The Relationship between Self-Concept and Locus of Control in Physically Abused Women

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The Relationship between Self-Concept and Locus of Control in Physically Abused Women

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science at Virginia Commonwealth University

by

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DEDICATION

To my husband Carl and daughter Emily for their patience and love through the whole journey of graduate school.
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Chapter 1

INTRODUCTION

History can provide some clues concerning the physical abuse of women by men. Beginning in biblical times, women were viewed as the property of men (Steinmetz, 1977). Until 1824 by law, a man was allowed to strike his wife if provoked (Bell, 1977). Under the law, some states still grant "spouse immunity" in cases of assault and battery, where married couples are involved.

The magnitude of abuse is uncertain. Straus reported a study of 2000 couples and their behavior within the confines of marriage. Using a tool called "wife beating index", he measured conflict resolution techniques. According to his survey, 3.8 percent of this random sample reported severe beatings and 28 percent had participated in at least one violent episode. If this sample was indeed an accurate cross section, then 3.8 percent of the general population or approximately 1.8 million women have been severely beaten (Straus, 1978). The F.B.I. claims that only one out of every 270 cases of wife abuse is ever reported to police, making it the most under reported crime in America (Steinmetz, 1977).

A woman's first attempt to get help often comes
through contact with the medical or mental health system. In this context, a nurse may be the first contact for an abused woman. These women are most often seen in the emergency room or mental health clinic. According to Behavioral Medicine (1979), women often did not admit the true cause of their trauma and used explanations such as a fall to explain bruises or lacerations. The following behaviors can alert health professionals to possible abuse. A scan of hospital records might include repeated emergency room visits for "falls" or "accidents". Women entering the mental health clinic setting may voice somatic complaints such as chest pain or headaches and may exhibit symptoms of depression such as insomnia, weight loss or psychomotor retardation (Hilberman and Munson, 1978).

Langley and Levy (1977) suggested various behaviors within a marriage that may alert a nurse or health worker to the possibility of wife abuse. Included were:

- heavy drinking by the husband
- violence during courtship
- history of violence by parents of either spouse
- cruelty to animals by husband
- low frustration tolerance by husband
- poor self-concept of either spouse
- morbid jealousy by husband

Given the above information, assessment can lead to identification of wife abuse by a nurse.

The method of intervention at this point becomes crucial—the nurse must have a complete understanding of the scope of the wife abuse problem. Often health professionals have served in the role of blaming the woman rather than
being her advocate (Nichols, 1976). Myths that women enjoy beatings or provoke violent behavior may cause nurses to let their own values affect their ability to be supportive (Waites, 1978).

The focus of this research was to examine the problem of wife abuse through the perspective of social learning theory. Using Roy's theory of adaptation (Roy, 1976), the investigator also examined the area of self-concept as it related to abused women. On the basis of the question, "What is the relationship between self-concept and locus of control in physically abused women?" the investigator surveyed a sample of 26 abused women to identify possible correlations among these variables.

**Conceptual Framework**

For many years the theory base for the study of abused women was the masochism element of psychoanalytic theory whereby women were believed to receive gratification from pain and humiliation. Freud suggested that maintenance of suffering in a masochistic relationship was all that mattered. He added, "The true masochist always holds out his cheek whenever he sees the chance of receiving a blow" (Freud, 1920:264).

Waites (1978:535) suggested that labeling wife abuse masochistic is an "evasion of the facts and a naive excuse for cruelty." Nichols (1976) felt that abuse is learned behavior as is being abused. A relationship was found to
exist between physical abuse and witnessing the same behavior in one's own parents (Elliott, 1977; Gelles, 1976; Roy, 1977). Because of developmental or cultural influences, abusive behavior may be seen as "normal". Often abused women are so socially isolated that they have no exposure to more adaptive behavior (Symonds, 1979).

Social learning theory as cited by Rotter (1954) explained the above phenomenon. In this model, behavior is described as a function of expectancies and reinforcement. According to Rotter (1966:1), "The potential for a behavior to occur is a function of the expectancy that the behavior will lead to a particular reinforcement and whether or not the reinforcement is seen as valuable." Rotter used the dimension of internal-external control as the expectancy variable within the social learning model. This measure of control is called locus of control and is identified as either internal or external (Lefcourt, 1976). By definition, internal locus of control suggests that a person perceives that a reward is contingent upon his own behavior. Persons with external locus of control feel that rewards are contingent on luck or the power of other persons (Windwer, 1977).

The investigator believed that abused women function on the basis of external control which reinforces their sense of powerlessness and may lead them to view themselves as "stuck" in a relationship. Related to locus of control is the concept of learned helplessness, whereby persons do not believe they can extricate themselves from duress.
Early research on learned helplessness was done using dogs and electric shock (Seligman, 1975). Dogs were given multiple small electric shocks from which they could sometimes escape and sometimes not. Within a short period of time, two-thirds of the dogs no longer even tried to escape, but accepted the shock as if they were giving up. Seligman suggested that the same behavior can occur in humans who become depressed in specific life situations. He stated that certain symptoms are present in learned helplessness. Included are:

- lowered initiation of voluntary responses
- negative cognitive set--inability to express or see self in any positive context
- lowered aggressiveness
- loss of appetite
- physiological changes--norepinephrine depletion
  (Seligman, 1975:82)

Abused women often present with the inability to make decisions, inability to fight back, and very negative feelings about themselves. They also experience loss of appetite, weight loss and many physical complaints. Symptoms of learned helplessness appear to have a connection with locus of control and behavior of abused women (Ball and Wyman, 1978).

Specifically mentioned in both the locus of control and learned helplessness literature is the relationship of self-concept to the previously mentioned concepts (Abramowitz, 1974; Foulds, 1971; Seligman, 1975; Ziller, 1969). The investigator used Roy's Adaptation Model to explain self-concept. According to Roy, 'Man is a biopsychosocial being
in constant interaction with a changing environment” (Roy, 1976:11). A positive response to a change in this environment is known as adaptation. Based on a survey of 500 samples of patient behavior, Roy (1976) suggested that man functions in four adaptive modes: physiological needs, self-concept, role function, and interdependence. For the purpose of this study, the investigator focused on the self-concept mode. Divisions of the self-concept mode include the physical self and personal self. The personal self is further divided into the moral self, ethical self, self-consistency, self-ideal, and self-esteem.

The literature suggested that a poor self-concept can be present in persons with external locus of control and also in persons suffering from learned helplessness (Seligman, 1975; Ziller, 1969). The investigator speculated that abused women suffer from poor self-concept, external locus of control and learned helplessness. The literature identified several studies which showed a relationship between self-concept and locus of control (Donovan, Smyth and Paige, 1975; Lamb, 1968; Organ, 1973; Reid, Haas and Hanekings, 1977). Felker (1974) suggested several possible explanations. First, he stated that persons with low self-concept could develop it by blaming others for failures (external locus of control). Conversely, persons with high self-concept could develop it by taking responsibility for own success or failure (internal locus of control). If the proposed relationship is validated, specific counseling
interventions could be designed with the goals of improving self-concept and of changing locus of control to more internal.

**Problem Statement**

What is the relationship between self-concept and locus of control in physically abused women?

**Hypothesis**

There is an inverse relationship between self-concept and locus of control in physically abused women. (The lower the self-concept, the more external the locus of control in these women.)

**Definition of Terms**

**PHYSICALLY ABUSED WOMEN**—women who have been purposefully physically injured by a man using the following behavior: pushing, shoving, grabbing, slapping, kicking, biting, hitting with fist, threatening with knife or gun or wounded by knife or gun.

**SELF-CONCEPT**—"Self-concept is viewed as the composite of beliefs and feelings that one holds about one's self at a given time, formed from perceptions particularly of other's reactions and directing one's behavior" (Roy, 1976:169). Self-concept in this investigation was the score on the Tennessee Self-Concept Scale (Fitts, 1965).

**LOCUS OF CONTROL**—"Degree to which the individual perceives that a reward follows from or is contingent on his own behavior versus the degree to which he feels the reward is controlled by forces outside himself" (Rotter, 1966:1). Locus of control in this investigation was the score on the Rotter Internal/External Scale (I/E Scale) which measures in the external direction."
Assumptions

1. Human beings have a self-concept.
2. Human beings feel an external or internal sense of power or control.

Limitations

1. Clients may have been in different stages of crisis when the interview took place and this timing may have affected their response.
2. The time frame of the sample included three six-week periods for collection of data.

Overview of Research Design

Since the body of nursing knowledge concerning abused women is rather sparse (the investigator found only four articles in the nursing literature concerning abused women), a correlational research design was selected in order to explore psychological variables related to being abused. Using the personal interview technique and administration of scales, the investigator collected data from 26 women. They were clients at an advocacy center for abused women in a southeastern city. Data were presented descriptively and analyzed using the Spearman's Rank Correlation Coefficient.
Chapter 2

REVIEW OF LITERATURE

Introduction

Much of the present literature concerning abuse seemed to stem from opinion rather than fact. The majority of theory articles had no research base. Research on treatment models and intervention seemed almost nonexistent. Most research has been descriptive focusing on the characteristics of the abused women. The investigator identified the need to research specified personality variables (self-concept and locus of control), as they relate to abuse. Using data gleaned from research concerning personality variables, clinicians may be able to design a more effective treatment model for dealing with abuse.

The Abused Women

Symonds (1979) stated that injured birds are often driven from the flock or sick animals outcast from the herd. Symonds implied that the same phenomenon may occur with abused women. Medical or mental health workers suggest to the woman that her injuries are avoidable. Friends or family tell the woman she is "crazy". Comments to the woman
on a professional or personal level may be:

You made your bed, now lie in it.
What did you do to provoke him?
Why don't you leave him?
You must like it (the beatings).
I would never let a man beat me.

