A COMPARISON OF DEPRESSED AND NONDEPRESSED MALE PERPETRATORS OF PARTNER VIOLENCE

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Thesis submitted to the faculty of the Virginia Polytechnic Institute and State University in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

In

Human Development

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June, 2000
Blacksburg, Virginia

Key Words: Depression, Male batterers, Physical violence, Psychological violence

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(ABSTRACT)

This study compares two groups of self-referred and court ordered male batterers: those who are depressed (n = 39), and those who are not depressed (n = 61). These two groups are compared along the following variables: alcohol use, anger, anxiety, beliefs about wife beating, jealousy, marital satisfaction, couple differentiation, psychological violence, and physical violence.

Results indicate that the depressed male batterers differ significantly from the nondepressed male batterers. Depressed batterers had higher levels of anger, more anxiety, lower levels of marital satisfaction, were more physically violent toward their partner, and were more psychologically violent toward their partner. The depressed and nondepressed male batterers did not differ significantly on level of jealousy, couple differentiation, or their beliefs about the justification of wife beating. These results have implications for further understanding and treatment of depressed male batterers.

To my family: Mom, Dad, Barb, Chris, John, and Catie who have taught me in so many different ways that hard work reaps endless rewards, and most importantly life is much easier when laughter is involved. Thank you for your unconditional love and support.

To my advisor and friend, Sandi Stith, and my supervisors and pals Eric, Karen, Jean, and Ed you have given me the opportunity and most importantly a place to grow into someone that I am truly proud of. Thank you.

ACKNOWLEDGEMENTS

I want to thank the faculty for allowing me to use data from the NIMH grant, doing so has enabled me to take a personal question and idea and turn it into something quite remarkable.

I have been given so many gifts from the people involved in this program. To my advisor, Sandi Stith, thank you very much for your constant encouragement, your enthusiasm throughout this project (sometimes more then my own), and for keeping me on my toes, it makes this all worthwhile. I will be forever grateful for your unconditional belief in my ability as a person, a student, a clinician, and even a researcher.

To the rest of my committee members and friends: Karen, Eric, and Jean. Each one of you has etched a special place in my heart and my soul. Karen, you don't know this but all throughout this process I've been thinking, what would Karen find in here that I missed? Your genius for detail and constant strive for perfection, coupled with gentle words and a contagious smile has pushed me to be my best as a student and a clinician. Thank you for giving me the space to figure things out for myself and excel in my own time. Eric, thank you for lending me your statistical know-how during this thesis process, I think I would have pulled my hair out if you didn't lend a hand. On a more personal note, (yuck, I know) thank you for noticing my need for one on one supervision, and offering your time to me. I am truly indebted to you for your guidance, giving me the space and challenging me relentlessly to believe and trust in myself, while all the while making me laugh. Jean, your interest in depression was the catalyst in my thinking about this topic, thank you for your passion and intensity in helping me pursue this. I will always remember your famous words, "follow your gut". I am thankful that you believed in my "gut", way before I did. You saw something that I now am able to see in myself. Thank you for believing in me.

To my friends who have each played a different role in providing me with perspective, support, and love: Each of you has played a part in keeping my head above water during this process and throughout the entire program. To all who have encouraged me along the way, thank you for the laughter, laughter, and more laughter: Aaron Dodini, Bill Giles, Amy Gribble, Ed Hendrickson, Jim Jones, Shelby Lake, Lisa Locke, Elise Long, Kirsten Lundeberg, Jenny Matheson, Cindy Mathis, Kim Middleton, Erin Morgan, Christa Moscovis, Eleni Paris, Carrie Penn, Susan Pinto, Kristi Ross, Wendy Snyder, David Ward, Mike Ward, and all my classmates.

I want to especially thank those of you have kept me going this past year: Deanna Linville, you are one of a kind, thank you for being you each and every day, your honesty, your advice, and your incredible support and love keeps me smiling. Michelle Ward, you are my touchstone, I love you for all you've shared with me, car talks, good food, a warm home, a new baby, and endless laughter. Laurie Howell, my dance partner, thanks for glances my way that say just the right thing, a common appreciation of solitude and silence, and an abundance of support. Your faces will stay with me for a lifetime.

And finally to my family: my dad, David Lundberg, for believing in me, being my rock, and reminding me that some day my hard work will pay off, its coming soon! To my stepmother, Barbara Lundberg, thank you for the relationship that we have come to find, and for offering your help to me throughout this thesis writing process I truly appreciate it. To my brother's John and Chris Lundberg, and my sister, Catie Lundberg, thanks for the jokes, the smiles and the love each of you has provided to me in different ways, I am proud to be your big sis as well as your friend. To my mother, Brenda Fuson, for constantly reminding me of what I am, what I can be, and giving me the confidence in knowing that any way I turn out, you will always be there. Thank you all for sharing this incredible experience with me.

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CHAPTER ONE – INTRODUCTION

Statement of the Problem

The issue of domestic violence is gaining recognition as one of the most serious domestic problems in the United States. Two to four million women are battered each year (American Bar Association, 1995). More then one in six households has been the scene of a domestic fight where one spouse hits another (O'Leary, 1999). According to Jones (as cited in Beasley & Stoltenberg 1992) domestic violence is considered to be the single largest cause of injury to women, with an average of four women being killed each day by men who batter. Other researchers estimate that half of all people in the United States, male and female, at some point in their marriages will experience at least one act of physical aggression from their spouses (O'Leary & Curley, 1986; Steinmetz, 1980).

Along with the physical injury resulting from abuse, many victims of abuse experience debilitating psychological abuse. Walker produced a descriptive analysis of domestic violence using self-referred women from New Jersey, New Brunswick, Denver, and England. In her book, The Battered Women she talks about most women describing incidents involving psychological humiliation and verbal harassment as their worst battering experiences, whether or not they have been physically abused (Walker 1979). Psychological abuse, like physical abuse is seen as a means of establishing power and control over the victim. The repercussions of these acts are great, couples have decreased marital satisfaction, psychological and physical health problems, and there are negative effects on the children in these families (Sonkin, Martin, & Walker, 1985).

Violent male partners have been found to vary along a number of important dimensions. A number of studies (Bernard & Bernard 1984; Gondolf 1988; Hale, Duckworth, Zimostrad, & Nicholas, 1988; Hamberger, & Hastings, 1986; Holtzworth-Munroe & Stuart, 1994; Jacobson, Gottman, & Shortt 1995; Rosenbaum, & O'Leary 1981; Stith, Jester, & Bird

1992) have sought to develop a profile of the violent man using one or more variables. Variables that have been examined include childhood history variables, personality variables including self-esteem, problem behavior including substance abuse, and relationship variables including marital conflict and marital satisfaction. Recent research has begun to examine depression as a contributing factor in domestic violence (Felbau-Kohn, Heyman, & O'Leary1998; Gondolf, 1988; Kaufman Kantor, & Jasinski 1998; Maiuro, Cahn, Vitaliano, Wagner, & Zegree 1988; Vivian & Malone, 1997).

Depression

There are gender differences in the manifestation of depression among men and women. Nolan-Hoeksema states, "women tend to ruminate, while men tend to engage in activities designed to distract themselves from their depressed mood", (as cited in Beach, Sandeen, & O'Leary, 1990 pg.17). Farington (1980) has proposed that in males, anger and anxiety frequently accompany frustration. According to the Clinical Practice Guideline written by the U.S. Department of Health and Human Services (1993), depression can manifest itself in apathy, anxiety, or irritability in addition to, or instead of, sadness.

While it appears that depression may be an important variable in understanding domestic violence, only a few studies have examined depression in men who batter women. Boyle and Vivian (1996) found a highly significant relationship between self-reported anger and depressive symptomatology in a sample of men seeking marital therapy (many of whom had been violent toward their spouses). Maiuro, Cahn, Vitakiano, Wagner, and Zegree (1988) found increased depressive symptomatology among domestically violent men, compared to generally assaultive men and a nonviolent control group. In a important study Pan, Neidig, and O'Leary (1994) found that for every 20% increase in depressive symptomatology, the odds of engagement in moderate physical aggression increased by 30%, and the odds of engaging in severe physical aggression increased by 74%.

After reviewing the research looking at depression linked to domestic violence it seems clear that further work needs to be done. While these studies have examined depression related to domestic violence some questions are left unanswered, for example, are there different profiles of men who are depressed and hit and those that are not depressed and hit? What accounts for the difference, what combination of variables might fit the profile of the depressed, violent man? While several studies found a relationship between domestic violence and depression I hope to see if there are differences among domestically violent depressed men and those that are not depressed. Three major questions I am interested in addressing are: "How do domestic violent men who are identified as depressed differ from those who are not identified as depressed on a number of abuse related variables (i.e., substance abuse, anger, anxiety, beliefs about wife beating, jealousy, marital satisfaction, dominance, couple differentiation, physical violence, and psychological violence)?", "Within a sample of domestic violence offenders, which variables correlate with depression?", and "What percentage of the sample will be depressed and what percentage nondepressed"?

Theoretical Framework

I am using the biopsychosocial model to guide my study. McKenry, Julian, and Gavazzi (1995), describe the perspective as "an attempt to understand health and illness through an appreciation of how biological, psychological, and social elements persist in affiliation with one another"(p 307). Other researchers such as, McDaniel, Hepworth, and Doherty (1992), define the term as "highlighting the interactive nature of biological, psychological, and social phenomena regarding health and illness, these phenomena have a reciprocal impact on each other", as cited in McKenry et al (1995). This way of viewing things fits with the study of domestic violence, a complicated phenomenon. Researchers are discovering that combinations of social and biological variables are related to aggression and violence (Jacobson & Gortner 1997). Jacobson and Gortner (1997) point out that more research needs to be done using a multivariate approach. They believe that one cannot explain the complexity of violence by using a simplistic model of research and that to further research we must continually combine psychological, social and biological variables in order to try to capture the complexity of male

against female violence. Hamberger and Hastings (1986) agree, research looking at domestic violence suggests that there is not a single explanation as to why or how spousal abuse occurs, there is not one profile that consistently defines all men who batter women.

The biopsychosocial model looks through three separate lenses, biological, psychological, and social. In this study I divided the ten independent variables into three subcategories. The first category: biological, includes use of alcohol. The second category psychological: includes anger, anxiety, and beliefs about wife beating. The third category, social: includes, jealousy, marital satisfaction, dominance, couple differentiation, physical and psychological violence. Therefore, the biopsychosocial model is useful in that it lends itself well to looking at violence through multiple lenses (Jacobson & Gortner, 1997).

All ten of these independent variables have been studied before in relation to domestic violence and lend well to further investigation of their relationship to depression. The combination of these variables, taken from three categories of interest in domestic violence will provide further information in the relationship between male perpetrated violence and depression.

Biological variables

Studies have shown a relationship between alcohol and depression in men. Studies show a strong link between alcohol and depression. "Alcohol abuse is one of the most common clinical presenting problems associated with depression" (Beach, Sanden, and O'Leary 1990 p.17). Studies by Kornstein, Schatzber, Yonkers; Fava, Abraham, Alpert et al.; and Reigier Burke, and Burke (as cited in Kornstein 1997) demonstrated that men with major depression report a higher lifetime prevalence rate of alcohol and substance abuse and dependence. The research has also shown that alcohol and domestic violence go hand in glove. Researchers such as Eberle, 1982; Gayford, 1975: Leonard and Jacob, 1988; Roy, 1977 (as cited in Pan, Neidig, & O'Leary, 1994) have shown a relationship between alcohol, drug use and violence.

