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Dysphoria and Hopelessness Following Battering: The Role of Perceived Control, Coping, and Self-Esteem

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Coping, perceived control, dysphoria, hopelessness, and self-esteem in a sample of 100 battered women were assessed. Participants reported dysphoria and low self-esteem, but not hopelessness. High perceived control over current abuse and greater use of drugs, behavioral disengagement, denial, and self-blame as coping mechanisms were associated with increased dysphoria and low self-esteem. High expectations for control over future abuse were associated with decreased dysphoria and hopelessness and increased self-esteem. After controlling for the effects of abuse severity and low self-esteem, self-blame was a unique contributor to dysphoria and high expectations for control of future abuse were unique contributors to hopelessness. Results are discussed in terms of their implications for clinical intervention with battered women.

KEY WORDS: abuse; control; coping; dysphoria; hopelessness; self-esteem.

SELF-ESTEEM, CONTROL EXPECTATIONS, AND COPING: WHAT DETERMINES DYSPHORIA AND HOPELESSNESS FOLLOWING BATTERING?

Domestic violence continues to be a daunting problem for our nation. In 1998, women were the victims of 1.5 million violent crimes committed by a partner or ex-partner (National Institute of Justice [NIJ], 1998). Victimization rates are reported to be three times higher in women separated from their husbands than those divorced and 25 times higher in single women than in married (Bureau of Justice Statistics [BJS], 1995). As many as one in three women report violence in their relationship within any given year with low income women being more likely to be abused (American Psychological Association [APA], 1996). Researchers have reported even higher rates of abuse in clinical populations of women (Herman, 1986; Jacobson & Richardson, 1987).

In addition to physical mortality and morbidity, an important consequence of domestic abuse is increased reporting of psychological symptoms, particularly depression and low self-esteem (Gleason, 1993; Housekamp & Foy, 1991; Scott-Gliba *et al.*, 1995). Clinically significant levels of depression with accompanying suicidal ideation and suicide attempts are commonly found among abused women (Bergman & Brismar, 1991; Sato & Heiby, 1992). These findings are important because research shows that the presence of depressive symptomology play a significant role in the maintenance of abusive relationships (Follingstad *et al.*, 1991; Gelles & Harrop, 1989). Higher levels of depression and lowered self-esteem loss have been associated with the experience of more severe abuse and with the perpetuation of abusive relationships (Cascardi & O'Leary, 1992; Walker, 1984, 1989).

Two variables that seem particularly important in whether a woman develops depressive symptoms following abuse are degree of effective coping (Claerhout *et al.*, 1982; Finn, 1985; Launius & Jensen, 1987) and degree of perceived control over abuse (Cantos *et al.*, 1993; Miller & Porter, 1983; Overholser & Moll, 1990). In this study, coping, perceived control, dysphoria, and hopelessness were assessed in a sample of 100 battered women in order to further our understanding of depressive reactions to abuse.

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We also assessed self-esteem in order to gauge the extent to which loss of self-esteem may moderate the relationship of low perceived control and ineffective coping relative to dysphoria and hopelessness.

Perceived Control, Depression, and Battering

Contemporary domestic violence researchers have devoted considerable effort toward investigating the relationship between low perceived control over abuse and depression following abuse (see reviews by Overholser & Moll, 1990; Umberson, *et al.*, 1998). Many of these investigators have applied "learned helplessness" theory in their analyses, because battering has traditionally been viewed as beyond one's control (Abramson *et al.*, 1978; Seligman, 1975; Walker 1984, 1993). According to learned helplessness theory, people exposed to uncontrollable stressful events come to believe that important outcomes are independent of individual responding. This belief is termed learned helplessness (Peterson & Seligman, 1983). Research has linked learned helplessness in abuse situations to depressive symptoms such as sadness, passivity, and impaired cognitive functioning (Lanius & Jensen, 1987; Sato & Heiby, 1992; Walker, 1991).

The learned helplessness model of depression was revised in 1989 in order to clarify causal pathways posited to lead to depression and is now called hopelessness theory (Abramson *et al.*, 1989). According to hopelessness theory, individuals who develop a generalized expectation of hopelessness regarding important life outcomes are vulnerable to a specific category of depressive disorder called hopelessness depression. The expectation of hopelessness consists of two factors: (1) the belief that important negative outcomes are likely, and (2) the belief that one will be helpless in preventing negative outcomes (Abramson *et al.*, 1989).

To our knowledge, the predictions of hopelessness theory have been applied to battering situations in only one study (Clements & Sawhney, 2000). In this study, abused women in shelters who expected to control future abusive episodes reported lower levels of dysphoria. Perceived control over current abuse was not related to dysphoria. Clements and Sawhney (2000) concluded that perceived control over current abuse was a less important determinant of dysphoria than perceived control over future abuse. These researchers theorized that higher expectations for control over future abuse might confer psychological benefits to abused women. One of the purposes of this study was to extend Clements and Sawhney's (2000) application of hopelessness theory to battering situations.

