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Depressive Symptomatology, Self-Esteem, and Self-Blame in Battered Women

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Thirty three currently battered women who sought counseling/support services from a Nassau County, New York community agency that provides services to victims of domestic violence participated. Eighty-nine percent of the women experienced severe acts of physical abuse and 31% of the women required surgery or suffered concussions as a result of their injuries. Fifty-two percent of the women scored above 20 on the Beck Depression Inventory. As the number, form, and consequences of physically aggressive acts increased and/or worsened, the women's depressive symptoms increased and self-esteem decreased. However, only 12% of the women in this sample blamed themselves for causing their partner's violence. Further, neither self-blame nor partner blame was associated with length of abuse or the frequency and severity of physical aggression. However, self-blame was marginally associated with depressive symptomatology.

KEY WORDS: spouse abuse; depression; self-esteem.

INTRODUCTION

Research on the attributions made by victims of crimes suggests that they tend to blame themselves for their victimization (e.g., Janoff-Bulman and Frieze, 1983). Self-blame is believed to influence coping and adjustment of victims positively because it restores one's perceived control over the environment. For example, a mugging victim who blames herself for walking alone down a dark alley can believe that future probability of a mugging will be lessened by more careful attention to her surroundings

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and walking with others. Blame attribution studies on samples of battered women have placed battered women under the theoretical rubric of crime victims because of their criminal victimization by a partner. Theories of self-blame developed from samples of victims of assault, rape, and robbery have been applied to studies of battered women in an effort to more completely understand battered women's perceptions of the causes of their victimization and target points of intervention.

SELF BLAME AND BATTERED WOMEN

Miller and Porter (1983) investigated self-blame in a shelter sample of battered women. While they did not report data on self-blame and severity of violence, they suggested that as violence increased in severity and the violent indicents occurred more frequently, partner plame would increase and women would blamc themselves less. Frieze (1979) provided support for the view that blame attributions shifted from self to partner as the severity of violence increased. Nineteen percent of the women at a battered women's shelter blamed themselves for the first episodes of violence, but only 9% blamed themselves for the violent episodes in general. However, O'Leary *et al.* (1985) reported that 33% of the battered women in their sample from a community agency for victims of domestic violence blamed themselves for causing their partner's violence. Further, Andrews and Brewin (1990) in a working class, community sample of women at risk for depression (15% were severely assaulted by a partner), found that 53% of the battered women blamed themselves for causing their partner's violence. The discrepancy across studies regarding degree of self blame in battered women may be due to varying samples (shelter, community agency, and community samples) and to different methods of attribution assessment.

A review by Holtzworth-Monroe (1988) found that in *no* study that examined attributions made by battered women from help-seeiking sources (i.e., counseling agencies, community agencies concered with victims of domestic violence) did the majority of women blame themselves as the cause of their partner's violence. Yet, in clinical accounts of physical victimization, blame has been posited to mediate the link between depression and physical victimization; and most battered women have been reported to suffer from depression (Walker, 1984). It follows logically that in order for self blame and depression to be related, self blame would be a frequenlty reported attribution. It has been hypothesized that women who blame themselves for their physical victimization will become depressed.

SELF BLAME AND DEPRESSION IN BATTERED WOMEN

Walker (1979) asserts that: (1) battered women blame themselves for causing their partner's violence, and (2) self-blame ultimately leads to depression if the violence persists. Andrews and Brewin (1990) examined the association between self-blame and depression in a community sample of battered women. Four hundred twenty women were solicited from the community to participate in a study on the development of depression over a 3-year period. Seventy of these women had reported physical victimization by a partner in the past, 92% were classified as severely assaulted by the Conflict Tactics Scale [items 15-18] (Straus, 1979). An association was found between self blame and depression; however, this association depended on the status of the women's relationships with their partners. That is, among women who had left their partners ($N = 51$), those who still blamed themselves for the violence were significantly more depressed than women who blamed their partners for the violence. However, there was no association between self blame and depression among women who were currently living with their abusive partner ($N = 19$). Generalizations from this sample to other samples of battered women are limited because the population was a community sample at risk for depression.

