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Evaluation of a psychoeducational program designed to affect attitudes associated with intimate partner violence in an inmate population

Melani Magee Wheeler
Louisiana Tech University

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EVALUATION OF A PSYCHOEDUCATIONAL PROGRAM DESIGNED TO
AFFECT ATTITUDES ASSOCIATED WITH INTIMATE PARTNER
VIOLENCE IN AN INMATE POPULATION
by
Melani Magee Wheeler, B.GS.

A Dissertation Presented in Partial Fulfillment
Of the Requirements for the Degree
Doctor of Philosophy

COLLEGE OF EDUCATION
LOUISIANA TECH UNIVERSITY

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Advisory Committee

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ABSTRACT

The purpose of this study was to evaluate the effectiveness of a group intervention designed to impact male attitudes associated with the perpetration of intimate partner violence in a correctional setting. Specifically, the group intervention addressed gender role stereotypes and conflict, healthy and unhealthy entitlement attitudes, attitudes toward women, and effective communication and anger management. The group intervention also sought to increase positive attitudes toward seeking psychological assistance among participants. Results of the MANCOVA did not support the efficacy of the psychoeducational program in impacting attitudes among inmates. Implications and suggestions for future research are discussed.
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CHAPTER 1
INTRODUCTION

Over the last 15 years, research exploring the psychology of men has examined the ways in which masculine gender role socialization impacts the interpersonal functioning of men and contributes to the use of violent or abusive behaviors within intimate relationships. Gender role socialization is defined as the “process whereby children and adults acquire and internalize the values, attitudes, and behaviors associated with masculinity, femininity, or both” (O’Neil, 1981, p. 203). Gender role conflict theory suggests that masculine gender role socialization causes men to rigidly adhere to specific attitudes and behaviors associated with masculinity and to reject feminine attitudes and behaviors (O’Neil & Harway, 1997). Rigid adherence to the traditional male role may lead to the experience of masculine gender role conflict and may foster the development of sexist or negative attitudes toward women, along with a sense of entitlement. Additionally, rejection of attitudes and behaviors associated with femininity has been found to negatively impact male help-seeking behaviors including seeking or receiving psychological assistance. Because men are often socialized to restrict emotional expression and to deny personal weakness, they may be reluctant to seek assistance in resolving interpersonal conflict. As a result, men may utilize maladaptive behaviors, such as violence, in their interpersonal relations with others because they have been encouraged to employ behaviors that are detached and competitive in their interactions (Mahalik, 1999).
As counseling psychology historically has been dedicated to the prevention of intra- and interpersonal conflict, counselors are obligated to respond to such findings through the development and evaluation of interventions that prevent individuals from experiencing further distress (Gilbert, 1992; Hage, 2000). Studies of men and masculinity consistently indicate that gender role conflict, sexist or traditional attitudes toward women, and a sense of entitlement develop as a result of the masculine socialization process (Marin & Russo, 1999; O'Neil & Harway, 1997). Because each of these variables is associated with an increased propensity to initiate violence or abuse within intimate relationships, it is reasonable to conclude that preventive interventions aimed at increasing men's awareness of these variables may reduce future violence or abuse (Nadkarni, Steil, & Malone, in press; O'Neil & Nadeau, 1999).

Gender role conflict is defined as "a psychological state in which gender roles have negative consequences or impact on the person or others" (O'Neil, 1981, p. 25). It occurs when "rigid, sexist, or restrictive gender roles learned during socialization result in personal restriction, devaluation, or violation of others and self" (O'Neil, 1990, p. 25). Cohn and Zeichner (2006) assert that rigid enactment of masculine attributes, such as the need for power and control, activates an underlying need to appear dominant, concomitantly increasing a man's inclination to engage in violent behavior.

Gender role conflict is significantly related to abusive behaviors in relationships and to other variables that are empirically linked to the initiation of intimate partner violence. Finn (1986) discovered that college men who had traditional masculine attitudes of superiority and authority were more likely to endorse a husband's use of
violence against his wife than those who held less traditional attitudes. Moreover, men who maintained an exaggerated masculine ideology responded to negative feedback from women with greater anger and reported more past sexual aggression than men who didn’t subscribe to this belief (Vass & Gold, 1995). Gender role conflict also is related to reports of hostility towards women (Lisak & Roth, 1988; O’Neil, Good, & Holmes, 1995), tolerance of sexual harassment (Kearney Rochlen, & King, 2004), traditional stereotypes of women (Rando, Brittan, & Pannu, 1994), and entitlement (Schwartz, Magee, Griffin, & Dupuis, 2004). Together, these studies indicate that men who experience high levels of gender role conflict are likely to possess attitudes supportive of violence toward women. Because attitudes are strong predictors of behavior, preventive interventions that address the underlying attitudes associated with gender role conflict may prevent abusive or violent behavior.

In addition to their relation with gender role conflict, male attitudes toward women also may influence abusive or violent behaviors in men’s interpersonal relationships with women. Attitudes toward women are reflective of male values and beliefs surrounding the roles and responsibilities of females and include the expectations and limitations imposed on women by a male-dominated society. Such opinions are linked to social perceptions of females’ positions in the home, in the bedroom, and at work (Spence & Helmreich, 1972).

Attitudes toward women may or may not be conservative. Conservative attitudes reflect historical perceptions surrounding the subordination and inequality of women, such as, “a woman’s place is in the home.” They are associated with poor relationship quality (Glick, Diebold, Bailey-Werner, & Zhu, 1997), irrational
relationship beliefs (Wood, 2004), tolerance of sexual harassment, and higher levels of gender role conflict in men (Wood, Robinson, & Buboltz, 2000). Violent husbands tend to possess more conservative attitudes surrounding the female role than their nonviolent counterparts (Telch & Lindquist, 1984).

Conversely, liberal attitudes toward women reflect more modern perceptions of women as having rights and opportunities equal to those of men (Twenge, 1997). More egalitarian attitudes are associated with greater relationship satisfaction, lower levels of gender role conflict (Wood et al., 2000), and lower rates of conflict and violence in relationships (Fitzpatrick, Salgado, Suvak, King, & King, 2004). In light of these findings, possession of more conservative attitudes toward women may negatively impact intimacy between men and women and contribute to intimate partner violence. Preventive interventions that examine the ways through which attitudes toward women are socialized may enable men to re-evaluate their own attitudes toward women and their roles. Such reconsideration of personal attitudes may foster the development of more liberal attitudes and lead to lower levels of relationship conflict and violence.

Male attitudes toward women may be further influenced by an underlying sense of "masculine" entitlement. Entitlement is defined as “a set of attitudes about what persons believe they have a right to and can expect from others both as individuals and as members of a social group” (Nadkarni et al., in press, p. 26) and is said to impact a man’s propensity for abuse (Walker, 1984). Such attitudes reflect either a healthy sense of entitlement or an exaggerated, narcissistic one. Healthy entitlement is related to high self-esteem, assertiveness, and more intimacy, whereas narcissistic entitlement
is linked to rape myth acceptance, rape-related attitudes and behaviors, and disregard for the rights of others (Hill & Fischer, 2001; Nadkarni et al., in press). Furthermore, narcissistic entitlement theoretically is correlated with the perpetration of relationship violence and may play a crucial role in causing violent attitudes and behaviors (Hill & Fischer, 2001). Interventions designed to replace unhealthy or narcissistic entitlement with a healthy sense of entitlement may lead to better interpersonal relations and improved quality of life (Magee & Schwartz, in press).