Perceived Control, Coping, Depression, and Battering

Researchers examining coping in samples of abused women have generally found that battered women are less likely to engage in active and problem-focused coping behaviors than nonbattered women (Follingstad *et al.*, 1988). Abused women are more likely to cite factors beyond their control as solutions to problems (e.g., luck or passage of time). In comparison to nonbattered controls, battered women generate more avoidant and dependent coping responses and show a greater tendency to ignore problems (Claerhout *et al.*, 1982; Clements & Sawhney, 2000; Finn, 1985).

A controversy exists in the domestic violence literature over whether or not battered women use ineffective strategies to cope with abuse. Some of this controversy is based on a more general literature showing that coping strategies may differ in effectiveness depending on whether or not it is possible for an individual to control the outcome (Vitaliano *et al.*, 1993; Winkel & Vrij, 1993). Some investigators find that problem-focused strategies confer greater psychological benefit than emotion-focused strategies in situations under individual control. Emotion-focused strategies may confer greater benefit in uncontrollable circumstances (Valentiner *et al.*, 1994). For example, Vitaliano *et al.* (1990) found that problem-focused coping resulted in decreased depression in situations perceived as controllable while emotion-focused coping resulted in increased depression. In situations perceived as uncontrollable, emotion-focused coping resulted in decreased depression.

To the extent that the experience of abuse is seen as beyond one's control, these more general findings do not seem to generalize to the domestic violence literature. The few controlled investigations of coping in domestic violence situations seem to indicate that the use of emotion-focused strategies (e.g., venting one's feelings) is associated with *increased* depressive symptoms (Clements & Sawhney, 2000; Mitchell & Hodson, 1983). Problem-focused coping strategies are associated with decreased depressive symptoms. Thus emotion-focused strategies do not appear to be psychologically beneficial in coping with domestic abuse.

Depression, Hopelessness, Self-Esteem Loss, and Battering

Many researchers interested in domestic violence theorize that battering results in depressive reactions largely through its impact on self-esteem. Although

depression and hopelessness appear to be common reactions to abuse, low self-esteem is also widespread (Aguilar & Nightingale, 1994; McCauley *et al.*, 1995). Some investigators argue that abused women begin to show depressive symptoms due to gradual erosion of self-esteem engendered by ongoing episodes of battering (Sackett & Saunders, 1999). If gradual erosion of self-esteem is the primary determinant of depression and hopelessness then low perceived control and ineffective coping should not be significant determinants of depression once low self-esteem is taken into account. To our knowledge, there have been no investigations of psychological variables related to depression and hopelessness following battering which control for the effects of low self-esteem.

RATIONALE

In this study we investigated the influence of low perceived control on dysphoria and hopelessness following battering within the theoretical framework provided by the hopelessness theory of depression. This would extend Clements and Sawhney's (2000) research to applications of hopelessness theory in battering situations. We assessed the effect of specific forms of coping on dysphoria and hopelessness using a more comprehensive measure of coping than Clements and Sawhney (2000). We examined the role of self-esteem as a moderator of the influence of low perceived control and ineffective coping on dysphoria and hopelessness. Clements and Sawhney (2000) did not assess self-esteem. We also collected more extensive demographic information in order to better characterize our sample of battered women (Peterson *et al.*, 1993).

Extracting determinants of dysphoria and hopelessness following abuse may enable earlier identification of battered women most in need of psychological intervention. This would allow more effective allocation of clinical resources in the acute abuse situation. It would also enable clinicians to tailor interventions targeted to specific contributors to negative emotional reactions following abuse. It might further serve to decrease overall rates of domestic violence to the extent that dysphoria and hopelessness are associated with continuing risk for abuse (Follingstad *et al.*, 1991; Walker, 1989).

We acknowledge that establishing causal relationships between low perceived control and ineffective coping, dysphoria, and hopelessness requires the use of a prospective design. It is probable that reciprocal relationships exist between these variables. Because shelter samples are often transient, cross-sectional designs represent one practical method of collecting this information. Longitudinal studies would be necessary to gauge the extent to which low perceived control and ineffective coping in abuse situations are actually causing dysphoria and hopelessness.

We use the rationale of the hopelessness theory of depression and Clements and Sawhney's application of hopelessness theory in make the generating the following hypotheses: (1) Women who report low perceived control over current abuse will report high levels of dysphoria and low self-esteem; (2) Women who report high control expectations for future abusive episodes will report low levels of hopelessness and dysphoria and higher self-esteem; (3) Women who report ineffective coping with abuse (e.g., denial and self-blame) will report more dysphoria and hopelessness and will show lower self-esteem; (4) Ineffective coping and low expectations for control over future abusive episodes will be predictors of dysphoria even after controlling for the effects of abuse severity and low self-esteem; (5) Ineffective coping and low expectations for control over future episodes of abuse will be predictors of hopelessness even after controlling for the effects of abuse severity and low self-esteem.

