Marital Aggression

Impact, Injury, and Health Correlates for Husbands and Wives

Michele Cascardi, MA; Jennifer Langhinrichsen, PhD; Dina Vivian, PhD

• The overall aim of the current study was to comprehensively evaluate the prevalence, impact, and health correlates of marital aggression in a clinic sample of maritally discordant couples seeking psychological treatment. Participants were 93 consecutively presenting clinic couples and 16 maritally satisfied matched control couples from the community. Overall, 71% of clinic couples reported at least one act of marital aggression during the past year. Although 86% of the aggression reported was reciprocal between husbands and wives, impact and injuries sustained as a function of this aggression differed between husbands and wives. Specifically, wives were more likely than husbands to be negatively affected and to sustain severe injuries (eg, broken bones, broken teeth, or injury to sensory organs). Additionally, wives who experienced marital aggression reported clinical levels of depressive symptomatology. Recommendations are offered and risk markers are identified to improve detection by physicians of patients who may be involved in violent marriages.

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In 1980, domestic violence emerged from "behind closed doors" with the national survey of family violence by Straus et al.[1] In the decade since that survey, domestic violence has been recognized as a serious health problem. In fact, former Surgeon General C. Everett Koop[2] declared violence against women as the number one health problem of American women in 1985.

Straus et al[1] assessed the prevalence of marital violence in a national random survey of more than 2000 households. These researchers used a self-report questionnaire, the Conflict Tactics Scale (CTS), which assesses the frequency of physically aggressive tactics experienced or engaged in by partners during marital conflicts. They found that 28% of the couples surveyed had engaged in either husband-to-wife (H->W) or wife-to-husband (W->H) aggression at some time during the marriage.[1] Husbands and wives self-reported engaging in similar frequencies of physical aggression; however, the CTS did not assess whether the injuries or impact sustained were equivalent for the two sexes.

Other researchers[3-5] have documented that the injuries sustained by women as a result of their partner's physical aggression can often be quite severe (eg, black eyes, broken teeth, broken bones, or concussions) and may require emergency medical attention. For example, Stark and Flitcraft[6] found that at any point in time, 40% of women in emergency departments were victims of wife abuse and 10% of the women repeatedly seen by emergency department physicians were victims of repeated assaults by a partner. Additionally, data collected between 1973 and 1982 by the National Crime Survey indicated that 94% of reported domestic violence incidents were committed against women; 95% of all the cases involved injuries and medical treatment for women.[7] Moreover, Cantos et al,[8] in a sample of US military couples (n=284) referred for domestic violence treatment, found that 69% of husbands and wives sustained some injury from a domestic violence incident. Of these cases, 57% of the wives and 8% of husbands reported being the sole recipient of injuries. In the remaining 35% of couples, both spouses reported sustaining some injuries. Husbands and wives also indicated on a self-report measure whether the injury necessitated medical attention. The scale ranged in severity from no medical treatment to surgery. Cantos et al[8] found that the military wives reported sustaining significantly more severe injuries that resulted in medical treatment than did their husbands.

However, the use of the emergency department or the severity of the injury are not the only measures of the impact of H->W aggression on women's health. In fact, injury alone may not be the best index with which to evaluate the impact of physical aggression, since the majority of marital aggression may not result in injury. Stets and Straus[9] used several diverse measures of the impact of physical aggression perpetrated by either partner on a sample of women (n=336) and men (n=264) drawn from the community.[9] The participants were asked to report whether the injury resulting from marital aggression required medical treatment, time off from work, and/or days spent in bed because of illness. Significantly more women (3%) than men (0.4%) reported needing medical attention as a result of their injuries. Similarly, 9% of the women took time off from work, whereas 6% of the men did, and

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From the Department of Psychology, State University of New York at Stony Brook.

Reprint requests to Department of Psychology, State University of New York at Stony Brook, Stony Brook, NY 11794-2500 (Dr Vivian).

18% of the women spent at least 1 day in bed because of illness, contrasted with 13% of the men. Although these latter gender differences were not statistically significant, they still suggest a trend for women to be more adversely affected by their partners' aggression than men.

There is also some evidence that women who have experienced H->W aggression are at risk for a variety of health complaints. Follingstad et al[10] documented that 65% of abused women (n=234) solicited from the community suffered from three to seven of the following symptoms (listed in order of reported frequency): headaches, back and limb problems, frequent colds, fainting and dizziness, stomach and gastrointestinal problems, gynecologic problems, heart and blood pressure problems, lung and breathing problems, and/or skin problems. In addition, Stets and Straus[9] reported that as the severity of H->W aggression increased, reports of psychosomatic complaints, stress, and depression also significantly increased.