Overall, the masculine socialization process is theorized in some cases to authorize violence within intimate relationships by fostering attitudes supportive of relationship violence. Additionally, it may contribute to relationship difficulties by promoting a fear of emotional expression, which may prevent men from requesting psychological assistance when stressed. Studies consistently find that men who strongly endorse traditional male gender roles and who experience greater levels of gender role conflict report more negative attitudes about psychological help-seeking than other men (Good, Dell, & Mintz, 1989; Good & Wood, 1995; Robertson & Fitzgerald, 1992). This is relevant to the prevention of intimate partner violence, as men most in need of psychological assistance to cope with interpersonal conflict may be the least likely to ask for help. Despite these implications, a review of the literature did not reveal any studies that considered all of these factors (i.e., gender role conflict, attitudes toward women, entitlement, attitudes toward help seeking) in the design of interventions aimed at preventing intimate partner violence.

In an effort to fill this gap in the literature, the current study was designed to evaluate the effectiveness of a psychoeducational group intervention aimed at changing
male attitudes associated with the perpetration of intimate partner violence.
Specifically, this intervention was designed to (a) increase awareness of male attitudes
toward women and foster the development of more positive attitudes toward women,
(b) promote awareness of masculine gender role conflict and thus reduce gender role
conflict among participants, (c) affect entitlement attitudes by increasing self-reliance
and self-assurance and reducing narcissistic expectations and self-promotion, and (d)
increase help-seeking attitudes and behaviors. By strengthening knowledge of each of
these constructs, preventive interventions may help men improve their capabilities of
having healthy intimate relationships free from violence or abuse, and decrease men’s
fears associated with seeking professional help.

In accordance with Heppner and Clairbom’s (1989) recommendation that
counseling psychology base research assessing attitude change on relevant social
psychological literature in that domain, the design of the current intervention is
consistent with Petty and Cacioppo’s (1986) elaboration likelihood model (ELM) of
attitude change. Additionally, didactic and experiential activities were based on the
therapeutic factors identified by Yalom (1995) and planned so as to complement each
of the stages of group development and change (Prochaska & DiClemente, 1982;

Counseling psychologists have suggested preventive interventions are likely to
be more effective when directed toward specific at-risk populations or environments
(Hage, 2000). Accordingly, the present intervention was implemented in a military-
style, correctional boot camp for men. Boot camp settings value traditional masculine
attributes and stress the importance of being forceful and strong-willed. Such
atmospheres openly reward toughness, bravado, and aggression (Karner, 1998). As a result, male offenders may learn to value forceful control and to associate success with stereotypical masculine characteristics, which may further influence their propensity to initiate aggressive or violent behavior. In a study by Lutze and Murphy (1999), inmates who defined the prison environment as possessing more masculine qualities were more likely to report greater levels of assertive interactions and conflict with both staff members and other inmates than those who defined the prison environment as less masculine.

In addition to promoting aggression and competitiveness, the boot camp climate may foster feelings of helplessness and lead to isolation (Morash & Rucker, 1990). Inmates in “ultramasculine” prison settings reported higher levels of isolation, stress, and feelings of helplessness than those in more traditional prison environments. Morash and Rucker found they also were more apt to perceive their environment as providing lower levels of safety, emotional feedback and support, and greater levels of coercion.

Such findings indicate that prisons that strongly conform to traditional notions of masculinity may inhibit inmate adjustment and rehabilitation. Prior research on inmate adjustment shows that safety, support, emotional feedback, and positive interactions with others are important for prosocial change (Ajdukovic, 1990; Goodstein & Wright, 1989; Lutze, 1998); yet, it appears that these very attributes are compromised in atmospheres that emphasize male sex-role stereotypes and may be exacerbated in the boot camp environment.
Statement of the Problem

Counseling psychologists’ efforts to address intimate partner violence (i.e., violence against women) are directed primarily towards the development of victim interventions that reduce or mitigate the effects of abuse (Hage, 2000). Although important, these interventions usually assist the victim and do little to impact the actual perpetration of abuse. It was not until domestic violence was deemed a crime that programs targeting perpetrators of abuse were considered. Historically, batterers’ interventions were dictated by the legal system and developed in the absence of psychological theory or research. Such “rehabilitation” has been and remains generally a combination of punishment and court-mandated counseling (Rosenfeld, 1992) and appears to do little to prevent further abuse.

Although increased attention has been given to the evaluation of abusers’ interventions, far less emphasis is placed on actual prevention of intimate partner violence. Existing initiatives, often directed toward adolescents and young adults, address dating violence and date rape prevention, while deterrence of the actual perpetration of intimate partner violence is largely ignored (Kilpatrick, Resick, & Williams, 2002). Programs that emphasize prevention are criticized for developing interventions “in-house” and for their failure to rely on structured, theoretically-based approaches. Furthermore, extant efforts rarely target individuals identified as at risk for perpetrating violence or abuse.

In order to reduce or prevent intimate partner violence, the design of effective preventive interventions should be based on scientific findings of contributing factors. Gender role conflict, entitlement, and attitudes toward women are widely studied areas...
of interest that are theoretically and empirically linked to the initiation of violence toward women. Gender role conflict is associated with hostility towards women, rape myth acceptance, tolerance of sexual harassment, entitlement, low self-esteem, mistrust, detachment, and hostility, and stereotypical attitudes toward women (Kaplan, 1992; Kaplan, O’Neil, & Owen, 1993; Kearney et al., 2004; O’Neil et al., 1995; Sharpe & Heppner, 1991). Through each of these associations, the experience of masculine gender role conflict negatively impacts interpersonal relations and may initiate abusive behavior (O’Neil & Nadeau, 1999).

Narcissistic entitlement also appears to play a crucial role in understanding violent behaviors and attitudes such as violence toward women (Hill & Fischer, 2001). It is related to gender role conflict, a disregard for the rights of others, an emphasis on achievement and control over others, self-esteem, and rape myth acceptance. Moreover, it may mediate the relation between rape-related attitudes and behaviors and encourage negative attitudes toward women (Hill & Fischer, 2001). Attitudes toward women are related to poor relationship quality (Glick et al., 1997), irrational relationship beliefs (Wood, 2004), tolerance of sexual harassment, and higher levels of gender role conflict in men (Wood et al., 2000).

Because gender role conflict, narcissistic entitlement, and attitudes toward women are linked with relational violence, preventive interventions designed to address these variables may be effective in reducing relationship violence. Partial support for this hypothesis was demonstrated by Schwartz et al. (2004) in an evaluative review of the efficacy of a group intervention designed to decrease risk factors and increase protective factors associated with dating violence in college students.
Specifically, the psychoeducational treatment was effective in reducing gender role conflict related to the rigid restriction of emotional expression and in increasing healthy entitlement. These findings are significant as gender role conflict surrounding the restriction of emotional expression is correlated with the perpetration of abuse suggested to contribute to abusive behavior in men (Mahalik, 2000; O'Neil et al., 1995; O'Neil & Harway, 1997). The observed increase in healthy entitlement is encouraging, as healthy entitlement is linked to positive decision making in relationships and is hypothesized to contribute to successful relationships (Nadkarni et al, in press).

Because the extension of research beyond the college student population is strongly encouraged (Heppner, 1995), the current study will explore the implementation of a prevention program in a boot-camp prison. As the inmate population possesses many of the factors associated with the perpetration of abuse (e.g., substance abuse, witnessing interparental abuse, low education) and the boot-camp environment reinforces traditional male attitudes and behaviors linked with violent and aggressive behavior, individuals in this setting are an appropriate target for this intervention.

**Justification**

The impact of interpersonal violence extends beyond the intimate relationship in many ways. Relationship violence results in physical injury, psychological trauma, and sometimes death (Gelles, 1997; Kernic, Wolf, & Holt, 2000; Rennison & Welchans, 2000). It places a substantial financial burden on society with costs exceeding $48.3 billion (CDC, 2003). This includes direct medical and mental health care and lost productivity (Max, Rice, Finkelstein, Bardwell, & Ledbetter, 2004), but
does not include legal costs associated with perpetration (i.e., incarceration and rehabilitation). This finding is staggering given that perpetrators are unlikely to stop their battering unless they become involved in the legal system (Kilpatrick, 1990). Involvement in the legal system, however, does not necessarily diminish the perpetration of intimate partner violence and may merely suspend abuse temporarily by reducing access to a victim. Legal involvement without intervention may only put abuse on hold or serve to make matters worse. Interventions aimed at preventing intimate partner violence have the potential to substantially decrease the physical, psychological, and economic damage caused by violence against women.

