Characteristics of Women Physically Abused by Their Spouses and Who Seek Treatment Regarding Marital Conflict

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Physically abused women seeking treatment for marital difficulties (abused women, \( n = 49 \)) were compared with maritally discordant, nonabused women (discordant only, \( n = 23 \)) and maritally satisfied nonabused women (community control, \( n = 25 \)). Abused women reported significantly more fear of their spouses and reported that their spouses were significantly more coercive and psychologically aggressive than women in the 2 matched nonabused groups. Abused women did not report higher rates of abuse as a child, nor did they report higher rates of past psychopathology than women in the nonabused groups. However, abused women and nonabused discordant women reported higher rates of emotional abuse in childhood than maritally satisfied, nonabused women. Furthermore, both clinical groups had a tendency to have higher lifetime rates of major depression before their current marriage than the maritally satisfied women. This result suggests that childhood abuse and a history of depression may be risk factors for women in abusive and nonabusive discordant relationships. As expected, abused women reported higher rates of posttraumatic stress disorder than women in the discordant-only and community control groups. Treatment implications for both standard treatments for marital problems and treatments for victims of physical abuse are discussed.

There has been a dramatic expansion of research in domestic violence and marital aggression during the past 2 decades. The majority of research conducted with battered women has been descriptive in nature and has excluded relevant control groups (e.g., Browne, 1987; Gleason, 1993; Walker, 1979, 1984). In a different vein, surveys of representative samples of American adults have focused on comparisons between women who report physical victimization by a spouse and those who do not (e.g., O’Leary, Barling, Arias, Rosenbaum, Malone, & Tyree, 1989; Gelles & Straus, 1988). Controlled investigations have examined differences between battered women seeking services at domestic violence agencies and nonbattered women in discordant marriages (e.g., O’Leary & Curley, 1986; Rosenbaum & O’Leary, 1981). A critical comparison that has received scant attention is that of women who are physically abused by their partners and who seek treatment for marital problems versus those who are not abused and are seeking treatment for marital problems.

This comparison is important because 65% to 70% of women seeking treatment for marital problems report at least one act of physical victimization by a spouse in the year before assessment, but only 3% to 6% spontaneously mention physical aggression as a problem for which they are seeking treatment (Cascardi, Langhinrichsen, & Vivian, 1992; O’Leary, Vivian, & Malone, 1992). The ways in which abused women who seek treatment for marital problems differ from women who are not abused yet seek treatment for marital problems will help in making informed decisions about for whom standard marital intervention may be appropriate. For example, if a woman desiring treatment for marital difficulty reported that she had been slapped several times by her partner in the past year, disclosed fear about her partner’s future behavior, felt limited in her capacity to make decisions for herself because of her partner’s coercion, and experienced symptoms of posttraumatic stress disorder (PTSD), then standard marital intervention may not be appropriate. However, to date, no studies compare the experiences of abused women seeking treatment for marital problems to those not abused by their partners who are also seeking treatment for marital problems.

Coercion by and Fear of One’s Spouse

Battering relationships have frequently been described as coercive, fear producing, and unpredictably violent (Browne, 1987; Martin, 1976; Murphy & Cascardi, 1993; Okun, 1986; Pagelow, 1981; Tolman, 1989; Walker, 1984). Interviews with currently and formerly battered women identified several uni-
fying themes in battering relationships: the use of jealousy and possessiveness, economic pressures, threats, destruction of property, social isolation, and emotional abuse (insults, verbal attacks) to control one's partner (Okun, 1986; Walker, 1979). Tolman (1989), in a study of men and women seeking or mandated to treatment in a domestic violence agency, has provided additional empirical support of these coercive patterns of behavior.

Cantos, Neidig, and O'Leary (in press), in an evaluation of women whose husbands were mandated to treatment, found that wives in aggressive marriages were significantly more fearful of their husbands than were their husbands of their wives. Furthermore, in a comparison between battered women seeking individual treatment and nonbattered marital discordant women seeking marital treatment, battered women displayed significantly more fear of their spouses (O'Leary & Curley, 1986). Such fear, coercion, and unpredictable violence are hypothesized to give rise to battered-woman syndrome (Walker, 1989), as well as other features of psychopathology: depression, substance abuse, somatic and anxiety disorders (particularly PTSD; Follingstad, Brennan, Hause, Polek, & Rutledge, 1991; Gleason, 1993; Stets & Straus, 1990; Walker, 1984). However, fear and coercion have not been systematically evaluated in samples of women seeking treatment for marital problems. Without such research, it is unclear whether these constructs characterize the highly conflicted and violent relationships seen in marital clinics. If these constructs do indeed characterize the experience of women in physically aggressive relationships who seek treatment for marital problems, then standard marital interventions may need to be reconceptualized and systematic evaluation of marital aggression, fear, and degree of coercion should be incorporated into intake assessments.

