs. The batterer's tactics to counteract these suspicions typically involved attempts to isolate his wife socially and to disparage her identity, sexuality, and self-worth.

Lack of Empathy or Genuine Remorse

A controversy at the center of divided camps on the treatment of domestic violence and the understanding of the "battered woman syndrome" has revolved around views on the batterer's capacity for remorse. Clinicians have frequently spoken of the batterer's Jekyll-Hyde personality and cited it as a major factor that explained why women persist in the abusive relationship. For example, Lenore Walker (1979, 1984) theorized that it was the "Jekyll" aspects of the batterer's personality that emerged in the nonviolent, honeymoon phases of the abuse cycle that endeared the batterer to the battered woman and motivated her to stay in the relationship. According to Walker, during this honeymoon period, the batterer expressed contrition or remorse for the physical and emotional injuries he inflicted. In addition, the notion that batterers were capable of genuine remorse has typically been at the center of issues of rehabilitation and treatment.

However, research has contradicted the finding that batterers experienced true remorse. According to Vaselle-Augenstein and Ehrlich (1992), increasing research evidence has found that batterers do not feel genuine empathy for their victims. They frequently used

high levels of denial to mask and deflect responsibility, used the mechanism of projection to justify the battering and abuse, and ultimately blamed the victim. The most common observation among psychotherapists (e.g., Coleman, 1980; Gondolf, 1985) has been that batterers feel little guilt or concern other than concern generated by self-interest (e.g., possible arrest, trial, or permanent loss of and separation from spouse). Whether batterers, as a group, are capable of genuine remorse has strong implications for treatment and intervention.

Murphy, Meyer, and O'Leary (1992) found that 75% of male batterers participating in a domestic violence treatment program obtained significantly elevated scores (>85) on the aggressive/sadistic personality disorder scale of the MCMI. Further, 62% of these men had elevated scores on the antisocial personality disorder scale. They also computed measures of autonomous and expressive personality disturbance. Hastings and Hamberger (Hamberger & Hastings, 1986; Hastings & Hamberger, 1986) administered the MCMI, the Beck Depression Inventory, and the Novaco Anger Scale to batterers and non-batterers and found significant differences on most of the scales. The results indicated

greater overall pathology in the batterers, particularly in regard to comfort in intimate relationships.

After reviewing the research on men who batter, Vaselle-Augenstein and Ehrlich (1992) concluded that remorse was rarely manifested in the lives and personality dynamics of this group of men. They observed that subsequent data contradict Walker's (1979, 1984) earlier theoretical assertion that the batterer expressed authentic contrition for his behavior. Dobash and Dobash (1984) found that batterers rarely, if ever, experienced regret even after a severe attack and, if contrition was expressed, it was usually short-lived, occurring only after the first attack.

Similarly, Kelly, Berscheid, Christensen, Harvey, Huston, Levinger, et al. (1983) found that battered women were split relatively evenly in their perceptions regarding their husband's remorse over the attack. In fact, almost half of the sample did not subscribe to the conviction that the batterer was regretful or contrite at all. Hastings and Hamberger (1986) supported these observations on the basis of observed differences in test profiles between batterers and nonbatterers on the MCMI, which showed that batterers, in comparison to nonbatterers, were generally lacking in empathy.

These findings have seriously challenged the credence attached to several core concepts underlying learned helplessness as an explanatory mechanism accounting for battered women's behavior. In contrast to learned helplessness, the research has suggested the following description: Many battered women seemed aware of, and objective about, the limitations of their abusers and were not gullible in their belief of contrition or spontaneous positive change. Many women did not remain in the violent relationship due to the assumption that the batterer is all powerful and they were helpless; that he was right in his perceptions and they were wrong in their beliefs; that he was the injured party and it was "all their fault"; and that he, rather than they, defined their identity. The following provides a summary and overview of the personality and characterological deficits prevalent in male batterers' profiles.

Bernard and Bernard (1983) studied a sample of male batterers (N=46) who voluntarily sought help for their abusive behavior. These researchers examined two sources of data: clinical observations of male batterers' behaviors derived through treatment, and MMPI scores. Bernard and Bernard cited several notable findings. They observed, for example, that socially desirable sets of

characteristics of the male batterer often camouflaged deeper inadequacies. Superficial interpersonal social skills combined with appealing personal characteristics obscured underlying psychological dysfunction. Mean MMPI profile scores and clinical observations of male batterers confirmed: (a) intense feelings of inadequacy; (b) deep unmet dependency needs; (c) denial of violence; (d) projected blame; (e) affective expression of anger that shifted between patterns of passivity or explosive aggression; (f) jealousy; and (g) an inability to articulate and understand their own emotions. Based on MMPI profiles, Bernard and Bernard (1983) described the male batterer as:

A man who is angry and irritable, erratic and unpredictable, and who has problems with impulse control leading to asocial acting out. Such individuals tend to be distrustful of others, isolated, and to feel insecure and alienated. In fact, this profile may be seen as indicating a severely alienated person with a character disorder. These men maintain strong masculine identification, although they may be excessively concerned about their own masculinity or obsessed with sexual thoughts.