Men may also suffer adverse health consequences as a result of marital aggression. Some evidence suggests that men who engage in H->W aggression in fact experience more stress than do nonaggressive men.[1] Stress has been linked to a variety of chronic health problems such as high blood pressure, ulcers, chronic pain, and heart disease.[11] Moreover, anger and hostility are known correlates of heart disease in men.[12] Thus, it appears that both partners in violent marriages experience health problems that could be linked to the marital aggression.

Physicians and other health care professionals may fail to identify patients who have experienced domestic violence injuries or negative health consequences because of patients' reluctance to disclose the presence of marital aggression. For example, within the field of mental health, Hilberman and Munson[13] found that only 4% of women in marital therapy spontaneously admitted physical victimization by a partner. When these same women were asked directly about the presence of H->W aggression, 14% confirmed its occurrence. Even more dramatically, O'Leary,[14] in a marital clinic sample, noted that only 6% of the wives and 1.5% of the husbands spontaneously reported marital aggression as a presenting problem during the intake interview. However, 53% of these same husbands and wives (or 67% of the couples) had reported some act of H->W aggression on the CTS within the past year. In a related study, Riggs et al[15] examined the willingness of male and female college undergraduates to self-report relationship aggression. They documented that men and women were more likely to report having experienced, rather than having engaged in, relationship aggression, suggesting that individuals underreport their own levels of aggression.

In summary, research on domestic violence indicates that the prevalence of marital aggression is remarkably high in normative samples and even higher in clinic samples. Second, it is likely that marital aggression has a larger negative impact on women's health than on men's health in terms of injuries sustained and other, more general, emotional and somatic complaints. However, studies that have examined the impact of marital aggression have focused primarily on women. In addition, studies examining the differential effects of marital aggression on men and women are recent and not representative of the majority of marital violence research. Finally, it is clear that neither men nor women readily disclose marital aggression to helping professionals.

The overall aim of the current study was to comprehensively evaluate the impact and health correlates of physical aggression in a clinic sample of maritally discordant husbands and wives seeking psychological treatment. Findings of previous studies demonstrated that exclusive assessment of either injury or health problems related to marital aggression did not provide the most complete evaluation of the impact of marital aggression. A particularly unique aspect of this study was the multidimensional assessment of the impact of marital aggression (ie, injury, perceived impact, depressive symptomatology, past and current health problems, and current medication use).

The first goal of the study was to assess the prevalence of marital aggression in this clinic sample. Marital aggression was defined to include both H->W and W->H aggression. Based on Straus and colleagues'[1] finding of similar frequencies for men's and women's aggressive behavior, it was expected that husbands and wives in this sample would also report engaging in similar frequencies of aggression.

The second objective was to assess the impact of marital aggression on husbands and wives. It was hypothesized that experiencing marital aggression would be perceived as more negative and would result in more severe injuries for wives than for husbands. Moreover, it was expected that couples experiencing mild aggression would report the impact as less negative and would report less severe injuries than would couples experiencing severe aggression.

The documented association among marital aggression, demographic variables such as age and education, and marital distress warranted examination of these variables in this study.[16] It was expected that younger couples with less education and lower levels of marital satisfaction would be at the greatest risk for marital aggression. Finally, given the relationship between marital aggression and health complaints (eg, back pain, headaches, and depression), it was expected that wives in aggressive marriages would be more likely to report health problems and depressive symptomatology than would nonaggressive, maritally discordant wives or nonaggressive, maritally satisfied wives. In addition, based on the associations among stress, anger, aggression, and health problems, it was expected that husbands in aggressive marriages would be more likely to report health problems and depressive symptomatology than would nonaggressive, maritally discordant husbands or nonaggressive, maritally satisfied husbands.