Psychopathology in Response to Abuse

A consistent finding across varied clinical samples (i.e., women in a shelter, those seeking services from a community agency, those seeking treatment for marital problems, and victimized women in the community) is that abused women are depressed or have elevated depressive symptomatology at the time of assessment (i.e., Cascardi & O'Leary, 1992; Cascardi et al., 1992; Gleason, 1993; Hartik, 1982; Walker, 1979, 1984). In addition, research suggests that level of depressive symptomatology is associated with increases in the severity of violence (Cascardi & O'Leary, 1992; Gelles & Straus, 1988).

In addition to depressive symptomatology, abused women across various samples also report high rates of somatic and anxiety-related symptoms. Follingstad et al. (1991) documented that 65% of battered women solicited from the community frequently suffered headaches, fainting and dizziness, stomach and gastrointestinal problems, heart and blood pressure problems, or breathing problems. In addition, 46% of severely victimized women sampled from the community reported feeling nervous or stressed, 31% reported headaches or pains in the head fairly or very often in the past year, and 6% of these women reported cold sweats (Gelles & Straus, 1988). In a more severely victimized sample, Gleason (1993) found that between 15% to 50% of battered women at a shelter and 24% to 50% of battered women living with their abusive partners suffered from anxiety disorders (i.e., phobias, agoraphobia, social phobia, obsessive compulsive disorder, and panic disorder) in the month before assessment. More recently, PTSD has been offered as a useful framework to understand psychological reactions to severe battering (Browne, 1993). Rates of PTSD in reaction to battering among women seeking safe refuge at battered women's shelters range from 31% to 84% (Dutton, 1992; Gleason, 1993; Houskamp & Foy, 1992; Kemp, Rawlings & Green, 1991). To date, no study has examined the incidence of PTSD in a sample of women seeking treatment for marital problems.

Risk Markers

Psychopathology has also been used to explain why a woman is battered (e.g., Snell, Rosenwald, & Robey, 1964). Studies from psychiatric populations of women illustrate that 50% of women seeking treatment for psychological difficulties at a mental health facility were battered and had previously sought treatment for depression, alcoholism, schizophrenia, or personality disorders (Hilberman, 1980). Similarly, Rounsaville (1978) found that 23% of battered women referred from the emergency room for psychiatric treatment had sought some form of treatment before their involvement in an abusive relationship. Gleason (1993) documented significantly higher lifetime prevalence rates of anxiety, substance abuse or dependence, and major depressive disorders in battered women than women surveyed a nationally representative sample, the Epidemiological Catchment Area Study.

Other risk marker studies have attempted to discern whether childhood victimization increases a woman's risk for wife abuse (e.g., Hotaling & Sugarman, 1990). Women victimized by their spouses have frequently been found to have experienced physical, emotional, or sexual abuse in childhood (Andrews & Brown, 1988; Gelles & Straus, 1988; Labell, 1979; Lewis, 1987; Walker, 1989). Uncontrolled studies from shelter populations and comparison studies from community samples have generally found that women physically victimized by their spouses were more likely to have been abused in childhood than nonvictimized married women. However, in a review of the literature and in an analysis of over 600 nationally representative women from the community, Hotaling and Sugarman (1986, 1990) concluded that the frequency of abuse in childhood was not significantly associated with victimization by a spouse. Although childhood victimization may not increase a woman's risk for wife abuse, it may exacerbate the psychological impact of such abuse in marriage.

It is imperative to begin to discern differences among women who seek marital intervention in regard to the aforementioned characteristics to inform treatment strategies and etiologic models. No evaluation to date has examined psychopathology (current and lifetime) within the context of childhood victimization and abusive relationship features using relevant control groups (e.g., maritally distressed, nonabused women). This is also the first study to assess generalized and spouse-specific fear systematically. The present study evaluated the rates of childhood victimization, relationship abuse characteristics, and affective and anxiety disorders in abused women seeking treatment for serious marital conflict in marriage.