Mature heterosexual relationships are especially difficult for men showing this pattern of scores.... Lastly, the pattern of scores ...also suggests a proneness to abuse alcohol and/or drugs. It should be noted that while the personality description derived from analysis of the group MMPI is more detailed and elaborate than impressions gained from extensive clinical experience in working with abusers, the general themes from both sources are quite similar in indicating that the abusive male had some serious psychological problems. (p.545)

These investigators provided additional research evidence to support the consistent finding that the majority of male batterers displayed considerable pathology.

Learned helplessness views battered women and children as passive; defenseless; and cognitively, motivationally and emotionally impaired. Learned helplessness is predicated on the cycle of violence, which, in turn, presupposes a contrite abuser, and a naively forgiving battered woman. In contrast, health psychogenesis views battered women as active, ingenious, survivors and effective long-term planners. These are

women who do not believe their abusers' promises; who survive because they are realistic and practical and plan for their safety, often delaying leaving until they have a well thought out plan. Obviously, to weigh the strength of findings on either side requires consideration of research data on the male batterer. The substantive findings presented in this chapter create a foundation for the results of the analysis of outcome presented in Chapter 8.

CHAPTER VIII

Results:**Outcome Evaluation: Learned Helplessness versus
Health Psychogenesis**

In this chapter, the emphasis focuses on overall outcome. Table 8.1 was designed to integrate findings across shelter and community samples. The data were reported in a different way: level of design quality by design outcome. This provided the basis for quantitative evaluation of the research evidence on both sides of the learned helplessness-health psychogenesis debate. Based on findings derived from this analysis of outcome, recommendations for future research and treatment are offered.

Learned Helplessness versus Health Psychogenesis:**Research Evaluation****Research Plan**

The analysis and evaluation of research findings supporting learned helplessness and health psychogenesis

proceeded along nine steps. These steps are summarized below.

1. At the single study level, the literature on shelter and community samples was surveyed and studies were identified.

2. Studies were reviewed and salient study characteristics and major research findings were summarized (by this investigator) and were reported (described) in Tables 5.1 and 6.1.

3. In addition, because children and the male batterer are also implicated in the abuse dynamic (family violence literature) and are central to a number of core concepts/assumptions of both theories (learned helplessness and health psychogenesis), the research data on children and male batterers was examined. The research on children was reviewed and analyzed to ascertain whether the separate literatures on women and children permitted an integration of their experiences into a joint recovery process (systems level view). Similarly, research on the male batterer was examined, specifically in relation to the individual-systems interface question. The results are reported in the sections on children and male batterers.

4. Individual studies on battered women were then evaluated (rated) by this investigator along a range of methodological criteria. A four-category method of evaluation was devised to quantify methodological adequacy. Each study was evaluated along four dimensions and assigned a numerical value in each of these areas: (a) sample size, sampling procedures, and power; (b) instrumentation; (c) statistical analysis; and (d) hypothesis testing. These results were reported in Tables 5.2 and 6.2.

5. Each study was also assigned an overall rating or Total Design Quality Score (TDQS). This rating represented the sum of the four numerical values assigned to each study across the four dimensions cited above (sample, instrumentation, statistical analysis, and hypothesis testing). The results of these analyses were reported in Tables 5.2 and 6.2, respectively, and described in the sections on shelter and community samples.

6. The studies were also analyzed along a four-category outcome dimension. Outcome was determined on the basis of the majority of the study's findings. Each study's findings were identified and rated separately as falling into the category of pro-health psychogenesis,

pro-learned helplessness, both, or not directly applicable. A tally was then made to determine in what camp the majority of a study's evidence (research findings) fell; a two-thirds decision rule was applied. When a finding in a study was not directly applicable ("NDA"), it was excluded from the outcome analysis. Similarly, when an entire study showed no direct relationship to a test of core concepts of either theory, it was also eliminated from the overall analysis. Accordingly, study outcomes were assigned to one of four categories: pro-health psychogenesis, pro-learned helplessness, both or equally supporting each theory, or not directly applicable (NDA). The results of these outcome ratings were discussed in the previous sections on shelter and community samples.