Psychological variables

Anger has been a variable studied in relation to domestic violence perpetrated by males. Men who have been identified as batterers are expected to exhibit more anger when compared with nonbattering men (Galdstone, 1987, Hamberger & Hastings, 1986, Murphy & O'Leary, 1989, Symonds, 1978) as stated in Beasley and Stoltenberg (1992). In a study conducted by Beasley and Stoltenberg (1992) men who were identified as batterers scored significantly higher on the State anger scale and the Trait anger scale. As I mentioned in the earlier discussion it has been shown that men manifest symptoms of depression in the form of irritability, anger, and rage (Boyle and Vivian, 1996). Because anger can manifest itself in depression and is related to violence, the exploration of anger as a variable that relates to depression in male batterers should be further explored.

Anxiety is the reaction to a real or imagined threat, and a general feeling of uneasiness or dread. It is often accompanied with trembling, sleeplessness, dry mouth, headaches, irritability, and muscle tension (American Psychiatric Association 1994). Anxiety is seen to be a result of low self-esteem in males that abuse (Neidig, Friedman, & Collins, 1984). Anxiety and depression have been linked together in previous studies (Hecht, von Zerssen, & Wittchen, 1990). Although the relationship between anxiety and violence has not been studied, because it is so strongly linked to depression it warrants investigation in the study of profiles of depressed violent men.

Beliefs about wife beating have been studied in the domestic violence realm. The literature shows that certain societal values, beliefs, or attitudes that lead to abusive behavior directed at women are internalized and ascribed to by those who abuse (Neidig et.al, 1984). Therefore, this study shows the importance of including this variable in the study of violence against women.

Social variables

Jealousy is related to abuse. For example, Dutton, van Ginkel, and Landolt (1994) found that male batterers self-reported a strong association between jealousy and their abusiveness. Female partners in that same study reported jealousy to be a factor as well. Abusive men have elevated levels of jealousy compared to non-abusive men (Barnett, Martinez, & Bluestein 1995). The relationship between jealousy and depression has not been studied. Jealousy and violence have a strong relationship, which warrants the inclusion of jealousy as it is related to depression and violence.

Marital satisfaction and depression have been linked in past studies. Weissman (1987) reports, a spouse in a discordant marriage appears to be 25 times more likely to be depressed than a spouse in a non-discordant marriage, and this is true for both husbands and wives, as cited in Beach, Sanden, and O'Leary 1990. Another study by Beach, Sanden, and O'Leary, (1990) reports that about half of depressed patients present with marital problems. Lastly, Vivian and Malone (1997) find that physically abusive husbands report more negative cognitions about the marriage than non-physically abusive husbands. Marital satisfaction has been studied extensively in relation to domestic violence. O'Leary (1999) reports that, "men and women who are experiencing a lack of satisfaction with their partners tend to engage in psychological aggression against their partners" (p.12). Furthermore, marital discord was found to be the strongest correlate of spousal aggression (Rosenbaum, & O'Leary 1980). A relationship between depression, marital satisfaction and violence exists. It is important to study this further.

Dominance has been defined by (Hamby 1995) as a deviation from an egalitarian relationship. Hamby (1995) cites the work of Campbell, 1992; Coleman & Stauss, 1986; Frieze & McHugh, 1992; Gelles, 1983; Koss et al., 1994; Stets, 1992; Yllo, 1984, who have found that "male dominance may be the most widely mentioned risk factor for physical assaults on an intimate partner". Hamby (1995) offers a new conceptualization of dominance in which authority, restrictiveness, and disparagement are looked at. She found that restrictiveness, (limiting activity with other people) in dominance was the most important correlate of

psychological aggression, physical assault and injury in terms of partner abuse. These findings support the idea that dominance is a variable worth examining in relation to male domestic violence.

Variables such as physical and psychological abuse are linked with depression. Pyschological abuse and physical abuse have a strong relationship, some researchers believe that psychological abuse precedes physical abuse (O'Leary 1999). Research has shown that the more psychologically abusive one is, the more likely one is to be physically abusive (Straus 1970; Straus & Smith 1990). Past research has not differentiated physical abuse from psychological abuse in terms of a profile of the abuser. This study will help to identify how physically vs. psychologically abusive men vary on depression.

Bowen defines differentiation as the ability to separate thoughts from emotions and to control one's emotional reactivity. Differentiation in couple hood has been studied and linked with domestic violence (Rosen, Bartle-Haring, & Stith 1996). Rosen & colleagues (1996) found that couple differentiation accounted for most of the variance in dating violence when family of origin violence was controlled for. This is an area that needs further exploration in relation to violence and depression.

Purpose

The present study is designed to examine two subgroups of violent men, depressed and nondepressed. I hope to find out if the two groups, depressed and nondepressed, are different on the above-mentioned biological, psychological, and social, predictor variables.

Research questions are 1) what percentages of men in this study are depressed and what percentages are nondepressed according to the SCL-90 depression index? 2) How is depression correlated with each of the following variables; substance abuse, anger, anxiety, beliefs about wife beating, jealousy, marital satisfaction, dominance, couple differentiation, and psychological and physical violence? 3) How do depressed versus nondepressed male batterers

differ on these same variables (i.e. substance abuse, anger, anxiety, beliefs about wife beating, jealousy, marital satisfaction, dominance, couple differentiation, and level of psychological and physical violence)?

Rationale for the study

As a graduate research assistant managing an NIMH-funded grant to develop a couples treatment program for domestic violence I have administered many intakes to male perpetrators of violence. As part of the intake I meet with the client alone for approximately 45 minutes to an hour. During this time I obtain demographic information and ask questions pertaining to violence. I began to notice a pattern. Many male perpetrators showed symptoms of depression and often stated feeling suicidal, or being incredibly sad or worried all the time. I was surprised by the number of men that I came across who seemed to exhibit depressive tendencies. I wondered if depression, in relation to male violence, was something that we as clinicians and researchers were not looking at closely enough. As stated earlier, few studies have looked at depression and domestic violence. The clinical implications of studying this phenomenon are great. If a depressed violent man looks different from a nondepressed violent man then we as clinicians should modify our treatment of these men, depending on their profile. Knowing that depression is a treatable phenomenon I want to look at how much it influences violence in men. Exploring the profile of a depressed violent man will fill in another hole in this complex issue of violence against women.

Why study male perpetrators?

It is well known that men and women can be violent toward their relationship partners (Stets & Straus, 1990). I am choosing to look at male perpetrators of violence in relationships although previous research has indicated that both men and women use aggression in relationships. Most published research in the field looks at male perpetrated violence because the severity of injury is much greater for women then for men. Rosenbaum and O'Leary (1981) state that, "wives that are abused frequently receive physical injuries that need medical attention or hospitalization, and many are murdered annually" (p.63). According to O'Leary and Curley,

1986 and Berk et al.1983, (as reported in O'Leary, Barling, Arias, Rosenbaum, Malone, & Tyree (1989) women's aggression engenders less fear and inflicts less physical harm than man's aggression. In addition, husband violence has consistently been found to have more detrimental effects then wife violence. "Wives are more likely then their husbands to suffer severe physical injuries and depressive symptomatology" (Cascardi, Langhinrishsen, & Vivian, 1992; Stets & Straus, 1990). Thus, this research will focus on violent men.

Why use multiple variables?

The majority of research done in this area explores few variables at a time, which leaves readers questioning the influence of other variables and the impact that they may have. By looking at a combination of predictors together one can look at a bigger picture. The use of multiple variables has been limited in the types of variables explored, the combination of variables and the sample population involved in the research. By looking at subsamples of depressed and nondepressed batterers using the same combination of variables I will be able to understand if these subgroups of men look different and if certain factors are more important within each subgroup. For example, the depressed men may score higher on physical abuse and psychological abuse and lower on marital satisfaction than the non-depressed group. I anticipate that understanding how these factors vary within these subgroups will help us know if we need to target specific treatment interventions to these subgroups and if so, how to target intervention.

CHAPTER TWO: LITERATURE REVIEW

Introduction

In the following chapter I will describe the symptoms of depression in terms of Major Depressive Disorder and Dysthymia, explain the ways depression manifests itself differently in men and women, and report the prevalence. Next I will describe various studies that support each variable I will use in my study. Following the biopsychosocial framework the variables alcohol, anger, anxiety, beliefs about wife beating, jealousy, marital satisfaction, dominance, couple differentiation, and psychological violence, will be explained in relation to depression and physical violence.

Depression

Terrence Real (1997) states that an estimated 11 million people struggle with depression each year. According to the Diagnostic and Statistical Manual of Mental Disorders 4th edition (1994), depression is broken down into different types,

> "Major Depressive Disorder includes five or more of the following symptoms during a two week period that represents a change in functioning.
>
> 1) depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others.
>
> 2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
>
> 3) significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day.
>
> 4) insomnia or hypersomnia nearly every day
>
> 5) psychomotor agitation or retardation nearly every day, (observable by others, not merely subjective feelings of restlessness or being slowed down)
>
> 6) fatigue or loss of energy nearly every day
>
> 7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day.
>
> 8) diminished ability to think or concentrate, or indecisiveness, nearly every day
>
> 9) recurrent thoughts of death, recurrent suicidal ideation with out a specific plan, or a suicide attempt or specific plan for committing suicide.

> The symptoms do not meet criteria for a Mixed Episode, they cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, they are not due to the direct physiological effects of a substance or a general medical condition, and they are not better accounted for by Bereavement.

Dysthymic Disorder is another form of depression in which, "depressed mood lasts for most of the day, for more days than not, and has the presence of two or more of the following symptoms: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self esteem, poor concentration or difficulty making decisions, and feelings of hopelessness"(DSM-IV 1994). Clinicians and researchers have identified depression as manifesting differently in men and women. Farington (1980) has proposed that in males, anger and anxiety frequently accompany frustration. According to the Clinical Practice Guideline written by the U.S. Department of Health and Human Services (1993), depression can manifest itself in apathy, anxiety, or irritability in addition to, or instead of, sadness.

Terrence Real author of the book, I don't want to talk about It: Overcoming the secret legacy of male depression, also believes that depression manifests itself differently in men. He writes from his own experience as a clinician and presents the idea that male depression is different from female depression. He also stresses the stigma attached to being male and being depressed, thus creating the under diagnoses of the problem. Real (1997) talks about depression developing covertly. For example, a man may try to soothe his pain through abusive behavior, alcoholism, and workaholism. He believes that hidden depression drives problems such as domestic violence, and alcohol and drug abuse. It has been Real's experience as a therapist working with men, that clinicians "fail to identify depression because men tend to manifest it differently then women"(p.23). Real goes on to say that "addiction to substances has long been recognized as having a relationship to depression, but we are just now exploring the relationship of depression to other addictive choices, such as to activities like violence"(p.62). Real describes one case in particular where his client, Jimmy, describes violence as a magic elixir that transformed his shame into grandiosity, shifting his sense of helplessness to control

(p.67). "Jimmy used rage to physiologically pump up his sense of deflation"(p.67-68). Real makes an interesting point in saying "the stable ratio of women in therapy and men in prison teaches us about the ways in which each sex is taught to handle pain"(p.83). Real (1997), believes that it is time to conceptualize depression in men as a wide-ranging spectrum- the common denominator being violence toward self or others (p.85). Real believes that "understanding depression in men means coming to grips with men's violence (p.199)". Terrence Real sees a strong relationship between male violence and depression. At this point it is worthy to look more specifically at research examining the relationship between depression and violence.