To address more fully the association between blame attributions and depression, it is important to clarify the function of self-blame for battered women. Perhaps battered women cannot be likened to other victims of violent crimes where self-blame is viewed as adaptive since the dynamics of the relationship are different for battered women than for victims of crimes commited by strangers. Burglary crime victims may be able to blame themselves for not having locked a door or not having hidden jewelry. They may be able to see that additional burglaries can be avoided by their own actions. On the other hand, a battered woman experiences *repeated* physical intimidation and injury and she may not be able to avoid such victimization. Self-blame, by definition, may not be a functional coping mechanism to avoid future abuse because it may erroneously lead her to believe that her actions will alter her partner's behavior and increase the likelihood that she will continue to experience abuse.

The primary purpose of the study was to assess the incidence and magnitude of depressive symptomatology and poor self-esteem in a clearly identified sample of currently battered women who sought counseling/support services from a community agency providing services for victims of domestic violence. The second aim of the investigation was to examine the association between depressive symptomatology and self-esteem with the frequency, severity, and consequences of physical aggression. It was hypothesized that as the frequency, severity, and consequences of physical

aggression increased, depressive symptomatology would increase and self-esteem would decrease. The third purpose was to assess the interaction of depressive symptomatology, self-esteem, and battering using regression analysis. It was predicted that self-esteem and depressive symptomatology would each contribute uniquely to the reported battering experienced.

The fourth aim of the study was to assess the degree of self-blame in battered women and the association of blame attributions to the psychological characteristics assessed, length of abuse and degree of battering. *First*, it was hypothesized, based on the results of past studies, that self-blame would be greater for attributions about the violence in the beginning of the relationship than attributions about the violence in general. *Second*, since self-blame was believed to decrease over time, it was hypothesized that as the length of abuse in the relationship increased, self-blame would decrease. *Third*, it was hypothesized that self-blame would be positively correlated with depressive symptomatology and poor self-esteem and that partner blame would be positively correlated with the frequency and severity of violence.

METHOD

Subjects

Thirty-three women participated who sought therapeutic assistance from the Nassau County Coalition Against Domestic Violence. Counselors at the agency asked new clients to complete the assessment battery after an intake interview but before they received services from the agency. The return rate of women who initially agreed to participate was 65%. Women received $25 for participation in the study.

This sample consisted primarily of white, Catholic, married and unemployed women. They had been involved with their partners for approximately 10 years and had been battered for approximately 5 of those years.

Eighty-nine percent of the women experienced severe acts of physical aggression. Seventy-five percent of the women reported being beaten up by their partners within the past year, and 84% sustained at least superficial wounds within the past year. Thirty-one percent required surgery or suffered a consussion as a result of their injuries. The group of women in this sample represents severely battered women, 25% of whom were beaten up more than 20 times in the past year. These women sought help from an agency that provides services for victims of domestic violence which indicates some level of acknowledgment that they have been battered.

Table I. Characteristics of Sample

Variable	Mean	Range
Subject age	30.76	19-50
Partner's age	33.44	21-51
Subject's income	7662.67	0-34,000
Partner's income	24,985.52	0-90,000
Length of relationship	112.91 months (9.5 years)	5-362 months (1-30 years)
Length of abuse	56.69 months (4.6 years)	1-264 months (1-22 years)
Subject's religion Catholic	60.6%	
Subject's ethnicity White	66.7%	
Sujbect's employment unemployed	57.6%	
Marital status		
Married	66.7%	
Single	27.3%	
Divorced	6.1%	

Table II. Forms of Physical Aggression Experienced

	Ever experienced in past year
Something thrown at her	77.4%
Pushed/grabbed/shoved	84.6%
Slapped	80.0%
Kicked/Bit/Hit	77.4%
Choked/strangled	51.6%
Forced to have sex	61.3%
Beaten up	75.0%
Threatened with a knife or gun	46.9%
Used a knife a gun	31.2%
	Injuries sustained
None	15.6%
Superficial bruises	12.6%
Nonsuperficial bruises	6.3%
Broken bones, stitches, and/or black eye(s)	34.4%
Required surgery and/or resulted in concussion	31.3%

Measures

Individuals completed the following self-report psychological assessments:

The Modified Conflict Tactics Scale (MCTS)

Neidig and Friedman (1984) developed a modified version of the CTS (Straus, 1979) which includes additional items for more specific assessment of the topography of physical aggression. The scale measures the occurrence and frequency (from never occurred to occurred more than 20 times) of three conflict resolution domains: reasoning, verbal aggression, and physical aggression within the past year. Barling *et al.* (1987) found two stable factors on the CTS: verbal and physical aggression. The CTS yields high internal reliability (Straus, 1980). Only one dimension of battering, frequency, was developed from the MCTS for this study due to the extremity of the MCTS items endorsed by the women in this sample. Thus, any weighting procedure applied to the more severe physically aggressive acts on the MCTS would add little to the analyses. The *frequency* of physical aggression was computed by adding the physical aggression items [items 17-25].