It was expected that abused women would report (a) that their
spouses were more coercive and (b) that they would be more fearful of their spouses than nonabused married women. On the basis of past research, abused women were not expected to report higher rates of physical or sexual abuse as a child than nonabused married women. Emotional abuse as a child was examined in an exploratory manner because it has not received systematic attention in the literature. Last, abused women were predicted to report higher rates of current depression, PTSD, generalized anxiety, and panic disorders than nonabused married women. However, it was predicted that abused women would not report higher rates of this psychopathology before their current relationships than nonabused married women.

Method

Participants

Three groups (n = 49 abused women, n = 23 maritally discordant, nonabused women (discordant only), and n = 25 maritally satisfied, nonabused women (community controls)) matched on age and income were recruited for participation. Abused and discordant-only women were also matched on levels of marital distress. Discordant-only and community control groups were matched to the abused women using the 95% confidence interval for these variables.

Abused women were sampled from married women recruited to participate in a treatment study for serious marital conflict. Women in this group were screened over the telephone for the presence of physical aggression. For inclusion in this study, the women reported at least two acts of husband-to-wife physical aggression in the year before the telephone screening. For example, a woman who reported that her spouse pushed or shoved her two times was included as was a woman who reported that her husband beat her up twice in the past year.

To recruit the discordant only women, advertisements were placed in a local newspaper for women who self-identified as having problems in their current relationships than nonabused married women.

Procedure

A brief interview to gather information about family history and current stressors and the Structured Clinical Interview for DSM-III-R (SCID–Axis I; Spitzer, Williams, Gibbon, & First, 1992) were administered to all eligible participants for the two control groups. Five self-report questionnaires were administered after completion of the interview. In total, the assessment protocol required 45 to 120 min to complete depending on the level of psychopathology reported by the participant.

Participants who met the aforementioned initial screening criteria for the spouse abuse treatment program participated in the screening protocol required for inclusion in the treatment study. Only the information necessary for the present study was extracted from the treatment study protocol (family history and current stressor interview, SCID–Axis I, the same five self-report questionnaires administered to the control groups, and a marital violence interview). The entire treatment study protocol necessitated 2 to 3 hr to complete.

Measures

SCID. The SCID with psychotic screen for Axis I disorders, including the PTSD module, was administered to all participants. The following diagnostic categories were evaluated because of their perceived relevance to abused women: PTSD, major depressive disorder, generalized anxiety disorder, and panic disorder.

The inter-rater and test–retest reliability of the SCID is reported to be consistent with the reliability of other established diagnostic instruments, such as the National Institute of Mental Health Diagnostic Interview Schedule (Endicott & Spitzer, 1978) and the Schedule for Affective Disorders and Schizophrenia (Robins, Helzer, Croughan, & Ratcliff, 1981). In a multisite evaluation of the test–retest reliability for the SCID, kappas for current and lifetime diagnoses were adequate (ranging from .61 to .68). However, agreement was lower for nonpatient samples: kappa = .37 for current diagnosis and kappa = .51 for lifetime diagnosis (Williams et al., 1992). These data raise some concern about the reliability of current diagnosis for nonpatient samples. Therefore, special care was taken to train interviewers to reliability.

Four interviewers administered the SCID for the participants in this study: the primary investigator, one graduate student in clinical psychology, and two research assistants who were undergraduate psychology majors. All interviewers were trained to reliability through the use of SCID training tapes and sample SCID interviews. The interviewers

Table 1

Sample Characteristics: Means and Standard Deviations

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Abused women (n = 46)</th>
<th>Discordant only (n = 23)</th>
<th>Community control (n = 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>33.1 (7.3)</td>
<td>34.5 (6.8)</td>
<td>31.9 (5.1)</td>
</tr>
<tr>
<td>No. of years married</td>
<td>7.1 (6.7)</td>
<td>10.7 (6.7)</td>
<td>7.4 (6.1)</td>
</tr>
<tr>
<td>Total family income ($)</td>
<td>42,017 (20,222)</td>
<td>43,521 (19,775)</td>
<td>48,200 (17,034)</td>
</tr>
<tr>
<td>Education (no. of years)</td>
<td>13.5 (1.9)</td>
<td>14.4 (2.0)</td>
<td>14.6 (2.1)</td>
</tr>
<tr>
<td>No. of children</td>
<td>1.7 (1.9)</td>
<td>1.8 (1.0)</td>
<td>1.6 (0.8)</td>
</tr>
<tr>
<td>Marital satisfaction rating</td>
<td>75.8 (15.4)</td>
<td>81.4 (13.4)</td>
<td>117.1 (8.0)</td>
</tr>
</tbody>
</table>
continued training until 95% agreement was achieved for endorsement of specific symptoms of depression and anxiety.