METHOD

Participants

One hundred and fourteen women seeking shelter services for domestic abuse at five different North and South Carolina shelters were asked to participate in this study. Study investigators obtained written consent prior to participation. Of the 114 women recruited during the study period, 107 agreed to participate. Seven respondents were dropped from subsequent statistical analyses because of incomplete data on both coping and control measures. Participants who were dropped from subsequent analyses did not differ statistically from those not dropped on demographic characteristics, abuse severity, dysphoria, hopelessness, or self-esteem.

Women who participated in this study were in their mid-30s ($M = 36.5$ years; $SD = 9.34$). Seventy-four percent were Caucasian. Twenty-six percent were African American. Participants had spent an average of 5 years in the battering relationship ($SD = 6.79$). The modal number of abusive incidents participants reported in the past year was 16 or more. The reported mean level of violence as assessed by the Conflict Tactics Scale (CTS; Straus, 1979) was 54 ($SD = 34.24$) which is comparable to that reported by other researchers in shelter samples (Clements & Sawhney, 2000; Straus & Gelles, 1986). The mean CTS score including verbal abuse items was 66

Table I. Sample Characteristics and Abuse Characteristics Percentages ($N = 100$ Battered Women)

Sample characteristics	%	Abuse characteristics	%
Marital status		When abuse began	
Dating	11.0	1st year	42.3
Married	38.5	After 1st year	44.3
Separated/divorced	29.7	Violence outside relationship	
Living together	20.9	Yes	34.0
Number of children		No	64.9
0	12.1	Life threatened	
1–3	79.2	Yes	50.0
4–6	8.3	No	46.0
Employment		Abuse before marriage	
Unemployed	53.8	Yes	26.0
Employed	46.2	No	68.0
Income		Severity of injury	
Less than $15,000	69.3	1–5 hospital visits	7.2
$15,000–$40,000	22.0	Severe injury	7.2
More than $40,000	7.3	Minor injury	18.6
Income change		No MD required	57.7
Increased	12.1	Abused as a child	
Decreased	30.8	Yes	72
Stayed the same	23.1	No	28

Note. Numbers may not add up to 100% due to missing data.

($SD = 36.91$). Other demographic information and abuse severity characteristics can be seen in Table I.

Measures

The Demographic and Abuse Severity Questionnaire (DASQ; Clements & Sawhney, 2000)

The demographic and abuse severity questionnaire is a 16-item self-report inventory assessing eight demographic factors (e.g., age, race, religion, employment, number of children, and independent income level) and eight abuse severity indices (e.g., number of incidents of physical violence in the past year, most severe injury sustained in the current relationship, and number of years of abuse in current relationship).

The Conflict Tactics Scale (CTS; Straus, 1979)

The CTS is a 16-item self-report measure designed to assess the degree to which couples use physical violence and verbal aggression to resolve interpersonal conflict (Straus, 1979). The frequency with which one's partner engages in 16 different abusive behaviors is rated on a scale ranging from 0 (*never*) to 6 (*more than 20 times*). Fourteen items were added to the CTS to assess sexual abuse as well as nonphysical forms of abuse. Nonphysical forms of abuse included items such as "refused to allow you access to spiritual or psychological counseling" and "denied you access to your paycheck or other forms of money you receive." Two overall severity of violence indices were obtained; one by summing frequency ratings over all 30 items and one by summing frequency ratings over the 16 physical violence items.

Previous research indicates that CTS items reliably discriminate acts of violence from nonviolent interactions (Marshal, 1992; Rodenberg & Fantuzzo, 1993). The modified version of the CTS has demonstrated good reliability in previous research ($\alpha = .91$, split-half = .86; Clements & Sawhney, 2000) and was reliable in this study as well ($\alpha = .95$).

Beck Depression Inventory (BDI; Beck *et al.*, 1979)

The BDI is a 21-item self-report inventory that has been used to assess dysphoria in clinical and nonclinical populations for over 25 years (Beck *et al.*, 1979). The suicide item (# 9) was dropped from the BDI in this study because the UNC-Wilmington Institutional Review Board would not allow us to assess suicidal ideation. The 21-item BDI is a psychometrically valid and reliable measure of depressive symptoms in both psychiatric ($\alpha = .86$) and nonpsychiatric samples ($\alpha = .81$; Beck *et al.*, 1988). The 20-item scale used in this study was also highly reliable ($\alpha = .89$). Per Kendall *et al.* (1987) guidelines we use the term "dysphoric" rather than "depressed" to describe women who scored above nine on the BDI. This designation was used because a clinical interview was not conducted.

Hopelessness Scale (HS; Beck *et al.*, 1974)

The HS is a 20-item self-report instrument designed to measure individuals' generalized negative expectancies about the future (Beck *et al.*, 1974). The HS has demonstrated adequate reliability in cross-sectional ($\alpha = .92$) and prospective ($\alpha = .85$) studies (Holden & Fekken, 1988; Young *et al.*, 1992). The HS showed good reliability in this study as well ($\alpha = .93$). Examples of HS items include "There is no use in really trying to get something I want because I probably won't get it" and "I have great faith in the future."