SUBJECTS AND METHODS

Subjects

Ninety-three couples consecutively seeking therapy at the University Marital Therapy Clinic, Stony Brook, NY, from mid 1989 through late 1991 participated in this study. No couples were excluded. The University Marital Therapy Clinic is a research-based treatment facility affiliated with the Department of Psychology at the State University of New York at Stony Brook. It is known in the Suffolk County community for providing marital treatment for a wide variety of marital and individual problems including depression, sexual problems, communication problems, and physical aggression. An advertisement was used only to recruit community control couples. A telephone screening was conducted to eliminate maritally discordant or aggressive couples from the study's control group. Cou-

ples were accepted into the community control group only if both spouses agreed that they were maritally satisfied and nonaggressive throughout the duration of their marriage. Eligible couples were then matched with the overall sample of clinical couples according to age, education, years married, and income. At the time of this study, 16 community couples had been recruited. All spouses in the study gave written consent to participate in an extensive assessment procedure used for clinical and research purposes.

The clinic and community groups were compared on all demographic variables to assess the effectiveness of the matching procedure. A 2 (gender) × 2 (group) mixed-design multivariate analysis of variance was conducted on all demographic variables (ie, age, education, years married, and income) to determine overall group and gender effects. There were group and gender main effects (Rao's $R[4,61]=4.11$, $P<.01$, and Rao's $R[4,61]=3.06$, $P<.05$, respectively). Univariate analyses of variance gave evidence that age differed between the clinic and community groups and between husbands and wives ($F[1,80]=4.67$, $P<.05$, and $F[1,80]=9.90$, $P<.01$, respectively).

The mean age of the clinic husbands was 38 years (SD=10.10 years); the mean age of the clinic wives was 35 years (SD=11.35 years). The average age of the community husbands and wives was 44 years (SD=8.47 years) and 39 years (SD=7.38 years), respectively. Tukey HSD post hoc analyses revealed that the community control group was significantly older than the clinic group and husbands were significantly older than wives across groups. There were no differences in income, education, or years married between the clinic and community control groups or husbands and wives. Clinic and community control couples reported a mean family income of $48 051 (SD=$28 343), averaged 14.1 years of education, and were married 12 years on average.

Procedures

During their first visit at the University Marital Therapy Clinic, each spouse was interviewed separately for approximately an hour and a half. While one spouse was interviewed, the other spouse completed a comprehensive battery of paper-and-pencil questionnaires. The present study was derived from a subset of data that are being collected for a larger ongoing investigation of communication and cognitive patterns of maritally distressed and aggressive couples, which is being conducted by one of us (D.V.). The clinic and the community couples who participate in all aspects of the ongoing study receive $80. Examples of excluded measures pertained to psychological domains such as sexual coercion in marriage, relationship beliefs, perceived problem-solving ability, and assertion with one's spouse. This information was not germane to the health questions of interest in this study. Therefore, only the information from the following self-report questionnaires was included: the Dyadic Adjustment Scale,[17] the Modified CTS,[18] the Beck Depression Inventory,[19] and "Questions Related to Physical Illness."

Measures

Dyadic Adjustment Scale.—The Dyadic Adjustment Scale is a widely used 32-item measure of marital satisfaction.[17] The psychometric properties of this instrument are well documented. Typically a score below 100 reflects marital discord.

Modified CTS.—The Modified CTS is a 29-item questionnaire that assesses marital aggression used as a conflict tactic during the year prior to assessment. This instrument is an expanded and modified version of Straus'[20] CTS and Neidig's Modified CTS.[8] The Modified CTS assesses the frequency of 10 aggressive acts on a 7-point scale (1, never; 2, once; 3, twice; 4, three to five times; 5, six to 10 times; 6, 11 to 20 times; and 7, more than 20 times in the past year), as well as the impact and injuries sustained as a consequence of engaging in and/or experiencing mildly or severely aggressive acts.

The frequency items were dichotomized into presence/absence of any aggressive act in order to separate the aggressive and nonaggressive clinic groups. Based on past research and classification traditions within the field, items 19 through 22 (ie, pushing, grabbing, and shoving; controlling physically; throwing something; and slapping) were designated as mildly aggressive. The severely aggressive items were 23 through 29 (ie, kicking, biting, and hitting with a fist; hitting with something other than a fist; choking or strangling; forcing partner to have sex; beating up; threatening with a knife or a gun; and using a knife or a gun). This method of classification is widely accepted in the marital violence area.[1]

The impact of mildly and severely aggressive acts was assessed separately using a 7-point Likert scale (1 represents an extremely negative impact on self; and 7, an extremely positive impact on self). Five (yes/no) items were used to assess the injuries sustained because of mildly and severely aggressive acts from a spouse: (1) no injury; (2) superficial bruises, cuts, or abrasions (mild); (3) nonsuperficial cuts or abrasions (moderate); (4) broken bones, broken teeth, or injuries to sensory organs (severe); and (5) internal injuries or concussions (extreme). For some of the analyses, an injury index was formed by summing across the injury categories, weighting the injuries in order of severity (1, mild; 5, moderate; 10, severe; and 15, extreme).