The Modified Conflict Tactics Scale (MCTS). Neidig and Friedman (1984) developed a modified version of the Conflict Tactics Scale (CTS; Straus, 1979) that includes additional items for more specific assessment of the topography of physical aggression. The scale measures the occurrence and frequency of three conflict resolution domains: reasoning, verbal aggression and physical aggression within the past year. Barling, O'Leary, Jouriles, Vivian, and MacEwen (1987) found two stable factors on the CTS: verbal aggression and physical aggression. The CTS yields high internal reliability (Straus et al., 1980). In an interview format, participants were asked about the injuries sustained resulting from battering according to five categories of injury: (a) minor cuts and bruises, (b) serious cuts and bruises, (c) broken bones, teeth, black eyes, (d) internal injuries, and (e) other. Participants were also asked to report how many separate episodes of physical aggression there had been in the past year to supplement frequency data from the MCTS.

Locke–Wallace Short Marital Adjustment Test (SMAT). The SMAT is a 20-item scale of marital adjustment developed by Locke and Wallace (1959). It assesses the amount of agreement and disagreement between husband and wife on various issues; other items tap areas related to marital satisfaction. A cutoff score of 100 is used to discriminate maritaly distressed and maritaly satisfied couples. This measure has been found to correlate with numerous marital indices and to be sensitive to changes in marital satisfaction in treatment outcome research (O'Leary & Arias, 1987).

Psychological Maltreatment of Women Scale (PMTW). Tolman (1989) developed a 56-item, self-report questionnaire to assess the psychological maltreatment of women. Items were chosen to reflect a batterer's attempts to control his partner's contact with others and the outside world, to demand subservience, to degrade and humiliate, to define her reality, and to threaten. Responses on the scale ranged from never to always over the past 6 months. Factor analysis revealed two factors: dominance-isoation and emotional-verbai assault. The dominance/isolation factor was of interest for this study. Subscale reliability for this factor was high in Tolman (1989), r = .94 for women, and r = .91 for men. For the present study, an abbreviated version of the dominance/isolation subscale was used. The 14 items with factor loadings greater than .59 comprise the scale. Cronbach's alpha reflects high internal consistency of this measure in the present sample of women (r = .89).

Spouse-Specific Fear Measure (SSFM). This self-report scale was developed by O'Leary and Curley (1986). Participants were asked to rate on a scale ranging from 0 (never) to 4 (always) how often they were scolded or yelled at, hit or slapped, or beaten by their mothers or fathers (or both parents). Internal consistency for this portion of the measure was adequate (r = .70).

Results

Spouse-Specific Fear

A one-way multivariate analysis of variance (MANOVA) followed by a one-way univariate analysis of variance (ANOVA) and Tukey honestly significant difference (HSD) post hoc analyses were used to examine group differences on the three spouse-specific fear measures: worry about upsetting one's spouse, overall fearfulness of one's spouse, and the number of fear-producing behaviors. There was an overall group effect, Rao's $R(6, 178) = 10.56$, $p < .001$. The groups differed significantly on each dependent variable: worry about upsetting spouse, $F(2, 93) = 12.28$, $p < .001$; overall fearfulness of one's spouse, $F(2, 94) = 15.37$, $p < .001$; and number of fear-producing behaviors, $F(2, 94) = 35.31$, $p < .001$. Post-hoc analyses indicated that abused women were significantly more worried about upsetting their spouses than community controls, Tukey HSD < .05, but did not differ from discordant-only women. Abused women were also significantly more generally fearful of their spouses than discordant-only women and community controls, Tukey HSD < .05. Abused women reported that they feared their spouses would engage in significantly more fear-producing behaviors than discordant-only women and community controls, Tukey HSD < .05. Unexpectedly, discordant-only women also reported significantly more fear-producing behaviors than community controls, Tukey HSD, $p < .05$. Means and standard deviations for each group are presented in Table 2.

