Aggressors Against Women in Prison and in the Community: An Exploratory Study of a Differential Profile

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Abstract: *The current study compares the demographic and psychopathological characteristics of 54 men, who were in prison because of a serious offence of violence against women, and of 42 men, who belonged to a program of community treatment for violence against women in the home. There were no significant differences in demographic variables between the two samples. However, from a psychopathological point of view, psychiatric antecedents and current emotional instability were much more frequent and severe in aggressors within the community. Therefore, two possible differential profiles among the violent men are presented. Implications of these results for further research and clinical practice are commented on.*

Keywords: *aggressors against women; psychopathology; prison; community*

Violent behavior in marital relationships involves an attempt by one person to control the other and reflects an abuse of power (Echeburúa & Corral, 1998). This explains why violence is vented by men on women, children, and the elderly, the most vulnerable members of a household (Corsi, 1995). However, violence in marital relationships always gives rise to negative physical and emotional consequences and both degrades the victim and diminishes the perpetrator's self-esteem.

The most up-to-date figures on the percentage of violence against women are alarming: between 4% and 12% in Spain (Ministerio de Trabajo y Asuntos Sociales e Instituto de la Mujer, 2000) and between 15% and 30% in the United States (Goldman, Horan, Warshaw, Kaplan, & Hendricks-Matthews, 1995; Straus & Gelles, 1990). These disturbing figures have led to a greater interest on the part of the scientific community in studying the perpetrators of this violence, and this has resulted in a greater knowledge of the clinical characteristics of violent men (Echeburúa, Fernández-Montalvo, & Amor, 2003).

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From a psychopathological point of view, numerous studies have indicated the existence of psychiatric upsets in violent men. More specifically, alcohol abuse is present in more than half of the aggressors (Bland & Orn, 1986; Conner & Ackerley, 1994; Fernández-Montalvo & Echeburúa, 1997a; Kaufman & Straus, 1987; Van Hasselt, Morrison, & Bellack, 1985), and the violence incidence rates for drug consumers fluctuate between 13% and 35% of the participants studied (Bergman & Brismar, 1993; Fagan, Stewart, & Hansen, 1983; Roberts, 1988).

One clinically significant aspect is the presence of pathological jealousy. Thirty-eight percent of aggressors considered in the study by Fernández-Montalvo and Echeburúa (1997a) were found to have sexual jealousy, a finding that is in keeping with other previous studies (Faulkner, Stoltemberg, Cogen, Nolder, & Shooter, 1992; Howes, 1980; Saunders, 1992).

Personality disorders have also often been identified in study participants (Bernard & Bernard, 1984; Dinwiddie, 1992; Hamberger & Hastings, 1986; Stewart & DeBlois, 1981), the most frequent manifestations being the antisocial, borderline, and narcissistic disorders (Hamberger & Hastings, 1988a, 1991; White & Gondolf, 2000).

Likewise, when men who show violence toward women are compared with the general population, they have been found to be more anxious and depressive, emotionally cold, dominant, and hostile, with little control over their outward expression of anger and impulses in general (Bersani, Chen, Pendleton, & Denton, 1992).

From the point of view of interpersonal relationships, aggressors against women tend to possess very poor communication skills, inadequate problem-solving strategies, and a low frustration tolerance (Corsi, 1995). All of this makes it clear that the everyday conflicts and frustrations of such people, even if no greater than usual, are enough on many occasions to set off violent incidents (Faulkner et al., 1992; Hamberger & Hastings, 1988b).

Cognitive bias is frequently found to be present. This type of bias refers, on one hand, to mistaken thoughts about sexual roles and the inferiority of women and on the other hand, to distorted ideas about the legitimacy of violence as a way of resolving conflicts (Corsi, 1995; Echeburúa et al., 2003; Fernández-Montalvo & Echeburúa, 1997a; Howes, 1980).

All of this does not mean, however, that perpetrators of violence against women form a homogeneous group, as witnessed by the different typologies produced by various studies (Fernández-Montalvo & Echeburúa, 1997a; Gleason, 1997; Holtzworth, 2000; Huss & Langhinrichsen, 2000). Establishing classifications is of interest not only from the psychopathological perspective but mainly from a therapeutic point of view. Only in this way can the most suitable treatment be chosen for each particular case.