Depression and Domestic Violence

Depression has been a variable used widely in research looking at male violence. There have been numerous studies where a typology or profile of the male batterer has been developed, depression being one characteristic of batterers (Beasley & Stoltenberg 1992; Hale, Duckworth, Zimostrad, & Nicholas 1988; Hamberger & Hastings 1986; Holtzworth, Munroe & Stuart 1994). These studies have sought to create subtypes of batterers based on pathology and psychiatric characteristics taken, for example, from measurements such as the Millon Clinical Multiaxial Inventory –II. Examples of subtypes created are; family only, generally violent/antisocial, and dysphoric/borderline, where the batterer is divided into categories based on violent behavior and motivations for violent behavior. Other studies in the field of violence have looked solely at depression as a consequence, or serious repercussion of physical and psychological violence, both in women and men (Beck, Ward, Mendelson, et al. 1961; Gortner, Gollan, & Jacobson 1997; O'Leary 1999; Zlotnick, Kohn, Peterson, & Pearlstein 1998).

Few studies have examined the relationship between male depression and male to female violence closely. Felbau-Kohn, Heyman, and O'Leary (1998) specifically investigated the association between a male's depressive symptomatology, or Major Depressive disorder, and the frequency of physical aggression toward his wife. The researchers sampled 89

physically aggressive men who volunteered for treatment with their wives. Twenty seven percent of the aggressive men sampled had moderate levels of depressive symptomatology, and 9% had severe levels of depression according to the Beck Depression index. After a structured interview 11% met criteria for Major Depressive Disorder (MDD). The rate of aggressive men who had MDD was higher than reported in the general population of non-offenders. Results indicated that a significant but weak linear relationship was found between increased depressive symptomatology and frequency of physical aggression. After anger was controlled through multiple regression analysis there was no longer a significant link between depression and violence. The researchers cautioned other researchers to look for other variables that may be maintaining elevated levels of depressive symptomatology in partner violent men. The researchers also recommended further studies to include those men that are court-ordered and have higher rates of violence. These findings bring attention to anger and violence and may support Real's (1997) notion of depression manifesting differently in men.

A second study conducted by Maiuro, Cahn, Vitaliano, Wagner, and Zegree, (1988) studied anger, hostility, and depression across a sample of violent men. The sample consisted of 100 men who were undergoing treatment for anger management, and 29 nonviolent men matching the demographic characteristics of the violent men (recruited from a dental clinic) served as the control group. The majority of the men in anger management were court ordered (72%). The 100 men undergoing treatment for anger management were split into three groups, domestically violent, general assaulters, and combined. Results indicated that the domestically violent men had higher levels of anger and hostility then the control subjects. Two- thirds of the sample scored within the clinical range for depression. More men in the domestically violent group scored as depressed ($r = -.63$, $p < .001$), than in the control or general assaulters groups. These findings support the idea that in some maritally violent men, anger and hostility are accompanied with depression. The authors note that " a simultaneously angry and depressed man may attempt to compensate for his perceived lack of power and self efficacy by forcibly manipulating a less powerful, easily victimized female mate who is immediately available

within the privacy of the home environment" (p 21). The results of the study indicate that anger and hostility in domestically violent men is frequently accompanied by depression.

Vivian and Malone (1997), a third group to specifically study the relationship between depression and violence examined the association among relationship factors, depressive symptomology, and marital violence. The sample consisted of 327 self-referred couples seeking therapy. The sample was split into three groups: verbal abuse only, mild physical abuse, or severe physical abuse. The Beck Depression Inventory measured depression. Results indicated that husbands' severe physical aggression was associated with decreased marital satisfaction, increased aggression, and increased depressive symptomology.

A fourth study, conducted by Hanson, Cadsky, Harris, and Lalonde (1997), sampled 997 batterers, 184 non-abusive, 517 moderately abusive, and 296 severely abusive from a clinical population, to determine correlates among battering men. The researchers used the Beck Depression Index to measure depression and the Tennessee self-concept Scale to measure self-esteem. They found that the batterers felt generally worse about themselves then did the 184 self reported non abusive men. Both groups of batterers, severely abusive and moderately abusive, had mean scores of 12.3 and 14.3, both above the cut off score of 10, used to determine moderate depression.

In conclusion, the above studies give credence to the further exploration of male depression and domestic violence. Although depression has been examined in terms of characteristics of the male batterer, and has been examined as a consequence of battering, no studies have looked at how depressed, violent men are different from nondepressed, violent men. This study will identify how these groups are similar and different.

BIOLOGICAL

The biological realm in the biopsychosocial model and for the purposes of my study includes those factors that influence the body, are put into the body, or alter the body in any way. The variable that is included under this category is alcohol use.

Alcohol use and Depression

Both alcohol use and depression have been examined in relation to domestic violence. Various studies have shown a link between alcohol use and depression (Dawson & Grant 1996; Fava, Abraham, Alpert, et al 1996; Kornstein, Schatzberg & Yonkers, et al 1996; Reiger, Burke, & Burke 1990; Zisook & Schuckit 1986). For example Schuckit (1996) conducted a literature review in which he examined the comorbidity of alcohol abuse and intense depression or intense anxiety. He found mixed support for the order in which each manifest. Some researchers believe that alcohol is used as a result of depression, while others believe that alcohol use precedes depression. He states that alcoholics are more likely to present with depressive or anxiety symptoms. Schuckit (1996) concluded that the many alcohol-dependent people that present with depressive or anxiety symptoms must be recognized and addressed as much as those who don't present with these symptoms. Schutte, Hearst, and Moos (1997) looked at the change in alcohol use and depressive symptomology over time in relation to gender. They sampled 207 men and 207 women recruited from detox centers or other alcohol services and took data at baseline, one year, and then three-year follow up. Results indicated that heavier alcohol consumption and later depression was the same for both men and women but different in terms of timing. Men were more likely to experience depressive symptoms 1-3 years afterward, whereas women experienced depressive symptoms between baseline and 1 year. Regardless of the timing, the commorbity of alcohol use and depression has been strongly linked in both sexes. Schuckit (1982) sampled a group of male students at a university setting, and gathered data from 964 men. One hundred seventy three (18%) of these men suffer from or have a history of depression, and of these 173 men, 44-48% reported substance abuse problems occurring along with depression, more so then the group of men reporting no depression.

Alcohol use and Violence

A variety of studies describe a link between violence and alcohol use. In a study conducted by Schuerger and Reigle (1988) a sample of 44 men being treated for wife abuse was examined. The researchers found that 69% of the men scored above a six on the MAST (Michigan Alcoholism Screening Test), the minimum score to be considered to be abusing alcohol, while 54% of these men scored above 9 on this measure. Researchers reported that the percentages of men who abuse alcohol are probably higher because those men that were involved in AA were not included in this study. Telch, Ummel, and Lindquist (1984), conducted a study in which they looked at the characteristics of violent vs. nonviolent couples. Some of the variables used in differentiating the groups were self-concept, sex role stereotype, marital adjustment, communication, assertion, and alcohol consumption. They found that the strongest predictor of violent couples was alcohol consumption. The violent group reported significantly greater drinking problems than the control group. The results from both of these studies give support to the widely held contention that substance abuse is related to domestic violence.

Terrence Real, author of, I don't want to talk about it (1997), views alcohol as "both providing a relief from depression and simultaneously creating more of it" (p 79). The link between alcohol use, depression, and violence has been shown to exist in numerous studies. For example, Dinwiddie (1992) examined a clinical sample of 61 self-reported abusers and 319 non-abusers. He found that 87% of the self-reported abusers were diagnosed with alcoholism, 33.3% with major depression, while 65% of the non-abusers were diagnosed with alcoholism and 19% with depression. This evidence supports the commorbitity of alcohol abuse and depression in a sample of domestically violent men.

A study conducted by Oriel and Fleming (1988), sampled men from three health care clinics to understand the prevalence of violence. Out of 237 men, 32 men reported physical violence toward their partner in the last 12 months. The researchers found that probability of violence was 7% in the sample, and increased to 41% if depression or drinking more than two

drinks on average was present. These results also suggest a relationship between these variables.

Pan, Neidig and O'Leary (1994) sampled 11,870 white randomly selected army personnel. Thirty percent of the men used physical aggression once in the past year. Results indicated that an increase in depressive symptomology increased the odds of becoming mildly aggressive 30%, and severely aggressive 74%. The existence of an alcohol problem increased the odds by 70%. According to this study the rate of depression influences violence in army personnel. In conclusion, alcohol is related to both depression and violence and is a variable that has been supported and continues to be supported throughout research. Therefore, it is important to use alcohol use as a variable related to marital violence and depression.

PSYCHOLOGICAL

The psychological realm of the biopsychosocial model and for the purposes of my study includes traits within the self, for example pathology or personality style. The variables used in this study that fall under this category are beliefs about wife beating, anxiety, and anger.

Beliefs about wife beating and Violence

Beliefs about wife beating have been and continue to be examined in domestic violence research. For example, Hanson, Cadky, Harris, and Lalonde (1997) found the single strongest group difference among a sample of 997 severely abusive, moderately abusive, and nonabusive men taken from a clinical population, to be attitudes tolerant of wife assault. The results of the study found 68% of the severely abusive men, and 51% of the moderately abusive men to endorse one or more items such as "an unfaithful wife deserves to be hit", and "I might slap my wife if she made me really angry", whereas only 22% of the non-assaultive men endorsed those items. Margolin, John, and Foo (1998) included the variable, beliefs about wife beating in their research of physical and emotional violence against women. After sampling a non-clinical population of 175 volunteers, results showed that men who were considered to be emotionally abusive scored higher on attitudes condoning aggression. Sugarman, and Frankel (1996) found

assaultive husbands to report more positive attitudes toward marital violence and score lower on masculine and feminine gender schema scales than nonassaultive husbands. Thus it has been shown that there is a relationship between domestic violence and men's attitudes toward violence.

Beliefs about wife beating and Depression

I found no research that looked at beliefs about wife beating and depression. I will include this variable because of its strong relationship to domestic violence and explore whether differences exist between depressed and nondepressed male batterers.

Anxiety and Depression

Research has demonstrated the comorbitity of anxiety and depression. Hecht, von Zerssen, and Wittchen (1990) sampled the general population consisting of 483 men and women. Using the DSM-III criteria for assessing mood disorders, researchers determined the percentage of the group that was depressed, anxious, or had a combination of both over the past six months. Results indicated that more than one third of the depressive cases from the sample had simultaneously suffered from an anxiety disorder as well over the past six months. Results indicated an overlap between depression and anxiety, in more then one third of the cases studied. Stavrakaki and Vargo (1986) conducted a literature review on the relationship between anxiety and depression. They concluded that there is research to support the relationship. However, the presence of a mixed anxiety/depression diagnosis, and the high rate of misdiagnosis, for example, diagnosing as depressed when one is anxious, suggests that there needs to be further research in order to better clarify the difference.

This gives support to looking at anxiety along with depression that assessment of both should go hand in hand. Researchers focusing on this issue have not yet come to terms with how to separate anxiety and depression, therefore using both variables in studying violence is important.

Anxiety and Violence

There have been no studies that look directly at the link between anxiety and violence. Because of anxiety's link to depression and depression's link to violence, I will include this as one of the variables looked at in my study.