Because abused and nonabused discordant-only women both reported significantly more fear of their spouses than non-

<table>
<thead>
<tr>
<th></th>
<th>M (and SD)</th>
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<tbody>
<tr>
<td><strong>Fear</strong></td>
<td></td>
</tr>
<tr>
<td>Abused women</td>
<td>(n = 47)</td>
</tr>
<tr>
<td>Discordant only</td>
<td>(n = 22)</td>
</tr>
<tr>
<td>Community control</td>
<td>(n = 25)</td>
</tr>
<tr>
<td>Worry about upsetting spouse</td>
<td>4.4 (1.7)°</td>
</tr>
<tr>
<td>Overall fear of spouse</td>
<td>3.4 (1.6)°</td>
</tr>
<tr>
<td>No. of things participant fears that spouse may do</td>
<td>5.5 (2.6)°</td>
</tr>
</tbody>
</table>

° Abused women > discordant only. ° Abused women > community control. ° Discordant only > community control.

1 Data were collected on women in all three groups on general fearfulness. No group differences were found on this variable. These data were not reported in the text because they were not central to the questions of interest. However, they warrant mention because of the significant differences found on spouse specific fearfulness: that is, abused women were not more fearful in general, but rather were only more fearful of their spouses than the comparison groups.
Table 3
Psychological Coercion and Aggression by a Spouse: Means and Standard Deviations

<table>
<thead>
<tr>
<th>Psychological coercion and aggression</th>
<th>M (and SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abused women (n = 47)</td>
<td>Discordant only (n = 23)</td>
</tr>
<tr>
<td>Psychological coercion</td>
<td>28.2 (9.8)b</td>
</tr>
<tr>
<td>Psychological aggression</td>
<td>34.2 (7.9)b</td>
</tr>
</tbody>
</table>

* Abused women > discordant only.  b Abused women > community control.  c Discordant only > community control.

abused, nondiscordant women, it was important to clarify the specific nature of the fears expressed by the abused and nonabused discordant women. Significantly more abused women were fearful that their spouses would get upset (79% vs. discordant-only, 52%), $\chi^2(1, N = 70) = 5.18, p < .03$; start an unpleasant argument (79% vs. discordant-only 52%), $\chi^2(1, N = 70) = 5.18, p < .03$; become verbally threatening (68% vs. discordant-only 30%), $\chi^2(1, N = 70) = 8.87, p < .003$; become physically threatening (57% vs. discordant-only, 9%), $\chi^2(1, N = 70) = 15.12, p < .001$; do something unpredictable (55% vs. discordant-only, 22%), $\chi^2(1, N = 70) = 7.06, p < .008$; lose control of themselves (66% vs. discordant-only, 35%), $\chi^2(1, N = 70) = 6.08, p < .01$; physically assault them (45% vs. 0% discordant-only, 22%), $\chi^2(1, N = 70) = 14.68, p < .001$; or physically injure them (23% vs. 4% discordant-only), $\chi^2(1, N = 70) = 6.08, p < .01$. Abused and discordant-only women were equally likely to fear that their spouses might destroy property or leave them. Abused women were also significantly more likely to fear their spouses would engage in all of the aforementioned behaviors, compared with community controls. However, discordant-only women were significantly more fearful that their spouses would get upset, start an unpleasant argument, verbally threaten, destroy property, or leave them than the community controls.

Psychological Coercion and Aggression

One-way MANOVA, ANOVAs and Tukey HSD post hoc analyses were also used to evaluate group differences on frequency of psychological aggression and coercion perpetrated by a spouse. There was a significant overall group effect, Rao’s $R(4, 182) = 23.21, p < .001$. One-way ANOVAs and Tukey HSD indicated that abused women reported significantly more psychological coercion and aggression than discordant-only and community control women. For coercion, $F(2, 94) = 12.28, p < .001$, Tukey HSD < .05; for aggression, $F(2, 94) = 59.25, p < .001$, Tukey HSD < .05. Discordant-only women also reported that their spouses were significantly more psychologically aggressive and coercive than community-control women, Tukey HSD < .05. Means and standard deviations are presented in Table 3.