The approach to treatment is much more complex.
Symonds (1979) theorized that the abused woman is extremely isolated. This isolation can lead the woman to react similar to a person brainwashed. In theory, she suggested three phases:

1. Impact phase--woman suffers shock, denial and disbelief. "This can't be happening to me."
2. Terror phase--woman lives in frozen fright. She is willing to do anything to appease the situation.
3. Depressive phase--woman may blame herself and feels hopeless and stuck.

Singer (1979) reinforced the above theory. She compared abused women to members of a cult. Singer pointed out that after a period of courting behavior the five D's usually occurred in the abused woman:

deception
dependency
dread of what will happen if she leaves
debilitation by overwork
desensitization to her own suffering

This same kind of brainwashing occurs in cult behavior, leaving the victim frozen in the situation.

According to Walker (1979), abuse is a continuous cycle. This cycle affects the attitude, motivation and type of intervention necessary. Timing of this cycle can vary
depending on the individual couple. The cycle includes three stages:

1. Tension building stage--many minor incidents occur. (Example: husband throws dinner on the floor because food is cold. Wife will apologize and quietly clean it up.) The wife is very placating and deferential--she is willing to go to any length to avoid a beating. Minor battering incidents will escalate. Husband reacts in a very jealous, oppressive manner. He feels the need to "keep her in line."

2. Acute battering stage--major destructiveness and loss of control are present in this stage. Both partners realize rage is out of control. The element of "overkill" may be present. This phase may last from two to twenty-four hours, sometimes up to a week. Only the man seems able to stop the cycle. The only alternative is for woman to seek shelter elsewhere. Police may be involved at this point. When attack ends, the woman often does not seek help for from 24-48 hours. The reaction is similar to a disaster victim--the person is very listless and may appear "in shock" during this period.

3. Kindness and contrite, loving behavior--the man knows he has gone too far. He tries to make up to the woman. He may buy gifts, send flowers. A period of calm settles in. The man promises that he will never hurt her again. Both mates really want to believe the promises. An agency may see the woman when this part of cycle is about to begin. This loving behavior may be the largest contributing factor
in her inability to break away from the relationship.

Weingourt (1979) strengthened the theory base with her suggestion that abused women go through a grief reaction. Using the Kubler-Ross grief model, Weingourt suggested that an abused woman will go through denial, anger, bargaining and depression before she can reach the acceptance phase. During the acceptance phase, the woman may get the courage to terminate the relationship.

With such knowledge, the nurse or health worker may gain a better understanding of why women will live for years in a violent home or leave home only to return three to five times before final termination of the relationship (Hilberman and Munson, 1978).

**Myths about Abuse**

Hilberman and Munson (1978) stated that certain myths must be identified and challenged early in the treatment of abused women. Included were:

1. Violence is normal--this myth is especially likely if the family of origin is violent for either spouse. In a study by Gelles (1976), 66 percent of women or men who had witnessed domestic violence during childhood were presently involved in an abusive relationship.

2. Violence is rationalized--the woman may suggest that she is beaten because husband is an alcoholic, unemployed or under stress.

3. Violence is justified--the woman feels that she
provoked the argument or feels she is a "bad" person and deserves punishment.

4. Violence is controllable--the woman feels if she is deferential, placating and compliant that beatings will cease.

Once the woman accepts that violence is inappropriate, leaving the relationship may still be difficult. Several factors contribute at this point. The woman

still loves her husband
can't survive alone
stays for the "sake of the children"
believes the man will change (Hilberman and Munson, 1978)

**Why the Woman Stays**

The woman stays in the relationship for many reasons. Such reasons are basic themes with the abused woman and also may compose the "problem list" to be used for assessment and planning in treatment. Davidson (1978), Martin (1976), Ridington (1978), Roy (1977), and Walker (1979) all suggest basic reasons why women stay in an abusive relationship. A summary of these includes:

1. Guilt--The woman may believe in the traditional role where she is responsible for the happiness and comfort of her husband. Battering may reinforce that she does the job poorly. She gets a feeling of failure in her primary role and may feel she deserves the beatings.

2. Low self-esteem--This concept is well documented in the literature. If the woman does leave, the choice is
often because the abuse is somehow affecting the children (Moore, 1975). She often does not feel good enough about herself to leave for her own sake.

3. Emotional dependence--The woman and her husband are often in a symbiotic relationship. She feels a great need to take care of him and play the "rescue" or "victim" role.

4. Economic dependence--In violent marriages, the husband usually totally controls the family finances. Many women do not work and those who do usually give up their paycheck to their husband.

5. Depression--Anger is often masked by these victims and turned inward as depression. This depression may produce a low energy level, making it difficult for the woman to make decisions or seek help.

6. Isolation--Such a woman usually has few contacts with the outside world. The man may monitor her telephone conversations or trips to the grocery store. His extreme possessiveness will discourage her from developing friendships. In response, most of her input about her value as a person comes from the man who beats her.

7. Fear--A battered woman lives in a constant state of anxiety. An acute sense of impending doom is present. Suicide or homicide are a reality for either spouse in many of these relationships. The woman feels the man will kill her if she tries to leave.

8. Ambivalence--The woman may be ambivalent because
of factors previously mentioned. Ambivalence is often present when the woman still loves her husband and hopes that he will change.

9. Embarrassment and shame--A woman may feel very ashamed of herself for becoming or remaining a "battered woman". She would rather bear her secret than share it with the world. She may often not initially admit the cause of her trauma--she may make excuses such as a "fall" or "car accident".

Research about Abuse

Nursing research about wife abuse is very sparse. Kit Munson (Hilberman and Munson, 1978) is a psychiatric nurse. The purpose of her research study was to establish criteria for use in identifying abused women. Areas of inclusion were:

- history of homicide in family
- pregnancy
- alcoholic father
- physical or sexual abuse as a child
- somatic complaints (headache, backache, chest pain)
- nightmares
- children suffering behavior problems (enuresis, truancy, etc.)
- frequent clinic or emergency room visits

Using this criteria, the investigators identified 56 women whose "secret" was abuse. The above article also discusses appropriate intervention.

Most research about abused women has been done by psychologists or sociologists. Stark and McEvoy (1970) interviewed a random sample of 1,100 Americans concerning
attitudes toward violence. Results of this study suggested that violence can cut across all social classes and races. Middle class violence is merely more secretive and may be dealt with through private counselors or lawyers. Dealing with police or social agencies make the poor more visible.

Gelles (1976) used a 10 point scale to measure conflict resolution in 80 families where violence was a known problem. He also surveyed severity of attacks, battering history in family of origin and community resources available for referral. Most striking was the high incidence of abuse (66 percent) in couples where abusive behavior had been observed in the family of origin. Such information reinforces social learning theory.

Steinmetz (1977) also studied intrafamily conflict resolution. Her results showed that 30 percent of her 78 person sample had witnessed violence in family of origin. Some problems with design may affect the strength of these data. Steinmetz did identify four specific categories of physical aggression that she considered typical of wife abuse.

Roy (1977) and Hanks and Rosenbaum (1977) both did descriptive studies of women already identified as abused. In Roy's research (a random sample of 150 cases), she found the strongest correlation in data was the history of abuse in the husband's family of origin to abuse in the present relationship. Hanks and Rosenbaum suggested that alcoholism in the present relationship or abuse in the family of origin
are factors significant to the abuse of women.

Rounsaville, Lifton and Bieber (1979) have done some research in the area of intervention. Implications for treatment suggested group therapy as a treatment modality and dealt with the problem of attrition among group members. In this study, 75 clients expressed interest in group treatment, 31 returned for initial interview but only six became regular members attending group sessions. Information gathered by this investigator from the local YWCA suggests a similar problem.

In a study done by the Kansas City police, results showed a distinct relationship between domestic related homicides and prior police intervention for disputes. In 85 percent of homicide cases, police had answered a previous call during an abusive dispute. Findings imply use of prediction using police statistics on domestic calls as a possible tool to assess families with high potential for violence (Fleming, 1979).

A major sociological research survey was a random sample of 2000 done by Strauss (1976). Results predicted a level of severe abuse affecting 1.8 million people on a national level. Methodological problems of this study included the sample criteria of intact cohabiting couples only, restriction of focus to one year prior to interview, and the use of retrospective self report. All of these criteria could lead to under reporting and under estimation, according to Pagelow (1979).
Treatment

The ideal treatment situation for an abused woman seems to be the shelter concept (Fleming, 1979). At a shelter, a woman and her children can stay for up to six weeks to consider the options of returning home or starting a new life. Staff at the shelter provide counseling for the woman during this period. Other choices include the use of the "safe home" where the woman and her children stay for a limited period in a private home as guests. Community citizens provide the "safe homes".

Referrals for services come from police, emergency room personnel, or as a result of public education campaigns. A woman will often receive a card with hot line emergency information and keep it for many months before taking the risk to make contact as a client.

Lynch and Norris (1978) suggested that abused women need help in the following areas:

- someone to reach out to
- physical safety needs
- material needs
- emotional needs
- focus on life planning and goal-setting

Once a woman presents herself, intake assessment is necessary and helpful. Areas to be included are:

- violence in family of origin?
- alcohol abuse in present relationship?
- reaction of children to abuse?
- economic status?
- woman's perception of violence?
- woman's present support system?
- woman's response to violence?
- physiological or psychological problems? (Hilberman and Munson, 1978)
In treatment, Ridington (1978) suggested that a reconceptualization of self-image must occur. With this must come the ability for the abused woman to become self nurturing and to develop her own potential.