Control, Attributions, and Expectations Questionnaire (CAEQ)

Clements (1990) developed a modified version of the Attributional Style Questionnaire (Peterson & Seligman, 1984) to assess perceived control over current life events and expectations of control for future events. Participants

reported control beliefs for their most severe and their most recent battering incidents. Clements (1990) has demonstrated adequate reliability of the CAEQ ($\alpha = .69$ for control perceptions about positive events and $\alpha = .62$ for perceptions about negative events) in nonabused samples. The CAEQ has demonstrated adequate reliability in abuse samples ($\alpha = .60$ for control over current abuse and $\alpha = .85$ for expectations of control for future abuse; Clements & Sawhney, 2000). CAEQ items were reliable in this sample as well ($\alpha = .70$ for control over current abuse and $\alpha = .78$ for expectations for control over future abuse).

COPE (COPE-B)

The COPE-B is a 28-item self-report inventory designed to assess the extent to which participants used 14 distinct strategies to cope with their abuse (Carver, 1997). COPE-B subscales contain strategies measured by more widely used instruments, including problem-focused activities, seeking of social support, self-blame, and avoidance. The COPE-B also includes strategies not measured by other instruments. These include activities such as humor, turning to religion, denial, and acceptance (Carver, 1997). Participants were instructed to rate how often they used each strategy to cope with "the abuse you have experienced" on a 1 (*I haven't been doing this at all*) to 4 (*I have been doing this a lot*) Likert scale.

Although the COPE-B is a relatively new measure, its' subscales have demonstrated good reliability (α's range from .54 for *denial* to .90 for *drug use*; Carver, 1997). In this sample, reliabilities ranged from .07 for *planning* to .92 for *drug use*. We eliminated COPE-B subscales with reliabilities less than .60 from subsequent analyses (active and emotion-focused, planning, suppression of competing activities, and acceptance). Of the remaining nine subscales, four did not involve direct action strategies to solve the problem of abuse. These four demonstrated adequate reliability: drug use, $\alpha = .92$; denial, $\alpha = .75$; behavioral disengagement, $\alpha = .66$; and self-blame, $\alpha = .64$. These strategies were designated as our "ineffective coping" variables in regression analyses.

Rosenberg's Self-Esteem Scale (ROSE)

The ROSE is a 10-item self-report measure of self-esteem (Rosenberg, 1965). Participants respond on a 5 point Likert scale ranging from 1 (*disagree*) to 5 (*agree*). The ROSE has demonstrated good reliability in a great deal of previous research ($\alpha = .88$; Fleming & Courtney, 1984) and in domestic violence samples ($\alpha = .90$; Mitchell & Hodson, 1983). For interpretive purposes, it should be noted that higher scores on the ROSE indicate lower self-esteem.

Procedure

Participants were told that the purpose of the study was to "understand how battering affects women." They completed study questionnaires after investigators obtained informed consent. Questionnaires were administered during community meetings or support group sessions by the investigators or by counselors trained by the investigators. All participants were fully debriefed.

RESULTS

DESCRIPTIVE STATISTICS

As can be seen in Table II, women in our sample reported moderate to severe levels of dysphoria on the BDI. This level of dysphoria is consistent with that found in previous investigations of the emotional consequences of battering (Aguilar & Nightingale, 1994; Clements & Sawhney, 2000). Women in this study did not report hopelessness. Almost 70% scored 5 or below on the HS. This lack of hopelessness is similar to that found by Clements and Sawhney (2000) and to that seen in undergraduate normative samples (Lennings, 1992). Participants reported low self-esteem at levels consistent with that seen in other domestic violence samples (Scott-Gliba *et al.*, 1995; Tuel & Russell, 1998).

Seventy-two percent of this sample reported that they "did not control their current episode of abuse." Sixty-eight

Table II. Means and Standard Deviations of Emotional Status Variables, Coping, and Perceived Control

Variable	*M*	*SD*	*n*
BDI	18.31	10.52	98
HS	5.80	5.23	100
ROSE	23.42	9.27	90
CAEQ—Control for current abuse	2.18	1.35	95
CAEQ—Expectations for control over future abuse	4.39	1.50	90
COPE-B Self-Blame	2.18	.97	99
COPE-B Denial	1.88	.98	99
COPE-B Behavioral Disengagement	1.82	.92	99
COPE-B Drug Use	1.54	.91	99

Note. BDI—Beck Depression Inventory; HS—Hopelessness Scale; ROSE—Rosenberg Self-Esteem Scale; CAEQ—Control, Attributions & Expectations Questionnaire; COPE- B—Brief Cope.