While the Modified CTS is a new instrument, the CTS is the most widely used topographical measure of marital aggression. Its psychometric properties have been well documented.[1,20]

Beck Depression Inventory.—The Beck Depression Inventory[19] is a 21-item self-report measure of depressive symptomatology. It evaluates vegetative, cognitive, and behavioral signs of depression in the week prior to administration. A score equal to or greater than 14 is believed to represent moderate levels of clinical depression, while scores above 20 represent severe levels of clinical depression.[21]

Questions Related to Physical Illness.—Three health-related (yes/no) questions taken from the written intake packet were included in the study: (1) Have you ever been seriously ill? (2) Are you currently experiencing any physical problems? (3) Are you currently taking any medication? If the spouse responded yes to any of the health questions, she or he described in writing the nature of the health problem and/or the type of medication currently being used.

RESULTS

The *n*'s vary slightly across analyses because of missing data.

Marital Aggression in the Marital Clinic Sample

Husband-to-Wife Aggression.—The prevalence of H->W aggression was assessed based on each wife's report of her husband's behavior and/or the husband's self-report on the Modified CTS. According to the wives, 21% (n=18) of the husbands were classified as mildly aggressive and 33% (n=29) as severely aggressive (ie, 54% of the clinic husbands). In contrast, only 22% of the husbands (n=19) classified themselves as severely aggressive, while 33% (n=29) described themselves as mildly aggressive (ie, 55% of the clinic husbands). When *either/or* reporting was used (ie, reports by wives about their husbands aggression and/or reports by husbands about themselves), 27% of clinic husbands (n=25) were classified as mildly aggressive, while 34% (n=31) were classified as severely aggressive. Overall, 61% of couples seeking marital therapy reported at least one act of H->W aggression in the past year.

Wife-to-Husband Aggression.—The prevalence of W->H aggression was assessed based on each husband's report of his wife's behavior and/or the wife's self-report on the Modified CTS. According to the husbands, 12% (n=10) of the wives were classified as mildly aggressive and 45% (n=39) as severely aggressive (ie, 57% of the

Demographic Variables and Marital Satisfaction						
	Group, Mean (SD)					
	Aggression		Discord Only		Community Control	
	H	W	H	W	H	W
Education, y	13.2 (2.00)	13.6 (2.09)	15.5 (3.63)	14.7 (2.56)	14.9 (3.67)	13.8 (2.14)
Age, y	35.6 (8.11)	32.4 (9.91)	44.5 (13.09)	41.8 (12.29)	48.9 (14.66)	45.4 (16.48)
Years married	9.5 (8.71)		16.1 (13.92)		18.4 (16.34)	
DAS	82.2 (19.22)	73.9 (25.87)	100.6 (16.04)	93.1 (18.75)	122.1 (9.76)	122.1 (9.95)
Total family income, $	42 788 (25 742)		61 826 (29 104)		47 846 (31 817)	

*H indicates husbands; W, wives; and DAS, Dyadic Adjustment Scale.

wives). Likewise, 9% of the wives (n=8) classified themselves as mildly aggressive, while 36% (n=31) described themselves as severely aggressive (ie, 45% of the wives). When *either/or* reporting was used, 12% of clinic wives (n=11) were classified as mildly aggressive, while 50% (n=46) were classified as severely aggressive. Overall, 62% of couples seeking marital therapy reported at least one act of W->H aggression in the past year.

Couple Aggression.—The prevalence of couple aggression was assessed using the spouses' reports of H->W aggression and/or the spouses' reports of W->H aggression. This method of classification grouped the couples on the basis of the most severe tactic endorsed by either spouse. For example, if the wife reported severe aggression (either engaged in or experienced) and the husband reported mild aggression (either engaged in or experienced), the couple was classified in the severe aggression group. Accordingly, 19% (n=17) of the couples were classified as mildly aggressive, 52% (n=48) as severely aggressive, and 29% (n=26) as nonaggressive (two couples could not be classified because of extensive missing data). Of the aggressive couples, 86% reported reciprocal aggression. Only 14% of the couples reported unilateral aggression. Fifty percent (n=8) of the unidirectional violence was H->W aggression, and 50% (n=8) was W->H aggression. In addition, 98% of spouses in the severe aggression group also reported mild aggression. As a result of the overlap between mild and severe aggression in the severe aggression group, the analyses conducted for the impact experienced and the injuries sustained from mild aggression include both spouses who reported only mild aggression and spouses who reported both mild and severe aggression.