Injury Index

Women described the type of injuries they sustained. The open-ended responses were coded into six categories of severity: no physical consequences; cut or bruise; multiple cuts or bruises; non-superficial cuts or bruises; broken bones, stitches, black eyes; combination of nonsuperficial bruises and broken bones, stitches, or black eyes; and concussion or injury that required surgery. The *severity* of aggression was computed by multiplying the frequency of physical aggression by the injury index. This method was chosen to account for the impact and consequences of physical aggression on the women.

Blame Scale

Women were asked to describe what or who they believed caused the violence in the beginning of the relationship and in general. Their responses were coded, by three undergraduate raters, on a seven point continuum anchored on one end with "partner blame" and anchored on the other end with "self blame." Examples of self-blame include "I never know when to be quiet," "I stayed out too late," examples of partner blame include "He had too much to drink," and "He has a terrible temper." Interrater reliability was high (r = .81) for item one (cause of violence in the beginning of the relationship) and moderate (r = .62) for item two (in general, cause of violence in the relationship).

Beck Depression Inventory (BDI)

This 21-item scale is the most widely used self-report measure in treatment outcome studies of depression (Beck *et al.,* 1988). It assesses cognitive and behavioral depressive symptomatology experienced over a one week period (Beck, Rush, Shaw, and Emery, 1979). Internal consistency for the current sample was high (alpha = .82).

Rosenberg Self-Esteem Scale (RSE)

This scale is a global measure of self-esteem. This self-esteem scale has differentiated physically aggressive men from maritally discordant men (Goldstein and Rosenbaum, 1985). Internal consistency for the current sample was high (alpha = .86).

RESULTS

Approximately 70% of the women in this sample scored greater than 14 on the BDI. More startling, however, was the finding that approximately 52% of these women scored greater than 20—scores which reflect a severe level of depressive symptomatology.

Depressive symptomatology and self-esteem were highly correlated with the frequency, severity, and consequences of physical aggression. As the level of battering increased across the sample, depressive symptomatology increased and self-esteem decreased. In order to determine if self-esteem deficits and depressive symptomatology were independent results of severe battering, multiple regression analyses were conducted. Regression analyses revealed that self-esteem contributed more unique variance to battering than depressive symptomatology (R^2 = combined = .369, R^2 depressive symptomatology removed = .323). Self-esteem accounted for approximately 32% unique variance whereas depressive symptomatology ac-

Table III. Association with Victimization

	Frequency of Aggression	Severity of Aggression	Injury
Depressive symptomatology	.5396**	.5389**	.4037*
Self-esteem	-.5888**	-.5868**	-.4876*

*$p < .05$.
**$p < .01$.

Table IV. Blame Attributions

	Self	Both	Partner
Attributions for violence in general in relationship	12.5%	4.2%	83.4%
Attributions for violence in the beginning of the relationship	18.0%	10.7%	74.5%

Table V. Associations with Self-Blame Attributions

	Self-Blame for Beginning Incidents	Self-Blame for Incidents in General
Depressive symptomatology	.2109	.3653
Self-esteem	-.1157	-.2661
Length of abuse	-.3258	-.2913
Frequency of aggression	-.0886	-.0763
Severity of aggression	-.1492	-.0592

counted for 5% unique variance to physical aggression. Battering appears to have had its greatest influence on self-esteem (See Table III).

Twelve percent of the women blamed themselves for the violence in the relationship when asked to explain the general cause of violence and 18% of the women blamed themselves for the first episode of violence. However, this difference was not significant ($\chi^2 = 3.82, p > .05$) (See Table IV).

Neither self-blame nor partner blame attributions were significantly correlated with depressive symptomatology, self-esteem, length of abuse in the relationship, or frequency and severity of physical aggression. However, as self-blame for the cause of the violent episodes *in general* increased, depressive symptomatology increased ($p = .06$) (See Table V).