Concerning treatment models, some programs seemed to favor a client-centered approach (Rogers, 1951). In this treatment method, the therapist promotes a nurturing, trusting atmosphere to encourage self acceptance and personal growth in the client. This approach is nondirective and tends to give all responsibility for choices and alternatives to the client.

Feminist therapists felt the need to use the educational and problem-solving method and were much more directive in their approach. Wyckoff (1972) suggested that women need to become more aware of their own power and how to channel it. Using the Karpman Triangle (Karpman, 1968), the therapist may point out to the woman the potential stance of victim, rescuer or persecutor and how this applies to the woman's own life.

According to present research, no one model has been assessed and tested as "the effective model" for use in treatment of abused women. The fact that women in treatment may go from one abusive relationship to another may point to the reality that no effective treatment model presently exists (Walker, 1979).

Davidson (1978) suggested that a woman's treatment needs vary depending on desired outcome, such as the woman
who is

resigned to her fate and longs for help to endure;
wants to change the abuser or herself and keep the
marriage;
wants to terminate the relationship and start a new
life.

Women under each of these categories have different
goals and priorities in treatment. A goal in common for all
categories would be improved self-concept. Davidson (1978)
also suggested treatment interventions for children and the
abusing man and guidelines for professionals or lay support
persons.

Walker (1979) stated that traditional psychotherapy
may emphasize keeping families intact. With abused women,
this choice can be fatal. Blaming the woman or suggesting
she provokes the attack is seen as destructive and ineffec-
tive treatment. The group treatment modality is also sug-
gested with two types of groups--one to focus on crisis
intervention and one to focus on more long term goals and
behavior change.

Rounsaville, Lifton and Bieber (1979) discussed the
group mode and suggested that the group focus around pre-
viously mentioned themes. Authors suggested that group de-
emphasize individual dynamics and be nonconfronting and sup-
portive. Although group members may equate "getting better"
with leaving one's spouse, any encouragement from a counselor
to terminate the relationship may be seen as "pressure" by
the client. Long term members who are doing well can be
very supportive and able to offer hope to a new woman in
crisis.

The nurse who works with an abused woman must clarify her own values. If the nurse subscribes to the theory of masochism, she will probably not be effective in working with such a client. The nurse will need to acknowledge the woman's right to make her own choices and must realize that her perspective and that of the woman may be different. Measures of progress may come in small steps. Termination of the abusive relationship may come only after multiple trial separations. The role of the nurse is often to reinforce the concept that life without violence is a right and to offer the woman hope or awareness of new choices. Because of the frustrating nature of the work, a nurse working with abused women needs to seek support from other professionals to avoid the "burn-out syndrome" (Walker, 1979).

**Overview of Locus of Control**

Social learning theory underlies the construct of locus of control as developed by Rotter (1955). Locus of control is the degree to which the individual perceives that a reward follows or is contingent on his behavior (internal locus of control) versus the degree the person feels the reward is controlled by forces outside himself (external locus of control). Lefcourt (1976) saw locus of control as a circumscribed self appraisal which determines the degree to which persons view themselves in power in determining life events.
Extremes of locus of control in either the internal or external direction are seen as maladaptive. "Belief in control does not mean that one needs to control all outcomes" (Arakelian, 1980:37). Goodstadt and Hjelle (1973) suggested that the most controlling person is often the most externally oriented.

DeCharms (1965) stated that the term "pawm" can describe a person with external locus of control and "origin" describes a person with internal locus of control. More specifically, Levenson and Miller (1976) differentiated between persons with external locus of control who believe in chance and those who believe in powerful others. Hochreich (1974) stated that persons with an external locus of control are either "congruent" or "defensive"—those who are defensive are seen as less trusting.

In social learning theory as cited by Rotter (1966), it is suggested that the potential for a behavior to occur in any situation is the function of the expectancy that the behavior will lead to a particular reinforcement and the value of what that reinforcement will be.

Perceived control occupies a central theme in the formulation of social learning theory. Lefcourt (1976) defined perceived control as the expectancy for internal as opposed to external control of reinforcement.

Internal Locus of Control

Internal locus of control is the person's perception
that his own behavior is responsible for rewards (Rotter, 1966). Singer (1965) theorized that internal locus of control or the ability to change in that direction is the basis of all therapeutic efforts. Lefcourt (1966) stated that internal locus of control may be a prerequisite for competent behavior. Powell and Vega (1972) suggested that persons with internal locus of control will be more ambitious, less anxious, and of higher intellectual ability. The same authors research showed that a positive relationship did occur between internal locus of control and positive adaptive behavior. Gillis and Jessor (1970) hypothesized that success in psychotherapy can be measured by increase in internal locus of control. Their findings did support their hypothesis and were statistically significant at the .05 level.

Rotter (1966) hypothesized that people who have a strong belief that they control their own destiny will be more likely to

be more alert to the environment and useful information provided in life experiences;
take steps to improve the environment;
place greater value on skills and ability;
be resistant to subtle attempts to be manipulated by others.

Lefcourt (1976) further viewed internal locus of control as related to vitality or ability to grapple with life events or problem solve. Persons with internal locus of control seem more resilient in facing failure. This resilience may come from the hope of rectifying the situation given another chance or the tendency not to accept
defeat as final (Lefcourt, 1966). Internal locus of control is generally viewed as positive and healthy.

**Dangers of Internalization**

Although internal locus of control is seen overall as a positive quality, Wortman and Brehm (1975) warn that such belief can also cause problems. The response becomes maladaptive when persons strive and stress increases in situations with truly uncontrollable outcomes. Internal persons are said to suffer increased anxiety and feeling of failure after unavoidable trauma. Lowery and DuCette (1976) stated that increased complications occurred among diabetics with internal orientation when they realized that learning about their disease was not enough to control it. Strickland (1978) stated that the "Type A" personality who is prone to cardiovascular problems may be a person with an extreme internal locus of control. Kissinger (1979) confirmed this idea.

**Benefits of Internalization**

Conversely, other research concerning locus of control and the cardiac patient suggested that internal locus of control may be desirable. Strickland (1979) mentioned that internal persons, in comparison to externals, learn more about their diseases when stricken. Persons with internal beliefs may pay more attention to decreasing risk factors by developing positive attitudes about proper diet,
voluntary exercise and cessation of smoking. Internal persons tended to be more rapidly discharged from the hospital after illness and appeared generally able to handle stress in a positive manner.

Lacey (1979) differentiated between "outcome control" and "agenda control" in the internal person. Even when the outcome is inevitable, the human capacity to problem solve and re-think goals (agenda control) remains.

**Stability of Internalization**

Lefcourt (1976) cited an example concerning a minority group which implied that perceived control in either direction is a stable construct. Exposure to internalization techniques is not necessarily equated with change. Several studies attested to the need for continued follow-up for reinforcement even after change in perceived control is demonstrated by testing (McKenney, Shening and Henderson, 1973; Wilber and Barrow, 1972).

**External Locus of Control**

External locus of control is defined as the person's perception that rewards are controlled by the power of other significant people or circumstances such as luck or fate (Rotter, 1966). External locus of control may be related to dysfunctional behavior (Baker, 1979).

Phares (1979) explained external behavior as arising from a lack of nurturance from parents in early life or
inconsistent reinforcement during childhood. Bryant and Trockel (1976) reported that life stresses in preschool years are related to statements of external control in adulthood.

Garrity (1973) related one study where external locus of control was correlated with return to work after myocardial infarction and therefore seen as a positive quality. Conversely, according to Lefcourt (1976) and Abramowitz (1969), persons with conversion reaction hysteria, depression and schizophrenia showed a high degree of external locus of control during testing. Persons demonstrating neurotic behavior may be ignorant of the connection between immediate behavior and later consequences as such concepts relate to locus of control. Persons during crisis or illness may become more external as they become overwhelmed by the magnitude of a problem (Smith, 1970). Harrow and Ferrante (1969) in a research study found that persons of ethnic minorities or low socioeconomic or educational levels tended to be external. Persons with external locus of control in that study tended to relate in a more passive or conforming manner and were less willing to be involved in risk taking. Persons with external locus of control may also be more impulsive or may suffer in situations where deferred gratification is necessary. Furthermore, external persons may feel a great need to justify actions by explaining them in terms of others. Rationalization is used frequently by persons with external locus of control (Lefcourt,
Persons with external locus of control often present with an attitude of fatalism or apathy and are seen as having poor problem-solving skills. External locus of control is generally viewed as behavior that is not desirable in terms of personal growth or change.

Therapeutic Use of Locus of Control

If one of the purposes of psychotherapy is to gain control over one's life, measurement of locus of control could be valuable as an assessment tool. Abramowitz, Abramowitz, and Robach (1974) and Ziiler (1969) suggested that persons with external locus of control may require more prolonged or more intense therapy than persons with internal locus of control. Gillis and Jessor (1970) reported that movement toward internal locus of control is one measure of successful outcome or growth in therapy.

Suggested therapy approaches to strengthen internal locus of control are to focus on the "here and now" and the use of supportive confrontation. Felton and Biggs (1972) suggested using the language of responsibility—use of "I" and differentiation between "won't" vs. "can't" in conversation. The above authors discourage use of the word "why" and suggest the use of statements rather than questions. Diamond and Shapiro (1973) and Foulds (1974) recommended an atmosphere of problem solving with group or individual focus on safety and trust. To reinforce the concept of internal
locus of control, the therapist might question the client in the following manner: "Can you look at the problem so you can see what you are contributing and what your reaction is?" (Pierce, Schauble, Farkas, 1970)

Studies showing a change in the direction of internal behavior are numerous (Diamond and Shapiro, 1973; Etizen, 1974; Felton and Thomas, 1972; Foulds, 1971; Gillis and Jessor, 1970; Lynch, Ogg and Christensen, 1975; Martin and Shepel, 1974; Smith, 1970). These studies overall measure growth and effectiveness of treatment regime using the locus of control construct.