Mild and Severe Physically Aggressive Tactics

The most frequently reported acts of mild marital aggression were pushing, grabbing, or shoving. The most frequently reported acts of severe marital aggression were kicking, biting, or hitting with a fist.

Impact of Marital Aggression: Gender Differences

Husbands and wives were compared using paired *t* tests to determine whether experiencing aggression from a spouse had a more negative effect and resulted in more severe injuries for wives than for husbands.

Psychological Impact on Self.—Both wives and husbands were asked only to rate the perceived impact on *themselves* of their spouse's mild and/or severe aggression. When rating the impact of their spouse's mild aggression on them, the wives' mean impact rating was 1.79 (SD=.95), and the husbands' mean impact rating was 2.54 (SD=1.29) ($t[31]=3.94$, $P<.001$). The wives' mean impact rating of severe aggression was 1.79 (SD=1.05), while the husbands rated the impact at 2.45 (SD=1.18) ($t[18]=3.27$, $P<.002$). Overall then, the wives rated experiencing both mild and severe aggression as significantly more negative than the husbands did. Contrary to expectations, negativity of experienced impact did *not* differ for either husbands or wives ($t<1$, $P>.10$) depending on the level of severity of marital aggression from a spouse (ie, mild or severe).

Severity and Type of Injury.—χ^2 Analyses indicated that significantly more women than men reported sustaining injuries for each injury category. Given the low frequency of injury reports, these analyses were conducted by collapsing the mild and severe aggression acts into one group of any aggression. Moreover, since few spouses reported moderate, severe, or extreme injuries, these results must be interpreted with caution. To increase the stability and power of the findings suggested by the χ^2 analyses, an injury index was computed to transform the dichotomous data into continuous data (see "Measures" section). By transforming the data, a comparison of husbands and wives was possible on the full range of injuries sustained for mildly and severely aggressive acts separately.

As expected, for both wives and husbands, the severity of injury was significantly correlated with the frequency of marital aggression experienced ($r=.54$, $P<.05$, and $r=.30$, $P<.05$, respectively). That is, the more often a spouse reported that aggression occurred, the more likely she or he was to sustain injuries.

Consistent with our hypotheses, there were significant gender differences between husbands and wives on severity of injuries. The wives sustained significantly more severe injuries than the husbands as a consequence of mild marital aggression ($t[36]=2.27$, $P<.02$). There was also a trend for the wives to sustain more severe injuries than the husbands as a consequence of severe marital aggression ($t[15]=1.40$, $P=.09$).

Figures 1 and 2 offer descriptive information regarding the types of injuries sustained by husbands and wives who experienced mild and severe aggression. About half of the wives and two thirds of the husbands reported no injury as a result of experiencing both mild and severe marital aggression. Figure 1 shows that 15% of the wives who experienced mild aggression and 11% of the wives who experienced severe aggression reported sustaining broken bones, broken teeth, and/or injury to sensory organs. In contrast, as illustrated in Fig 2, only 2% of the