Table III. Correlations Between Emotional Status, Abuse, Coping, and Control

	Emotional status			Abuse severity			Coping				Control	
	1	2	3	4	5	6	7	8	9	10	11	12
1. BDI	—	.691***	.731***	.163	.165	.300**	.316**	.274**	.413***	.563**	.241*	−.300**
2. HS	—	—	.703***	.236*	.254*	.290**	.138	.217*	.331***	.373***	.155	−.308**
3. ROSE	—	—	—	.194	.236*	.280**	.309**	.247*	.425***	.494***	.111	−.251*
4. Outside violence	—	—	—	—	.204*	.239*	.110	.067	.147	.107	.150	−.058
5. When abuse began	—	—	—	—	—	.141	.116	.318**	−.016	−.074	.186	−.042
6. Abuse before marriage	—	—	—	—	—	—	.024	.071	.199	.049	−.067	−.373***
7. Drugs	—	—	—	—	—	—	—	.251*	.132	.334***	.071	.086
8. Denial	—	—	—	—	—	—	—	—	.303**	.341***	.299**	.045
9. Behavioral disengagement	—	—	—	—	—	—	—	—	—	.436***	.112	.009
10. Self-blame	—	—	—	—	—	—	—	—	—	—	.185	−.050
11. CAEQ control	—	—	—	—	—	—	—	—	—	—	—	−.157
12. CAEQ expectations	—	—	—	—	—	—	—	—	—	—	—	—

*$p < .05$. **$p < .01$. ***$p < .001$.

percent reported that they "expected to control future episodes of abuse." Almost 30% of the sample reported using "self-blame" as a coping strategy "a medium amount" or "a lot." Twenty-one percent reported using "denial" and 15% reported using "behavioral disengagement "a medium amount" or "a lot." Eleven percent reported using drugs as a coping strategy "a medium amount" or "a lot."

Correlational Analyses

Abuse Severity Variables

Correlations between abuse severity variables and emotional status measures are shown in Table III. Women who were abused before marriage showed more dysphoria and hopelessness and reported lower self-esteem. Women who experienced violence outside their relationship and whose abuse began earlier in their relationship reported more hopelessness. Women whose abuse began earlier in the relationship reported lower self-esteem and more hopelessness. Other abuse severity indices were unrelated to emotional status variables and are not shown in Table I, largest $r(99) = .17$, $ps > .05$.

Control and Coping Variables

As can be seen in Table III, perceived control over current abuse was unrelated to expectations for control over future abuse ($r = -.15$, $p > .05$). Participants with higher perceived control over current abuse were more likely to use denial as a coping strategy ($r = .29$, $p < .01$). All other ineffective coping strategies were unrelated to control perceptions, (largest $r(94) = .18$, $p > .05$).

Hypothesis 1. We hypothesized that women who reported low perceived control over current abuse and low expectations of control over future abuse would show higher levels of dysphoria and lower levels of self-esteem. As can be seen in Table III, contrary to our hypothesis, *high* perceived control over current abuse was related to increased reports of dysphoria ($r = .24$, $p < .05$). High perceived control over current abuse was not associated with self-esteem or hopelessness.

Hypothesis 2. According to Hypothesis 2, women who report high control expectations for future abusive episodes will report lower levels of hopelessness ($r = -.31$, $p < .01$) and dysphoria ($r = -.30$, $p < .01$) and higher self-esteem ($r = -.25$; $p < .05$). This hypothesis was supported. As can be seen in Table III, women who expected to control future abusive episodes reported less hopelessness. They also reported less dysphoria and showed higher self-esteem.

Hypothesis 3. According to Hypothesis 3, women who report ineffective coping with abuse (drug use, behavioral disengagement, denial, and self-blame) will be more dysphoric and hopeless and show lower self-esteem. As can be seen in Table III, with the exception of the nonsignificant association between drug use and hopelessness, increased use of drugs, denial, behavioral disengagement, and self-blame as coping strategies were all associated with increased dysphoria and hopelessness and lower self-esteem, smallest $r(99) = .22$, $p < .05$, between denial and hopelessness, largest $r(97) = .56$, $p < .001$, between self-blame and dysphoria.

Hypothesis 4. According to Hypothesis 4, ineffective coping and low perceived control over future abusive episodes will be unique determinants of dysphoria after

Table IV. Hierarchical Regression Analysis of Abuse Severity, Perceived Control, and Coping on Dysphoria Controlling for Self-Esteem ($n = 85$)

Variable	R^2	ΔR^2	B	$SE\ B$	β
Coping					
Step 1	.09	.09			
Abuse before marriage			6.59	2.3	.30**
Step 2	.53	.44			
Self-esteem			0.76	0.09	.69***
Step 3	.60	.07			
Drugs			1.07	0.88	.09
Self-blame			2.45	0.96	.25**
Denial			0.004	0.80	.004
Behavioral disengagement			0.59	0.92	.06
Perceived control					
Step 1	.10	.10			
Abuse before marriage			6.93	2.34	.32**
Step 2	.52	.42			
Self-esteem			0.73	0.09	.68***
Step 3	.54	.01			
Control expectations			−0.84	0.55	−.13

** $p < .01$. *** $p < .001$.

controlling for the effects of low self-esteem and abuse severity. To test Hypothesis 4 we constructed two hierarchal regression equations. Abuse before marriage was entered on the first step of both regression equations as the abuse severity variable and self-esteem was entered on the second step. On the third step of the first regression equation, drug use, self-blame, denial, and behavioral disengagement coping strategies were entered as a block. Expectations for control over future abuse were entered on the third step of the second equation. BDI scores were the dependent variable for both equations.