The aim of this study is to compare the demographic and psychopathological characteristics of aggressors sentenced to prison for an offence involving gender-based violence (Echeburúa et al., 2003) with those involved in community treatment. In short, the intention is to differentiate between the profiles of these two

types of aggressors, as certain authors have suggested (White & Gondolf, 2000). This purpose may be relevant because of the lack of previous studies about this topic. As a main hypothesis, batterers in prison would be expected to present a different and more disturbed psychopathological profile because they have been involved in a more serious crime and they have been living in prison for a long time. If so, specific intervention programs for these participants' types might then be designed at a later stage.

METHOD

PARTICIPANTS

The sample for this study consisted of 96 participants, all of them aggressors against women. In short, 42 participants, who were at the time living in a marital relationship, sought community outpatient treatment at the Program of Family Violence in Bilbao, Spain. The 54 remaining participants were at the time imprisoned for a serious offence of violence against their intimate partner. These last participants are part of a research study that ran in seven Spanish penal institutions in 2001 and 2002 about the effectiveness of a pilot program of psychological intervention with prisoners convicted of violence against women.

The rationale for being placed in an imprisonment or community treatment program was the severity of the offence against the partner. In the first case, men were convicted of a serious crime by the court; in the second case, men were living with their partners, and their partners, who wanted to continue living with them, had not reported any crime to the court or to the police.

According to the criteria for admission to the study, men had to (a) be adult males (between 18 and 65 years old) currently involved in a relationship, (b) behave in a violent way, either emotionally or physically, against their wives, without having been reported to the court or to the police, (c) not be suffering from any severe mental disorder or serious physical illness, and (d) take part voluntarily in the treatment program, financially supported by the social services of the local government.

Those selected for the sample in prison had to (a) be adult males (between 18 and 65 years old) having been involved in violence against their partner, (b) be serving a sentence for a serious offence in relation to gender violence, (c) not be suffering from any serious mental disorder or disabling physical disease, and (d) partake voluntarily in the program, having been properly informed of its characteristics.

ASSESSMENT MEASURES

The Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1975; González de Rivera, 2002) is a self-administered general psychopathological assessment

questionnaire. It comprises 90 items with 5 alternatives for each item on a Likert-type scale, ranging from 0 = *none* to 4 = *very much*. The aim of the questionnaire is to reflect participants' symptoms of psychological disturbance. As it has been shown to be sensitive to therapeutic change, it may be used for either single or repeated assessments. The SCL-90-R consists of nine areas of primary symptoms (somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism). It also provides three overall indices that reflect the participant's overall level of severity. The cut-off point of the general symptoms index is 63 points.

The State-Trait Anger Expression Inventory (STAXI-II; Miguel-Tobal, Casado, & Cano-Vindel, 2001; Spielberger, 1988) consists of 10 items related with state-anger (the intensity of the emotion of anger in a specific situation) and 10 items related with trait-anger (the individual disposition to experience anger habitually). Each item ranges from 1 (*not at all*) to 4 (*very much*). The range of scores is from 10 to 40 on each scale. The STAXI also has a third subscale of 24 items that connects with the form of expressing anger (anger expression-out, anger expression-in, and anger control).

The Self-Esteem Scale (Rosenberg, 1965) assesses the feeling of satisfaction that a person has about himself or herself. There are 10 general items, each carrying a score of between 1 (*fully agreed*) and 4 (*fully disagreed*) on a Likert-type scale, giving a questionnaire range of 10 to 40. The higher the score, the greater the level of self-esteem is. The cut-off point for the adult population is 29 points. Test-retest reliability is .85, and the internal consistency alpha coefficient is .92. Convergent validity and discriminant validity are likewise satisfactory (Zubizarreta et al., 1994). The Spanish version of the scale used in this study can be found in Fernández-Montalvo and Echeburúa (1997b).