Anger and Depression

Anger and depression have been shown to have a positive relationship in various studies. Robbins and Tanck (1997) examined 77 undergraduate students over the course of ten days, each day recording feelings of anger and depression measured by the Beck Depression inventory. Results indicated that on days when individuals reported feeling angry they also exhibited symptoms of depression. Another study conducted by Biaggo and Godwin (1987) examined 112 volunteer psychology students, where the Minnesota Multiphasic Personality Inventory (MMPI), the Hostility and Direction of Hostility Questionnaire, the Overcontrolled Hostility Scale, the Anger Expression Scale, and the State Trait Anger Scale were used to understand the relationship between anger and depression. Among those that scored as depressed results indicated that they experienced more intense hostility, and a lesser amount of control over anger or managing anger then those that did not score as depressed. Riley, Treiber, and Woods (1989) tested three groups of patients being treated at a hospital: patients being treated for depression, patients being treated for PTSD, and those that are neither depressed nor experiencing PTSD. Results indicated that the relationship between anger and depression was significant in those that were depressed. Those that were depressed did not express the anger but turned it inward, whereas those that had PTSD symptoms or those in the control group expressed them more readily.

Anger, Depression, and Violence

Some studies have looked at the relationship between anger, depression, and male partner violence. Maiuro, O'Sullivan, Michael, and Vitaliano (1989) compared 60 male psychiatric patients who exhibited assaultive or suicidal behavior with 22 nonviolent male psychiatric patients. The researchers found that both groups of violent men score higher on

hostility and depression than did nonviolent men. The assaultive group manifested their anger in an outward manner, more then the suicidal group, but the differences were not significant. Furthermore 45% of the individuals in the assaultive group scored within the clinical range of depression. This gives support to the fact that assaultive men show their anger and depression in a hostile fashion. Anger, depression, and male partner violence are related, and therefore warrant further investigation.

SOCIAL

The social realm of the biopsychosocial model and for the purposes of this study includes aspects of a relationship with a partner as well as outside social systems. Those variables that are dyadic or involving of others are included under this category. The variables examined in this study that fall under this category are marital satisfaction, dominance, couple differentiation, jealousy, psychological violence, and physical violence.

Marital Satisfaction and Depression

There has been research to show a relationship between marital discord and depression (Sher & Baucom 1992). Hinchliffe, Hooper, and Roberts, (1978) report that marital interactions of couples with one depressed partner are marked by negativity, asymmetry, and aggression. Hinchliffe et al., (1978), and Kahn, Coyne, and Margolin, (1985), find that compared to control groups, depressed spouses and their partners have a more negative and impaired communication style, resulting in destructive behavior. They found that the more depressed the couple is the more likely there will be conflict and discord. O'Leary, Christian, and Mendell (1994) found a significant association between depression and marital satisfaction, the association being similar for men and women. Fincham, Beach, Harold, and Osborne (1997) conducted a study that looked at marital satisfaction and depression in relation to gender. After sampling a non-clinical population, they found that for men, depression was causal to marital satisfaction, whereas for women, marital satisfaction had an effect on depression. In other words, in men, depression causes more dissatisfaction in marriage, whereas in women their satisfaction in the marriage affects their level of depression. There is strong

support for the relationship between depression and marital satisfaction in men and women. This gives weight to the inclusion of these variables in this study.

Marital Satisfaction and Violence

Marital Satisfaction is considered one of the most important variables in partner violence research (Miller, Veltkamp & Kraus 1997). Many researchers have found verbal aggression or psychological violence to have a stronger relationship to marital satisfaction then physical violence (Julian, McKenry, Gavazzi, & Law 1999; Margolin, John, & Foo 1998; Schamling and Jacobson 1990).

Others found marital satisfaction to be involved in both types of violence, for example, Pan, Neidig, and O'Leary (1994) sampled 11,870 white army enlisted males, and found when marital discord increased by 20%, mild aggression increased by 102%, and severe aggression 183%. Kahn, Cohn, and Margolin (1985) sampled 28 couples, 11 of which were from clinical settings, 3 were recruited through the newspaper and 14 met criteria of either spouse having a score of 14 or more on the Beck Depression inventory. Fourteen nondepressed couples were used as the control group; they were recruited through advertisements and word of mouth. Results indicated that all of the depressed persons and their spouses were more dissatisfied with their relationship, and reported more aggressive tendencies then those couples without a depressed spouse. Marital satisfaction has been shown to have a relationship with depression and partner violence.

Dominance and Depression

Research has shown a relationship between dominance or power and depression. For example, Mirowsky (1985) explored the idea of marital power lessening depression in marriage. He tested the hypothesis that you are less depressed if you dominate the marriage. The researchers sampled 680 men and 680 women in a couple relationship randomly by telephone survey measuring depression using the Center for Epidemiological Studies depression scale (CES-D), and measuring marital power and traditional sex roles through 10 short

questions. Results indicated that each spouse was less depressed if marital power is shared. Gray-Little and Burks (1983) using observational and self reported studies, found that high levels of marital satisfaction are found in marriages of equally dominant husbands and wives. Another researcher, Halloran (1998), describes marital power or dominance in marriage and depression as cyclical, just as marital power influenced depression, depression can influence marital power. In conclusion there is disagreement over what type of power relates to depression, but support is given for the relationship between the two.

Dominance and Violence

Researchers have also found a link between marital violence and dominance. A study conducted by Ronfeldt, Kimerling, and Ileana (1998) looked at 156 undergraduate men in serious dating relationships, and measured, through self report, the amount of physical violence, psychological violence, perceptions of power and satisfaction with power. Results indicated that dissatisfaction with relationship power predicted psychological and physical abuse. This confirms that idea that psychological and physical abuse is a means of gaining control in relationships. The more dissatisfaction that these men had in the level of power they had in the relationships the more likely they were to hit. Coleman and Straus (1986) sampled 2,143 couples nationally and divided them into three groups based on the power structure in the marriage; equalitarian, male-dominant, female-dominant, or divided power. Researchers found that couples in equalitarian marriages had the lowest rates of conflict. Those that were in male-dominated or female-dominated marriages had higher risk of violence. In conclusion couples in an equalitarian marriage, or couples that had equal power had the least amount of conflict. This supports the notion that dominance in marriage is a variable linked to violence and depression. Therefore further research is warranted.

Differentiation in Couple Relationship and Violence

Differentiation can be defined as the ability to separate thoughts from emotions and to control one's emotional reactivity. In terms of the couple, differentiation can be defined as the ability to tolerate fluctuation in closeness and distance, thus allowing each member of the couple

to be both autonomous as well as intimate. Research linking couple differentiation and marital violence is scarce, and there have been no studies exploring the relationship between depression and couple differentiation. One study by Rosen, Bartle-Haring, and Stith (1996) sampled 277 college students in serious dating relationships in order to understand the intergenerational transmission of partner violence. Researchers found that couple differentiation is related to dating violence. Specifically those in the sample that had experienced at least one act of violence had lower couple differentiation scores. Another study by Glickauf-Hughes, Foster and Jurkovic (1998) found that the less differentiated a couple is the more tendency for jealousy, possessiveness, patterns of reactivity and explosive fighting. Couple differentiation has been shown to have a relationship to marital violence. I hope to fill in the gap by further studying the relationship between depression, domestic violence, and couple differentiation.

Jealousy and Violence

In chapter eight of White and Mullen's book, Jealousy: theory, research and clinical strategies (1989), the authors state that jealousy comes from a state of mind where pain and anger give way to the jealous person's acts of aggression. White and Mullen (1989) go on to state that "jealousy contributes to creating the context in which violence emerges and to precipitating individual assaults"(p 221). The variable jealousy has been linked to violence in various studies (Barnett, Martinez, and Bluestein 1995; Dutton, van Ginkel, & Landolt; Holtzworth-Munroe, Stuart, & Hutchinson 1997; Holtzworth-Munroe & Hutchinson 1993). These researchers found that violent husbands tended to be more jealous, have more dependency on and preoccupation with their wives, and have less trust in their marriage.

Jealousy and Depression

There has been little research looking at the relationship between jealousy and depression. Mathes, Adams, and Davies (1985) explored the relationship between jealousy, depression, anger and anxiety. After sampling 40 men and 40 women from a college population they found loss of a partner to someone else (i.e jealousy) causes depression, and anger. They also found that loss of relationship adds to depression.

Further research needs to be conducted to examine the relationship between depression, violence, and jealousy. My study of jealousy will explore further the influence it has on depressed and nondepressed maritally violent men.

Psychological Violence and Physical Violence

Psychological violence has been examined along with physical violence and has been shown to precede physical violence and sometimes harbor more serious consequences (Murphy and O'Leary 1989; O'Leary and Curley, 1986). Gortner, Gollan, and Jacobson (1997) state that the primary intent and function of battering is the intimidation and control of another, and to that service batterers use threats, taunts, and ridicule. Jacobson, Gottman, Gortner, et al: (in press) found that emotional abuse remained at high levels even in instances when physical abuse decreased. The researchers also found that the perpetrator's negative affect and high levels of emotional violence predicted future physical violence. O'Leary, Malone, and Tyree (1994) explore the relationship between psychological abuse and physical violence using longitudinal data from an earlier study of O'Leary's (1988). The researchers found that psychological aggression assessed at 18 months had a direct path to first reported physical aggression for men at 30 months with a path coefficient of .36. These researchers were also able to show individuals that were dissatisfied with their marriage and had personality styles that were defensive and aggressive were more likely to be psychologically aggressive toward their partner.

Psychological Violence and Depression

Grandin, Lupri, and Brinkerhoff (1998) conducted a study looking at couple violence and psychological distress, which they later defined as having depressive symptomatology. A sample of 562 randomly selected couples was taken and results indicated that both male and female victims of either psychological only or physical violence were likely to report higher levels of psychological distress or depression, then non-victims. It was also found that both types of violence were associated with increased psychological distress for both men and women. Being a perpetrator of either psychological or physical violence was associated with increased depression and anxiety scores. Another study by Vivian and Langhinrichsen-rohling (1994)

examined couples taken from a marital therapy clinic that both reported bi-directional physical violence in the relationship. The couples were asked to rate the impact of physical aggression and psychological aggression. Both men and women rated psychological aggression as having a greater impact then physical aggression. The Beck Depression inventory was administered to both men and women and both groups scored in the moderate range of depressive symptomatology. This shows the link between perpetrated violence and depression in men, and the need for further specified studies.

Summary

Domestic violence and depression have often been explored as variables related to the total profile of a violent man. The majority of studies have concentrated on the victims' depression and not on the perpetrators' depression. Few studies have used multiple variables using depression and male perpetrated violence as the main variables of exploration. In this study I will attempt to understand the differences among depressed and nondepressed male batterers along biological, social and psychological variables in order to explore the complexity of domestic violence and the profile of the depressed violent male.

CHAPTER THREE – METHODS

The purpose of this study is to examine two subgroups of violent men, depressed and nondepressed, taken from a larger study. I hope to understand the profile of the depressed vs. nondepressed male batterer using biological (alcohol use), psychological (anger, anxiety, beliefs about wife beating), and social (jealousy, marital satisfaction, dominance, couple differentiation, psychological and physical violence) predictor variables. This chapter describes the research methods used for the study.

Participants and the Selection Process

The subjects for this quantitative study were 107 men who were court-ordered or self-referred to treatment for perpetration of physical violence toward their partner. This data is taken from an NIMH funded study conducted by faculty at Virginia Tech's marriage and family therapy program. Participants were part of a larger NIMH –funded study, a research and development program designed to develop and pilot test a manualized couple's treatment model for treating violent men and their partners. The larger study includes batterers in treatment with county domestic violence programs in the Northern Virginia area, as well as couples who responded to newspaper ads or flyers placed by the project targeting men who have anger problems.