7. To safeguard against investigator bias, three raters were trained by this investigator for the purpose of the analysis of outcome. Raters were trained in the core concepts and assumptions of learned helplessness and health psychogenesis. (Two raters, Rene Collins and Jennifer Kisselica, were undergraduate students in psychology at the University of Rhode Island. The third rater, Rosana Thornton, a master's level mental health clinician, served as the tie breaker.) The two

undergraduate students independently assessed and rated individual study findings; tallied the count of findings per study; and determined whether each study fell within the pro-learned helplessness, pro-health psychogenesis, both, or not directly applicable outcome categories. Inter-rater reliability was considerably high (94% agreement, shelter studies; 91% agreement, community studies). When the two independent raters did not agree, the judgment of a third independent rater was used to break the tie.

8. A single outcome measure did not appear to be sufficient, and thus the decision was made to qualify each study's outcome rating by the study's overall level of design quality (high, medium, low). Therefore, a study's outcome was considered more significant as design quality increased. Tables 5.3 and 6.3 (in Chapters 5 and 6) organized studies by level of design quality and outcome, or by which theory the research supported.

9. Next, outcome findings were integrated across shelter and community samples. Table 8.1, which appears later in this chapter, combined shelter and community sample findings (i.e., shelter and community study outcomes), crossing level of design quality by type of outcome. Therefore, the measure of the evidence on both

sides of the learned helplessness-health psychogenesis debate, involved the dual consideration of methodological adequacy and substantive outcome. This research approach (type of outcome by level of design quality) served as the primary basis of evaluation, or as a way of examining the research evidence on both sides of the learned helplessness-health psychogenesis debate.

Overview of the Principles and Core Concepts of Learned Helplessness

In an attempt to explain the battered woman's behavior, Lenore Walker (1979, 1984) proposed the "battered women syndrome." Although Walker rejected the notion of a victim-prone personality that predisposed the battered woman to violence, she did purport to identify characteristics of the battered woman in relation to the abuse experience. These characteristics encompassed socialization, gender, and psychological factors. Walker's theoretical orientation strongly emphasized a developmental, psychological perspective revolving around coping skill deficits. She combined historical development or childhood experiences with current relationship dynamics.

Walker's theory incorporated three main premises:

(a) battered women did not develop adequate self-protection skills in childhood, resulting in adult vulnerability to physical and sexual abuse; (b) social learning theories of modeling and aggression accounted for how personality patterns developed in both the abused and the abuser; and (c) battered women developed coping deficits in response to violence (Walker & Browne, 1985). Walker's "battered woman syndrome" has evolved within the clinical community as a diagnostic label associated primarily with psychological deficits and impairments.

In this clinical-research context, the battered woman has been typically portrayed as dependent and traditional in sex role adherence; having an unrealistically restricted perception of personal control, life choices, and alternatives; and having impaired cognitive skills, poor coping strategies, and low self-esteem. She has been depicted as a woman who is passive, indecisive, anxious, ambivalent, and socially isolated. According to Walker, these characteristics were more a result of the abuse than its antecedents. However, reviews of the literature on wife-assault theory, research, and treatment, by Hotaling and Sugarman (1986) and Russell, Lipov, Phillips, and White (1989)

failed to substantiate consistent findings across studies that battered women demonstrated significantly impaired cognitive functioning, traditional sex role adherence, or lack of assertiveness.

Although Lenore Walker claimed not to subscribe to a pathology-driven conception of the battered woman, her professed "social-psychological" perspective appeared to be predominately psychological. She emphasized the role of psychological risk markers, or what she referred to as the battered woman's "susceptibility to violence" in the abuse dynamic. Her research (Walker 1979, 1984) attributed this susceptibility factor to a range of experiences. These included: early and repeated sexual molestation and assault, a history of substantial family of origin violence, perceptions of critical or uncontrollable events in childhood, rigid sex role socialization and stereotypes, and other conditions in the battered woman's life that placed her at greater risk for depression. Walker (1979, 1984) extrapolated Seligman's (1975) research on depression and learned helplessness to explain the "battered woman syndrome." She proposed that battered women behaved the way they did because, like Seligman's trapped laboratory dogs and Abramson, Seligman, and Teasdale's (1978) cognitively

depressed adults, these women developed, through intermittent reinforcement, characteristics of learned helplessness.

To test her hypothesis, Lenore Walker divided her research sample into subgroups: women who had left the battering relationship and women who remained in the relationship. She asked both groups, in interview format, to describe their reactions to four separate battering incidents (the first, the second, the last, and, "one of the worst"). Battered women's responses were summarized across all four incidents and averaged by subgroups; subgroups were then compared. The summary measures across incidents by subgroup provided an overview measure of the development and progression of the battering relationship.