**Self-Concept**

"Self-concept is viewed as the composite of beliefs and feelings that one holds about one's self at a given time, formed from perceptions particularly of other's reactions and directing one's behavior" (Roy, 1976:169). In further discussion, Roy (1976) suggested that people need to feel adequate and define themselves. People want to know how they appear to others. This process occurs over a lifetime as a result of social experiences. Self-concept is seen as having a high degree of permanence--any change in self-concept is seen as a slow process. Some clinicians view therapy as a process to improve self-concept or merely hold the client at a present level and decrease the chance for regression (Combs, Avila and Purkey, 1971).
Theoretical Development of Self-Concept

As far back as Aristotle, men spoke of the distinction between a physical and nonphysical aspect of human functioning. The nonphysical aspect was seen as the "core" or "soul" which may have been an early beginning of the concept of self (Gergen, 1971). Two thousand years later, Descartes (1955, reprint) suggested a relationship between body and mind and makes the statement "I think, therefore I am." He speaks about the entity of "I" and is seen as a predecessor of self theory.

In 1890, James described the infant as without a self at birth. Symond (1951) agreed with James and suggested that as the infant views its mother as a person, the child begins to get vague images of self.

Freud (1920) also alluded to presence of self in his presentation of id, ego and superego.

Interpersonal relationships may form a framework for development of self-concept. Cooley (1902) used the term "looking glass self" to explain the concept of perceiving self in response to others' reactions or perceptions. Mead (1934) suggested that a person will perceive himself the way that significant others (especially family members) perceive him. The person may act in accordance with others' expectations of him. Sullivan (1953) used the term "reflected appraisals" to discuss self evaluations made based on the perception of others. Sullivan viewed others as providing the rewards or punishments in a person's life and placed emphasis
on the mother-child relationship in infancy. Rogers (1951) also discussed the importance of interpersonal relationships in his therapy approach.

**Self-Concept and Behavior**

The fact that self-concept can play a role in determining behavior also is evident in the literature. Combs and Snygg (1959) saw behavior as based on a phenomenal world; everything that the person is aware of at that moment. Within this world lies the inner cell of self-concept (the most vital beliefs a person holds about himself), the phenomenal self (nonvital beliefs), and the perceptual field. The perceptual field combines the inner cell and phenomenal self and adds perceptions outside self. According to these perceptions, the person will feel basically adequate or inadequate. The adequate person will view self positively but will also be able to accept negative information about self. Such a person feels basically comfortable and safe and behaves in such a manner. Using the phenomenal theory base, one can assume that self-concept becomes clearer as life progresses.

Lecky (1951) also viewed self-concept as affecting behavior. He claimed that persons need a sense of consistency and will be resistant to change because of this desire for harmony within self. Rogers (1951) suggested human beings need to feel congruent. In terms of behavior, Rogers felt that humans are capable of self direction and that
self-concept is connected to any movement or progress.

**Measurement of Self-Concept**

Wylie (1961) cited 200 instruments to measure self-concept through 1959. The problem in defining self-concept and measuring it may lie in the fact that it can be a unique and different entity for each person (Fitts, 1971). The most widely used tool to measure self-concept is the Tennessee Self-Concept Scale (Fitts, 1965). Such a tool has the limitations of being a pen and paper test but has some advantages, too. This tool applies to a broad range of people and has been widely used in research. Therefore, much comparison data are available. The Tennessee Self-Concept Scale assumes that self-concept is an index of personality integrity. In the primary study, Fitts (1965) tested large groups of persons chosen especially for their professional or personal success. These persons met certain criteria for emotional stability and were seen as fully functioning people. Healthy functioning is seen as important in measurement of self-concept.

Information from Rogers (1951) and Maslow (1954) may strengthen the relationship between positive self-concept and healthy emotional status. Rogers stated his belief in the form of a fully functioning person—a state of congruence between self and experience. Rogers saw growth and change as important. Maslow (1954) stated that all people need to feel capable and have a hierarchy of needs to
achieve interpersonal competence. He suggested self-actualization as a goal for which people strive.

The Wheel Model

Fitts (1970) combined the above beliefs to form an analogy called "the wheel model of interpersonal competence". Fitts viewed the interpersonal self as a wheel. Spokes of the wheel included involvement, responsibility, freedom, empathy, openness, caring and acceptance. The hub of the wheel was seen as the limits in relationship. Consistency made up the tire. Faith and trust were the material of which the wheel is made. The goal of this model was for the wheel to move forward to symbolize growth or progress. The relationship was seen as the vehicle, each wheel as one individual.

Summary of Self-Concept

Roy (1976:233) suggested that the "heart of adaptation of self-concept is to achieve and maintain a high positive value of self over time despite ever changing views." She saw the divisions of physical self (body image) and personal self (moral-ethical self) to be the components of the total person. Kinch (1963) and Veblen (1958) interjected that social interaction determines self-concept and influences behavior. Hall and Lindzey (1970) assumed that attitudes and activities combined to form the total self. Lynch (1968) and Vargas (1969) stated that a relationship existed
between self perception and reaction to life. Toffler (1970) suggested that serial selves exist. According to him, the self changes as the world changes. Hartshorne and May (1928) presented the same basic premise and suggested inconsistency in people is normal. Finally, Erikson (1963) suggested that there are eight transition points or crises in development of self. He saw the ability to separate experiences as one way to define self.

**Summary of Chapter**

The results of this chapter pointed to the idea that physically abused women felt powerless and poorly about their self-concept. These attitudes may contribute to their inability to leave abusive relationships.

In the study by this investigator, self-concept and locus of control were examined in a sample of physically abused women. The results of this descriptive study could provide a framework for construction of an intervention model. The basis of this treatment model could focus on improving self-concept and perceived control (measured by the locus of control construct). The hoped for end result might offer more options to the women presently living with an abusive mate.
Chapter 3

METHOD

Introduction

The purpose of this study was to examine the relationship between self-concept and locus of control in physically abused women.

The investigator used a convenience sample with a correlational focus. The investigator also examined several subject variables suggested by the literature (Gelles, 1976; Roy, 1977; Strauss, 1978). Variables included age, race, education, history of abuse in family of origin and alcohol consumption as a contributing factor to abuse.

Using the Spearman's Rank Correlation Coefficient, the investigator statistically examined the relationship between locus of control and self-concept. Measure of central tendency was used to suggest an attribute profile of women experiencing abuse.

Setting

The research was conducted in a southeastern metropolitan setting at an advocacy center for abused women. The center has a staff of seven paid workers and volunteer
workers, Social workers staffed the agency and served as director and public information coordinator. The four additional staff members served as patient counselors and volunteer coordinator. The program served abused women and rape victims and had a crisis intervention orientation. Services included a 24-hour hot line, crisis counseling, community referral service, emergency housing and some aftercare follow-up in the form of group or individual counseling. The agency was funded through United Way and supplemented to run this specific program through a federal grant.

The investigator used a small office to conduct interviews and administer scales. A table and chairs were available for client and investigator.

**Subjects**

The population consisted of female clients of any race or age presenting in person to the agency for counseling over a specified time frame. This time frame was three six-week periods. Subjects in the study were women presently in an abusive relationship with a man and either living with the man or separately. Exclusion factors were alcohol intoxication and psychotic behavior. Subjects spent the day at the agency and were referred to the investigator by individual counselors.

The sample consisted of 26 women. All 26 completed the testing, and 25 also completed information concerning attribute variables. Ages of subjects ranged from 19 to 46
years of age. The average age was 27.6 years. Thirteen of the subjects were Caucasian, and 13 were black. The average grade completed in school was 11.5 years. Vocational history showed five subjects to be presently working. Fifteen clients had held a variety of unskilled jobs for short periods. Five had never worked. Fifteen women were presently married to the man who abused them. Ten subjects were in an abusive relationship with a boyfriend. Seven of those women were living with the boyfriend when the initial contact with the agency was made. The length of time in the abusive relationship ranged from three weeks to 21 years. The average length of time in a relationship was 5.5 years. Seventeen clients related that the man had witnessed physical abuse between his own parents or guardians when growing up. Thirteen women witnessed physical violence between their own parents. Finally, 17 subjects identified a relationship between the man drinking alcohol and acting in an abusive manner. Fifteen of the women said physical abuse occurred only after the man consumed alcohol.

Instrumentation

1. Locus of control--The Rotter Internal/External Scale (I/E Scale) was used to measure locus of control. Permission was obtained to use the scale from Dr. Rotter (Appendix E). The Internal/External Scale consisted of 23 item pairs plus six filler questions. In each question, one statement reflected internal belief and one statement
reflected external belief. The client makes a choice between the internal and external statements. In scoring, the client receives a point for each external statement chosen. Scores range from 0 to 23 with 23 being the most external. The scale is self-administered and can be completed in 15 minutes (Robinson and Shaver, 1973). The internal consistency aspect of reliability has been demonstrated at .70 using a sample of 400 college students (Rotter, 1966). Test-retest reliability coefficients were computed for 60 students after one month with an r of .72 (Cowling, 1979; Rotter, 1966). "Discriminant validity was indicated by the low relationship with such variables as intelligence, social desirability and political liberalness" (Rotter, 1966:25). Using several large samples (from 50-1000 subjects) internal consistency ranged from .65 to .79 (Rotter, 1966).