Studies reveal that violence in the family is directly linked to community violence, other forms of aggression, and gender-based violence (Walker, 1999). Johnson and Ferraro (2000) found that children who witness interparental abuse exhibited higher rates of delinquency and aggression, including violent behavior against an intimate partner during adolescence. In addition, research with adults has found significant linkages between delinquency-related violence and partner violence (Brendgen, Vitaro, Tremblay, & Wanner, 2002). In an overview of the literature on adult male batterers, Holtzworth-Munroe and Stuart (1994) reported that at least half of the men who engaged in violent behavior against their partners had a history of delinquency outside the relationship. Resultantly, prevention efforts may be more effective when geared toward high-risk individuals such as those with a history of delinquency.

Inmates possess many individual characteristics associated with the perpetration of abuse. For instance, studies have found inmates exhibit higher levels of
anger and hostility and have a history of substance abuse and abuse as a child. At midyear 2005, 38% of state inmates nationwide reported experiencing symptoms of persistent anger and irritability (Bureau of Justice Statistics, 2006). In addition, 63% of state inmates had a history of violent behavior and 27% reported experiencing physical or sexual abuse within the family of origin. An additional 74% met the American Psychiatric Association (APA, 2000) criteria for substance dependence or abuse. If higher levels of anger and hostility, childhood abuse, and substance abuse contribute to the perpetration of relationship violence, then, based on the above statistics, the inmate population is an excellent target for violence prevention research.

Ultimately, the goal of studying intimate partner violence is the elimination of intimate partner violence. Preventing abusive or violent behavior is preferable to any form of treatment provided afterwards. A decade of growth in prison populations has not reduced interpersonal violence in American society. Now it is time to develop, test, and implement primary prevention programs that address factors empirically associated with intimate partner violence. Preventive interventions that focus on potential risk factors among high-risk individuals have the potential to decrease crime and violence at a fraction of the cost associated with the incarceration and “rehabilitation” of offenders. Also, it may reduce the harm experienced by both victims and perpetrators, and prevent future violence (Walker, 1994; Walker 1999).

Although an extensive body of literature exploring intimate partner violence has accumulated, research focused on primary prevention and early intervention remains scarce (Hage, 2000; Perez & Rasmussen, 1997). Preventive interventions designed to reduce predisposing factors for intimate partner violence clearly are
needed. Gender role conflict, a sense of entitlement, and attitudes toward women are theoretically and empirically linked with the initiation of intimate partner violence. Therefore, it is reasonable to suppose that prevention efforts aimed at impacting these areas may potentially reduce or prevent intimate partner violence. Because many men are reluctant to seek assistance in dealing with interpersonal conflict, endeavors that strive to increase the help-seeking attitudes and behaviors of men may help prevent instances of violence or abuse. Finally, the implementation of this intervention in a correctional boot camp is crucial as prisons reinforce traditional male attitudes and behaviors among individuals who already possess many of the individual profiles associated with the perpetration of violence and abuse.

Review of the Literature

Intimate Partner Violence

*History and definition of intimate partner violence.* Although incidents of intimate partner violence occurred in biblical times, the formal study of the phenomenon did not occur until the late 1960s and early 1970s as the feminist movement began to speak out about the oppression of women (Twenge, 1997). Prior to this, research exploring intimate partner violence was virtually nonexistent, as "battering" was considered private; thus, its seriousness was largely unknown. As a result, episodes of intimate partner violence were not openly discussed. If such occurrences were brought to society's attention, they were considered an aberration involving severely pathological and dysfunctional families.

While academicians were expressing concern over issues such as rape and domestic violence during the 1970s, research in this area primarily focused on
biological and psychological characteristics of the individual perpetrator or victim and did not examine the social dimensions of intimate partner violence (Marin & Russo, 1999). Feminist scholars, however, emphasized the influence of gender, power, and the larger social structure on the perpetration of abuse and viewed rape and other forms of male violence as a means of enforcing male power and control (Brownmiller, 1984; Medea & Thompson, 1974; Russell, 1975).

Initially, intimate partner violence was examined within the context of heterosexual marital relationships; however, more recent explorations show intimate partner violence exists within the context of “nontraditional” relationships as well. Thus, terms historically used to describe abuse toward an intimate partner (e.g., male violence toward women, battering, spousal abuse, marital violence, domestic violence, family violence dating violence) are today, in many cases, overly restrictive and not appropriate for capturing abuse within other types of intimate relationships (Harway & O’Neil, 1999). As a result, “intimate partner violence”, defined as physical or psychological maltreatment perpetrated by one person in an intimate relationship against another to gain or maintain power, control, or authority (American Psychological Association, 1996; Moore & Stuart, 2005; Walker, 1999) is replacing previous terminology and will be used interchangeably with “relationship violence” and “male violence against women” throughout this dissertation. While acknowledging that abusive acts are committed within the context of “nontraditional” intimate relationships and that both men and women initiate acts of partner violence, this study will focus on the occurrence and prevention of male violence against women.
Since the late 1970s, research has documented the incidence and dangerous implications of relationship violence and shown that male violence against women occurs in all age, class, race, and socioeconomic levels (Okun, 1986). Such findings have led to an increase in public awareness surrounding the reality of relationship violence and stimulated social discourse as to why some men are violent towards women.

Despite this interest, theoretical explanations have been slow to emerge, perhaps because many theoretical analyses are limited by their approach to understanding human behavior and are unable to fully explain the nature of violence against women. Feminist explanations for violence against women have gained the most attention and have influenced the development of most batterers’ interventions. Central to them is the idea that the oppression of women is a goal of violence against women. From this perspective, oppression includes violence against women and is the result of society’s adherence to traditional social structures grounded in patriarchal values and beliefs of male dominance and entitlement.

These values and beliefs may emerge from social constructions of gender and power and are proposed to be at the core of violence toward women (Marin & Russo, 1999). As a result, feminist interventions tend to emphasize the social context within which abuse occurs and on educating men about gender inequality and the tactics of power and control in relationships. Stopping the violence, abuse, and controlling behaviors is the goal of intervention, rather than providing assistance for individual psychological problems that may contribute to abusive or violent behavior.
More recently, research exploring the psychology of men suggests an alternative explanation for violence against women. Gender role conflict theory suggests male violence against women occurs as a result of conflict experienced by men surrounding the rigid limits of the traditional male role and may become apparent on either an inter- or intrapersonal level. Interpersonally, men may violate others as a result of their rigid enactment of stereotypical masculine roles and behaviors (O'Neil, 1990). Intrapersonally, they may experience a range of negative affective states ensuing from perceived failure to live up to their masculine gender ideals (Hayes & Mahalik, 2000; O'Neil et al., 1995; Pleck, 1981, 1995). Either outcome may impact a man’s propensity for abuse (O’Neil & Nadeau, 1999).

According to Harway and O’Neil (1999), interventions designed to increase awareness of the masculine socialization process may help reduce the occurrence of violence against women (Harway & O’Neil, 1999). Psychoeducation regarding the ways in which the male socialization process fosters attitudes supportive of violence against women may help men to see violent behaviors and attitudes as learned and amenable to change.

*Research on intimate partner violence.* Historically, the study of intimate partner violence has focused on heterosexual relationships. This may be due to popular emphasis on women as the victims of violence because statistics consistently relate that women are most likely to suffer physical and psychological injuries (Brush, 1990; Gelles, 1997; Rand & Strom, 1997; Rennison & Welchans, 2000).