Walker theorized that if a woman's "last" battering incident coincided with the end of the battering relationship, then this subgroup of women would exhibit the following pattern: These women, over time, would become less fearful, anxious, and depressed; show more anger, disgust, and hostility toward the abuse; and display increased help seeking behaviors. A contrasting pattern should emerge for the women still in abusive relationships. The reactions of these women to the

"last" battering incident would show higher levels of learned helplessness. For Lenore Walker (1984), the "battered woman syndrome," rooted in the notion of learned helplessness, reflected cognitive, motivational, and behavioral components.

Examination of the research results of women's emotional reactions to battering incidents over time appeared to support Walker's (1984) aforementioned theoretical assertion: Although feelings of anger, disgust, and hostility rose for both groups of women, for the women who managed to escape the battering relationship, the levels were higher, especially at the time of the "last" battering incident. The group who left the battering relationship differed from those women still in the abusive situation in the following way: These women reached a high point of fear, anxiety, and depression; then became less fearful, anxious, and depressed as their anger, disgust, and hostility toward the abuse rose and as their "resigned acceptance" decreased.

Acknowledging the influence and interaction of gender in conjunction with personal history as a precipitating factor in "abuse vulnerability," Walker and Browne (1985) added to the data that supported the

consensus that no particular personality pattern or trait leads to a person becoming a victim. Interestingly, a core concept of Walker's application of the learned helplessness theory to battered women, was predicated on a genetic view of childhood susceptibility. In the learned helplessness theory, women were viewed as vulnerable and, therefore, easy prey to their abusers.

Although the timeline for the onset of learned helplessness behavior, symptoms, and characteristics was designated, according to Walker's application, as beginning at the first abuse incident, her analysis of the progression and proclivity toward learned helplessness was described as often beginning in the woman's early childhood. The core concepts and basic assumptions of the learned helplessness theory were summarized in Chapter 5 (Figure 5.2).

Overview of Principles and Core Concepts of Health

Psychogenesis

Despite the popularity of Walker's views, no substantive or consistent body of research has yet emerged that confirms a victim-prone personality in relation to battered women. Instead, research has shown that battered women consider and try a broad range of solutions to resolve their relationship problems and stop

the abuse. Studies have indicated that battered women employ considerably more effective problem solving strategies than comparison groups of women in conflicted/distressed but man-battering relationships (Campbell, 1989); actively seek help in contrast to being compliant, passive, or help-resistant (Gondolf, 1988b); and show higher self-esteem than controls, a greater sense of self-worth, and less adherence to traditional sex role ideations (Hotaling & Sugarman, 1986). This research evidence contradicted the view that battered women displayed low self-esteem, denied or avoided help seeking behavior, were passive, and conformed more typically to traditional sex roles.

According to Bowker's (1983a, 1993) research, the reasons women stayed in abusive relationships (i.e., did not leave immediately but waited for the appropriate time to leave) involve realistic considerations. She identified six primary reasons. One was fear of retaliation, or that unsuccessful attempts to leave would escalate the severity and intensity of the violence. A second involved concern over harm to children, including threatened loss of legal custody. Third, these women feared retaliation against their support network, such as physical injury and harassment of close friends and

family. A fourth reason pertained the threat of starvation and homelessness exemplified by the harsh, economic realities that battered women and children faced when they were forced to leave their homes. A fifth consideration revolved around the shame, failure, and public scorn experienced when the "dirty little secret" of the violence and abuse was out in the open. A sixth reason involved the perceived loss of social identity when the battered woman forfeited all that was familiar to her, including her social status and role in the community. Bowker's research (1983a,1992)described the battered woman's experience as more active and rational than the concepts of learned helplessness and the "battered woman syndrome" would lead one to believe.

In contrast to Walker, Bowker (1983a) took a different research tack in the understanding of abused women's behavior. First, she investigated only those women who had successfully broken free from the abuse, interviewing them one year after they had terminated the battering relationship. In addition, she conducted a large, non-random national survey of battered women in various stages of the abusive relationship. She gathered extensive information on their abuse histories,

characteristics of the violent relationship, advice to other battered women, and their reasons or thought processes for remaining in the relationship. Her data presented jarring contradictions to a learned helplessness view. The core concepts and basic assumptions of the health psychogenesis theory were summarized in Chapter 5 (Figure 5.3).