2. Self-concept--The Tennessee Self-Concept Scale by Fitts was used to measure self-concept. The scale was purchased from Counselor Recording and Tests in Nashville, Tennessee. This test consisted of 100 self-descriptive statements with a 5-point scale ranging from "completely true" to "completely false" (Fitts, 1965). The test includes four major categories for analysis which include: self criticism, identity, self-satisfaction and behavior. Data were further subdivided into categories to give information about the physical self, personal self, family self, moral-ethical self and social self. Test-retest reliability
for 60 college students over a two-week period ranged from .60 to .92 (Fitts, 1965). Test is self administered and can be completed in approximately thirty minutes. A panel of judges voted unanimously on items as correctly classified before they were included in the scale. Thus content validity is seen as high. The scale also effectively differentiates groups. To elaborate, the test was given to a large sample (N = 995) of psychiatric patients and nonpatients. The test scores differentiated between who was a member of each group at the .001 level of significance. The scale has also been used to differentiate type of disorder and degree of disorder (Fitts, 1965).

3. Subject variables--The investigator collected data about subject variables suggested by the literature as criteria in identifying abuse. The investigator developed tool was used in a structured interview format to collect data regarding race, age, education, employment, marital status, length of abuse, history of abuse in family of origin, and alcohol consumption as a contributing factor to abuse (Hilberman and Munson, 1978). Tool was not field-tested but was reviewed for content validity.

Procedure

Permission to conduct the study was obtained from the University Committee on the Conduct of Human Research (Appendix F) and verbally from the Director of the Victim Advocacy Program. After agency staff completed initial
interview and assessment, the investigator interviewed subjects within the first 48 hours that they became clients.

The investigator explained the purpose of the study and obtained signed informed consent. The investigator interviewed the subjects using a semi-structured interview tool. Instructions for the Tennessee Self-Concept Scale were read aloud to the subject. This instruction was duplicated exactly for each client. The client completed the scale. Next the investigator read aloud instructions to the client concerning the Rotter Internal/External Scale. The client then completed the scale. All subjects in the sample could read. The actual process was duplicated as closely as possible for each client to provide an environment with as few extraneous variables as possible. Time for questions was provided during the instruction period. Tests were taken in the same order each time. During the actual testing the client was alone in the testing room. The subject was instructed on the investigator's location should questions arise. The investigator provided a play activity in another room for the subject's children who were often present during the testing period.

Problems in Data Collection

The original design mandated a sequential sample of all clients entering the agency over two six-week data collection periods. Problems concerning this method were present. The investigator ended the study with a convenience
sample of 26 subjects over three six-week periods.

To analyze the problem, the investigator found that the clients' stay in the agency was often only overnight or less than 72 hours. With clients who rapidly moved through the agency, staff and clients may have placed low priority on the research interview. Clients often used their stay at the agency to apply for welfare, find a job, find a place to live or seek medical care. Because of the time-consuming nature of these tasks, clients spent little time at the agency other than regular scheduled appointments with staff counselors. Therefore scheduling interviews with clients was difficult. Although the investigator called the Y.W.C.A. twice daily during data collection periods, daily contact with clients for interviews was not made.

Problems were also present concerning the data collection instruments. Although instructions suggest that both scales (Tennessee Self-Concept Scale and Rotter I/E Scale) could be completed in a total of 45 minutes, at least half the clients took 1 1/2-2 hours to complete the scales. Several clients told the investigator that the locus of control was too general and did not apply to their lives. Clients suggested that they were unable to relate to questions on the locus of control scale concerning politics. To counter the general nature of the Rotter I/E Scale, the investigator added four situation specific questions concerning feelings of control or lack of it in the abusive relationship. These situation specific questions were part of
the initial research design and may have been helpful in making the concept more relevant.

**Plan of Data Analysis**

A total of 26 persons completed the study. Using the scale results, the investigator determined if a correlation existed between locus of control and self-concept as hypothesized. The Spearman's Rank Correlation Coefficient test was used for this purpose (Siegal, 1956). The semi-structured interview also provided data on various subject variables which were descriptively analyzed.
Chapter 4

DATA ANALYSIS AND INTERPRETATION

Introduction

This study investigated the research question: What is the relationship between self-concept and locus of control in physically abused women? Interval level data were obtained using the Tennessee Self-Concept Scale and ordinal level data using the Rotter Internal/External Scale. The investigator added four situation-specific questions concerning abuse to validate information obtained from the Rotter Internal/External Scale. Descriptive information concerning selected subject attributes was also collected. Twenty-six subjects completed the scales during three six-week data collection periods over an eight-month period. Twenty-five of them completed the interview collecting descriptive data. The hypothesis for this study stated: There is an inverse relationship between self-concept and locus of control in physically abused women, the lower the self-concept, the more external the locus of control. Spearman's Rank Correlation Coefficient was used to test the hypothesis.
Subjects

The sample of 26 women included 13 whites and 13 blacks. The equally balanced racial groups occurred by chance. Discussion of specific subject attributes follows (Tables 1 to 4). (All 26 subjects completed the testing but only 25 completed interview on demographic data. Therefore the total number of responses in most tables equals 25.)

Table 1
Age of Subjects

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-29 years</td>
<td>18</td>
</tr>
<tr>
<td>30-39 years</td>
<td>5</td>
</tr>
<tr>
<td>40-49 years</td>
<td>2</td>
</tr>
</tbody>
</table>

The average age was 27.5 years with ages ranging from 19 to 46. The literature suggested that the age range can vary widely since abuse cuts across all age categories (Hilberman and Munson, 1978; Walker, 1979). The same sources stated that younger women may be more likely to seek help, as this sample suggests. Although the investigator did not collect specific data on number and ages of children, at least 20 of the women interviewed (77 percent) were mothers of children under the age of 16. Since the majority of women in this study were in their childbearing years, a major concern expressed was how to properly care for their children.
financially and emotionally should they leave the abusive relationship. In a study by Martin (1976), the 100 women studied had 315 children with some women being childless.

Table 2

<table>
<thead>
<tr>
<th>Range of Education</th>
<th>Number Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 8-10</td>
<td>7</td>
</tr>
<tr>
<td>Grade 11-12</td>
<td>13</td>
</tr>
<tr>
<td>College 1-2 years</td>
<td>0</td>
</tr>
<tr>
<td>College 3-4 years</td>
<td>5</td>
</tr>
</tbody>
</table>

The average grade of school completed was 11.5. Twelve of the subjects did not complete high school. Only one was a college graduate. As a result, few had marketable job skills or training in any specific job category. Although the investigator found no specific data concerning education, several sources (Hilberman and Munson, 1978; Martin, 1976) suggested that abused women married at a mean age of 16 often after becoming pregnant. Thus the probability for completion of high school was slim. Job training, education and job placement would be a high priority in working with this target population.
The employment category reflected a problem with the interview tool. The specific interview item did not allow the answer to be as specific as necessary to present a clear picture of employment. Although the number of women employed in the past was fifteen, the majority of these women worked from two weeks to two months at a variety of unskilled jobs. As mentioned before, job skills are not a strong area for this target population. Martin (1976) confirmed this fact as did Pfouts (1978).

Eleven subjects gave a positive history of abuse for
both themselves and the man involved. Eight subjects were the product of a broken home or were raised in foster care. Gelles (1972) and Pfouts (1978) confirmed the history of violence in the family of origin as a significant factor concerning abuse in the present generation. This finding supports social learning theory and the idea that behavior is learned (Rotter, 1966). Suggestions concerning intervention based on this information will be discussed later.

**Alcohol and Abuse**

Seventeen of the women interviewed said that a relationship existed between the man drinking alcohol and physical abuse occurring. Fifteen of the 25 women (60 percent) claimed they were abused only when the man was drinking. In another study (Hilberman and Munson, 1978), 56 out of 60 women studied (93 percent) associated alcohol consumption by the man and physical abuse. Hanks and Rosenbaum (1977) and Pfouts (1978) confirmed these findings. Bard (1977) in a police survey in New York City did not find a relationship between alcohol and abuse. Both Gelles (1972) and Gayford (1975) acknowledged the relationship between alcohol and physical abuse in their respective research. Drinking accompanied abuse in 44 percent of Gelles' sample and 52 percent of Gayford's sample.

**Time Frame of Personal Relationships**

Length of personal relationships ranged from three
weeks to 21 years with the mean being 5.5 years. Length of abuse in relationships ranged from three weeks to 18 years with the mean being 4.05 years. A study by Heppner (1978) found the mean length in relationships to be eight years. Two women reported a history of abuse during courtship. This behavior continued after marriage. The women who had lived for a number of years in an abuse-free marriage stated that the abuse began after the man became a heavy consumer of alcohol. Martin (1976) stated that abuse from one to 25 years was common in her sample of 100 women but did not categorize it further.

**Discussion of Subject Attributes**

The composite picture of an abused woman shaped from this study included a woman in her twenties with small children who has a poor educational background and a minimal history of employment at unskilled jobs. She frequently came from a family where divorce occurred and may not have been raised by her biological parents. According to the literature, the abused woman also married at an early age to escape an unhappy home life. She was possibly pregnant at the time (Hilberman and Munson, 1978; Martin, 1976; Roy, 1977; Walker, 1979). This investigation did not study these factors.