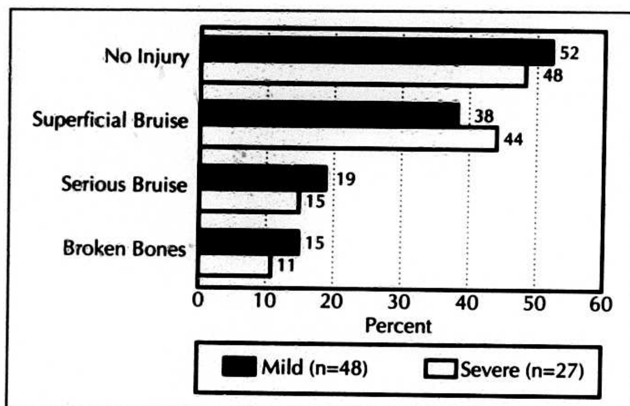

Fig 1.—*Wives' reports of injuries from mild and severe marital aggression.*

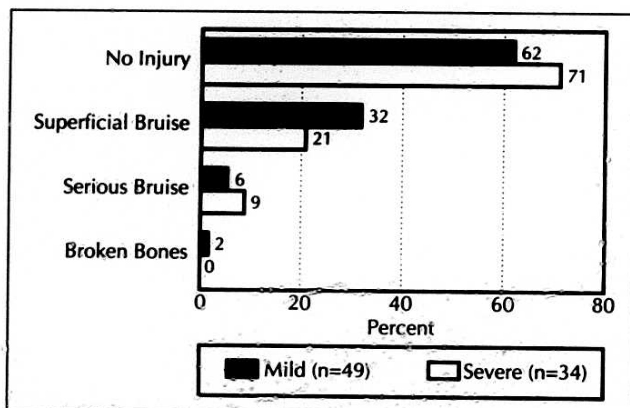

Fig 2.—*Husbands' reports of injuries from mild and severe marital aggression.*

husbands who experienced mild aggression and none of the husbands who experienced severe aggression reported sustaining broken bones, broken teeth, and/or injury to sensory organs.

Correlates of Aggression

Since injury and impact did not differ depending on the severity of aggression experienced, one aggression group was used for the remaining analyses. Membership in the aggression group was based on either the husband's or the wife's report of physical aggression because of the high degree of reciprocity in marital aggression. That is, if either spouse reported any physical aggression in the past year, he or she was included in the aggression group. The groups for the remaining analyses were as follows: marital discord/no aggression (discord only group, n=26), marital discord/any aggression (aggression group, n=65), and marital satisfaction/no marital aggression (community control group, n=16).

Demographics and Marital Satisfaction.—A 2 (gender) × 3 (group) mixed-factor multivariate analysis of variance revealed group and gender main effects (Rao's $R[8,120]=5.40$, $P<.001$), and Rao's $R[4,60]=4.36$, $P<.01$, respectively) for age, education, years married, income, and marital satisfaction. As depicted in the Table, the spouses in the aggression group were significantly younger than those in the discord only group ($F([2,79]=9.00$, $P<.001$); no significant difference emerged between the aggression and community control groups. (The reader may note that the couples in the community control group were older than the couples in the discord only and aggression groups. However, there were only significant differences in age between the discord only and aggression groups. The primary reason for the failure to find significant differences between the community control group and the aggression group is statistical power.) In addition, the wives were significantly younger than their husbands ($F([1,79]=16.27$, $P<.001$). The spouses in the aggression group reported significantly fewer years of education than the spouses in the discord only group ($F[2,99]=6.12$, $P<.005$). Finally, all of the groups differed significantly from one another on levels of marital satisfaction ($F[2,93]=38.94$, $P<.001$); and, overall, husbands were more maritally satisfied than their wives ($F[1,93]=5.83$, $P<.01$).

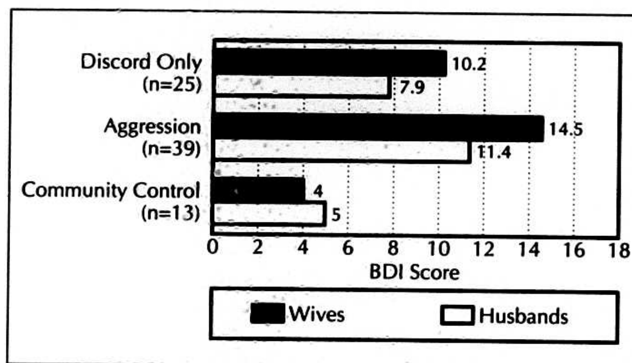

Fig 3.—*Mean Beck Depression Inventory (BDI) scores for wives and husbands.*

The three groups were then compared to determine if the aggression group also reported more depressive symptomatology and health problems than the discord only or the community control groups. Since age is correlated with depressive symptomatology and significantly differed across groups, it was used as a covariate in these analyses.

Depressive Symptomatology.—Figure 3 presents the mean Beck Depression Inventory scores for the husbands and wives in the three groups. A 2 (gender) × 3 (group) mixed-design analysis of covariance controlling for age revealed a significant main effect for group only ($F([2,57]=7.791$, $P<.001$). Using Tukey HSD post hoc analyses, both wives and husbands who experienced aggression reported significantly more depressive symptomatology than either the discord only or the community control spouses ($P<.09$ and $P<.02$, respectively). The mean amount of depressive symptomatology reported by the aggressive wives meets criteria for moderate levels of depressive symptomatology.[21]