Similar to other researchers (e.g., Gondolf, 1988b; Stark & Flitcraft, 1996) who fell into the sociological camp, Bowker raised strong reality based issues and rational explanations for battered women's behavior. Emphasizing women's competence and strength instead of their vulnerability and victimization, Bowker posed the obvious mental health question: "Otherwise, how could we explain the fact that so many previously battered women are now living free of the violence?" (p. 157). She continued:

Part of the solution to this mystery is that the decline of self-esteem suffered by battered women is not linear, but curvilinear. That is to say, the women's self-esteem is initially depressed by battering, and it falls lower and lower as the battering continues. Then, when all seems hopeless, a spark of innate health

ignites growth in the personalities of the victims. I call this reemergence of health psychogenesis, because it is often hard to find any external stimulus for this change. The U-shaped curve of self-esteem bottoms out and the battered women begin to become stronger, at first tentatively and then accelerating their personal growth until they succeed in ending the violence in their lives. (p. 157)

A core concept of normality differentiated health psychogenesis from the learned helplessness theory. For Bowker and socially-minded theorists, the timeline for the abuse dynamic did not begin in a precursor childhood but in the actual first incident when a woman was hit.

A number of studies have corroborated the prior mental health, well-being, and normalcy of battered women. They also have yielded negative evidence regarding self-blame and a cognitively deficient state. In this research light, battered women emerged as "heroes" and survivors who made informed decisions that, at first glance, appeared counter-intuitive to a non-abused social culture; but, on closer examination, made sound, practical sense.

Outcome Evaluation:

Learned Helplessness versus Health Psychogenesis

The main objective of this dissertation was to systematically evaluate the strength of the research evidence on both sides of the learned helplessness-health psychogenesis controversy and debate. The research procedure involved a two-step process: research analysis on the shelter and community sample level, followed by an overall evaluation of the shelter-community sample outcomes by design quality. The goal was to shift from the evaluation of design quality and outcome at the level of individual studies to a broader level of assessment.

In Chapter 3 on Methodology predictive outcomes were identified for classifying a study's findings: a pro-learned helplessness position, a pro-health psychogenesis position, and a modified pro-learned helplessness/pro-health psychogenesis position. In a pro-learned helplessness outcome, the majority of data would be found to support the learned helplessness theory, concepts, and assumptions: that the behavior of battered women reflected cognitive, motivational, and affective distortions. In a pro-health psychogenesis outcome, the

majority of data would be found to support the health psychogenesis theory, concepts, and assumptions: that the behavior of battered women reflected effective problem-solving skills, accurate perceptions, and adequate positive motivation. Battered women were psychologically healthy, proactive, competent, and emotionally strong. In a modified pro-learned helplessness/pro-health psychogenesis outcome, study results would be found to equally support aspects of both theories. Furthermore, outcomes found to equally support both theories, or aspects of each theory, might suggest reconsideration of both theories, or the importance of heterogeneity: that different women displayed contrasting characteristics, that is, battered women either displayed learned helplessness and the "battered woman syndrome," symptom-free, healthy responses, or a combination of both.

Tables 5.2 and 6.2 summarized the results of the individual design quality ratings per dimension per study. These tables also presented a total design quality score (TDQS) for each study. The tables were organized by sample type: Table 5.2 represented shelter samples and Table 6.2 depicted community samples. This provided the first step in the analysis: a numerical value of design quality that reflected high, medium, or

low methodological adequacy. In addition, each study was evaluated in terms of outcome: or which theory it generally supported.

Therefore, in the first step of this analysis, a study was classified into one of four categories: pro-learned helplessness, pro-health psychogenesis, "both" in which data equally supported learned helplessness and health psychogenesis, or as "not directly applicable" (NDA). NDA studies focused on general issues of abuse and battering (e.g., prevalence, demographics) but did not directly test core assumptions or related hypotheses of either theory.

Outcomes were analyzed in relation to design quality (TDQS). Thus, both the type of outcome and level of design quality were considered. Tables 5.3 and 6.3 organized studies into high, medium, or low design quality and reported their outcome: whether they supported learned helplessness, health psychogenesis, both theories equally, or were not directly applicable. Table 5.3 represented outcomes on shelter samples and Table 6.3 represented outcomes on community samples.

To provide an additional and somewhat different perspective on the data, Table 8.1 combined shelter and community samples across 29 studies. This 3 x 3 table

crossed level of design quality (high, medium, low) by outcome (pro-learned helplessness, pro-health psychogenesis, or both. (Studies designated "NDA" were dropped from this second step of the analysis, given the lack of relevance and applicability to the research questions.) In essence, studies that fell within the category of "both" reflected the modified pro-learned helplessness/pro-health psychogenesis outcome predicted in this research.