As can be seen in Table IV, in Regression 1, higher abuse severity, lower self-esteem, and greater use of ineffective coping each determined a unique proportion of the variance in reports of dysphoric symptoms. Increased use of self-blame was the only significant contributor to dysphoric symptoms in the ineffective coping composite. In Regression 2, greater abuse severity and lower self-esteem each accounted for a unique amount of the variance in reports of dysphoria while control expectations did not. These two regressions suggest that, after controlling for the effects of low self-esteem and abuse severity, self-blame but not control expectations was a unique determinant of dysphoric symptoms in this sample.

Hypothesis 5. According to Hypothesis 5, ineffective coping and low expectations for control over future abusive episodes will be unique determinants of hopelessness after controlling for the effects of low self-esteem and abuse severity. To test Hypothesis 5, we constructed two hierarchal regression equations. Violence outside the primary abusive relationship, when abuse began and abuse before marriage were entered as a block on the first step of both regression equations to control for abuse severity. Self-esteem was entered on the second step in both equations. In the first equation, ineffective coping strategies were entered as a block on the third step. In the second equation, control expectations for future abusive episodes were entered on the third step.

Table V. Hierarchical Regression Analysis of Abuse Severity, Control Expectations, and Coping on Hopelessness Controlling for Self-Esteem ($n = 85$)

Variable	R^2	ΔR^2	B	$SE\ B$	β
Coping					
Step 1	.16	.16			
Outside violence			1.25	1.14	.12
When abuse began			1.11	0.50	.24*
Abuse before marriage			2.23	1.18	.21
Step 2	.51	.35			
Self-esteem			0.34	0.05	.63***
Step 3	.52	.02			
Drugs			0.009	0.49	.02
Self-blame			0.69	0.54	.13
Denial			−0.31	0.49	−.06
Behavioral disengagement			0.26	0.51	.05
Perceived control					
Step 1	.16	.16			
Outside violence			0.57	1.19	.06
When abuse began			1.22	0.51	.27*
Abuse before marriage			2.45	1.23	.23*
Step 2	.49	.32			
Self-esteem			0.33	0.05	.61***
Step 3	.51	.03			
Control expectations			−0.62	0.31	−.18*

* $p < .05$. *** $p < .001$.

As can be seen in the first regression in Table V, high abuse severity and low self-esteem were unique determinants of hopelessness while greater use of ineffective coping strategies were not. In the sectond equation, high abuse severity, low self-esteem, and low perceived control over future abuse were each unique determinants of increased reported hopelessness. These two regressions suggest that, after controlling for the effects of low self-esteem and abuse severity, future control expectations but not ineffective coping were unique determinants of hopelessness in this sample.

DISCUSSION

We investigated the influence of perceived control and ineffective coping on dysphoria, hopelessness and self-esteem using the logic of the hopelessness theory of depression in a sample of 100 battered women. In

regression analyses we assessed the influence of perceived control and ineffective coping on dysphoria and hopelessness controlling for the effects of abuse severity and self-esteem.

Perceived Control, Dysphoria, and Self-Esteem

Like other investigations of emotional well-being following battering, participants reported moderate to severe levels of dysphoria and low self-esteem (Sackett & Saunders, 1999; Tuel & Russell, 1998). They reported low perceived control over current abuse but high expectations for control over future episodes of abuse. According to the logic of hopelessness theory, low perceived control over current abuse and low expectations for control over future abuse should be associated with greater risk for dysphoria and, indeed, participants who expected to control future episodes of abuse were less dysphoric. However, high perceived control for current abuse was associated with *increased* dysphoria.

Participants showing high perceived control over current abuse may grow more dysphoric as they attempt to exert control over an uncontrollable abusive situation. Peterson *et al.* (1993) have suggested that high perceived control may be maladaptive in situations which are objectively uncontrollable. These researchers posit that helplessness induced passivity may help conserve energy until such a time as responses can affect outcomes. Our data support Peterson *et al.*'s (1993) position and indicate that high perceived control over current abuse puts abused women at greater risk for dysphoria.

One possible interpretation of these data is that women who believe they control their current abuse situation are more likely to blame themselves for abuse or to suffer self-esteem loss as a result of abuse (Sackett & Saunders, 1999). However, the pattern of our correlations and regression analyses does not support this interpretation. High perceived control over current abuse was associated with greater use of ineffective coping strategies such as denial but was not correlated with increased self-blame or low self-esteem. This suggests that the effect of high perceived control over abuse on dysphoria may be independent of the effect of self-blame on dysphoria in abused women.