The Inadaptation Scale (Echeburúa & Corral, 1987) reflects the extent to which the participant's current problems affect different areas of daily life. This instrument also has a subscale that takes account of the overall level of maladjustment in every life. The self-report comprises a total of six items, each carrying a score of between 0 and 5 in accordance with a Likert-type scale (0 = *nothing*, and 5 = *very much*). The full range of the instrument is therefore 0 to 30, with 12 points representing the overall cut-off point. The higher the score, the greater the level of inadaptation is. The psychometric properties of this scale can be found in Echeburúa, Corral, and Fernández-Montalvo (2000).

PROCEDURE

All the participants completed the questionnaires individually in the psychologist's presence during pretreatment assessment of the intervention program. The assessment of convicted aggressors was carried out during September and October 2001 by prison psychologists under our direction. Likewise, the assessment of aggressors in communities was carried out when the participants arrived at the community program of family violence.

TABLE 1
COMPARISON IN SOCIODEMOGRAPHIC VARIABLES

	Agressors in Community (N = 42)				*Agressors in Prison (N = 54)*					
	M	SD	N	%	M	SD	N	%	t	χ^2
Age	42.1	10.2			40.2	8.4			0.99	
Marital status										54.4**
Married			36	85.7			9	16.6		
Single			3	7.1			3	5.5		
Divorced			3	7.1			31	57.4		
Widowed			0				11	20.3		
Education										7.17
None			3	7.1			2	3.7		
Primary studies			24	57.1			44	81.4		
Secondary studies			11	26.2			6	11.1		
University			4	9.5			2	3.7		
Socioeconomic status										5.70
Low			16	38.1			11	20.3		
Middle-low			10	23.8			20	37.1		
Middle			14	33.3			21	38.8		
Middle-high			2	4.8			2	3.7		
High			0				0			
Previous psychiatric history										5.65*
Yes			19	45.2			12	22.2		
No			23	54.8			42	77.7		

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

RESULTS

The following paragraphs present the results for comparison between the two samples (outpatient and imprisoned aggressors) in demographic characteristics as well as in psychopathological and adjustment variables.

SOCIODEMOGRAPHIC VARIABLES

Sociodemographic characteristics and results of the comparison between community aggressors and convicted aggressors are shown in Table 1. As it can be seen, there are two significant differences. The first of them is in marital status, with the convicted men having a higher percentage of widowed and divorced men and a greater rate of married men in community aggressors. To understand this difference, it should not be forgotten that the main cause of being in prison for convicted aggressors was the homicide (or attempted homicide) of the partner.

TABLE 2
RESULTS IN PSYCHOPATHOLOGICAL, VARIABLES OF THE SYMPTOM CHECKLIST-90-REVISED (Derogatis, 1975)

	Aggressors in Community (N =42)		*Aggressors in Prison (N = 54)*		
	M	SD	M	SD	t
GSI	71.6	8.7	46.2	11.1	9.91**
PSDI	58.7	9.3	46.2	11.6	4.67**
PST	64.9	9.7	45.7	14.6	5.88**
Somatization	60.6	8.8	50.8	12.9	3.39*
Obsessive compulsive	66.2	10.7	44.4	11.1	8.01**
Interpersonal sensitivity	71.1	7.1	41.2	15.7	8.79**
Depression	73.7	7.9	46.7	9.5	12.01**
Anxiety	69.6	8.5	43.5	13.4	8.70**
Hostility	67.7	9.3	40.3	18.1	7.04**
Phobic anxiety	62.2	10.1	39.6	20.2	5.15**
Paranoid ideation	68.1	7.2	46.8	15.5	6.32**
Psychoticism	67.4	8.4	41.6	19.2	6.29**

NOTE: GSI = General Symptoms Index; PSDI = Positive Symptoms Distress Index; PST = Positive Symptoms Total.
*$p < .01$. **$p < .001$.

The second relevant difference is that community aggressors were more likely to have a previous history of psychiatric problems than convicted aggressors were. The former ones were, in consequence, more emotionally unstable. With regard to the rest of studied variables, there were no significant differences.