Over the last 15 years, however, empirical evidence has indicated that both men and women perpetrate aggressive and violent behavior within romantic relationships...
A review of the literature reveals similar rates of violence across genders (Lewis & Fremouw, 2001; O'Keefe, Brockopp, & Chew, 1986; Riggs, O'Leary, & Breslin, 1990); however, female aggression is viewed primarily as a defensive strategy while male aggression is perceived as a maladaptive problem-solving strategy (Archer, 2000; Lewis & Fremouw, 2001).

"Intimate partner violence" encompasses numerous behaviors including physical and sexual aggression, verbal abuse, and threatening communication (Lewis & Fremouw, 2001). Physical abuse ranges from relatively minor behaviors, such as grabbing, biting, or slapping to more serious ones, such as using a weapon to threaten or hurt an intimate partner. Sexual abuse often encompasses aspects of both physical and psychological abuse and may include acts such as sexual assault, rape, or objectification. Only recently has research begun to explore aspects of psychological abuse in intimate relationships, although evidence suggests that among dating partners, an even greater proportion experience psychological abuse than physical abuse (Kasian & Painter, 1992; Stets, 1991).

Statistics regarding the occurrence of intimate partner violence vary across studies (Archer, 2000). Much of this variance can be attributed to differences in the way researchers define intimate partner violence and collect data (CDC, 2003). For example, some definitions include stalking and psychological abuse while others include only physical or sexual violence. Primary data sources consist of police departments, clinical settings, and university settings, which rely heavily on survey research. Despite the information gleaned from these sources, most incidents go
unreported. Recent estimates indicate that about 20% of rapes or sexual assaults, 50% of stalkings, and 25% of physical assaults directed toward women by their intimate partners go unreported (CDC, 2003). As a result, the true magnitude of the problem is likely underestimated.

According to the National Center for Injury Prevention and Control, nearly 5.3 million incidents of partner violence occur each year among U.S. women aged 18 and older (CDC, 2003). In a study by Makepeace (1987), one in five college students experienced at least one episode of physical abuse in a dating relationship. Additionally, 61% of the sample stated they knew someone who had experienced dating violence. More recently, a national study found that 29% of women had experienced physical, sexual, or psychological abuse during their lifetime (Coker et al., 2002). In addition, 42% of women who identified themselves as victims claimed to have sustained injuries during their most recent victimization. Although most of these injuries were considered minor (i.e., bruises, scratches), more severe physical and psychological consequences (i.e., broken bones, central nervous system disorders, symptoms of post-traumatic stress disorder) were observed among those who reported frequent abuse (Campbell et al., 2002; Heise & Garcia-Moreno, 2002; Plichta, 2004; Tjaden & Thoennes, 2000).

In many cases, the psychological consequences of intimate partner violence are more damaging than the physical consequences. Victims often experience depression (Campbell, Sullivan, & Davidson, 1995; Cascardi et al., 1992; Stets & Straus, 1990), anxiety (Follingstad, Wright, Lloyd, & Sebastian, 1991), symptoms of posttraumatic stress (Stets & Straus, 1990; Walker, 1993), low self-esteem (Lewis &
Fremouw, 2001), and suicidal ideations (Carmen, Rieker, & Mills, 1984). Moreover, women with a history of abuse are likely to display behaviors that present further health risks, such as alcohol and drug abuse (Kilpatrick, 1990), engagement in risky sexual behaviors (Crandall, Nathans, Kernic, Holt, & Rivara, 2004) and unhealthy diet-related behaviors (e.g., fasting, vomiting, abusing diet pills, overeating; Heise & Garcia-Moreno, 2002).

In addition to the effects experienced by victims, studies have identified indirect effects on child witnesses of interparental violence (Kolbo, Blakely, & Engleman, 1996; Wolak & Finkelhor, 1998), including physical, psychological, and behavioral consequences. Parkinson, Adams, and Emerling (2001) found that children of abused mothers were 57 times more likely to have suffered physical injury resulting from violent acts between their parents, compared with children of non-abused mothers.

Furthermore, children who observe violence in their family may be at risk for experiencing stress disorders and higher rates of aggression and delinquency (Johnson & Ferraro, 2000). These findings are consistent with research that has found childhood exposure to an aggressive family environment to predict delinquency-related violence (Brendgen et al., 2002; Farrington, 1989; Huesmann, Eron, Lefkowitz, & Walder, 1984; O'Keefe, 1997) and violent behavior against an intimate partner during adolescence (Capaldi & Clark, 1998; O'Keefe, 1998; Schwartz, O'Leary, & Kendziora, 1997). Long term effects also are documented, with college-age women who remember violence between their parents reporting lower self-esteem, lower social
competence, and more depression (Henning, Leitenberg, Coffey, Bennett, &
Jankowski, 1997; Silvern, Karyl, Waelde, Hodges, & Starek, 1995).

Because of the tremendous impact of intimate partner violence, a large portion
of the literature focuses on individual, relational, and societal factors that combine to
cause abuse. Individual factors include low academic achievement, unemployment/
low income (Black, Schumacher, Smith, & Heyman, 1999); acceptance of dating
violence (Bookwala, Frieze, Smith, & Ryan, 1992; Burke, Stets, & Pirog-Good, 1989;
Cate, Henton, Koval, Christopher, & Lloyd, 1982; Henton, Cate, Koval, Lloyd, &
Christopher, 1983; Makepeace, 1986); past experiences with dating violence
(Bookwala et al., 1992; Deal & Wampler, 1986; Gwartney-Gibbs, Stockard, &
Brohmer, 1987); traditional sex role attitudes (Burke et al., 1989); substance abuse
(Stets & Henderson, 1991; Tontodonato & Crew, 1992); low self-esteem (Magdol et
al., 1997; O’Keefe, 1998); and depression, anger, and hostility (Black et al., 1999;
Tjaden & Thoennes, 2000). Additionally, interpersonal variables, such as poor
problem solving and communication skills, may contribute as well (Folette &
Alexander, 1992; Lewis & Fremouw, 2001). Interventions that target individuals at
risk for perpetrating abuse may be more effective in preventing future abuse than
interventions that target the general population.

Relational factors that place men at high risk for committing violence or abuse
involve an interaction between individual and social variables. For example, sources
of stress or conflict within an individual or within the context of an intimate
relationship, such as economic concerns, general relationship instability, or a need to
dominate and control the relationship are associated with an increased risk for
perpetration of partner abuse (Tjaden & Thoennes, 2000). Such findings are informative in that they advance understanding of both inter- and intrapersonal variables associated with an increased risk for initiating intimate partner violence and, as a result, may lead to effective prevention, intervention, and treatment.

Clinical variables, such as substance use and perceptions of violence also are associated with the perpetration of violence or abuse. A significant positive correlation between male substance abuse and aggression suggests that the latter disinhibits aggression (Lewis & Fremouw, 2001).

Additionally, perceptions of violence as justifiable in the resolution of conflict increase the risk of relationship violence. In a sample of college students, use of violence in an intimate relationship was rated as unacceptable by the majority of violent and nonviolent participants; however, many participants identified situations in which aggressive behavior would be acceptable (Lewis & Fremouw, 2001). Similarly, Riggs et al. (1990) found that males were more accepting of their own violence in a relationship than females and that both sexes were more accepting of females' use of violence than males. Moreover, positive consequences were expected by males who initiated violence against their partners, whereas nonviolent males were significantly more likely to expect violence to negatively impact the relationship. Studies also indicate that male perpetrators possess low self-esteem and antisocial traits (Lewis & Fremouw, 2001; Magdol et al., 1997). The relation between low self-esteem and perpetration of abuse is unclear. However, research is inconclusive as to whether low self-esteem precedes the occurrence of dating violence, results from its occurrence, or if both result from other factors.
Traditionally, conceptualizations of male aggression and violent behavior have emphasized biology (Jakupcak, Lisak, & Roemer, 2002; Lorenz, 1963), with violent behavior in males linked to factors such as testosterone levels (Banks & Dabbs, 1996; Gray, Jackson, & McKinlay, 1991). With the advent of the feminist movement, however, conceptualizations of male violence against women shifted. Feminist theorists posited that violence against women was not based on biology or genetics but on a man’s “socialized androcentric need for power” (Walker, 1989, p. 695). In this regard, male violence against women was viewed as a form of social control used to enforce and maintain a woman’s status as subordinate (Marin & Russo, 1999). Feminist theorists also considered violence against women to be an outgrowth of male power, privilege, and reflective of the larger patriarchal structure of society. Thus, power was perceived as a way to enforce male entitlement and privilege. Violence often was viewed as a tool to exert power and control.