Results

As Table 5.3 on shelter samples indicated, in the high design category, three, or 10.3%, of the studies supported learned helplessness, twelve, or 41.3%, of the studies, supported health psychogenesis and one, or 3.4% of the studies supported both learned helplessness and health psychogenesis. At the medium or average design quality level, six, or 20.6%, of the studies supported learned helplessness and two studies, or 6.8%, supported health psychogenesis, and two studies, or 6.8%, supported both theories. In the low design category, one, or 3.4% of the studies supported learned helplessness and two, or 6.8%, supported health psychogenesis concepts.

Table 8.1: Combined Shelter/Community

Outcomes (N=29)

		Outcome		
		Pro-Learned Helplessness	Pro-Health Psychogenesis	Both
Design Quality	High	3	12	1
	Medium	6	2	2
	Low	1	2	0

As Table 6.3 on community samples indicated, two, or 14.2%, of the studies of high design quality supported learned helplessness and six, or 42.8%, of the studies supported health psychogenesis. One study, or 7.1%, of medium or average design quality supported learned helplessness; one study, or 7.1%, supported health psychogenesis; and one study, or 7.1%, supported both. One, or 7.1%, of the studies designated as low design

quality supported learned helplessness, with no studies falling into this category for health psychogenesis or both. Two studies, or 14.4%, were designated as not directly applicable. Overall, seven out of 14 studies or 50% supported health psychogenesis; 4 or 28.5% supported learned helplessness.

Table 8.1 combined results across shelter and community samples. This table further indicated that a greater proportion of evidence favored health psychogenesis. In the high design quality level, three, or 10.3%, of the studies supported learned helplessness; 12, or 41.3%, of the studies supported health psychogenesis; and one, or 3.4%, supported both theories. Of the medium design quality studies, six, or 20.6%, favored learned helplessness; two, or 6.8%, favored health psychogenesis; and two, or 6.8%, supported both. Of the low design quality studies, one, or 3.4%, supported learned helplessness and two, or 6.8%, supported health psychogenesis. Tallying across levels of design quality, ten (34.4%) of the studies supported learned helplessness; 16 (55.1%) supported health psychogenesis; and three (10.3%) supported both.

In sum, the majority of research (particularly that of high design quality) favored health psychogenesis

theory, and its basic concepts and assumptions. These concepts and assumptions included: (a) prior to the onset of abuse, battered women approximated the normal population and not victim-prone personality profiles; they appeared healthy and normal and without serious psychological difficulties; (b) in contrast to the concept of passivity and motivational deficits, battered women demonstrated efficacious, help-seeking behaviors to extricate themselves from the abuse; (c) battered women used practical, rational approaches to coping with the abuser; and (d) leaving the batterer was not always synonymous with the healthiest emotional or physical response a battered woman can make or was not the sine qua non of emotional and physical well-being. Other, more effective, problem solving criteria, such as safety and long-term planning typically took precedence over the single, superficial outcome criteria: "Has the woman left the abusive relationship?"

The issue and research topic of family violence is a complicated and perplexing dilemma. The analysis and interpretation of findings on battered women were found to be affected by ancillary factors, including research findings on the children of battered women and male batterers. To examine the research findings on both sides

of the learned helplessness-health psychogenesis debate required an analysis of the children and male batterers involved. The extant separate research on children and male batterers suggested the following: (a) children who witnessed or experienced family violence were at risk for psychological distress that was a function of the child's developmental level, temperament, severity, and chronicity of the abuse; (b) the effect of the abuse on the developing child was mediated by protective factors, including the quality of the mother-child relationship, the availability of other nurturing adults, and access to community, school, and other interpersonal resources; (c) and that the outcome for children of abuse was mixed. Although there was clearly elevated risk, there was also the genuine potential for resilience. In effect, analysis of the research indicated that the intergenerational transmission of family violence was not inevitable or a cause-effect given. Research also suggested (d) that in contrast to the normative view of battered women's prior mental health and present coping strategies, male batterers showed strong evidence of serious personality/character disorders and psychopathology.

It was also observed that, to date, there is very little research evidence of a systems perspective on the mother-children relationship minus the male batterer. Although the importance of accrued data on a systems perspective has been underscored in the treatment, research, and theoretical literature (Bograd, 1984; Hansen & Harway, 1993; Gondolf, 1988a; Pinsof & Wynn, 1995; Sprenkle, 2002), very little research on the ways battered women and children interact, develop, cope, and change as a family unit after the abuse has ended is available. This lack of a systems perspective may, in part, be a reflection of the practical, methodological, and treatment complexities inherent in research on the social problem of domestic violence.