PSYCHOPATHOLOGICAL AND ADJUSTMENT VARIABLES

On a psychopathological level, the results of the SCL-90-R (Derogatis, 1975) may be seen in Table 2. It is important to highlight the existence of significant differences in all of the psychopathological dimensions evaluated, both in the global indexes and in the dimensions of primary symptoms. The community aggressors, who were currently living in a marital relationship, were affected by many psychopathological symptoms and to a higher degree than those who were in prison.

The results in the other variables studied are shown in Table 3. The only significant differences may be seen in the STAXI-II. The aggressors in an outpatient setting suffered from a greater intensity of feelings of anger (state-anger) and a higher bias to the anger (trait-anger) than those who were in prison.

Regarding the self-esteem and the adjustment level, the scores were rather low in the total sample, and significant differences were not observed between the two groups.

TABLE 3
COMPARISON IN OTHER VARIABLES

	Aggressors in Community (N = 42)		*Aggressors in Prison (N = 54)*		
	M	SD	M	SD	t
State anger (range 10 to 40)	15.8	4.5	13.5	4.6	2.36*
Trait anger (range 10 to 40)	23.1	7.1	15.8	5.1	5.86**
Self-esteem (range 10 to 40)	29.1	4.5	29.8	4.5	0.87
Inadaptation (range 0 to 30)	18.4	6.4	17.8	7.6	0.44

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

DISCUSSION

An attempt has been made in this study to delimit the psychopathological differences between aggressors in prison and those who participate in a community domestic violence program.

From a sociodemographic point of view, the typical profile in both cases is a male, aged about 40, with only a very basic education, and of lower-middle or lower social class. The clearest differences between one group and the other lie in marital status and psychiatric history. In the group of prisoners, there was a high number of widowers and divorced men, and this is directly linked to the type of offence committed (homicide or serious bodily harm). The group of batterer men following community programs, on the other hand, contained mostly married men. This is connected with attendance at a community program not linked to the court (but to the social services), which, in some ways, is an attempt to save couples from breaking up.

The number of cases of previous history of psychiatric problems in the prison inmates group was only slightly higher than in the population as a whole. This was not the case with the community program group, however, where such histories were numerous: Almost half of the participants had a history of psychiatric problems, particularly related to depression, addiction, or personality disorders, as other studies have also found (Schumacher, Feldau-Kohn, Smith, & Heyman, 2001; White & Gondolf, 2000).

From a psychopathological viewpoint, the men in the community program group were much more conflictive and emotionally unstable with respect to controlling anxiety, anger, and jealousy than the imprisoned aggressors were. In other words, the profile of the imprisoned violent man equates with that of a relatively normal person, without a previous criminal career, who loses control in a fit of rage or passion and commits a serious offence, or it equates with that of, as Huss and Langhinrichsen (2000) state, a cold-blooded aggressor who, with no previous emotional instability, commits an offence in a nonempathic manner.

In short, batterer men who show violence toward women tend to be persons characterized by emotional instability, who frequently abuse alcohol and drugs and who have a history of psychiatric problems. However, side by side with this profile, which is the one most frequently studied in community programs for treating domestic violence, is the profile of violent men sent to prison, which corresponds to relatively normal persons who in a fit of rage or jealousy commit a serious gender-based violent offence. That is, this apparent lack of symptomatology could be owing to the absence of their partner in prison, the person most affected by a possible impulse control disorder or by intermittent explosive disorder. They were able to express their anger and either injure or kill their partner, against whom they had hostile feelings.

There are some limitations in this study. The differences between aggressors in the community and aggressors in prison are related to different profiles. However, the experience of being in prison for a long time may modify the specific psychopathological profile of the prison group. Likewise, the weight of social desirability in the low level of psychopathology encountered cannot be disregarded in this study. Such desirability in the group of batterers in prison may be greater than expected. In short, affecting a degree of normality in front of assessors may be one way of gaining faster access to probation. Therefore, further studies are needed to test these conclusions. If these psychopathological profiles are confirmed, treatment programs will have to be differentiated, and the personnel needed in each case (in prison and in the community) must be trained in accordance with these specific requirements.

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