The influence of feminist scholarship is reflected in current theoretical explanations for male violence against women. Research exploring the psychology of men suggests that violence against women largely reflects social constructions of masculinity. In attempting to explain its causes, O’Neil (1981) and others (Harway & O’Neil, 1999; O’Neil & Nadeau, 1999) point to the masculine socialization process and the conflicts that men may resultantly experience. Gender role socialization refers to the process in which males and females internalize socially constructed values, attitudes, and behaviors associated with masculinity or femininity (O’Neil, 1981).

Some researchers theorize that the process of masculine socialization, which encourages men to be dominant physically and stoic emotionally, results in their
feeling intense pressures to abide by traditional gender role norms (O'Neil & Nadeau, 1999). These pressures may cause men to rigidly enact restrictive masculine gender roles, which ultimately may lead to the experience of conflict surrounding the traditional male role. Additionally, the male socialization process is thought to produce misogynistic attitudes and emotions toward women, which further feed a propensity towards violence against women (Harway & O'Neil, 1999). In light of these findings, primary prevention efforts that increase awareness of the aspects of the male socialization process that lead to gender role conflict, and perhaps to violence towards women, are needed.

**Gender Role Conflict**

*History of gender role conflict.* The empirical study of gender role conflict began in the 1970s as the feminist movement began to explore ways in which women were oppressed (O'Neil, 1981). Gender roles are defined as the “behaviors, expectations, and role sets defined by society as masculine or feminine which are embodied in the behavior of the individual man or woman and culturally regarded as appropriate to males or females” (O'Neil, 1981 p. 203). Gender role socialization is the “process whereby children and adults acquire and internalize the values, attitudes, and behaviors associated with femininity, masculinity, or both” (O'Neil, 1981 p. 203).

As feminist scholars were considering the restrictive consequences of the female socialization process, those interested in the psychology of men and masculinity began to consider the possible consequences of socialization on males. By exploring ways in which women had been restricted and oppressed, it became apparent that men were also restrained and confined by traditional masculine gender roles. This led to a
heightened sense of interest in the process of gender role socialization and the effects
the socialization process may have on both intra- and interpersonal functioning.

The formal study of gender role conflict emerged from this increased focus on
the socialization process. O'Neil (1981) believed that if oppressive acts of sexism
were ever to be reduced, exploration of the negative effects of socialization had to
extend to men and women. Highly influenced by Pleck's (1995) Gender Role Strain
paradigm, which maintains that the socially constructed roles that men are expected to
enact, negatively impact their personal sense of identity, interpersonal relationships,
and work environments (Jakupcak et al., 2002), O'Neil began to explore the conflicts
and strains that emerge from the masculine socialization process. This research led to
the development of the Gender Role Conflict Scale (GRCS; O'Neil, Helms, Gable,
David, & Wrightsman, 1986) and the advancement of the psychology of men.

While the determination of what constitutes appropriate male and female
behavior remains up for debate, issues surrounding gender roles are relevant to the field
of counseling psychology (O'Neil, 1981). As male and female roles continue to
change, areas of research and practice must continue to explore and address the effects
these changes have on individuals and society. By increasing awareness of the ways in
which the socialization process shapes the attitudes and behaviors of men and women,
we help men and women to realize that attitudes and behaviors are learned and thus
amenable to change.

Definition of gender role conflict. Masculine gender role conflict is defined as
"a psychological state in which socialized gender roles have negative consequences on
the individual or others" (O'Neil & Nadeau, 1999). O'Neil (1990) ascertained that
gender role conflict in men occurs when “rigid, sexist, or restrictive gender roles, learned during socialization, result in personal restriction, devaluation, or violation of others and self” (p. 25). Thus, gender role conflict may manifest interpersonally when men violate others as a result of their rigid enactment of stereotypical masculine roles and behaviors or intrapersonally in which men may experience a range of negative affective states as a result of their perceived failure to live up to their masculine ideals (Hayes & Mahalik, 2000; O’Neil et al., 1995; Pleck, 1981, 1995). Either outcome, according to O’Neil (1981), has the potential to prevent men from achieving self-actualization.

By early conceptualizations, men’s gender role conflict related to their gender role socialization, the Masculine Mystique and Value System, men’s fears of femininity, and both personal and institutional sexism (O’Neil, 1981). The Masculine Mystique and Value System is a “complex set of sexist values and beliefs that define optimal masculinity in society and in men’s lives” (O’Neil & Nadeau, 1999, p. 95) and is based on various attitudes and assumptions surrounding what it “means” to be a man. It is hypothesized to directly influence men’s fears of femininity as traditional masculine ideology associates the expression of emotions, vulnerabilities, and intimacy with femininity and weakness. As a result, men are encouraged to restrict sentimentality in order to avoid appearing weak or vulnerable. Additionally, the masculine mystique maintains that men and masculinity are superior to women and femininity, that power, control, competition, and dominance are necessary to prove one’s masculinity and that one’s masculinity is measured by career successes and heterosexual potency (O’Neil & Nadeau, 1999).
Another negative consequence of socialized gender role conflict is gender role strain, which is “excessive mental or physical tension caused by gender role conflict and the effects of masculine, feminine, or androgynous roles” (O’Neil, 1981, p. 203). It may lead to intrapsychic problems such as low self-esteem (Garnets & Pleck, 1979). Pleck (1981, 1995) hypothesized that dysfunctional behaviors result from the strain men experience as a result of their adherence to restrictive male gender roles. Lash, Eisler, and Schulman (1990) found men demonstrated increased levels of stress and anxiety when performing activities that violated traditional masculine norms. Additionally, higher levels of anxiety, anger, and health risk behavior are also associated with masculine gender role strain (Eisler, Skidmore, & Ward, 1988).

Prior to the development of the Gender Role Conflict Scale, O’Neil (1981) identified six dimensions of conflict and strain thought to emerge from masculine socialization, the Masculine Mystique, and the fear of femininity. These dimensions include socialized control, power, and competition issues; restrictive emotionality; restrictive sexual and affectionate behavior; obsession with achievement and success, health care problems, and homophobia. Upon analysis and validation of the gender role conflict scale, these six dimensions were reduced to four: 1) Success, Power, and Competition; 2) Restrictive Emotionality; 3) Restrictive Affectionate Behavior Between Men; and 4) Conflict Between Work and Family Relations.

Success, Power, and Competition is a measure of a man’s rigid enactment of his need to be successful, powerful, and in control. Success refers to the degree to which an individual struggles against others for personal gain. Power involves the degree to which an individual exerts authority and control over others, and Control relates to an
individual's attempts to establish superiority over others. Men experiencing conflict in this area tend to be driven toward career advancement and likely feel they have to be in charge, or stronger than other men. Thus, among men, the need to be perceived as successful, powerful, and in control is often predominant, as men may base their personal value, as well as their masculinity, on the degree to which they achieve success, power, and control. As a result, the experience of gender role conflict related to Success, Power, and Competition is reflected in a man's attempts to be powerful and to defeat others. It is theorized to protect the man from feelings of weakness or inferiority.