DISCUSSION

Fifty-two percent of the women who participated in this study suffered from severe levels of depressive symptomatology. As the number, form, and subsequent consequences of physically aggressive acts increased and/or worsened, the woman's depressive symptoms increased and self-esteem decreased. A strong correlation existed between the frequency of a husband's physical aggression and both depressive symptomatology and poor self-esteem. In addition, there was also a strong correlation between the severity of a husband's physical aggression and both depressive symptomatology and poor self-esteem. Because of the restricted ranges on the three variables of interest (battering, depressive symptomatology, and self-esteem), the significant associations among these variables is especially noteworthy.

Results from the regression analysis indicated that self-esteem contributed more unique variance to physical aggression than depressive symptomatology. Given these results, continued and repeated physical abuse seems to hae a more lasting and dramatic effect on the self-esteem of these women than on their reported depressive symptomatology. In fact, low self-esteem has been found to be a vulnerability factor to the development of depression. And conversely, self-esteem enhancement has been related to lower levels of depressive symptomatology (Beach *et al.,* 1990). Thus, results of the regression analyses appear to be consistent with the marital literature on self-esteem and depression suggesting that self-esteem may act as a buffer against the development of depressive symptomatology. On the other hand, depressive symptomatology may not have contributed as much unique variance as self esteem because depressive symptomatology may vary cyclically such that some women would score high on the BDI one month and low the next (Andreassen and Black, 1991).

Given the association between depressive symptomatology and the frequency and severity of physical aggression and some related data reported below, it also seems plausible to believe that the frequency and severity of physical aggression are causally related to the depressive symptomatology observed in this sample. It could be argued that severely depressed women may prompt their partners to hit them; however, only 34% of severely depressed hospitalized women were physically victimized by their partners (Craighead and O'Leary, 1991). Although this percentage is somewhat lower than the 12% national average of women victimized each year by a spouse (Straus *et al.,* 1980), it is clear that the majority of depressed women are *not* abused by their spouses. Further, in analyses of couple interaction data, depression appears related, albeit inconsistently, to decreases in verbal aggression from a partner (Nelson and Beach, 1990; Schmaling and Jacobson, 1990).

The present results also support previous work in the area of self blame and battered women in that battered women do not blame themselves for their victimization (Frieze, 1979; Holtzworth-Monroe, 1988; Miller and Porter, 1983). Only 12% of the women in this sample blamed themselves as the cause of the violence from their partners. In addition, neither self-blame nor partner blame was significantly associated with depressive symptomatology, poor self-esteem, length of abuse, or the frequency and severity of physical aggression. However, the association

between self-blame for the violent incidents in general (but not the violent incidents in the beginning of the relationship) and depressive symptomatology was marginally significant ($r = .37$, $p = .06$). This association suggests that women who blame themselves for the violent incidents in general may be more stable in their attributions toward themselves. That is, for women who repeatedly blame themselves for the violence over time, self-blame attributions may influence the emergence of depressive symptomatology. However, more conclusive assertions require additional data.

Miller and Porter (1983) suggested that blame may shift over time such that women are more likely to blame themselves when the abuse is just beginning than they are to blame themselves after ongoing abuse. The results herein do not support this claim. Eighteen percent of the women blamed themselves for the first instances of violence whereas 12% blamed themselves for the incidents in general. Some have suggested that self-blame decreases as the frequency and severity of physical abuse increases. Surprisingly, there was no association between the frequency and severity of abuse and self-blame attributions in this sample.

It is important to note that there may have been *no* statistically significant associations between self-blame and the variables assessed because of the restriction of range on these variables. Perhaps a sample that exhibited a greater range over physical victimization would yield different results. Indeed, it should be emphasized that only 12% of these women who experienced severe physical abuse blamed themselves for their victimization. Other nonshelter battered women populations in which self-blame was assessed yielded self-blame rates that range from 33% to 53%. Clearly, the rate of self-blame in this study was markedly lower than that reported in previous efforts. This relatively low rate of self blame may be due to several factors: (1) these women had the strength to seek psychological and/or legal aid, (2) these women sought aid from an agency explicitly labeled to provide service to victims of domestic violence, and (3) heightened public awareness of wife abuse as a social problem (in the New York area, attention to this issue was prompted by repeated national media coverage of the Hedda Nussbaum case in New York City).

There are several limitations of this sample which prohibit generalizations to other populations that should be noted. The group of women in this sample represents severely battered women, 25% of whom were beaten up more than 20 times in the past year. These women sought help from an agency that provides services for victims on domestic violence; their help-seeking indicates some level of acknowledgment that they have been battered. Therefore, caution should be heeded in applying the results of this study to community samples of physically abused women who have not sought professional help or other less severely assaulted women.

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