In order to be eligible for participation in the larger NIMH-funded project, the batterers had to be 18 years old, identified as a perpetrator of mild to moderate relational abuse, involved in a serious ongoing relationship with the women he has physically abused, willing to participate in a men's anger management program if he had not already done so, and willing to participate in 12 sessions of conjoint couple therapy or multi-couple group therapy with a partner who is also willing to participate in therapy. Exclusionary criteria were used in order to ensure the safety of the couple during the process of couples counseling. The criteria includes, severe violence, a history of male violence outside of the home, anti-social personality disorder, alcohol or drug use, threat or use of weapons in violent events, possession of guns in the home (and refusal to

relinquish these guns), or refusal to sign a no violence contract. The main reason for exclusion in the research project was that the participant had no partner, or the participant or his partners were not interested in couples counseling. Of those participants involved in my project 30% (n=32 men) began couples treatment as part of the larger NIMH-funded project.

The majority of the data used in my study was gathered from a group of men that were not involved in the couples counseling portion of the research project but were court ordered or self referred for anger management. Approximately 50% (n=53) began the Anger Management Program only. These men did not meet the criteria for the larger NIMH-funded project. The inclusionary criterion for the men participating in strictly anger management includes; filling out intake information consisting of intake protocol, informed consent, and a pre-test booklet, attend 12 sessions of an anger management program with two allowable absences, and complete a post-test at the end of treatment. Not all men who met this criterion were included in the anger management group. Men were excluded for excessive alcohol or drug use, minimal English skills, anti-social personality disorder, and lastly at the discretion of the researchers. Twenty percent (n=22) of the participants in this project did not participate in either the NIMH couples project or the anger management program but did fill out the intake information. Most of these men were unable to be scheduled, were ineligible and referred elsewhere, or did not choose to participate in treatment after completing intake information.

Procedures

Participants were referred to the Couples counseling Project/Anger Management program in several ways: by a county employee at a domestic violence treatment program, by a probation officer, or by self-referral (seeing a newspaper advertisement or flyer for the program). After these referral sources were sought out, participants called Virginia Tech's research office and answered some questions on the telephone asked by a Graduate Assistant who was trained to speak with potential research participants. Questions pertaining to the type of incident, level of violence, substance abuse issues, psychiatric issues and referral source were asked. If the caller was interested in pursuing treatment and the graduate assistant felt the caller

was a potential participant, an appointment was made to come in and fill out intake paperwork. A Graduate assistant met with the participant and administered the intake. The research team then identified men who would not be excluded by the criteria outlined above, either for anger management class or the couples counseling program depending on the clients' interest. The men who were interested in the couples counseling project were asked if their partners were interested. The partner was called and introduced to the intake process and an intake appointment was made if she desired to come in. Both groups of men, those interested in the couples counseling project and those seeking out anger management were given an informed consent including a brief description of the research study, and the client's right to end participation at any time (see Appendix A). Those men only interested in anger management were given the same informed consent but information about the couples counseling research project was excluded and the participants were told about the anger management program only. Other intake information gathered included demographic information, a modified Conflict Tactics Scale, the Eureka scale, and the SMAST. In my study I am only looking at the SMAST and certain demographic information that I will outline in the next section. After filling out the intake information, the men were administered the pre-test booklet, and the intake administrator left the room. The pre-test booklet took from 30-60 minutes to complete. The intake administrator then collected the pre-test booklet and delivered the information to the grant manager. The intake administrator read participants the pre-test booklet if they had trouble reading or writing English.

One hundred twenty nine male intakes have been successfully administered in conjunction with the larger NIMH funded study, 107 were used in my study. Participants that were excluded from my study did not complete the pre-test, or were not entered in the database at time of analysis.

Group Membership

The male participants were separated into two groups, depressed and nondepressed, based on the following criteria. If the participants scored a 1.44 or above according to the

SCL-90 cut-off rate for male outpatients, they were considered depressed and placed in the depressed group. If the participant scored a 1.43 or below according to the SCL-90 cut-off rate for male outpatients they were considered nondepressed and placed in the nondepressed group.

Measures

Data was gathered via the responses given by participants in the pretest booklet and the intake protocol developed by Alexandria County Office on Women and Virginia Tech. The measures used in this study include the following: demographic questions; the shortened version of the Michigan Alcoholism Screening Test (SMAST), the adapted version of the NOVACO Anger index, SCL-90 depression subscale, the SCL-90 anxiety subscale, Inventory for beliefs about wife abuse; justified subscale, Romantic Jealousy scale, the Kansas marital satisfaction scale (KMSS), the differentiation in the Couple Relationship (DIFS-couple) scale, and the revised Conflict Tactics Scale measuring physical violence and psychological violence (CTS-2).

Demographics

Demographic questions such as age, race, and referral source were asked in order to obtain background information.

Short Michigan Alcoholism Screening Test (SMAST)

The SMAST contains 13 items related to problem drinking (Selzer, Vinokur & van Rooijen, 1975). Sample questions include, "Have you ever gotten in trouble at work for your drinking?" The scale is internally consistent (alpha .88 in a study done by Harison, Cadsky, Harns, & Lalonde 1997) and correlates strongly with other indices of alcoholism.

NOVACO for couples Anger Index

This self-report scale is designed for use in assessing the range and intensity of anger responsiveness, and is part of the Saunders Assessment Package (Novaco 1979). It consists of brief descriptions of situations that might provoke anger in an individual. The respondents

rate their degree of anger on a five-point scale, with five being the highest rate of anger. Sample scenarios include; "Being called a liar by a co-worker", "Your partner refuses to help you when asked", and "Being joked about or teased by a friend."

SCL-90 Depression and Anxiety subscales

The depression and anxiety subscales were taken from the SCL-90-R developed by Derogatis (1983). The depression scale consists of 13 self-report questions, and the anxiety subscale consists of 10 self-report questions. Each subscale is rated on a 5-point scale of distress (0-4), ranging from "not at all" at one pole to "extremely" at the other (Derogatis 1983). Sample questions from the SCL-90-R depression index are; "How much were you distressed by loss of sexual interest or pleasure?" and "How much were you distressed by feeling hopeless about the future"? Sample questions from the SCL-90-R anxiety index are; " How much were you distressed by nervousness or shakiness inside"? and "How much were you distressed by spells of terror or panic"?

The internal consistency measures on all 9 dimensions were taken from data of 219 symptomatic volunteers (Derogatis, Rickels & Rock, 1976), from which alphas ranging from .77 to .90. Test-test coefficients were obtained from a sample of 94 psychiatric outpatients who were assessed during an intake and then one week later, the coefficients hovered from .80-. 90. The measure was correlated with the MMPI and scores ranged from .40-. 68 (Derogotis, Rickels & Rock, 1976).

Inventory of beliefs about wife beating: wife justified subscale

Inventory of beliefs about wife beating, created by Saunders, Lynch, Grayson, and Linz (1987) has several subscales. The one included in this study; Wife beating justified (Wj), "reflects the attitudes that wife beating is justified in general or because of victims specific behavior" (p.42). Reliability tests drawn on Wj have concluded the subscale to have an alpha of .86. Rose (1984), as cited in Saunders et al. 1987, reported an alpha reliability of .73 for this subscale. The wife justified subscale (Wj) consists of questions like, "Sometimes it is OK

for a man to beat his wife", and "Wives could avoid being battered by their husbands if they knew when to stop talking." The participants answered on a scale ranging from 1, strongly agree, to 7, strongly disagree.

Romantic Jealousy Scale

The Romantic Jealousy Scale, developed by Gregory Lewis White (1976) is a six-item scale measuring romantic jealousy. It has high internal reliability and correlates as expected with dependency on relationships (Saunders 1996). The Romantic jealousy scale sample questions are, "How jealous do you get of your partner's relationship with members of the opposite sex?" The answers range from 1, not at all jealous, to 7, very jealous.

Kansas Marital Satisfaction Scale (KMSS)

The KMSS, developed by Schumm, Jurich, and Bollman at Kansas State University is a 3 Likert-type item scale that assesses three aspects of relationship satisfaction. Schumm, Nichols, Schectman, & Grisby (1983) report reliability as alpha's ranging from .89-. 98 and intercorrelations among items ranged from .93-. 95. The test retest reliability over a 10-week period of time was .71. The KMSS was significantly correlated with the Quality of Marriage Index and with the Dyadic Adjustment scale (Schumm et.al 1986). The Kansas marital Satisfaction scale asks how satisfied are you with your current marriage or relationship, the answers range from extremely dissatisfied, a one, to extremely satisfied, a seven.

Differentiation In The Couple Relationship Scale (DIFS-respondent)

The DIFS is used to assess the levels of differentiation in the couple relationship from the individual's perspective (Anderson, & Sabatelli 1990). There are 22 Likert-type items provide information about male and female relationship characteristics. An example of an item from the DIFS for the couple relationship is "I show respect for my partner's views". The higher the score, the higher the level of differentiation in the couple relationship. The internal consistency reliability for this total score was .88.

Revised Conflict Tactics Scale (CTS-2)

The revised conflict Tactics Scale (CTS-2) is a revision of the standard CTS developed by Straus, Hamby, Boney-McCoy, & Sugarman (1996) in which incidence of an individual perpetrating or experiencing physical, sexual, or emotional abuse against one's partner, is measured. Respondents are asked to indicate how often over the past year he or she did the following things described in the instrument. Response choices range from "No, this has never happened (coded 1) increasing to "More than 20 times in the past year" (coded 6). They are also given a choice to respond with "Not in the past year but it has happened before (coded 7). A sample question of the physical abuse subscale is, "I pushed or shoved my partner". A sample question of the psychological subscale is, "I called my partner fat or ugly." The internal consistency of the CTS-2 ranges from an alpha coefficient of .79-. 95 (Straus, Hamby, Boney-McCoy, & Sugarman 1996). In this study two subscales of the CTS-2, physical assault and psychological assault are used. The alpha of the subscale physical assault is .86; the alpha of the subscale psychological assault is .79 (Straus et al. 1996).

Analysis

In this quantitative analysis I ran a frequency test on the variable "depression" in order to find out what percentage of the sample is depressed and what percentage of the sample is nondepressed according to the cut off score for male outpatients on the SCL-90. I then examined the intercorrelations among the independent variables used in the study in order to identify which variables are interrelated (see Table 1). Next, an independent T-Test was used in order to determine if the depressed and nondepressed group differed according to the independent variables used (alcohol use, anger, anxiety, beliefs about violence, jealousy, marital satisfaction, couple differentiation, psychological violence and physical violence) (see Table 2). Lastly I ran chi-squares on a cross tab of the variables depression (depressed and nondepressed), and referral source (court-ordered and self-referred), and depression (depressed and nondepressed), and race (white, black, and other) to see how the group demographics differed along the depressed and the nondepressed groups.

CHAPTER FOUR: RESULTS

Analysis of Variables

Reliability of the variables used in this study was tested. Reliability for all variables except dominance ranged from .72 to .95. Mean, standard deviation and alpha scores are outlined on Table 3. The variable dominance was dropped from the study because of its low reliability; the reliability ranged from .12 to .42.

Demographics

One hundred and seven males participated in the present study; all reported at least one incident of violence (i.e.; pushing, shoving, slapping, hitting, kicking, beating) perpetrated toward their partner in the last year. Of the 107 men, most ranged from age 19 to 40; 9.3% (n= 10) ranged from 19-24 years of age, 20.6% (n=22) ranged from 25-29 years of age, 22.4% (n=24) ranged from 30-35 years of age, 18.7% (n=20) ranged from 36-40, 12.1% (n=13) ranged from 41-45, 8.4% (n=9) ranged from 46-50, 4.7% (n=5) ranged from 51-55, and 1.9% (n=2) ranged from 56-60 (See Figure 1).