Although the above profile implies that the abused woman may be from a lower socioeconomic class, the literature suggested otherwise. Stark and McEvoy (1970) performed
a study of 1,176 adults chosen specifically to represent a cross section of the United States population. Their results showed that the poor and less educated were not more prone to violence. The study did not focus specifically on wife abuse. In their study, physical abuse cut across all social and economic classes. The same investigators stated that the poor are merely more visible, more likely to call police or seek assistance through public agencies. Crowley (1980) suggested that the middle-class person has more to lose by denouncing the physically abusive relationship. The security of social status, income and comfortable housing may keep the middle class more hidden concerning their problem. Hilberman (1980) and Byers (1977) concurred. Most statistics found in the literature come from public agencies or university clinic settings. The middle and upper class abuse problem may be hidden in legal divorce records and private counselors' files.

Test Results

**Tennessee Self-Concept Scale**

Scores ranged from 205 to 376 on the TSCS with a mean score of 300.53 (Appendix G). The most positive score possible on the TSCS is 500. According to repeated testing of samples representing a cross section of persons, Fitts (1965) suggested that a score of 300 would place the subject at the eight percentile level with 92 percent of all persons answering the scale scoring above that level. Thompson
(1972) stated that the total score with economically disadvantaged adults is generally below average. Scores for the groups he cited ranged from 310 to 360. So subjects in the investigator's study ranked lower than the average economically disadvantaged adult. This meant that the 26 abused female subjects in this study had a lower self-concept than that of economically disadvantaged adults.

**Internal/External Scale**

Scores ranged from four to 18 on the Internal/External Scale with a mean of 10.92 (Appendix G). Scoring on the scale is in the external direction with 23 the most external score possible. The scale contains 29 paired items with six filler questions (Rotter, 1966). Therefore the average score on the investigator's study was in the less external direction but scores were higher (more external) than the mean scores cited by Lefcourt (1976).

The literature suggested minority groups are usually more external. For example, in a study of 120 persons (60 black and 60 white), the mean score on the Internal/External Scale for blacks was 8.97 and for whites was 7.87 (Lefcourt and Ladwig, 1965). This was statistically significant at the .05 level. In this investigator's study, the mean score on the Internal/External Scale was 10.5 for blacks and 11.3 for whites. These results showed blacks to be less external than whites (Appendix H), which is in contrast to general findings using college students and service corps populations. To further validate these findings, the blacks mean
score on the situation-specific questions was 2.17 (the higher the number the more internal) and the whites mean score was 1.88. Also the whites in the sample rated themselves as more powerless in this component.

Scores on the situation-specific questions ranged from one to four with a mean score of 2.02 (Appendix G). Since the score of "1" was used to reflect the powerless position and "5" to reflect the strong and capable position, the subjects' responses reflected a feeling of powerlessness in the situation of abuse. Later discussion of correlation data will explain the relationship of these situation-specific questions to the Internal/External Scale in more detail. Since the investigator designed these situation-specific questions, no research data exist for comparison.

The Hypothesis

Using the Spearman's Rank Correlation Coefficient, the investigator examined the major research hypothesis: There is an inverse relationship between self-concept and locus of control in physically abused women. The formula for the Spearman's Rank Correlation Coefficient is:

$$r_s = 1 - 6 \frac{d_i^2}{n(n^2-1)}$$ (Siegal, 1956)

An adjustment for ties was computed in each correlation in the research problem.

Results:

1. The Tennessee Self-Concept Scale and Rotter
Internal/External Scale—the correlation coefficient equals -0.64 which indicates an inverse relationship between the two scores. The critical value (Siegal, 1956) at the 0.05 level is .329. Therefore using the absolute value of -0.64 which is $r^S = .64$, the major hypothesis is supported. Therefore there is reason to believe that a significant association exists between scores on the Tennessee Self-Concept Scale and scores on the Rotter Internal/External Scale.

2. Rotter Internal/External Scale and Situation Specific Scores—the correlation coefficient ($r^S$) equals -0.04. The critical value (Siegal, 1956) at the 0.05 level is .329. Therefore there is reason to believe no association exists between Internal/External scores and Situation-Specific scores.

3. Tennessee Self-Concept Scale and situation-specific questions—the correlation coefficient ($r^S$) equals .21. The critical level (Siegal, 1956) at the 0.05 level is .329. Therefore there is reason to believe no association exists between Tennessee Self-Concept scores and situation-specific scores.

Discussion of Findings Related to Hypothesis

The findings supported the major hypothesis at the 0.05 level of significance. Thus, there was an inverse relationship between self-concept and locus of control in physically abused women. The lower the self-concept, the more external was the subject in her locus of control. Heppner
(1978) suggested that external tendencies were present in physically abused women as did Walker (1979). Barnhill (1980) and Parker (1979) concurred. Almost all references described the physically abused woman as suffering from low self-concept (Ball, 1977; Davidson, 1977; Elbow, 1977; Fleming, 1979; Iyer, 1980; Martin, 1976; Walker, 1979). The investigator found no studies in the literature to suggest any previous research done to investigate self-concept and locus of control in abused women. As mentioned in chapter two of this study, research has been done demonstrating a significant relationship between these two variables using other target populations such as college students and the elderly.

The investigator found no relationship to exist between the Internal/External Scale and situation-specific questions, both used to measure feelings of control or lack thereof. Lefcourt (1976), Phares (1979) and Rotter (1966) all suggested that the Internal/External Scale may be more general in nature and may not focus in on very specific situations or problems. One could feel somewhat in control of life in general but not in a specific area such as physical abuse. Scores on the situation-specific questions reflected a high degree of powerlessness. This result may have been because of the recent nature of the physical abuse and the fact that the subjects were presently in an agency to seek help with this specific problem. Situation-specific questions can serve as a descriptor for subjects pointing to the homogeneity of the group and the common problem to be dealt
with in treatment.

The investigator also found no relationship between the Tennessee Self-Concept Scale and situation-specific questions at the statistically significant level. However, a positive correlation was present \( (r^s = .21) \). This correlation did support the major hypothesis and suggested that the lower the self-concept, the more powerless the person felt.
Chapter 5

SUMMARY, CONCLUSIONS, IMPLICATIONS
AND RECOMMENDATIONS

Summary

The purpose of this study was to investigate the relationship between self-concept and locus of control in physically abused women. The investigator also gathered information concerning specific attributes which might be used as indicators of physical abuse.

Twenty-six subjects constituted the sample. Twenty-five of these subjects provided information concerning demographic attributes. Data collection consisted of a semi-structured interview between investigator and subject, followed by completion of the Tennessee Self-Concept Scale and Rotter Internal/External Scale. Four situation-specific questions were administered following the Rotter Scale. Data were analyzed descriptively for the subject attributes. The Spearman's Rank Correlation Coefficient was used to test the major hypothesis.

Conclusions

The subjects in this study can be considered representative of only one agency during a specific time period.
The findings cannot be generalized to the population at large. On the basis of the findings, the following conclusions were drawn.

1. There was an inverse relationship between self-concept and locus of control in physically abused women ($r^S = .64$). The lower the self-concept, the more external was the subject in her locus of control. Results were statistically significant at the 0.05 level using a one-tailed test.

2. Blacks as compared to whites were seen as less external on both the Rotter Internal/External Scale and situation-specific questions. This finding is contradictory to the findings in the literature (Lefcourt and Ladwig, 1965).

3. There was no significant relationship between situation-specific scores and the Tennessee Self-Concept Scale. A positive correlation ($r^S = .21$) was found between feelings of powerlessness in the abuse situation and lower self-concept.

4. There was no significant relationship between situation-specific questions and the results of the Rotter Internal/External Scale.

**Implications for Nursing**

Nursing literature seldom mentioned emotional care of the physically abused women as a nursing care problem. Only six articles dealing with physical abuse of women were
found in current nursing literature (Hendrix, LaGodna and Baker, 1978; Iyer, 1980; Lieberknecht, 1978; Parker, 1979; Prince, 1980; Weingourt, 1979). Nurses probably contact physically abused women each day, but may not identify them as such. Nurses in emergency rooms, medical-surgical units, outpatient clinics, community mental-health clinics, and public health services all serve the population of abused women. Agencies providing public education concerning physical abuse need to identify nurses as a target population for education in the assessment of and intervention for physically abused clients. On the professional level, nursing schools and inservice educators need to consider adding training sessions on this subject.

Although nurses may not function as the primary therapist for such a client, they need to know the resources available for help. A warm, nonjudgmental attitude is essential in encouraging the client to seek further assistance.

In terms of the research concern of this study, implications for nursing would include creation of a clearer model of intervention for use with the physically abused woman. This model would provide a framework for counseling strategies and establishing realistic goals. This task would be appropriate for a master's prepared nurse in mental health. The study of intervention is in its infancy in all social disciplines. Most literature is descriptive in nature pointing out characteristics of the physically abused woman or possible theories to explain the occurrence of the
problem. Social learning theory as cited by Rotter (1966) and learned helplessness (Seligman, 1975) are both identified as influencing the occurrence of physical abuse of women. More specific information concerning intervention and treatment strategies is needed. If the nurse decides that improved self-concept and a more internal locus of control are desirable, she needs to find out how to help clients accomplish this goal. Majumber, Greeves, Holt and Friedland (1973) discussed specific techniques used with disadvantaged youths to increase perceived control. Results were optimistic and students in the experimental group did become more internal. A sample transcript from a counseling session demonstrated the technique.

The investigator suggests use of the group treatment modality as a possible treatment intervention. Rounsaville, Lifton and Bieber (1979) discussed this treatment modality and mentioned its major drawback as high attrition rate among group members. In their study, helplessness was a major theme among group members and could provide the focus for problem solving in this area.