Discussion and Recommendations

Although the majority of the research evidence in this investigation appeared to support the pro-health psychogenesis theory, the difference between the percentage of evidence that supported health psychogenesis versus learned helplessness was modest (16 studies, or 55%; 10 studies, or 34%). It may be argued that a theory that appears to be validated (correct)

approximately fifty percent of the time (health psychogenesis) or approximately one third of the time (learned helplessness) does not reflect a strong or well-articulated theory. One would expect that a theory's predictions would, at least, be greater than chance.

In addition, it may also be argued (a) that this investigation's chosen method of analysis (i.e., examination of the status of each theory's research database) reflected one of a range of alternative approaches (e.g., meta-analysis may have been another option) and (b) that the "sample" of studies selected (upon which this study's results are based) represented one possible "sampling" of the data. Both the chosen method and pool of studies (identified for analysis) pose limitations, and introduce qualifications regarding interpretation of findings.

Another limitation of this research involves the potential influence/confound of investigator bias. Although independent raters were used, the initial data (study findings) which formed the basis for the independent ratings, were identified (organized) by this investigator. However, the process of identifying findings and study characteristics was relatively straight-forward and required minimal influence. These

limitations noted, the following discussion of findings and general issues of family violence research are offered.

Considered in total, research bearing on learned helplessness-health psychogenesis debate would appear inconclusive, inconsistent, or perhaps contradictory, raising more questions than providing answers. Perhaps the research accrued, to date, may be characterized as inchoate, reflective of a field and set of theories in developmental infancy. Based on this study's findings (evaluation of research evidence), it would not seem as if one theory was superior to another, but rather that it might be advantageous, in addition to conducting more research on each theory's position, to adopt an integrative view, or aspects of both theories.

A number of studies analyzed in this research appeared to support both theories, providing evidence for a mixed as opposed to clear-cut view of the current status and scientific understanding of the battered woman's experience. The issues raised by findings derived from studies, falling in the outcome category of "Both", highlighted the problems and complexities characteristic of an investigation of the psychological phenomenon and sociological problem of wife battering.

Rounsaville's research (1978) will be used to illustrate this point. Although his study was conducted in the late 1970's, it continues to underscore a number of conceptual dilemmas that persist today. Rounsaville examined a self-selected, demographically representative community sample of battered women. Using a two hour protocol that combined structured interview and standardized instruments to assess depression, social adjustment, and the occurrence/impact of recent life events, he compared evidence that supported a predominantly sociological (i.e., health-psychogenesis) and psychological (i.e., learned helplessness) perspective on battered women.

Similar to experiments with the Necker cube, Rounsaville's research suggested that two precepts or paradigms of the battered woman were possible. Both "cubes," or theories of different orientations, can effectively coexist. Instead of being forced to accept one interpretation over another (one theory as superior to another or the only valid theory), clinicians and researchers can perhaps choose to combine theories or, more exactly, devise an integrative theory that purports and accommodates a heterogeneous model and

multidimensional assessment perspective on battered women. From assessment and diagnosis, treatment plans flow, carrying strong, practical implications for the lives of battered women and children.

For example, Rounsaville found that a significant proportion (80%) of the sample reported a substantial level of depression with 20% reporting a level of depressive symptoms comparable to those of hospitalized patients. He also observed alternating dependence and passive-aggressive behaviors. He found that the majority of women in his sample tolerated significantly high levels of abuse, using mechanisms such as denial and minimization. Women left abusive relationships only when the physical abuse and associated emotional stress became severe. He concluded that practical factors alone did not account for the battered woman's behavior, i.e. inability to leave the abusive relationship. These findings supported components of learned helplessness theory.

However, he also found evidence that contradicted a childhood history of violence or a "vulnerability" factor in battered women. The majority of the sample reported no exposure to intrafamilial violence in childhood. Additionally, in contrast to the view that battered women

were attracted to and remained with male batterers because of psychological deficits, dependency and low self-esteem, Rounsaville noted that the preponderance of sampled women became involved with the abuser for largely economic reasons (e.g., need for support) or as a result of an unexpected life event (e.g., leaving parental home, death of parent, job loss, physical illness). These findings supported a normalizing profile of the battered women and sociocultural factors as major contributors to the battered woman's experience and dilemma. Rounsaville advocated a "systems" perspective (here, defined in its broadest sense, not as synonymous with a family therapy model). He wrote: "The evidence supports all of the social and psychological explanations offered... This supports the need for a 'systems analysis' approach to the problem, viewing family violence as the final, common pathway of multiple determinants" (p. 11).