Childhood Victimization

Chi-square ($2 \times 2$) analyses were used to examine group differences on perceptions of abuse as a child. A $p$ value less than .02 was necessary to achieve statistical significance to correct for multiple comparisons. Rates of physical and sexual abuse in childhood did not differ significantly across groups, $\chi^2(2, N = 97) < 1, p > .1$. However, abused and discordant women reported significantly higher rates of emotional abuse in childhood than did community-control women, $\chi^2(1, N = 74) = 11.97, p < .001$, and $\chi^2(1, N = 48) = 5.65, p < .01$, respectively. Rates per group are displayed in Table 4.

No group differences emerged on objective ratings of child abuse using a one-way MANOVA to evaluate mean frequency of physically abusive behaviors. Abused women did not report that they were scolded or yelled at, hit or slapped, or beaten by their mothers or fathers more often than the controls, Rao’s $R(12, 154) = 1.21, p = .28$. The mean frequency for each item ranged from often for being scolded or yelled at to sometimes-rarely for beaten hit, slapped, or beaten across groups.

Psychopathology (Current and Lifetime)

Group differences on each diagnosis were evaluated by 3 (group) $\times 2$ (diagnosis: yes—no) chi-square analyses. A $p$ value less than .007 was necessary to achieve statistical significance to correct for multiple comparisons (seven overall diagnostic comparisons were conducted). If the overall $3 \times 2$ chi-square for diagnosis was significant, post hoc $2 \times 2$ chi-square analyses were conducted to determine the source of significance.

There were overall group trends for past and current major depression, panic disorder, and generalized anxiety disorder, $\chi^2(2, N = 96) = 6.28, p < .04$; $\chi^2(2, N = 96) = 7.72, p < .02$; $\chi^2(2, N = 96) = 7.45, p < .02$; and $\chi^2(2, N = 96) = 5.72, p < .06$, respectively. An examination of rates of these disorders across groups shows that both abused and discordant-only women had elevated rates of depression, panic disorder, and generalized anxiety disorder, compared with community-control women. The rates for current PTSD were significantly different across groups, $\chi^2(1, N = 71) = 9.9, p < .001$, and community-control women, $\chi^2(1, N = 73) = 3.6, p < .05$. No significant differences on rates of dysthymia or past PTSD were found. Interestingly, the mean age of onset of major depression for women who reported a history of depression predated their current marriages (mean ages ranged from 19.3 [abused women] to 23.6 [maritally satisfied women]). Rates are presented in Table 5.

Table 4
Subjective Report of Childhood Victimization

<table>
<thead>
<tr>
<th></th>
<th>% abused women (n = 49)</th>
<th>% discordant only (n = 23)</th>
<th>% community control (n = 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>10</td>
<td>17</td>
<td>12</td>
</tr>
<tr>
<td>Emotional</td>
<td>58*</td>
<td>48*</td>
<td>16</td>
</tr>
<tr>
<td>Sexual</td>
<td>13</td>
<td>9</td>
<td>0</td>
</tr>
</tbody>
</table>

* Abused women > community control.  * Discordant only > community control.
The fear experienced by each of these groups would be expected to lead to the higher rates of PTSD observed in the abused women in the present study. Although 11% of the maritally satisfied community controls met symptom criteria for PTSD within the past month, their symptoms were in response to events unrelated to the marriage (e.g., car accident, sexual abuse in childhood, Hurricane Andrew). None of the groups differed on rates of past PTSD.

An interesting finding from the present study is that women in discordant relationships, regardless of whether they are also physically abusive, can be characterized by perceived imbalances of power; that is, both abused and nonabused discordant women were significantly more fearful, more likely to feel as if they were coerced by their spouses, and endured significantly more psychological aggression than maritally satisfied community controls. This finding may call into question certain systems-oriented treatment perspectives that assume equivalent distribution of power between spouses (Yllo, 1990).

The rates of major depression in the community-control group were consistent with national prevalence estimates (Kessler et al., 1994). Although the group differences in the rates of current major depressive episode (MDE) did not reach statistical significance with the correction for number of comparisons made, nearly twice as many abused women met symptom criteria for current MDE than did discordant-only women (38% vs. 22%). Women in both maritally distressed nonabused and physically abused groups reported higher rates of current MDE than the community controls. Unexpectedly, both the abused and discordant-only women were more likely to report a history of major depression that predated their current marriage. Fifty-eight percent of the abused women and 48% of the discordant-only women experienced at least one episode of major depression in their lifetimes. These results suggest that a history of depression may be a risk factor both for women in abusive and nonabusive discordant relationships.