Health Problems.—To determine specific group differences, two groups were compared at a time (eg, discord only vs aggression, discord only vs community control, and aggression vs community control) for wives and husbands on the three health questions. A z statistic based on the binomial distribution was used to assess the difference between the proportions across groups.[22] As depicted in Fig 4, 42% of the wives in the aggression group indicated that they were ill at the time of intake. Only 35% of the discord only wives and 29% of the community control wives reported being currently ill. Although the proportions were in the expected direction, these group dif-

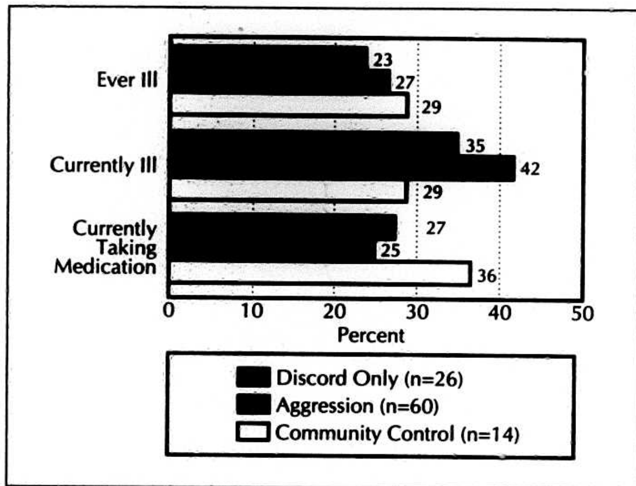

Fig 4.—*Wives' report of illness.*

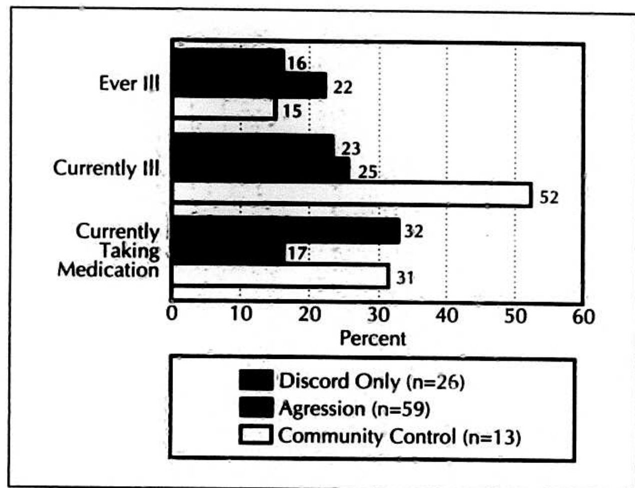

Fig 5.—*Husbands' report of illness.*

ferences were not statistically significant ($z<1.96$). The four primary current health problems reported by wives were chronic pain (33%), psychological difficulty (eg, fainting, dizziness, and anxiety) (10%), gastrointestinal and bladder (7%), and gynecologic (7%). No significant differences emerged across groups for wives for past illness or current medication use ($z<1.96$).

Figure 5 illustrates group differences on the health questions for the husbands. Twenty-five percent of the husbands in the aggression group reported being ill at intake vs 23% of the discord only husbands and 52% of the community control husbands. None of the group differences on the health questions were significantly different ($z<1.96$). The three most often reported current health problems by husbands were chronic pain (46%), coronary (17%), and gastrointestinal and bladder (12%). There were no differences among the three groups of husbands in current medication use or history of serious illness ($z<1.96$).

COMMENT

The results of this study are consistent with previous research documenting an alarmingly high prevalence of marital aggression in distressed couples seeking marital therapy. This rate was consistently high irrespective of classification method (H->W, W->H, or couple aggression). In fact, the most inclusive classification strategy (couple aggression) identified 71% of the clinic sample as maritally aggressive.

Also consistent with prior research,[1,9] husbands and wives reported experiencing and engaging in aggression at approximately the same rate. More specifically, the majority (86%) of aggression reported by the couples in this sample was reciprocal. That is, 56 couples reported H->W aggression, 57 reported W->H aggression, and 65 reported any aggression (either H->W or W->H). In spite of the mutuality of aggression, when impact experienced and injuries sustained were considered, a very different picture emerged. Specifically, wives were more likely than husbands to be negatively impacted by their spouse's aggression and to sustain severe injuries (eg, broken bones, broken teeth, or injury to sensory organs).