Rounsaville's work encapsulated the problems facing researchers in the family violence arena. These complexities have been noted in the studies analyzed in this research and also have been highlighted in the literature. Several general dilemmas become prominent when one surveys the landscape of battered women and domestic violence. There is the problem of point of entry

or access into the data: What does the researcher select when studying the battered woman's experience and what effects does this have on outcome findings? Obviously, assessing women immediately after they have left the abusive experience and are in crisis (e.g., shelter residents) is qualitatively different than women interviewed a year or two after leaving the relationship (whose lives have stabilized). The psychological distress/depression as well as the cognitive, motivational, and behavioral deficits observed in battered women may be situational and transitory. Or, some proportion of this heterogeneous group may never report symptoms severe enough to require treatment.

There is also the issue of what constitutes a successful outcome or index of mental health. Some studies have simply examined the differences between "In's" and "Out's", equating mental health with women who leave the male batterer and psychological dysfunction with women who remain for a period of time in the relationship. Perhaps a more finely gradated approach might be more useful, in which researchers choose other outcome criteria: Does the battered woman have a plan? Where is she in her one-to-seven on average attempts to leave? Is she staying for valid practical reasons?

Research consensus (Gelles, 1997; Leeder, 1994; Straus, Gelles, & Steinmetz, 1990; Straus & Gelles, 1980) has suggested that a battered woman is at greatest risk to her physical safety when she does leave the abuser. Therefore, it may be argued that, in contrast, a battered woman's decision not to leave impulsively (without a safe plan in place) may be a more accurate index of problem solving. It may prove more informative for future research to devise multidimensional outcome criteria and to more closely examine the underlying cognitive, motivational, and emotional processes informing the battered woman's complex survival behaviors.

In light of the above observations, several limitations of the methodological approach used in this research should be addressed. Although efforts were made to survey the extant research literature and identify relevant studies, this investigation worked within practical time constraints and, therefore, does not claim to represent an exhaustive search. The studies that were examined comprised studies regarded as major studies in the family violence/battered woman field. Another qualification related to the choice of method of evaluation. One alternative approach which may have been equally applicable (e.g., an alternative method) may have

been the use of meta-analysis. Meta-analysis uses quantitative techniques (e.g., effect size as a common metric) to examine cumulative results across diverse scientific studies in relation to specific research questions (Shadish & Baldwin, 2002).

However, the field of family violence, in the context of wife battering and the learned helplessness-health psychogenesis debate, presented an extremely small data pool (less than 35 studies). Meta-analytical methods typically were designed for comparisons among large numbers of diverse studies. In addition, the purpose of this research (and the clinical and research questions posed) involved a close examination/evaluation of research findings on a qualitative level, followed by quantitative analysis. The main objectives were to: (a) examine the sample (shelter and community) research on an individual study level (individual study findings); (b) rate studies on design quality and outcome (which theory the research findings supported); and (c) assess the overall (combined shelter-community) evidence on both sides of the learned helplessness-health psychogenesis controversy.

One other limitation of this research pertained to the method of obtaining ratings. Individual study

findings were identified by this investigator; this list of findings per study provided the initial data pool for interrater reliability. Three raters (two undergraduate students in psychology and one graduate level mental health clinician, serving as a tie breaker) were trained (by this investigator) in the core concepts and assumptions of each theory and asked to independently rate the findings as providing evidence for learned helplessness, health psychogenesis, or equally supporting both theories. This may present a possible confound. However, interrater reliability was found to be high (92%, shelter sample; 94%, community sample). Additionally, the identification and listing of findings was relatively straightforward and, therefore, less susceptible to investigator bias.

Based on the above discussion, the following recommendations are proposed:

1. In the context of clinical practice with battered women, learned helplessness has almost, at times, functioned at the level of an assumptive given. Learned helplessness and the battered woman syndrome, concepts well known in popular culture, have also been widely embraced by the clinical community. However, in light of the preliminary evidence obtained in this investigation,

it would seem advantageous to rethink these concepts: i.e., consider both theoretical orientations in devising assessment/treatment protocols.

2. Adopt an integrated meta-theoretical perspective that draws the on aspects of both learned helplessness and health psychogenesis.

3. Based on this meta-theoretical approach, develop a multi-dimensional decision branching tree of outcome, assessment, diagnosis, and treatment in clinical work and research on battered women and children. View battered women and children as a heterogeneous rather than homogeneous population with a wide range of social-service needs.

4. Based on the paucity of research that addresses mothers and children as a newly evolving family unit, design research that simultaneously studies and combines data on both mother's and children's experiences. Create a transactional view of their family experience and recovery.

5. Conduct further research on children, per se, that is developmentally-focused and gender-specific.

6. Paralleling the recommendation for transactional research on the mother-child family unit, create educational treatment programs that unite and integrate

personal narratives and different perspectives of mothers and children as survivors of abuse.

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