If high perceived control and self-blame are indeed independent contributors to dysphoria then women who show both should be at greater risk for experiencing dysphoric symptoms following abuse. Early identification of those abused women showing high perceived control over abuse and self-blame might enable more effective intervention, perhaps before dysphoric symptoms begin to significantly interfere with functioning. Our data indicate that interventions designed both to reduce self-blame and perceived control over current abuse may be more effective than those focusing solely on one of these issues (Barnett *et al.*, 1997; Kaner *et al.*, 1993).

It is important to note that this study did not provide a complete test of the applicability of hopelessness theory to battering situations. According to hopelessness theory, individuals who develop a generalized expectation of hopelessness regarding important negative outcomes will develop hopelessness depression. The expectation of hopelessness consists of two factors, a negative outcome expectancy and a helplessness expectancy (Abramson *et al.*, 1989). In this study, the helplessness expectancy component of the model was assessed. An examination of outcome expectancies in addition to helplessness expectancies would be necessary to fully test the utility of hopelessness theory in cases of abuse. To our knowledge no investigator has assessed both types of expectations in a sample of abused women.

It might also be useful to examine the effect of control expectancies on other known psychological correlates of abuse. High rates of Posttraumatic Stress Disorder and anxiety-related symptoms have been shown in samples of battered women (Kemp & Green, 1995; Saunders, 1994). High expectations for control over future abuse may attenuate anxiety-related symptoms as they seem to have attenuated dysphoric symptoms in this study. Alternatively, women with high perceived control over future abuse may experience *increased* anxiety-related symptoms as they continue their efforts to control an uncontrollable situation. Prospective research in this area would be especially beneficial because it would enable researchers to assess whether high perceived control over future abuse is causally related to the onset of anxiety symptoms. If this is so, clinical interventions addressing perceived control over abuse should result in reduced anxiety-related symptoms in abused women.

Our data suggest that high expectations for control over future abuse may be beneficial in terms of their association with lower levels of dysphoria. Research is needed on correlates of high control expectations that may be less beneficial. An inexplicable but repeated finding in domestic violence research is that abused women tend to return to their abuser, sometimes more than once (see Rhodes & McKenzie, 1998 for a review). Women who expect to control future abuse may be more likely to believe that they can change the outcome of future abusive episodes (Holtzworth-Monroe, 1988; Painter & Dutton, 1985). Thus high control expectations over future abuse may make return to abuser more likely (Doran, 1980; Ferraro, 1983). If this relationship is indeed established,

interventions designed to reduce expectations for control over abuse may result in decreased likelihood of return to abuser and consequent decreases in mortality and morbidity associated with repeated abuse.

Perceived Control, Hopelessness, and Self-Esteem

The lack of hopelessness found in these data is consistent with one previous study examining hopelessness in battered women using the HS but is inconsistent with findings in the general clinical literature (Clements & Sawhney, 2000). Studies in clinical populations commonly find that high levels of hopelessness co-occur with more severe dysphoria (Beck *et al.*,1976, 1988). It is relatively rare to find individuals with moderate to severe levels of dysphoria who do not report hopelessness.

Why would a group of battered women who report high levels of dysphoria and low self-esteem not report hopelessness? Clements and Sawhney (2000) suggested that the lack of hopelessness found in their sample of abused women might have reflected the fact that participants had chosen to seek shelter services and thus expected a better future. It is likely that this occurred in our sample as well. It is further probable that any shelter services participants received prior to the study contributed to the lack of hopelessness found. Prospective studies in which women are assessed at the initiation of shelter contact in addition to after receiving services are needed to assess these possibilities.

The finding that high expectations for control were associated with low levels of hopelessness is consistent with hopelessness theory. Further, the fact that coping style was not a significant determinant of hopelessness supports the notion that control perceptions contribute to hopelessness in the manner specified by hopelessness theory. According to this theory, individuals who expect to control important life outcomes will not develop a more generalized expectation of hopelessness, or indeed, hopelessness depression (Abramson *et al.*, 1989). Participants with high expectations for control over future abuse may not have believed that abuse was likely to happen to them again. This belief may have enabled them to develop a more hopeful outlook.

This lack of hopelessness also implies that the high levels of dysphoria participants reported were not symptomatic of hopelessness depression. Future studies using measures specific to hopelessness depression would clarify whether battered women are showing symptoms of this disorder or of more generalized dysphoria. Prospective studies are needed to establish the causal relationship between control expectations and hopelessness.