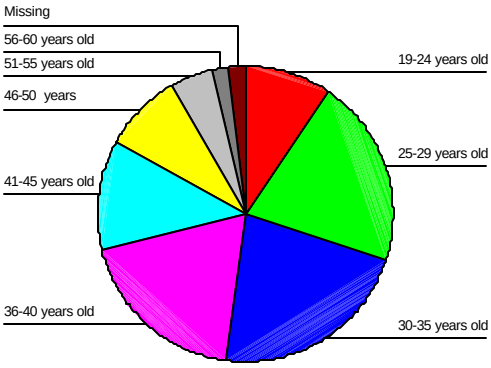

Figure 1: Male Batterers ranges of ages in Research Study

Of the 107 participants in the study 60% (n=64) were court-ordered to participate in a Men's Anger Management course, while 40% (n= 43) were self-referred to participate in either the Men's Anger Management course or the couples counseling project (see Figure 2).

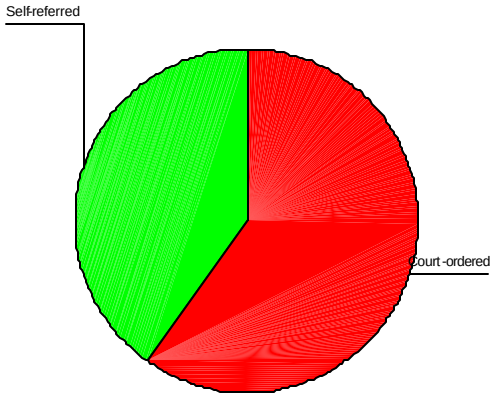

Figure 2: Participants source of referral

In terms of ethnicity, 40.2% (n=43) were African American, 37.4% (n=40) were Caucasian, 7.5% (n=8) were Asian, 6.5% (n=7) were Hispanic, 3.7% (n=4) of mixed race, 3.7% (n=4) other, and finally .9% (n=1) Native American (see Figure 3).

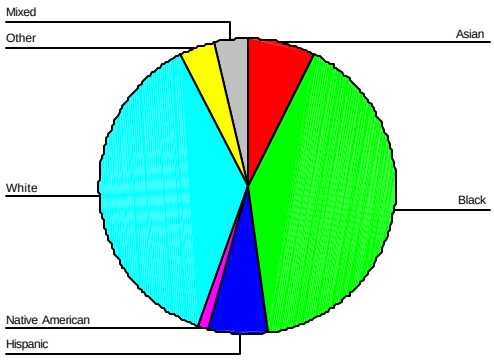

Figure 3: Participants ethnicity

Participants in this study were broken into two groups, depressed and non-depressed men. Fifty-seven percent (n=61) of the male batterers fell below the 50th percentile in out-patient depression standards according to the SCL-90, the instrument used to measure depression in this study, while 36.4% (n=39) fell above the 50th percentile and are considered to express depressive symptomology, while 6.5% of the sample did not answer this particular scale, therefore seven of the men cannot be measured as depressed or nondepressed (see Figure 4).

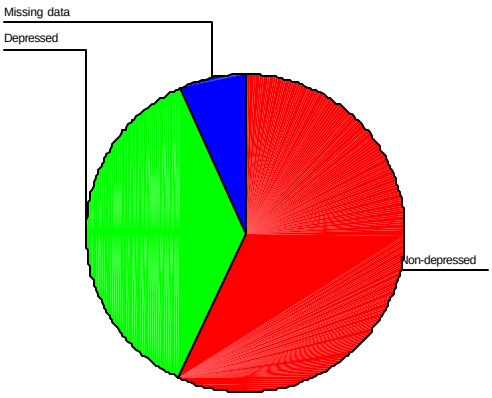

Figure 4: Male groups in study

Correlation Analysis (Table 1)

The following variables were correlated in order see the relationship between each variable used in the study (alcohol use, anger, depression, anxiety, beliefs about wife beating, jealousy, marital satisfaction, couple differentiation, psychological violence, and physical violence). The variables will be explained and were correlated in the order of the Biopsychosocial framework, which guides this study.

Of the 56 correlations, 20 were significant; 5 at the .05 level and 15 at the 0.01 level (see Table 1). There were significant relationships between alcohol use and depression ($r = .32$, $p < .01$), and alcohol use and anxiety ($r = .35$, $p < .01$). These relationships indicate that as

alcohol use increases so does depression and anxiety. There was a significant relationship between alcohol use and psychological violence ($r = .24$, $p < .05$). This relationship indicates that as alcohol use increases so does psychological violence.

There were significant relationships between anger and psychological violence ($r = .42$, $p < .01$), anger and depression ($r = .47$, $p < .01$), anger and anxiety ($r = .40$, $p < .01$), and anger and jealousy ($r = .28$, $p < .01$). These relationships indicate that as anger increases psychological violence increases, as anger increases depression increases, as anger increases anxiety increases, and as anger increases jealousy increases. There was a significant relationship between being angry and being physically violent ($r = .24$, $p< .05$), which indicates that as anger increases, physical violence increases.

There were significant relationships between depression and anxiety ($r = .75$, $p < .01$), depression and physical violence ($r = .26$, $p < .01$), and depression and psychological violence ($r = .57$, $p < .01$). This indicates that as depression increases anxiety increases, as depression increases physical violence increases, and as depression increases psychological violence increases. There was a significant negative relationship between depression and marital satisfaction ($r = -.47$, $p <. 01$), which indicates that as depression increases marital satisfaction decreases.

There was significant relationship between anxiety and jealousy ($r = .24$, $p < .05$), which indicates that as anxiety increases jealousy increases. There was a significant relationship between anxiety and physical violence ($r = .29$, $p < .01$), which indicates that as anxiety increases, physical violence increases. There was a significant relationship between anxiety and psychological violence ($r = .56$, $p < .01$), which indicates that as anxiety increases, psychological violence increases.

There was a significant negative relationship between beliefs about wife beating justified and differentiation ($r = -.53$, $p < .01$), which indicates that as wife beating is justified increases

couple differentiation decreases. There was a significant relationship between beliefs about wife beating justified and physical violence ($r = .24$, $p < .05$), which indicates that as wife beating is justified increases, so does physical violence.

There was a significant relationship between jealousy and marital satisfaction ($r = .23$, $p < .05$), which indicates that as jealousy increases marital satisfaction increases.

There was a significant negative relationship between marital satisfaction and psychological violence ($r = -.26$, $p < .01$), which indicates that as marital satisfaction increases psychological violence decreases.

There was a significant relationship between psychological abuse and physical violence ($r = .63$, $p < .01$), which indicates that as psychological violence increases, physical violence increases.

There were no significant relationships between alcohol use and wife beating justified, alcohol use and jealousy, alcohol use and marital satisfaction, alcohol use and couple differentiation, alcohol use and physical violence, or alcohol use and anger. There were no significant relationships between anger and wife beating justified, anger and marital satisfaction, or anger and couple differentiation. There were no significant relationships between depression and wife beating justified, depression and jealousy, or depression and couple differentiation. There were no significant relationships between anxiety and wife beating justified, anxiety and marital satisfaction, or anxiety and couple differentiation. There were no significant relationships between wife beating justified and jealousy, wife beating justified and marital satisfaction, and wife beating justified and psychological violence. There were no significant relationships between jealousy and couple differentiation, between jealousy and psychological violence, and between jealousy and physical violence. There were no significant relationships between marital satisfaction and couple differentiation, and marital satisfaction and physical violence. There were no significant relationships between couple differentiation and psychological violence and couple differentiation and physical violence.

T-Test (Table 2)

Independent sample t-tests were run comparing depressed vs. nondepressed male batterers on each of the independent variables (alcohol use, anger, anxiety, beliefs about wife beating justified, jealousy, marital satisfaction, couple differentiation, psychological violence and physical violence) (see Table 2).

Alcohol Use

There were no significant differences between the groups on alcohol use ($t = -1.8$, df 95, $p <$ ns). The mean score for depressed males (n=37) was 3.6, the mean score for nondepressed males (n=60) was 2.7 (see Table 2).

Anger

There were significant differences between the groups on anger ($t = -3.1$, df 80, $p < .001$). The mean score for depressed males (n = 33) was 87.3, the mean score for nondepressed males (n = 49) was 73.3 (see Table 2).

Anxiety

There were significant differences between the groups on anxiety ($t = -6.0$, df 97, $p < .001$). The mean score for depressed males (n = 38) was 1.3, the mean score for nondepressed males (n = 61) was .24 (see Table 2).

Beliefs about wife beating; wife beating justified

There were no significant differences between groups on beliefs about wife beating justified ($t = .42$, df 93, p =ns). The mean score for depressed males (n = 38) was 63, the mean score for nondepressed males (n = 57) was 64 (see Table 2).

Jealousy

There was no significant differences between groups on jealousy (t = -.05, df 96, p = ns). The mean score for depressed males (n = 38) was 15.8, the mean score for nondepressed males (n = 60) was 15.7 (see Table 2).

Marital Satisfaction

There were significant differences between groups on marital satisfaction (t = 3.9, df 98, p < .001). The mean score for depressed males (n = 39) was 10.4, the mean score for nondepressed males (n = 61) was 14 (see Table 2).

Couple Differentiation

There was no significant relationship between groups on couple differentiation (t = 1.9, df 91, p = ns). The mean score for depressed males (n = 36) was 37, the mean score for nondepressed males (n = 57) was 39 (see Table 2).

Psychological Violence

There were significant differences between groups on psychological violence (t = -5.8, df 95, p < .001). The mean score for depressed males (n = 39) was 22, the mean score for nondepressed males (n = 58) was 11(see Table 2).

Physical Violence

There were significant differences between groups on physical violence (t = -2.4, df 95, p < .05). The mean score for depressed males (n = 38) was 9.7, the mean score for nondepressed males (n = 59) was 5.5(see Table 2).

Chi-Squares

Chi squares were run on two of the demographic questions, referral source and race in order to see if there were differences among depressed and nondepressed male batterers in terms of referral source and racial background.

Referral Source

There were no significant differences between groups on referral source (self referral or court ordered), (x^2. = 1.184 df 1 p = < n.s.). Of the 39 depressed batterers, 20 were court referred and 19 were self-referred. Of the 61 nondepressed batterers 38 were court ordered and 23 were self-referred.

Race

There were significant differences among groups on race (white, black, and other), (x^2. = 10.421 df 2 p = < .005). Of the 39 depressed batterers, 22 were white, 13 black, and 4 other (Asian, Hispanic, Native American, or other). Of the 61 nondepressed batterers, 16 were white, 27 black, and 18 other (Asian, Hispanic, Native American, or other). The depressed group tended to be white, while the nondepressed group tended to be black.