Restrictive Emotionality describes the fear and difficulty a man has with the expression of personal feelings and is a measure of inflexibility manifested in avoidance of softer emotions. Men who experience this type of gender role conflict have difficulty finding words to express their emotions and are uncomfortable with both their own emotional self-disclosure and the emotional expression of others. For men, the restriction of emotional expression is suggested to reflect fear of femininity (O'Neil, 1981). Because men are socialized to avoid all things feminine, they may have difficulty recognizing and expressing traditionally feminine emotions such as fear and love. As a result, a man who constrains emotional expression may attempt to protect himself by blocking the awareness and expression of vulnerable emotions and deny others the right of emotional expression. Experience of gender role conflict related to Restrictive Emotionally inhibit men's help-seeking behaviors, interpersonal communications, and may potentially lead to anger, aggression, and/or abuse patterns in relationships (Harway & O'Neil, 1999).
Restrictive Affectionate Behavior Between Men is a measure of a man’s discomfort with, and unyielding avoidance of, thoughtful and emotional expression between men. This factor is presumed to reflect men’s fears surrounding femininity, which manifest as fears of homosexuality (David & Brannon, 1976; O’Neil, 1981). A man who experiences gender role conflict in this area has problems developing and maintaining close personal relationships with other men and restricts emotional expression or behavior in his interactions with men due to his fear of being perceived as effeminate or homosexual.

The final type of gender role conflict is Conflict Between Work and Family Relations, which reflects a man’s level of distress associated with the difficulty of balancing work-school and family relations (O’Neil et al., 1986). Men who experience gender role conflict relating to this factor may experience high levels of stress and health problems, be over worked, and lack leisure time (O’Neil et al., 1995). As this factor is suggested to reflect situational stress, as opposed to an overall pattern of gender role rigidity, it is frequently not examined (Mahalik, Cournoyer, DeFranc, Cherry, & Napolitano, 1998).

Research has documented the impact that each of the preceding four gender role conflict factors has on the intra- and interpersonal functioning of men. However, it cannot be assumed that all men who experience gender role conflict will experience it in exactly the same way. Because gender role conflict factors occur in different combinations and interact with individual and environmental factors, it is likely that its behavioral manifestation will differ among men. Overall, however, men are suggested to experience gender role conflict in situational contexts’ when they: 1) deviate from,
violate or fail to meet masculine gender role norms (Pleck, 1981); 2) experience discrepancy strain (i.e., discrepancies between their real self-concepts and their ideal self concepts) based on gender role stereotypes (Garnets and Pleck, 1979); 3) personally devalue, restrict, or violate themselves or others because of gender role stereotypes (O’Neil, 1990); and 4) experience personal devaluations, restrictions, or violations from others (O’Neil, 1990). Each of these situational contexts is associated with the initiation of violence in relationships.

Some dimensions of masculine gender role conflict may influence the use of violence in relationships more than others. Abusive or violent behavior may occur in specific situations that threaten a man’s conceptualization of how he should enact the masculine gender role (Eisler, Franchina, Moore, Honeycutt, & Rhatigan, 2000). Therefore, men may enact certain rigid gender role conflict patterns when they feel their masculinity is being challenged (Harway & O’Neil, 1999; Pence & Paymer, 1993; Walker, 1984). Harway and O’Neil (1999) suggest that issues surrounding success, power, control, and restrictive emotionality contribute to male violence against women. Men may perceive the use of violent or abusive behaviors as justifiable in that use of force is seen as a way to terminate the aversive situation and restore a man’s sense of power and control (Babcock, Waltz, Jacobson, & Gottman, 1993; Eisler et al., 2000). Theoretical support was provided by Schwartz, Waldo, and Daniels (2005) who found the experience of gender role conflict surrounding Success, Power, and Competition related to physically abusive behavior in a sample of men court mandated to partner abuse treatment.
The gender role conflict factor, Restrictive Emotionality, is also associated with the perpetration of male violence against women. Surprisingly, studies show men who possess both high and low levels of gender role conflict regarding Restrictive Emotionality initiate acts of violence against female intimates. Research suggests that men who indicate they express emotions (low RE) tend to use intimidation and threats in their intimate interactions (Schwartz et al., 2005), while men who restrict emotional expression (high RE) tend to have difficulty developing and maintaining intimacy within a relationship and to experience conflict within relationships, including domestic violence (Rando et al., 1994).

In addition to the direct effects gender role conflict may have on the initiation of relationship violence, research suggests the existence of indirect effects, as well. For example, gender role conflict surrounding Conflict Between Work and Family Relations, although not directly associated with relationship violence, appears to impact relationships and relationship beliefs (Good et al., 1995; Hammen & Brennan, 2002) and is associated with psychological factors (e.g., low self esteem, anxiety, depression) linked to abusiveness (Lewis & Fremouw, 2001; Sharpe & Heppner, 1991).

*Research on gender role conflict.* Research on gender role conflict primarily has explored the construct in relation to the psychological well-being and interpersonal functioning of men. More recently, it has begun to examine therapeutic and multicultural issues associated with gender role conflict. The following is a brief summary of current research in each of these areas.
Studies exploring the impact of gender role conflict on men’s psychological health consistently demonstrate the adverse effects of such conflict on psychological well-being (Blazina & Watkins, 1996; Mahalik et al., 1998). Masculine gender role conflict predicts psychological distress (Blazina & Watkins, 1996) and is associated with traditional measures of psychological well-being, such as anxiety (Sharpe & Heppner, 1991), guilt (Thomson, 1995), and depression (Good & Mintz, 1990; Shepard, 1994). Blazina and Watkins found high levels of conflict surrounding Success, Power, Competition, and Restrictive Emotionality to be strongly predictive of psychological distress.

The experience of masculine gender role conflict may undermine psychological well-being by fostering the development and utilization of maladaptive defense strategies. Mahalik et al. (1998) hypothesized that men use psychological defenses to manage the painful affect they experience as a result of their staunch conformance to male gender role restrictions. Mahalik et al. suggest that men who experience high levels of gender role conflict tend to utilize immature and neurotic defenses in order to reduce distress resulting from threats of interpersonal intimacy or its loss (Vaillant, 1992) and to alter private feelings or the expression of such feelings (Vaillant, 1992). They are likely to value success, power, and competition and to devalue emotional expression (Mahalik et al., 1998). Increased gender role conflict surrounding Success, Power, and Competition is associated with greater psychopathology, while the use of immature defenses is associated with mood and personality disorders (Coumoyer & Mahalik, 1995; Good et al., 1995; Vaillant, 1977). In addition, positive associations between gender role conflict and psychological disturbances, such as psychotic
thinking and behavior, paranoia, and obsessive – compulsive disorder, are also documented (Good et al., 1995).

A review of the literature on the psychological well-being of men demonstrates the negative impact of gender role conflict on overall psychological health; however, men’s psychological health may also be affected further by their reluctance to seek professional assistance. Good et al. (1989) and others documented negative associations between gender role conflict and help-seeking behaviors of men. At first glance, such findings seem obvious as males typically are socialized in attitudes that are in stark opposition to the tenets of traditional psychotherapy (Chamow, 1978; Nadler Maler, & Friedman, 1984). Fischer and Turner (1970) found that interpersonal openness was a significant aspect of positive help-seeking attitudes. Such openness is unlikely to occur among males who have restricted the expression of vulnerable emotions. In fact, research suggests that men who experience conflict surrounding Restrictive Emotionality are less likely to share personal concerns with others or to request their assistance (Good et al., 1989).

The gender role conflict factors Success, Power, and Competition and Restrictive Affectionate Behavior Between Men also are negatively associated with help-seeking attitudes and behaviors (David & Brannon, 1976; O’Neil, 1981). Robertson and Fitzgerald (1992) found that college men who experience gender role conflict related to Success, Power, and Competition and Restrictive Emotionality tend to possess more negative attitudes toward seeking psychological help. Similarly, men who restrict emotional expression reported that they were less likely to seek
professional assistance in the future and had requested less help in the past from others than men who did not restrict emotional expression (Addis & Mahalik, 2003).