As reviewed elsewhere, a number of different models have been used to explain the gender differences in the use of marital aggression.[23] Biological models, for example, would suggest that testosterone differences between men and women result in men's greater use of aggression. According to sociological models, men use violence to maintain power and control over women, and their wives in particular. Lastly, psychological theories of marital aggression suggest that (1) men may use physical aggression to resolve conflicts; (2) gender differences in socialization processes may cause men to have greater difficulty in coping with anger; and (3) men may use physical aggression to control their aversive affective arousal during conflict.[23,24] While results from the present study do not advance any particular etiologic model, they provide strong support for our proposal that any model of marital aggression should take into account gender differences in the consequences of aggression.

Another finding in the present study was that mild and severely aggressive groups did not differ by age, income, education, or consequences of marital aggression, namely, impact or injury. One conclusion is that whenever marital violence occurs, no matter how seemingly mild or severe, it warrants attention and may be a risk factor for health consequences and distress for both partners. Another possibility is that our sample may not have included the most serious cases of wife abuse. That is, wives who are still willing to attend marital therapy with their husbands may not yet have experienced extremely negative health consequences as a result of the aggression. Couples characterized by more severe aggression and experiencing extremely severe injuries may have self-selected out of this sample. This self-selection may also have occurred because of the University Marital Therapy Clinic procedures and policies (eg, fees, acceptance of couples only, etc). Finally, the lack of differences on impact and injury between mild and severe aggression may be due to the fact that only 19% of the couples reported experiencing mild aggression alone. Therefore, the results from the mild impact ratings primarily reflect the reports of those couples who experienced both mild and severe aggression.

However, even in a sample of couples who were committed enough to their marriage to seek marital therapy, 12.8% of the wives who experienced any aggression reported a broken bone, broken teeth, and/or injury to sensory organs. Clearly, marital aggression has serious medical consequences irrespective of the level of aggres-

sion described by a patient. Further, an unfortunate consequence of addressing the correlates of marital aggression or distress (eg, depression, stress, and somatic complaints) through medical treatment alone is that one of the possible root causes of the problems, namely marital aggression, is not directly treated. This may leave women in potential danger.[3,6] Failure by professionals to address marital aggression may inadvertently perpetuate the cycle of violence.

The results of the present study highlight the need for professionals to educate patients about the impact of marital aggression. Health professionals should be prepared to discuss the negative and dangerous consequences of men's aggression on their partners. This approach is recommended even if men state that their partners are equally or more severely aggressive than they are. Likewise, women should be informed about their vulnerability to injury and marital distress when they are experiencing aggression, even if they self-report engaging in reciprocal aggression toward their husbands or are blaming themselves for the marital aggression.

The lack of demographic differences between clinic and community groups most likely indicates that successful matching occurred. As expected, however, the aggressive group differed in many significant ways both from the discord only group and from the community control group. In general, couples experiencing aggression were younger, less well educated, more depressed, and more dissatisfied with their marriages than were either of the other groups. Age differences within the clinic groups (aggression and discord only groups) indicate that young couples may be more at risk for aggression in their marriage, especially if they are experiencing marital difficulties. Contrary to our hypotheses, we did not find that the wives or husbands in the aggression group were more ill or more likely to be taking medication than were those in the discord only group or the community control group. In sum, younger, less educated, depressed, and maritally dissatisfied spouses may be at risk for marital aggression.

Overall, the group and gender differences obtained in this study make a strong case that physicians who are treating patients for injury, depression, or stress should routinely inquire about the patients' marital functioning. This is particularly important in light of past research documenting men's and women's reluctance to spontaneously disclose marital aggression.[14] For example, physicians may ask patients the following questions:

1. In general, how satisfying is your marriage?
2. What happens when you and your partner argue or fight?
3. Have you ever been physically aggressive toward your partner (ie, pushed, shoved, kicked, hit, or slapped him or her)? During the past 12 months?
4. Has your partner ever been physically aggressive toward you (ie, pushed, shoved, hit, slapped, or kicked you)? During the past 12 months?

Patients who respond affirmatively to questions about physical aggression should be asked about the frequency and severity of these acts. They also should be advised of the negative impact of physical aggression on their mental and physical health as well as the increased likelihood of further aggression taking place. Lastly, to prevent further aggression, it is extremely important to give patients a referral number to a therapist or community agency specializing in domestic violence. (The Hotline number for the National Coalition against Domestic Violence is (800)-333-SAFE.) To avoid further victimization of women, the referral source should be sensitive to gender differences regarding marital aggression.

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