Table 1

Intercorrelations Between Measures

	SMAST	Anger	Depres	Anxiety	Wjust[1]	Jealous	KMSS	MPDIF[1]	Psyagg
SMAST									
Anger	.184								
Depres	.322**	.469**							
Anxiety	.347**	.396**	.745**						
Wjust[1]	.069	.014	-.026	-.034					
Jealous	.033	.282**	.161	.244*	-.046				
KMSS	-.115	-.155	-.472**	-.191	.116	.226*			
MPDIF[1]	.147	-.046	-.198	-.118	.526**	-.063	.170		
Psyagg	.243*	.424**	.568**	.557**	-.082	.179	-.263**	-.065	
Phyaslt	.053	.236*	.264**	.294**	-.240*	.131	.005	.042	.629**

**. Correlation is significant a the 0.01 level (2-tailed)
*. Correlation is significant at the 0.05 level (2-tailed)

SMAST= Shortened Michigan Alcoholism Screening Test
Anger= NOVACO couples anger index, adapted version
Depres: SCL-90 Depression subscale
Anxiety= SCL-90 anxiety subscale
Wjust= Inventory of beliefs about wife beating subscale; justified
Jealous= White's Romantic Jealousy scale
KMSS= Kansas Marital Satisfaction scale
MPDIF= Couple Differentiation scale
Psyagg= CTS-2 psychological violence subscale
Phyaslt= CTS-2 physical violence subscale

[1] Reverse code

Table 2

Independent Samples Test

Subscale	Sample	Mean	sd	t	p
SMAST	Depressed	3.6	2.9		
	Nondepressed	2.8	2.0	-1.84	.070
anger	Depressed	87.3	20.6		
	Nondepressed	73.3	19.8	-3.10	.001
anxiety	Depressed	1.3	1.1		
	Nondepressed	.2	.3	-6.01	.001
Wj	Depressed	63.0	12.1		
	Nondepressed	64.1	12.0	.42	1.05
jealousy	Depressed	15.8	7.8		
	Nondepressed	15.7	7.9	-.05	.965
KMSS	Depressed	10.4	4.9		
	Nondepressed	14.1	4.5	3.92	.001
MPDIF	Depressed	36.9	5.1		
	Nondepressed	39.3	6.5	1.86	.067
psyasslt	Depressed	21.6	8.7		
	Nondepressed	11.5	8.4	-5.8	.001
physasslt	Depressed	9.7	10.3		
	Nondepressed	5.5	7.0	-2.4	.05

SMAST= Shortened Michigan Alcoholism Screening Test
Anger= NOVACO couples anger index, adapted version
Anxiety= SCL-90 anxiety subscale
Wj= Inventory of beliefs about wife beating subscale; justified
Jealousy= White's Romantic Jealousy scale
KMSS= Kansas Marital Satisfaction scale
MPDIF= Couple Differentiation scale
Psyasslt= CTS-2 psychological violence subscale
Physasslt= CTS-2 physical violence subscale

Table 3

Analysis of Variables

	Mean	Range	Standard Deviation	Alpha
Alcohol Use SMAST	3.9	1-8	1.7	.99
Depression SCL-90	1.26	0-3.54	.93	.93
Beliefs about wife beating Wjust	63.6	39-84	12.0	.72
Anxiety SCL-90	.64	0-4	.87	.95
Anger NOVACO	77.7	32-131	21.9	.94
Dominance restrictiveness	22.1	10-68	6.8	.42
Dominance disparagement	23.0	11-166	15.4	.12
Dominance authoritative	27.5	15-38	4.6	.64
Marital Satisfaction KMSS	12.7	3-21	5.1	.95
Differentiation MPDIF	38.4	26-53	6.1	.72
Jealousy jealous	16.0	6-36	8.0	.88
Psychological Aggression CTS-2	15.4	0-41	9.7	.84
Physical Aggression CTS-2	7.0	0-54	8.5	.87

CHAPTER FIVE: DISCUSSION

Summary of Findings

This study supported previous research in finding a relationship between male batterers level of depression and their alcohol use, anger, anxiety, marital satisfaction and level of psychological and physical violence. In addition, I found that depressed batterers were more angry, more anxious, more dissatisfied in their marriages, and more psychologically and physically violent than nondepressed male batterers. Interestingly, I found no differences between depressed batterers and nondepressed batterers in their alcohol use, level of jealousy, couple differentiation, and beliefs about the justifiability of wife beating (which has been shown in some studies to be the most important predictor of abusive behavior). Since alcohol use, jealousy, differentiation, and beliefs about justifiability of wife beating have been demonstrated to be highly related to relationship violence, these findings suggest that there might be some important differences among the depressed group that are accounting for the difference in violence, anger, anxiety, and marital satisfaction. This study provided support for the possibility that depression may be an underlying factor that increases the risk for violence in male batterers.

The biopsychosocial model guided this study. Important differences existed between depressed and nondepressed batterers in the realm of biological, psychological, and social variables in this study. Because there was not one particular category of variables that accounted for the differences among groups it is important to use to biopsychosocial framework that encourages and supports the use of multiple variable from an array of categories. These results highlight the value of using the biopsychosocial model to guide inquiry into this complex issue.

In this study I answered three questions: 1) What percentage of men in this study are depressed and what percentage are nondepressed according to the SCL-90 depression index? 2) How is level of depression correlated with each of the following variables; alcohol use, anger, anxiety, beliefs about wife beating, jealousy, marital satisfaction, dominance, couple

differentiation, and level of psychological and physical violence? 3) How do depressed versus nondepressed male batterers differ on these same variables (i.e. alcohol use, anger, anxiety, beliefs about wife beating, jealousy, marital satisfaction, dominance, couple differentiation, and level of psychological and physical violence). The next section of this chapter will discuss the results from each of these questions.

Question One

In response to the first question, I found that 36% of the male batterers in my study were depressed, according to their score on the SCL-90. This finding is consistent with some studies and lower then others. Feldbau-Kohn, Heyman, and O'Leary (1998) found similar results; one third of their sample (89 self-referred men who had been violent at least once toward their partner) demonstrated depressive symptomotology. Another study by Maiuro, Cahn, Vitaliano, Wagner, and Zegree (1988) reported that 67% of men sampled were depressed. One hundred of these men had histories of assaultive behavior and were enrolled in anger management class, 72% were court ordered, 28% were self-referred, while 29 served as the demographically matched nonassaultive control group. Only 29 out of the 129 men were domestically violent, others fell into categories of general assaulters (assaulted strangers, friends) and mixed assaulters (assaulted a mate and a nonintimate victim). The differences in these findings are interesting and noteworthy. They could be attributed to the fact that the second study sample consisted of a broader range and type of violence then the current sample. Differences might also be attributed to the fact that different measures of depression were used in the three studies being compared. While the percentages of batterers who are depressed differed in all three studies, the percentage of depressed batterers in these studies are higher then the rate of depressed men in the general population, 7-12% (U.S. Department of Health and Human Services 1993). Which suggests that depression is a serious problem among male batterers that should be addressed by treatment providers.

Question Two

The second question that guided this study was how is level of depression correlated with alcohol use, anger, anxiety, beliefs about wife beating, jealousy, marital satisfaction, dominance, couple differentiation, and level of psychological and physical violence? I found significant relationships between depression and alcohol use, anger, anxiety, marital satisfaction, physical violence, and psychological violence.

All of these findings are consistent with current research. For example, many research studies support the strong link between alcohol use and depression (Dawson & Grant 1996; Fava, Abraham, Alpert, et al 1996; Kornstein, Schatzberg & Yonkers, et al 1996; Reiger, Burke, & Burke 1990; Schuckit 1982; Schuckit 1996; Schutte, Hearst, and Moos 1997; Zisook & Schuckit 1986). Consistent with these findings, the relationship between anger and depression is supported throughout research (Biaggo & Godwin 1987; Mairuo, O'Sullivan, Michael, & Vitaliano 1989; Real 1997;Robbins & Tanck 1997). Also, there is research to support a strong relationship between anxiety and depression (Hecht, von Zerssen, & Wittchen 1990; Stavrakaki & Vargo 1986). Marital satisfaction and depression have been found to have a significant negative relationship, which is consistent with findings in this study (Fincham, Beach, Harold, & Osborne 1997). Lastly, depression and physical as well as psychological violence are significantly correlated. This is consistent with research that links depression and psychological violence (Grandin, Lupri, & Brinkerhoff 1998; Vivian & Langhinrichsen-Rohling 1994) as well as depression and physical violence (Beasley & Stoltenberg 1992; Hale, Duckworth, Zimostrad, & Nicholas 1988; Hamberger & Hastings 1986; Holtzworth, Munroe & Stuart 1994). I did not find significant relationships between depression and wife beating justified, depression and jealousy, and depression and couple differentiation. This is consistent with the nonexistence of research looking at these relationships.

Other significant relationships found among the variables used are noteworthy. There was a significant relationship between psychological violence and physical violence in this sample, which is consistent to findings that point out the path of psychological violence to

physical violence (Gottman, & Gortner, et al: (in press); Malone, & Tyree 1994; Murphy & O'Leary 1989; O'Leary & Curley, 1986). There was a significant relationship between marital satisfaction and psychological violence, but not between marital satisfaction and physical violence. This finding is interesting in terms of further research looking at the severity of psychological abuse versus physical abuse from the male batterers perspective and how it affects his view of his relationship. There is research evidence that a relationship between marital satisfaction and impaired communication and destructive behavior or conflict exists, but it is uncertain if this could be considered psychological violence or physical violence (Hinchliffe et al., 1978, and Kahn, Coyne, & Margolin 1985). Further research to examine these differences is warranted. There is a significant relationship between beliefs about wife beating and physical violence. This is consistent with current research (Hanson, Cadky, Harris, & Lalonde 1997; Sugarman & Frankel 1996). I found no previous research to support the relationship between anxiety and violence. Because the results of this study point to a strong relationship, further investigation is warranted. Anger and psychological as well as physical violence are significantly related in this study. These findings are consistent with other research (Biaggo & Godwin 1987; Mairuo, O'Sullivan, Michael, & Vitaliano 1989; Real 1997; Robbins & Tanck 1997).

These findings were not consistent with current research in finding a significant relationship between couple differentiation and violence (Rosen, Bartle-Haring, & Stith 1996). Furthermore, this study did not find a relationship between jealousy and violence, whereas other studies have (Barnett, Martinez, and Bluestein 1995; Dutton, van Ginkel, & Landolt; Holtzworth-Munroe, Stuart, & Hutchinson 1997; Holtzworth-Munroe & Hutchinson 1993). The nonexistence of these relationships is perplexing. The results are based on self-reported answers and it is proven that men underreport. We did not include a social desirability scale as part of this study therefore we don't know if these answers are due to the fact that a majority of these men are court ordered to be involved and might be inclined to report what is socially acceptable.

Also, there was no significant relationship between alcohol use and violence. This finding is inconsistent with the current research that states that alcohol use and violence are strongly linked (Oriel & Fleming 1998; Real 1997; Schuerger & Reigle 1988). One research team, Telch, Ummel, and Lindquist (1984) found alcohol use to be the strongest predictor of violence. This finding is perplexing but could be substantiated by the fact that as part of the inclusionary criteria for the NIMH funded grant we do not accept men that have high levels of alcohol use into our study. Therefore, this sample is not representative of the general population of violent men. Because of the low variance of alcohol use there lacks a significant relationship between alcohol use and violence.

Question Three

The third question that guided this study was, How do depressed versus nondepressed male batterers differ on these same variables (i.e. substance abuse, anger, anxiety, beliefs about wife beating, jealousy, marital satisfaction, dominance, couple differentiation, and level of psychological and physical violence). This study found important differences among groups of depressed and nondepressed men. Men that are depressed and violent differed in, level of anger, level of anxiety, marital satisfaction, amount of physical abuse, and amount of psychological violence. As expected, depressed male batterers differed from nondepressed male batterers on psychological and physical violence. An earlier study by Grandin, Lupri, and Brinkerhoff (1998) found that both types of violence were associated with increased depression for both men and women. Findings from this study looking at differences among groups in relation to anger are supported, for example, violent men score higher on anger and depression then nonviolent men (Maiuro, O'Sullivan, Michael, & Vitaliano 1989). Findings leading to differences among groups on marital satisfaction are consistent with results indicating depressed persons were more dissatisfied with their relationship and reported more aggressive tendencies then those couple that were not depressed (Kahn, Cohn, & Margolin 1985). Because of the strong relationship between anxiety and depression (Hecht, von Zerssen, & Wittchen 1990; Stavrakaki & Vargo 1986), it makes sense that depressed male batterers are more anxious then

nondeppressed male batterers, even though there is no research to support the relationship between anxiety and violence.