Values related to Success, Power, and Competition may also affect help-seeking by men. Because men are socialized to seek power and control, they may view help seeking as an admission of failure or weakness. Thus the acknowledgement of vulnerable emotions and the pursuit of assistance in dealing with these emotions is unmanly (Warren, 1983). Some men experience negative consequences for seeking assistance such as rejection by their male peers (Hammen & Peters, 1977; Warren, 1983). As a result, men may be highly motivated to hide or restrict vulnerable emotions and thus unable to recognize or seek help for such problems (Warren, 1983).

In addition, the nature of the therapeutic relationship may prevent the man who experiences conflict surrounding Success, Power, and Competition from seeking psychological assistance. Such men are likely to feel uncomfortable relinquishing power and control to a therapist, particularly if the therapist is male. In a sample of men, Good et al. (1989) found traditional attitudes about the male role in society, concern about expressing affection toward other men, and concern about expressing emotions related to negative attitudes toward seeking help, and to fewer reports of past help-seeking behavior.

Although the negative impact of high levels of gender role conflict on the help-seeking behavior of men is well documented, researchers suggest that men who experience lower levels of conflict may be more prone to seek assistance. Wisch, Mahalik, Hayes, and Nutt (1993) found that males who experience low levels of gender role conflict are most likely to seek help. Similarly, males' views of psychological
help seeking were found to become more positive as their values regarding the male role became less traditional (Addis & Mahalik, 2003).

Numerous studies have explored the ways in which gender role conflict negatively impacts interpersonal relationships. Thomson (1995) found an association between gender role conflict and possessing a diminished capacity to establish, develop, and maintain relationships based on mutual love, respect, and concern for others. Additionally, men who experience high levels of gender role conflict are likely to have difficulty experiencing intimacy within their interpersonal relationships (Mahalik, Locke, Theodore, Cournoyer, & Lloyd, 2001; Sharpe & Heppner, 1991). Sileo (1995) found negative correlations between intimacy and Success, Power, and Competition; Restrictive Emotionality; and Restrictive Affectionate Behavior Between Men, with the highest negative correlation being between Restrictive Emotionality and intimacy. These findings are consistent with Fischer and Good’s (1995) study that found Restrictive Emotionality to significantly predict fear of intimacy. In addition, Campbell and Snow (1992) found men who had high levels of gender role conflict also encountered relationship complications.

Overall, the experience of gender role conflict predicts extreme or negative, interpersonal behaviors in all relationships (Mahalik, 1996). In a study examining the association between gender role conflict and interpersonal functioning, Mahalik found a significant correlation between college men’s gender role conflict and extreme interpersonal behavior. Specifically, Success, Power, and Competition was related to dominance and hostility, while Restrictive Emotionality was related to hostile-submissive behavior, mistrust, being cold, detached, and inhibited. Similarly, in a
study examining the relationship between husbands' gender role conflict and wives' marital adjustment, Breiding (2004) found husbands' who experienced gender role conflict were more likely to engage in hostile behaviors during marital interactions.

Gender role conflict also appears has a negative effect on marital satisfaction (Campbell & Snow, 1992; Mintz & Mahalik, 1996). Mintz and Mahalik (1996) propose that men who experience high levels of gender role conflict surrounding Success, Power, and Competition are likely to adhere to traditional male-dominant family roles as opposed to sharing roles and responsibilities equally with their wives. Thus, traditional male attitudes surrounding the female role may lead to lower levels of marital relationship satisfaction for wives.

A similar line of scientific inquiry has explored the association between gender role conflict and attitudes toward women. Woudenberg (1977) found that attitudes toward women impacted male views about sexual behavior and relationship beliefs. Male attitudes toward women's rights and responsibilities may become more conservative as levels of gender role conflict increase (Wood et al., 2000). Such conservative attitudes may cause problems in relationships and lead to lower levels of satisfaction (Glick et al., 1997). Wood (2004) also found low gender role conflict in the areas of Restrictive Emotionality; Restrictive Affectionate Behavior Between Men; and Success, Power, and Competition related to more liberal male attitudes toward women's vocational, educational, intellectual, social, and marital rights.

Men who experience high levels of gender role conflict may also possess maladaptive relationship beliefs (Wood, 2004). Gender role conflict in the areas of Success, Power, and Competition; Restrictive Emotionality; Restrictive Affectionate
Behavior Between Men; and Conflict Between Work and Family Relations appears to be related to irrational relationship beliefs. Wood identified associations between each of the gender role conflict patterns and the beliefs that disagreements are destructive, males and females are different, and partners cannot change. She suggests that men who believe that disagreement in a relationship is destructive and who believe they must perform perfectly in sexual relations are likely to also have a need for success, power, and control and to restrict emotional expression. Men with these beliefs might seek to control relationship partners by avoiding disagreement. Moreover, a man’s need for sexual perfection may actually lead to his withholding affection from intimate partners (Wood, 2004). Therefore, maladaptive relationship beliefs resulting from masculine gender role conflict may further contribute to problems in a man’s intimate and interpersonal relations.

Research has also revealed a relation between gender role conflict and interpersonal violations of others, specifically, violence against women. O’Neil and Harway (1997) suggest that violence against women is linked to the socialized components of the male gender norms that promote success, power, competition, control, and the restriction of emotions. Hence, violence towards women is often initiated by men who view their partners as a threat to their sense of power and control. Aggressive behavior toward women can result in an effort to resolve and express a man’s emotions related to such a threat (O’Neil & Harway, 1997). Rando et al. (1994) identified that the three dimensions of gender role conflict (Success, Power, and Competition; Restrictive Emotionality; and Restrictive Affectionate Behavior Between
Men) were significantly related to rape myth acceptance, hostility toward women, traditional stereotypic views of women, and feelings of inadequacy.

Although an extensive body of literature documenting the negative impact of gender role conflict on interpersonal relations has accumulated, there is little experimental evidence demonstrating the influence of gender role conflict on male relationships with other males. O’Neil (1981) theorized that male relationships with other men are severely restricted as a result of their fears surrounding their own sexual or interpersonal attraction to other men. Such anxiety associated with the development of close relationships with other men is suggested to stem from a male’s fear of femininity. As a result, males may suppress all interpersonal and intimate feelings or impulses toward other men (Morin & Garfinkle, 1978). While numerous studies suggest that homophobia may limit intimacy among men (Lehne, 1976; Lewis, 1978; Morin & Garfinkle, 1978) very few explore the affect of gender role conflict on male-male relationships (Horhoruw, 1991). Research has shown, however, that males who experience gender role conflict related to Success, Power, and Competition; Restrictive Emotionality; and/or Restrictive Affectionate Behavior Between Men have difficulty establishing closeness with their male friends (Sileo, 1996).

The literature has revealed many potentially negative outcomes associated with the experience of masculine gender role conflict, especially violence against women. As a result, psychologists are strongly encouraged to develop an understanding of gender role conflict, as well as an awareness of the impact gender role conflict has on the emotional and interpersonal lives of men (O’Neil, 1981; Wisch et al, 1993). Mahalik (1996) suggested that therapy focused on maladaptive interpersonal patterns
might be particularly useful with men experiencing gender role conflict. In addition, those working with men should understand the socialization process and assist male clients in recognizing the effects of such rigid adherence to male and female stereotypes. Preventive efforts should be directed toward populations of men at high risk for experiencing gender role conflict as males who experience problems resulting from gender role conflict are often reluctant to seek assistance.

Although racially and culturally diverse men are likely to conceptualize and experience gender role conflict differently, a paucity of research exploring it in multicultural and special populations exists (Stillson, O’Neil, & Owen, 1991). Most studies examining masculine gender role conflict are conducted with middle class, college educated, European-American males (Stillson et al., 1991). Such an approach has been criticized as being unsophisticated and one-dimensional (Tolson, 1977).