Roy (1976) stated that self-concept is formed in a large degree from the perceptions of others. The group model would emphasize positive reinforcement among members and stress the support elements of this treatment modality. Group interaction might improve self-concept in time. Specific guidelines for group counseling with physically abused women were developed by the investigator (Appendix H). The
subject attributes in this study also suggested implications for nursing care. Any mental health nurse doing case management with a physically abused woman would need to assess her need for job skill training or child care should the woman seek assistance. According to the findings regarding history of abuse, primary prevention might focus on non-violent discipline of children and the importance of nurturing in the parenting role. Although Bowen (1976) suggested that major behavior change within families takes three generations, promotion of nonviolence should start with the present one.

Finally, the nurse needs to help the abused woman become familiar with other support organizations such as Alanon if alcoholism has compounded the problem of physical abuse. Some community resources also provide crisis intervention services for the man should he desire treatment for his drinking problem. The client needs to know this information.

Recommendations

As a result of this research, the investigator recommends the following ideas for further study:

1. A correlational study between counselors' perceived control scores and those of their clients.

2. A replication study but using a different locus of control measure, possibly the Nowicki-Strickland Scale (1975) or the Reid-Ware Three Factor Internal-External
Scale as cited by Lefcourt (1976).

3. A study to focus on the interactional dynamics that precede the physical abuse as suggested by Pagelow (1979).

4. Longitudinal studies of clients for evaluation purposes.

5. A study focusing on the children in a physically abusive family and how they are affected.

6. A study focusing on the effectiveness of the family therapy approach in the treatment of physical abuse.

7. Experimental study using a counseling intervention, possibly the group treatment modality, aimed at raising self-concept of physically abused women who sought help.
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Crowley, Sheila

Davidson, Terry

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Iyer, Patricia W.  

James, William  

Kansas City Police  

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APPENDIX A

ROTTER INTERNAL/EXTERNAL SCALE
(INCLUDING 4 SITUATION-SPECIFIC QUESTIONS)
ROTTER INTERNAL/EXTERNAL SCALE

Key--External response is underscored in this copy. Filler questions are not marked

1. A. Children get into trouble because their parents punish them too much.
   B. The trouble with most children nowadays is that their parents are too easy with them.

2. A. Many of the unhappy things in people's lives are partly due to bad luck.
   B. People's misfortunes result from the mistakes they make.

3. A. One of the major reasons why we have wars is because people don't take enough interest in politics.
   B. There will always be wars, no matter how hard people try to prevent them.

4. A. In the long run people get the respect they deserve in this world.
   B. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. A. The idea that teachers are unfair to students is nonsense.
   B. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. A. Without the right breaks one cannot be an effective leader.
   B. Capable people who fail to become leaders have not taken advantage of their opportunities.

7. A. No matter how hard you try some people just don't like you.
   B. People who can't get others to like them don't understand how to get along with others.

8. A. Heredity plays the major role in determining one's personality.
   B. It is one's experiences in life which determine what one is like.

9. A. I have often found that what is going to happen will happen.
   B. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.
10. A. In the case of the well-prepared student there is rarely if ever such a thing as an unfair test.
   B. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. A. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
   B. Getting a good job depends mainly on being in the right place at the right time.

12. A. The average citizen can have an influence in government decisions.
   B. This world is run by the few people in power, and there is not much the little guy can do about it.

13. A. When I make plans, I am almost certain that I can make them work.
   B. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14. A. There are certain people who are just no good.
   B. There is some good in everybody.

15. A. In my case getting what I want has little or nothing to do with luck.
   B. Many times we might just as well decide what to do by flipping a coin.

16. A. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
   B. Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.

17. A. As far as world affairs are concerned, most of us are the victims of forces we can neither understand nor control.
   B. By taking an active part in political and social affairs the people can control world events.

18. A. Most people don't realize the extent to which their lives are controlled by accidental happenings.
   B. There really is no such thing as "luck".

19. A. One should always be willing to admit mistakes.
   B. It is usually best to cover up one's mistakes.

20. A. It is hard to know whether or not a person really likes you.
   B. How many friends you have depends on how nice a person you are.
21. A. In the long run the bad things that happen to us are balanced by the good ones.
   B. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. A. With enough effort we can wipe out political corruption.
   B. It is difficult for people to have much control over the things politicians do in office.

23. A. Sometimes I can't understand how teachers arrive at the grades they give.
   B. There is a direct connection between how hard I study and the grades I get.

24. A. A good leader expects people to decide for themselves what they should do.
   B. A good leader makes it clear to everybody what their jobs are.

25. A. Many times I feel that I have little influence over the things that happen to me.
   B. It is impossible for me to believe that chance or luck plays an important role in my life.

26. A. People are lonely because they don't try to be friendly.
   B. There's not much use in trying too hard to please people, if they like you, they like you.

27. A. There is too much emphasis on athletics in high school.
   B. Team sports are an excellent way to build character.

28. A. What happens to me is my own doing.
   B. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. A. Most of the time I can't understand why politicians behave the way they do.
   B. In the long run the people are responsible for bad government on a national as well as on a local level.
SITUATION-SPECIFIC QUESTIONS

1. When it comes to my relationship with my spouse or boyfriend, I feel
   Helpless Neutral Strong & capable
   1 2 3 4 5

2. When there is tension building in my home, I feel there is
   Very little I Neutral A great deal I can do do to help myself
   1 2 3 4 5

3. In my present home situation I feel I have
   Very little chance of protecting myself Neutral Adequate ways to cope
   1 2 3 4 5

4. When it comes to my relationship with my spouse or boyfriend, I feel
   Powerless Neutral Powerful
   1 2 3 4 5
APPENDIX B

TENNESSEE SELF-CONCEPT SCALE
TENNESSEE
SELF CONCEPT SCALE

by

William H. Fitts, Ph.D.

Published by
Counselor Recordings and Tests
Box 6184 - Acklen Station
Nashville, Tennessee 37212
INSTRUCTIONS

On the top line of the separate answer sheet, fill in your name and the other information except for the time information in the last three boxes. You will fill these boxes in later. Write only on the answer sheet. Do not put any marks in this booklet.

The statements in this booklet are to help you describe yourself as you see yourself. Please respond to them as if you were describing yourself to yourself. Do not omit any item! Read each statement carefully, then select one of the five responses listed below. On your answer sheet, put a circle around the response you chose. If you want to change an answer after you have circled it, do not erase it but put an X mark through the response and then circle the response you want.

When you are ready to start, find the box on your answer sheet marked time started and record the time. When you are finished, record the time finished in the box on your answer sheet marked time finished.

As you start, be sure that your answer sheet and this booklet are lined up evenly so that the item numbers match each other.

Remember, put a circle around the response number you have chosen for each statement.

<table>
<thead>
<tr>
<th>Responses</th>
<th>Completely false</th>
<th>Mostly false</th>
<th>Partly false and partly true</th>
<th>Mostly true</th>
<th>Completely true</th>
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<td>2</td>
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You will find these response numbers repeated at the bottom of each page to help you remember them.

© William H. Fitts, 1964
1. I have a healthy body................................................................. 1
3. I am an attractive person............................................................. 3
5. I consider myself a sloppy person................................................ 5
19. I am a decent sort of person.......................................................... 19
21. I am an honest person................................................................. 21
23. I am a bad person........................................................................ 23
37. I am a cheerful person................................................................. 37
39. I am a calm and easy going person.................................................. 39
41. I am a nobody.............................................................................. 41
55. I have a family that would always help me in any kind of trouble.... 55
57. I am a member of a happy family................................................... 57
59. My friends have no confidence in me.............................................. 59
73. I am a friendly person................................................................. 73
75. I am popular with men................................................................. 75
77. I am not interested in what other people do.................................... 77
91. I do not always tell the truth.......................................................... 91
93. I get angry sometimes.................................................................... 93

Responses— Completely false Mostly false Partly false and partly true Mostly true Completely true
1 2 3 4 5
2. I like to look nice and neat all the time.

4. I am full of aches and pains.

6. I am a sick person.

20. I am a religious person.

22. I am a moral failure.

24. I am a morally weak person.

38. I have a lot of self-control.

40. I am a hateful person.

42. I am losing my mind.

56. I am an important person to my friends and family.

58. I am not loved by my family.

60. I feel that my family doesn't trust me.

74. I am popular with women.

76. I am mad at the whole world.

78. I am hard to be friendly with.

92. Once in a while I think of things too bad to talk about.

94. Sometimes, when I am not feeling well, I am cross.

Responses—

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<th>Completely false</th>
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<th>Partly false and partly true</th>
<th>Mostly true</th>
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<td>2</td>
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<td>5</td>
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</tbody>
</table>
7. I am neither too fat nor too thin. ................................................................. 7
9. I like my looks just the way they are. ................................................................. 9
11. I would like to change some parts of my body. .................................................. 11
25. I am satisfied with my moral behavior. ............................................................... 25
27. I am satisfied with my relationship to God. ....................................................... 27
29. I ought to go to church more. ................................................................................. 29
43. I am satisfied to be just what I am. ....................................................................... 43
45. I am just as nice as I should be. ............................................................................. 45
47. I despise myself. ..................................................................................................... 47
61. I am satisfied with my family relationships. ......................................................... 61
63. I understand my family as well as I should. ......................................................... 63
65. I should trust my family more. .............................................................................. 65
79. I am as sociable as I want to be. ............................................................................ 79
81. I try to please others, but I don't overdo it. ........................................................... 81
83. I am no good at all from a social standpoint. ....................................................... 83
95. I do not like everyone I know. ............................................................................... 95
97. Once in a while, I laugh at a dirty joke. ............................................................... 97

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<tr>
<th>Responses</th>
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<th>Mostly false and partly true</th>
<th>Mostly true</th>
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</tbody>
</table>
8. I am neither too tall nor too short...............................................
10. I don't feel as well as I should..............................................
12. I should have more sex appeal..............................................
26. I am as religious as I want to be...........................................
28. I wish I could be more trustworthy....................................... 
30. I shouldn't tell so many lies................................................
44. I am as smart as I want to be.............................................. 
46. I am not the person I would like to be....................................
48. I wish I didn't give up as easily as I do..................................
62. I treat my parents as well as I should (Use past tense if parents are not living).............................................
64. I am too sensitive to things my family say................................
66. I should love my family more................................................
80. I am satisfied with the way I treat other people......................
82. I should be more polite to others.......................................... 
84. I ought to get along better with other people..........................
96. I gossip a little at times.......................................................
98. .t times I feel like swearing................................................