Limitations

A number of limitations lead to caution in interpreting the results from this study. First, the sample size, while appropriate for this type of analysis, was not large. Only 107 men participated in the study. Furthermore, the participants were a convenience sample of those men who volunteered to participate in the study. They were not randomly selected so we cannot assume that results from this study can be generalized to all men who are violent to their wives.

Also, all the variables assessed in this study are based on the self-reports of participants. We did not assess tendency to give socially desirable responses.

Furthermore, the exclusionary criterion used as part of the larger NIMH study could possibly limit the variance in terms of level of violence and substance abuse. By screening out those men that reported high levels of violence, and high rates of alcohol use in the study we limited the generalizability of the sample.

Finally, the analyses used in this study (correlations and t-tests) were univariate and did not control for the number of analyses conducted. We were also not able to control for interaction effects or the indirect effects of certain variables on other relationships.

Future Research

Further research is warranted in the area of depression and violence among men. Clearly there are many differences among groups of depressed and nondepressed male batterers, and in order to explore these differences further a multivariate analysis would be useful. A path analysis which explains direct and indirect relationships would further the understanding of the differences among these groups of batterers.

I was intrigued by the relationship between anger, violence, and depression in this study and by Real's (1997) theory that anger is a symptom of depression in men. Real's (1997) comment that, "the stable ration of women in therapy and men in prison teaches us about the ways in which each sex is taught to handle pain" (p. 83) stays with me as I look at this issue and see the benefit of further research on this topic. Further research looking at the relationship between anger, violence, and depression men could provide a justification for revising tools that are currently used to measure depression. It is possible that current instruments are missing some men that are depressed and that instruments measuring depression in men need to include items that assess anger and aggression.

Since depression seems to be strongly linked to domestic violence, another valuable study would be to compare men who receive specific treatment for depression with their anger management treatment (e.g., antidepressants and/or psychological treatment of depression) and compare their outcome with those who receive anger management treatment as usual.

Another interesting study might be to examine the path of depression in the male batterer, is the timing of administering the depression scale important in terms of depression as situational or depression as a pattern of cognitive impairment? It would be noteworthy to examine pre and posttest depression measures to help us better understand whether or not depression decreased over time, in turn supporting the notion that what we as researchers are measuring may be situational. Furthermore, studying the rate of drop out in treatment of male batterers would be useful to examine. Are those that are dropping out more apt to be depressed? Findings like these would warrant investigation of appropriate treatment protocol for the depressed male batterer.

Clinical Importance

In previous studies relationships have been found that were not found when examining male depressed batterers. This raises that question that if there are differences should treatment be the same? Previous treatment of male batterers have focused on issues of power and control, this study presents different findings within a specific population, the depressed male

batterer. If the two groups did not differ on certain issues such as jealousy and couple differentiation, both having to do with external things then should treatment be more be more about regulating internal resources? Further research looking at violence as a means of affect regulation versus power and control would be useful to determine if different mean of treatment needed to be offered to this type of population. Current treatment of male batterers is based on discussing and informing men about issues of power and control and entitlement. Could the depressed male who is experiencing low cognitive resources be violent in reaction to a feeling of personal threat and general agitation, or a feeling of powerless over his environment. Because treatment of male batterers has little to do with regulating depression and the assumption is that violence is all about power and control, what if for depressed male batterers violence is a means for them to regulate their own state. A means for them to regulate external circumstances that they cannot regulate any other way because of their cognitive impairment. Treating male batterers assuming that each individual's violence is attributed to power and control issues could have ethical implications as well. If the men that we as clinicians are treating are cognitively impaired and we are not treating that component we are neglecting a major piece, therefore not acting in the best interest of the client.

Furthermore, depression does not look the same in every individual, as every violent man does not look the same. In order to adequately treat each individual we as clinicians should not assume treatment is the same for every individual. Just as depression may be manifesting as violence in this sample of men, it may manifest as something else in a different male. A thorough assessment at time of treatment is necessary in order to provide optimal care and correct treatment of the problem. Looking for depression in the male batterer should be included in this thorough assessment.

As a Marriage and Family Therapist one must look carefully at the complexity of the violent depressed man, and see the usefulness in examining multileveled influences such as biological, psychological, and social phenomenon that allow for differences in the male batterer. In order to fully work from a systemic approach one must be mindful and recognize the possible

issue of depression in violent men and be open to appropriate treatment. From a clinical standpoint the use of medication and the importance of referring a client for a psychological evaluation should be stressed. Understanding and exploring all aspects of the male batterer, while putting attention on what is needed and backed by research will make for better treatment.

Summary

The present study has shown that it is useful to assess male batterers for depression. This study revealed that depressed and nondepressed male batterers differed significantly along the levels of alcohol use, anxiety, marital satisfaction, anger, physical violence, and psychological violence. This information can be helpful to clinicians treating male batterers and should encourage them to be mindful of symptoms of depression. It would seem that medication might be helpful in the treatment of depression in male batterers. Being careful to assess and treat depression might lead to better treatment of this complex issue or at the very least lead to cognizance on the part of clinicians working with this population.

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APPENDIX A

VIRGINIA TECH COUPLES TREATMENT PROGRAM

INFORMED CONSENT

What is it?

- The Virginia Tech Couples Treatment program is a research project designed to see if adding couples treatment to a men's domestic violence program will be helpful to couples trying to end the violence in their relationships.

What Will I Have to Do?

- Fill out questionnaires before the beginning of treatment, at the end of treatment, and three months after that. Filling out the questionnaires should take about an hour.
- Male partners only: attend all required sessions of an anger management program if you haven't already completed one
- Female partners only: attend a minimum of two sessions of women's group (number of sessions and format -- group or individual -- to be determined based on individual needs).
- Attend an additional 12 sessions of couples therapy (either in a group with other couples or you and your partner alone with a counselor) if you are randomly assigned to receive couples therapy
- Allow your couples therapy sessions (whether group or individual) to be videotaped for research purposes
- Complete a short questionnaire after each couples therapy session
- If asked, do a tape-recorded interview with a researcher about how the treatment has or has not been helpful

What are the Benefits and Risks?

- You will be helping us test a treatment that may help other people with some of the same problems you are having
- You will get additional therapy to help you work on problems in your own relationship
- Like any therapy, you may be asked to talk about upsetting or difficult issues
- It is possible that working on problems as a couple may lead to angry or violent feelings. You will be asked to sign an agreement to control these feelings. Your counselor will help you follow through with the agreement
- There is no guarantee that by participating in this project the violence in your relationship will end or that you will stay together.

Is it Private?

- All information you give in treatment is confidential. We will use our certificate of confidentiality that we have received from the Federal Government to help protect your privacy. However, there are times when your counselor may need to break that confidentiality.
    - If you threaten to hurt yourself or someone else, the counselor must take steps to protect you or others
    - If you reveal information that leads the counselor to think that a child or dependent adult has been abused, appropriate county officials must be notified

Will I get Paid?

- We will pay each of you $20 ($40 per couple) to complete the first set of follow-up questionnaires upon completion of therapy, and $50 each ($100 per couple) to complete the second set of questionnaires (3 months after the completion of treatment). You will not be paid for any other activity that is part of the project.

Can I quit if I want to?

- The couples counseling project is voluntary. You may withdraw from it at any time.

Approval of Research

- This research project has been approved, as required, by the Institutional Review Board for projects involving human subjects at Virginia Polytechnic Institute and State University, and by the Department of Family and Child Development.

Participants' Agreement and Responsibilities

- I have read and understand what my participation in this project entails and I know of no reason that I cannot participate in this project. I have had all my questions answered and hereby give my voluntary consent for participation in this project.
- Should I have any questions about this project or its conduct, I can contact any of the following: Dr. Sandra Stith, Principal Investigator (703-538-8460); Dr. Gloria Bird, Department of Family and Child Development (540-231-4791) or Dr. H. T. Hurd, Chair of the Virginia Tech IRB (540-231-5281).

_____ _____

Signature Date

_____

Printed Name

_____ _____

Witness Date

VIRGINIA TECH COUPLES COUNSELING PROJECT

INFORMED CONSENT

PARTICIPANT'S INFORMATION

Should you have any questions about this project or its conduct, you can contact any of the following people:

- Dr. Sandra Stith, Principal Investigator (703-538-8460);
- Dr. Gloria Bird, Department of Family and Child Development (540-231-4791)
- Dr. H. T. Hurd, Chair of the Virginia Tech IRB (540-231-5281).

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Education:

MS, Marriage and Family Therapy, Virginia Tech, Northern Virginia Campus, Falls Church, VA. GPA, 3.9, Thesis: A Comparison of Depressed and Non-depressed Male Perpetrators of Partner Violence. Five hundred direct client contact hours accumulated from this accredited program.

BS, Family and Child Development, Human Services, Virginia Tech, Blacksburg, VA, May 1996, GPA in Major, 3.7- GPA (Overall), .3.3.

Clinical Experience:

Therapist Intern, CENTER FOR FAMILY SERVICES, Falls Church, VA. August, 1998-present. Maintains a caseload of four clients a week under supervision of Licensed Marriage and Family Therapists. Works systemically with individuals, couples and families. Over 500 hours of practical counseling experience accumulated.

Therapist Intern, FORT BELVOIR FAMILY LIFE CENTER, Alexandria, VA August, 1999-present. Supervises a caseload consisting of five to seven couples, individuals, or families a week. Works from a solution focused approach with military families at an on-post clinic.

Therapist Intern, ALTERNATIVE HOUSE, Vienna, VA. January, 1999-May 1999. Provides crisis counseling and therapy to adolescents and families in a temporary teen shelter under the supervision of an AAMFT approved supervisor.

Co-Facilitator, MEN'S ANGER MANAGEMENT GROUP, Virginia Tech. Fall 1998. Co-facilitated a 12-week psychoeducational group for court ordered and self referred male perpetrators of domestic violence.

Intern, RAFT ACCESS SERVICES, Blacksburg, VA. May, 1995-August 1996. Evaluated various community services of RAFT branches to identify effectiveness and population reached. Paraprofessional counselor providing immediate emergency crisis intervention to callers, including problem identification and referrals.

Peer Educator, VIRGINIA TECH UNIVERSITY HEALTH SERVICES, Blacksburg, VA. August 1995-May 1996. Facilitated discussion groups on Sexually Transmitted Diseases, Interpersonal Skills/Communication, Breast Cancer, Contraception, Alcoholism, and other major college health and social issues.

Facilitator, NEW RIVER VALLEY MENTAL HEALTH ASSOCIATION, Radford, VA. December 1994-May, 1995. Facilitated instruction in self-esteem and other health issues for elementary students using group techniques.

Research Experience:

Graduate Research Assistant, VIRGINIA TECH UNIVERSITY, Falls Church, VA. September 1997-present. Administers and manages a grant through the National Institute of Mental Health to help develop a model of conjoint therapy for couples experiencing mild to moderate levels of domestic violence. Conducts research and manages a grant with the United States Air Force/ USDA Family Advocacy project.

Mentoring Trainer, VIRGINIA TECH/GEORGE MASON HIGH SCHOOL, Falls Church, VA. September 1997-May 1998. Key player in development and presentation of training program for high school mentors for middle school students.

Professional Organizations:

Student Member 1996-present

American Association of Marriage and Family Therapy

Certified member 2000-present

Prepare/Enrich premarital program