Consistent with expectations, abused women did not report experiencing significantly more abuse in their family of origin than women in the two control groups. The abused women were no more likely to have been physically assaulted nor to have perceived themselves to have been physically or sexually abused than maritally distressed nonabused women. Although there were no group differences on physical or sexual abuse, both abused and nonabused distressed women perceived themselves to have experienced significantly more emotional abuse while growing up than maritally satisfied nonabused women. These results suggest that women who were raised in "emotionally abusive" home environments may be at risk for dysfunctional marital relationships; that is, abusive home environments may not necessarily leave women at risk for physically abusive relationships; rather they may increase the probability that their marital relationships are marked by overall distress and conflict. Alternatively, finding oneself in a discordant relationship may prompt re-evaluation of one’s upbringing to explain current marital difficulty.

The high and similar rates of emotional abuse in childhood and histories of major depression between abused and nonabused discordant women have important etiologic and treatment implications. Post hoc analysis indicated a statistically significant association between childhood emotional abuse and major depression for abused women (phi = .43, p < .05) and

### Table 5

<table>
<thead>
<tr>
<th>Pathology</th>
<th>% abused women (n = 48)</th>
<th>% discordant only (n = 23)</th>
<th>% community control (n = 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past major depression</td>
<td>63a</td>
<td>57b</td>
<td>32</td>
</tr>
<tr>
<td>Current major depression</td>
<td>38a</td>
<td>22b</td>
<td>8</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>13</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>13</td>
<td>26b</td>
<td>0</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>10</td>
<td>26</td>
<td>4</td>
</tr>
<tr>
<td>Past PTSD</td>
<td>15</td>
<td>26</td>
<td>12</td>
</tr>
<tr>
<td>Current PTSD</td>
<td>33*</td>
<td>0</td>
<td>11</td>
</tr>
</tbody>
</table>

*Abused women > community control. **Discordant only > community control. **Abused women > discordant only.

### Discussion

Abused women seeking treatment for marital difficulties were significantly more likely to be in coercive and psychologically aggressive relationships than nonabused matched discordant controls and maritally satisfied community controls. Although discordant-only women were significantly less likely to experience coercion and psychological aggression than the abused women, they reported significantly more psychological aggression by their spouses than did community controls. In the present study, as the level of psychological aggression increased, the probability of marital violence also increased, from community-control to discordant-only to physically abused women. It has been well documented that psychological aggression is a precursor to physical aggression in marriage (Murphy & O'Leary, 1989; O'Leary & Jouriles, 1993; O'Leary, Malone, & Tyree, 1994). An important contribution of this study, however, is that husbands' psychological coercion, a particular form of psychological aggression, was highest for abused women. These women reported that their spouses engaged in significantly more attempts to dominate or control their behavior than did discordant-only or community-control women. This finding lends support to the belief that coercion and dominance distinguish maritally distressed violent relationships from those that are distressed and nonviolent.

In addition, physically abused women were significantly more fearful of their spouses than nonabused women. Interestingly, nonabused discordant women were also significantly more fearful of their spouses than community controls, which is consistent with the work of O'Leary and Curley (1986). However, in the present study, only the physically abused women were fearful that their spouses would physically threaten them, assault them, or injure them. In addition, significantly more of the abused women feared that their spouses would physically harm them, whereas the fear of the discordant-only women. This qualitative difference in the type of fear experienced by each of these groups would be expected to lead to the higher rates of PTSD observed in the abused women in the present study. Although 11% of the maritally satisfied community controls met symptom criteria for PTSD within the past month, their symptoms were in response to events unrelated to the marriage (e.g., car accident, sexual abuse in childhood, Hurricane Andrew). None of the groups differed on rates of past PTSD.

An interesting finding from the present study is that women in discordant relationships, regardless of whether they are also physically abusive, can be characterized by perceived imbalances of power; that is, both abused and nonabused discordant women were significantly more fearful, more likely to feel as if they were coerced by their spouses, and endured significantly more psychological aggression than maritally satisfied community controls. This finding may call into question certain systems-oriented treatment perspectives that assume equivalent distribution of power between spouses (Yllo, 1990).