Responses -

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<th>Mostly false</th>
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</table>
13. I take good care of myself physically. .............................................. 13
15. I try to be careful about my appearance ........................................... 15
17. I often act like I am "all thumbs" ...................................................... 17
31. I am true to my religion in my everyday life ....................................... 31
33. I try to change when I know I'm doing things that are wrong .............. 33
35. I sometimes do very bad things ......................................................... 35
49. I can always take care of myself in any situation .............................. 49
51. I take the blame for things without getting mad .............................. 51
53. I do things without thinking about them first .................................. 53
67. I try to play fair with my friends and family .................................... 67
69. I take a real interest in my family .................................................... 69
71. I give in to my parents. (Use past tense if parents are not living) ....... 71
85. I try to understand the other fellow's point of view .......................... 85
87. I get along well with other people .................................................... 87
89. I do not forgive others easily ......................................................... 89
99. I would rather win than lose in a game ............................................ 99

Responses

<table>
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<tr>
<th></th>
<th>Completely false</th>
<th>Mostly false</th>
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<td>I feel good most of the time</td>
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<tr>
<td>16.</td>
<td>I do poorly in sports and games</td>
<td>2</td>
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<tr>
<td>18.</td>
<td>I am a poor sleeper</td>
<td>3</td>
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<tr>
<td>32.</td>
<td>I do what is right most of the time</td>
<td>4</td>
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<td>34.</td>
<td>I sometimes use unfair means to get ahead</td>
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<tr>
<td>36.</td>
<td>I have trouble doing the things that are right</td>
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<td>50.</td>
<td>I solve my problems quite easily</td>
<td>2</td>
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<td></td>
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<tr>
<td>52.</td>
<td>I change my mind a lot</td>
<td>3</td>
<td></td>
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<tr>
<td>54.</td>
<td>I try to run away from my problems</td>
<td>4</td>
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<tr>
<td>68.</td>
<td>I do my share of work at home</td>
<td>5</td>
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<tr>
<td>70.</td>
<td>I quarrel with my family</td>
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<td>I do not act like my family thinks I should</td>
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<tr>
<td>86.</td>
<td>I see good points in all the people I meet</td>
<td>3</td>
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<td>88.</td>
<td>I do not feel at ease with other people</td>
<td>4</td>
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<tr>
<td>90.</td>
<td>I find it hard to talk with strangers</td>
<td>5</td>
<td></td>
<td></td>
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<tr>
<td>100.</td>
<td>Once in a while I put off until tomorrow what I ought to do today</td>
<td>1</td>
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Responses: Completely false, Mostly false, Partly false and partly true, Mostly true, Completely true
APPENDIX C

INTERVIEW SCHEDULE
INTERVIEW SCHEDULE

Number: ______
Age: ______
Highest Grade in School: ______
Never been Employed? ___ Presently Employed? ___ full time
___ part time
Relationship to Man: _____ married
____ living together
_____ girlfriend, living apart
Length of Relationship to Man: ______
Length of Abuse in Relationship: ______

Is there a history of physical abuse in the man's family? (Was he physically abused as a child? Did he witness his parents abusing each other?)

Is there a history of physical abuse in your family? (Were you abused as a child? Did you witness your parents abusing each other?)

Does your husband or boyfriend drink alcohol at the time of or prior to abusing you?
APPENDIX D

CONSENT FORM
CONSENT FORM

I agree to participate in a study conducted by Betsy Shires, a graduate student in nursing at Virginia Commonwealth University, Medical College of Virginia. The purpose of the study is to examine feelings about self and perception of control of women who are in a situation of abuse. The study will take approximately one hour and will consist of a brief interview followed by the completion of two written questionnaires.

I understand that the information gathered in the study is confidential and that my participation is strictly voluntary. I understand that my answers will in no way hinder the services available to me. I may withdraw at any time if I so desire. I agree to participate in this study.

Signature ______________________

Witness ______________________ (non-investigator)

Date ______________________
APPENDIX E

LETTER OF PERMISSION
FOR USE OF SCALE
Betsy Shires

Dear Ms. Shires:

You have my permission to reproduce the I-E Scale for your research, providing you are supervised by or consult with someone trained in the use and interpretation of personality measures.

Very truly yours,

[Signature]

JBR/isw

Enc1.
APPENDIX F

COMMITTEE ON THE CONDUCT OF HUMAN RESEARCH APPROVAL
TO: Ms. Betsy W. Shires  
(Advisor, Dr. Barbara A. Munjas)  
Dr. Pat Wiley  
Dr. Martha B. Conway  

Principal Investigator  
Chairman of Department Concerned  
Administrator of Research Grants & Contracts  

TITLE OF INVESTIGATION: A Study of the Relationship Between Self-Concept and Loams of Control in Abused Women  

VCU ASSIGNED NUMBER: 6 - 3S - 80  

The Committee on the Conduct of Human Research of Virginia Commonwealth University met on June 25, 1980, and the above Investigation was reviewed and approved. 

You are cautioned to note that:  

1. Informed, written consent is required of each human subject or his legally qualified guardian or next-of-kin, unless specifically excluded.  

2. Any deviation from the above named protocol, or the identification of unanticipated problems which may involve risk to subjects, must be reported to this committee for review and approval.  

3. Your study is subject to continued surveillance by this committee, and it will be reviewed periodically. The next review is scheduled for June 1981. At that time you must make available to the committee a roster of all subjects, a file of the completed permission slips and a summary of the results obtained, especially any adverse or unexpected effects.  

4. All requests for Information related to this investigation must include the exact title, the Investigator, and the VCU Study Number as noted above.  

5. This Investigation has been indentified as being submitted to the Department of Health, Education and Welfare, and will be certified to H. E. W. Yes _____ NO _____  

6. In some Instances approval is contingent upon compliance with changes designated by the committee. If such are imposed, they are listed on an attached sheet, one copy of which must be signed and returned to the committee to indicate the investigator's acceptance of the changes. Where there is no attachment, the study was accepted.  

Donald L. Brummer, M.D., Chairman,  
Committee On The Conduct of Human Research  

DLB/AD  

(Revised Form Dated 5/1/76)
APPENDIX C

MENTAL HEALTH STANDARDS FOR GROUP COUNSELING WITH ABUSED WOMEN
Concerning the Group:

1. The group will support women to work through their trauma by allowing women in crisis to "tell their story" or discuss the specific battering incident as a means of catharsis.

2. The group will exchange information as demonstrated by discussion about housing, child care or the legal system.

3. The group will focus on use of nonviolent discipline of children as demonstrated by role playing or introduction of P.E.T. active listening information to the group.

4. The group will focus on problem solving as demonstrated by members asking for and giving feedback in specific situations. Use of techniques of force field analysis may help women develop an awareness of present feelings.

5. Group will encourage women to give emotional support to each other as measured by exchange of telephone numbers or contact outside the group.

6. Group will reinforce self-nurturing behavior as demonstrated by any behavior that indicates an increase in independent functioning, improved personal appearance, the reporting of small accomplishments (i.e., the right to attend church).

By Betsy Shires
MENTAL HEALTH STANDARDS FOR GROUP COUNSELING WITH ABUSED WOMEN

For the Counselor:

1. Counselor will read to get background information about abused women. Suggested books are *Stopping Wife Abuse*, Jennifer Baker Fleming, and *The Battered Woman*, Lenore Walker.

2. Counselor will evaluate theories concerning abused women (masochism vs. learned helplessness) and will clarify her own values.

3. Counselor will recognize that if she subscribes to the theory of masochism that she may not be effective in working with abused women.

4. Counselor will acknowledge woman's right to make her own choices.

5. Counselor will acknowledge that the measure of progress in abused women may come in small accomplishments.

6. Counselor will acknowledge that a woman may not be strong enough emotionally to separate from a batterer when she first seeks help.

7. Counselor will recognize that her power may lie in the ability to give the woman a seed of hope or awareness of new choices.

8. Counselor will recognize that her perspective and that of the client may be different.

9. Counselor will reinforce the concept that life without violence is a right.
10. Counselor will discuss her own feelings and frustrations about working with abused women with other "professionals" to lessen the possibility of "burn-out".

11. Counselor will realize that women need to be ready emotionally before they can take legal or police action against men.

By Betsy Shires
APPENDIX H

TEST SCORES FOR TSCS, I/E SCALE
AND SITUATION-SPECIFIC QUESTIONS
# TEST SCORES

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APPENDIX I

TEST SCORES COMPARED IN BLACKS AND CAUCASIANS
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**Mean Score**  
302  
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VITA

Betsy Wright Shires was born in Amherst, Virginia in 1950. She attended public schools and graduated from University of Virginia, in 1972, with a Bachelor of Science degree with a major in nursing. She has worked as a staff nurse in medical-surgical nursing and inservice-education instructor at the Veterans Administration Hospital in Albuquerque, New Mexico. She has also worked at the McGuire Veterans Hospital in Richmond, Virginia as a staff nurse on in-patient psychiatry and also in the recovery room.

She is married and the mother of one child.