Although in the short term, lack of hopelessness may be beneficial for women in this sample, it may be detrimental in the long run. Like high control expectations, lack of hopelessness was associated with lower rates of dysphoria. However, women who are less hopeless may be more likely to believe that their relationships are salvageable and therefore more likely to return to the abuser. It would be important to assess the relationship between abuse specific hopelessness beliefs and likelihood of return to abuser to examine this possibility. If more hopeful women are more likely to return to the abuser then clinical interventions may be needed to inculcate relationship specific hopelessness.

Coping, Dysphoria, Hopelessness, and Self-Esteem

Almost one third of our sample reported the use of ineffective coping strategies, particularly self-blame. Use of these strategies was associated with increased levels of dysphoria and hopelessness and lower levels of self-esteem. After controlling for abuse severity and low self-esteem, self-blame was the only significant contributor to dysphoria among the ineffective coping strategies. These data are consistent with a large literature finding a relationship between dysphoria and self-blame among abused women (Andrews & Brewin, 1990; Barnett & Martinez, 1996; Miller & Porter, 1983). Our data support this body of literature and indicate that low self-esteem and abuse severity are not accounting for this relationship.

These data indicate that reducing depression in abuse populations may involve more than improvements in self-esteem. Full remediation of depressive symptoms may not occur unless the use of self-blame as a coping strategy is reduced. They also suggest that self-blame is more dysphoria engendering than other ineffective coping strategies (e.g., denial, drugs, or behavioral disengagement). Although prospective studies are needed to address this possibility, self-blame may place women at greater risk for poor emotional adjustment following abuse. If this proves to be the case, then early intervention with women who blame themselves for abuse may prevent the occurrence of dysphoric symptoms.

Because this study was cross-sectional in nature, we are unable to speak to the causal nature of the relationships between self-blame, dysphoria, hopelessness, and low self-esteem. It may be the case that self-blame produces negative affective states such as low self-esteem and hopelessness. Alternatively, as Sackett and Saunders (1999) suggest, depression, hopelessness, and self-blame may appear as self-esteem erodes. Prospective studies are needed to examine the temporal associations between

these variables. If changes in self-esteem or self-blame, for example, do indeed precede the emergence of dysphoria and hopelessness, then early intervention targeting low self-esteem or self-blame should prevent the onset of dysphoria and hopelessness.

The ineffective coping strategies shown by a large portion of this sample suggest a passive approach to the abuse situation, as do the data showing low perceived control over current abuse. Passivity in the face of continuing abuse is a common finding in the abuse literature and represents a dilemma for clinicians and researchers attempting to intervene with abused women. Some investigators have posited that passive coping may actually serve a survival function for abused women in reducing the volatility of the acute battering situation (Peterson *et al.*, 1993; Walker, 1989). It would be important to assess coping dynamically in abuse situations to determine whether or not abused women are "actively" pursuing passive coping in acute battering episodes. Data from such assessments might enable more effective early intervention in abuse situations.

Limitations

Our ability to generalize these findings to the diversity of battered women is dependent on the extent to which women who access shelter services are representative of all abuse victims. Participants had all made an active attempt to seek help for the abuse they had experienced. It would be important to assess women who have not accessed shelter services to see how they may differ on variables such as perceived control over abuse, coping and emotional status from participants in this study. It would also be important to compare groups of abused women to women in distressed but nonviolent relationships to identify differences in perceived control, coping, and emotional status that are specific to the experience of domestic abuse.

Self-report instruments may not represent the best methods of obtaining information in abuse situations. Data collection techniques aimed at increasing rapport (e g., structured interviews) may enable researchers to develop a more complete picture of individuals who experience abuse. Behavioral assessments may be of further benefit in gaining information about typical coping patterns utilized in abuse situations.

The cross-sectional design of this study limits our ability to make causal inferences. Although prospective research would allow researchers to make such inferences, there are often safety issues involved with prospective research in abuse situations. Prior to shelter contact women are often living with their abusers. Contact with researchers about ongoing abuse may further endanger participants. High rates of return to abuser and relocation to avoid abuser make shelter follow-up difficult. Although greater collaboration of researchers with shelters and community agencies may make some follow-up possible, cross-sectional designs might well represent the most feasible method of collecting data about abused women until such a time as research strategies can be developed to guarantee their safety.

Conclusions

Our data indicate that high expectations for control over future abuse is associated with lower dysphoria and hopelessness. Self-blame shows a positive correlation with increased hopelessness and dysphoria following abuse. This implies that interventions with abused women designed to lessen dysphoria and hopelessness should address perceived control and coping. Moreover, interventions designed to enhance self-esteem may not reduce dysphoric symptoms unless perceived control and coping are also addressed. Prospective research conducted in ways that does not jeopardize participant safety is necessary to assess whether perceived control and coping are causally related to hopelessness, dysphoria, and low self-esteem. Prospective research examining the applicability of hopelessness theory to abuse situations might benefit from assessing outcome expectancies in addition to helplessness expectancies, using control groups of women in distressed, nonviolent relationships. Finally, it may be beneficial to determine whether perceived control and coping are associated with other known psychological sequelae of abuse (e.g., PTSD).

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