The rates of major depression in the community-control group were consistent with national prevalence estimates (Kessler et al., 1994). Although the group differences in the rates of current major depressive episode (MDE) did not reach statistical significance with the correction for number of comparisons made, nearly twice as many abused women met symptom criteria for current MDE than did discordant-only women (38% vs. 22%). Women in both maritally distressed nonabused and physically abused groups reported higher rates of current MDE than the community controls. Unexpectedly, both the abused and discordant-only women were more likely to report a history of major depression that predated their current marriage. Fifty-eight percent of the abused women and 48% of the discordant-only women experienced at least one episode of major depression in their lifetimes. These results suggest that a history of depression may be a risk factor both for women in abusive and nonabusive discordant relationships.

Consistent with expectations, abused women did not report experiencing significantly more abuse in their family of origin than women in the two control groups. The abused women were no more likely to have been physically assaulted nor to have perceived themselves to have been physically or sexually abused than maritally distressed nonabused women. Although there were no group differences on physical or sexual abuse, both abused and nonabused distressed women perceived themselves to have experienced significantly more emotional abuse while growing up than maritally satisfied nonabused women. These results suggest that women who were raised in "emotionally abusive" home environments may be at risk for dysfunctional marital relationships; that is, abusive home environments may not necessarily leave women at risk for physically abusive relationships; rather they may increase the probability that their marital relationships are marked by overall distress and conflict. Alternatively, finding oneself in a discordant relationship may prompt re-evaluation of one’s upbringing to explain current marital difficulty.

The high and similar rates of emotional abuse in childhood and histories of major depression between abused and nonabused discordant women have important etiologic and treatment implications. Post hoc analysis indicated a statistically significant association between childhood emotional abuse and major depression for abused women (phi = .43, p < .05) and
some suggestion of a relationship between these factors for discordant, nonabused women (phi = .31, p < .15). Cognitive-behavioral marital interventions and etiologic perspectives have not typically considered the influence of a history of emotional abuse. Future research should examine the role of this background factor, particularly as it relates to attributional style and self-perceptions of these women and to self-reported depression and marital distress. The role of the spouses in the maintenance of exacerbation of childhood experiences is another area in need of inquiry.

The significant differences between abused and nonabused discordant women and those between nonabused discordant-only and community-control women are not likely to have been due to demographic factors such as income, education, or age because groups were matched according to these variables. Abused and nonabused discordant women were also matched on level of marital discord. Thus, significant differences between these two groups of women are not likely to have been due solely to marital discord. However, the type of sample selected for this study limits generalizations to several other populations. For example, the women in the present study were White and reported some college experience. In addition, all discordant women were married at the time of assessment, committed to resolving marital conflict, and had spouses who were willing to participate in treatment that addressed marital conflict. This differs from women who seek refuge at battered women's shelters because they fear for their lives, from those who seek community services for themselves because their spouses are unwilling to participate in treatment, and from the women who are too fearful to participate in treatment with their spouses. The modal forms of aggression experienced by the abused women were pushing, grabbing, shaking, and slapping; 30% of the women also reported that they had been threatened with a knife or a gun. Overall, 40% of the abused women sustained minor cuts or bruises, 25% reported serious cuts or bruises, and 6% required medical treatment. Although the abuse experienced by these women is notable, it is less severe than that reported by women because groups were matched according to these variables. These findings may have important implications for marital interventions. As suggested by Gleason (1993), a subpopulation of maritally distressed women who have a history of depression that is independent of their marital distress may be best treated with psychotropic medication, individualized psychotherapy, or both. It is critically important to determine the contributions of emotional abuse in childhood and current marital difficulties to depression of wives in discordant marriages. Moreover, it is important to examine the independent contribution of spouse abuse to current depression, if any. Future research should examine the multivariate associations of historical and current relationship and abuse factors to past and current depression and PTSD. Cognitive-behavioral marital intervention strategies, although shown to be effective in ameliorating wives' depression when marital discord is also present (Beach & O'Leary, 1986; Beach, Sandeen, & O'Leary, 1990; Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky, 1991; O'Leary & Beach, 1990), may require modification when abuse histories, depression histories, or ongoing spouse abuse is present. In addition, PTSD and spouse-specific fear identified among abused women raises important questions about the most appropriate method of intervention. If an abused woman is highly fearful and anxious, what impact do these symptoms have on her ability to participate actively in a marital intervention? Future research will need to address the issues of spouse-specific fear, psychological coercion, and trauma-related symptoms to avoid revictimization of abused women through treatments that may increase their fear and in turn worsen their PTSD.

References


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