Comparisons of gender role attitudes between European-American males and African-American males show that European-American males tend to possess more traditional gender role attitudes than their African-American counterparts (Finn, 1986). Both races, however, expressed similar attitudes surrounding the use of physical force (Finn, 1986). Stillson et al. (1991) found Success, Power, and Competition; Restrictive Emotionality; and Conflict Between Work and Family Relations significantly related to low vocational strain and high physical strain in European-American, African-American, and Hispanic men. Asian men however demonstrated different patterns of gender role conflict.

Asian men who experience high levels of gender role conflict appear to have difficulty with acculturation in America (Kim, O’ Neil, & Owen, 1996). Likewise,
Mexican-American males with high levels of gender role conflict have lower rates of acculturation (Fragoso, 1996). Fragoso found gender role conflict, machismo, and acculturation to predict stress in Mexican-American men. The presence of gender role conflict also is documented among Russian-American men (O’Neil, Owen, Holmes, Dolgoplov, & Slastenin, 1994).

Therapists working with ethnically diverse males need to understand gender role conflict within the context of multiculturalism. Because the socialization process may vary across cultures and cultures may differ in their definitions of appropriate gender role behaviors and attitudes, counselors must be aware of and be sensitive to the influence and impact of cultural issues related to gender (Wade, 1996).

**Entitlement**

*History and definition of entitlement.* The clinical construct of entitlement emerged from the psychoanalytic literature in the early 1900s as a result of Freud’s observations of individuals he labeled “the exceptions” (Nadkarni, 1994). These people perceived themselves as having special rights and privileges due to personal injuries or injustices experienced during infancy/childhood. Levin (1970) and later Kriegman (1983) deviated from Freud’s view of entitlement as pathology and identified a range of entitlement attitudes discernible in all individuals: 1) excessive or exaggerated; 2) restricted; and 3) normal.

Excessive or exaggerated attitudes of entitlement were those witnessed in Freud’s description of individuals labeled as exceptions. Those who possess such attitudes expect and demand more than they deserve and believe they can have and do whatever they want, whenever they want, regardless of the feelings or desires of others.
(Kriegman, 1983). Tenzer (1987) considered this sense of grandiosity to serve as a defense against underlying feelings of inadequacy and shame. An exaggerated sense of entitlement is characteristic of both narcissistic and antisocial personalities (Nadkarni, 1994) and is associated with self-esteem disturbance.

Grey (1987) suggested that an exaggerated sense of entitlement indirectly reflects a negative view of the self and emerges as a defense mechanism designed to protect the “true” self. Individuals possessing these attitudes manipulate others to avoid the responsibilities and obligations of a given role yet subsequently demand the benefits affiliated with that role. They are thought to possess a fundamental fear of insignificance, which is defended against by a sense of specialness (Nadkarni, 1994). This fear of insignificance often results in feelings of rage and a desire to humiliate others in order to control them through entitlement demands.

Restricted entitlement, reflective of a negative self-view, is defined as entitlement that is being withheld and not expressed (Moses & Moses-Hrushovski, 1990). Nadkarni (1994) observes these individuals to be inhibited, cautious, reserved and unsure of what they are entitled to have or pursue. They often have a poor sense of identity and perceive themselves as worthless, inadequate, and defective. Because they are prone to idealize others and denigrate themselves, they experience difficulty expressing their opinions and generally feel unentitled to their feelings. Although a restricted sense of entitlement is a significant indicator of self-esteem disturbance, it is likely to be overlooked in therapy because it involves non-action.

Normal entitlement attitudes have received the least attention in the research literature and are defined as an individual’s expectation of having time and space to
pursue and obtain appropriate satisfactions in life (Kriegman, 1983). Nadkarni (1994) described it as rights which one feels justified in granting to one's self. Thus, the extent to which one is able to realize personal expectations is seen as fundamental to the development of a healthy sense of entitlement.

More recently, Nadkarni et al. (in press) combined social and clinical perspectives of entitlement to arrive at a new bi-dimensional conceptualization that consists of a set of attitudes about what people believe they have a right to and can expect from others, both as individuals and as members of social groups. The Entitlement Attitudes Scale (EAS: Nadkarni et al., in press), reflective of this bi-dimensional conceptualization, is designed to measure healthy and unhealthy entitlement. Healthy entitlement is the opposite of restricted entitlement, and unhealthy entitlement is viewed as either exaggerated or restricted. Individuals with a healthy sense of entitlement are self-reliant, self-assured, possessing self-confidence, and an ability to stand up for themselves. Conversely, those with an exaggerated sense of entitlement are self-centered and demanding, which reflects a tendency toward narcissism.

Research on entitlement. The majority of psychological literature on entitlement is theoretical in nature with very few studies subjecting the construct to empirical scrutiny. As a result, much of this review examines entitlement from psychoanalytic, social psychological, and feminist perspectives.

A sense of entitlement is implied in virtually all psychoanalytic theories of development. Although a wide range of entitlement attitudes is now believed to exist, early psychoanalysts focused on exaggerated entitlement and viewed the construct as
pathological in nature. In the earliest clinical discussions, entitlement was considered a hindrance to the achievement of psychological maturity and thought to reflect a pathological disturbance of the id. Early psychoanalysts described individuals with an exaggerated sense of entitlement as having inflated ideas of their personal rights and demanding more than their due (Kriegman, 1983; Tenzer, 1987). Whenever self-defined rights were frustrated, these individuals became highly indignant and depreciative of others (Nadkarni, 1994).

Classical psychoanalytic interest centered on the etiology of an exaggerated sense of entitlement with theorists postulating that it was due to emotional deprivation in childhood (Bishop & Lane, 2000) that occurred as a result of maladaptive parent-child interactions in which the primary caretaker either overvalued a child for his or her own personal gratification or failed to respond to a child’s needs (Bishop & Lane, 2002). Parental overvaluation of a child prevents a child from growing beyond the narcissistic “special” position and results in the child’s experiencing feelings of fear and shame. As a result, the child develops a distorted sense of entitlement which is used as a defense against feelings of fear, shame, and hurt associated with being used as a narcissistic extension of one’s parents (Bishop & Lane, 2002). Conversely, failure to respond to a child’s needs may also result in the development of an exaggerated, defensive sense of entitlement. Support for this hypothesis was documented by Meyer (1991) who found individuals that reported being reared by parents who were inattentive to their emotional needs as children to also possess an exaggerated sense of entitlement.
Psychoanalytic research on entitlement also examined the influence of birth order on the development of an exaggerated sense of entitlement (Levin, 1970; Moses & Moses-Hrushovski, 1990). Moses and Moses-Hrushovski maintain that exaggerated entitlement attitudes are more likely to occur among first-born children as they are likely to perceive themselves as being the center of attention and thus highly entitled (Levin, 1970). Additionally, the birth of a sibling may induce the development of an exaggerated sense of entitlement and serve to protect the child from feelings of deprivation and loss (Moses & Moses-Hrushovski, 1990).

Although classical psychoanalytic conceptualizations of entitlement focused on the grandiose or pathological characteristics of entitlement, more recent scholarship has focused on a wider range of entitlement attitudes and examined the impact of such attitudes on individual self-esteem (Kriegman, 1983; Levin, 1970). In addition to exaggerated or excessive entitlement attitudes, Kriegman proposed the existence of both restricted and normal entitlement attitudes. Restricted entitlement is conceptualized as being the opposite of exaggerated entitlement and is withheld and not expressed (Blechner, 1987; Moses & Moses-Hrushovski, 1990). According to Meyer (1991), individuals who exhibit a restricted sense of entitlement tend to have a limited sense of identity and view themselves as worthless and inadequate. In clinical case examples, those who display a restricted sense of entitlement are described as possessing a poor sense of self-esteem, a deferential interpersonal style, and an inability to assert themselves (Kriegman, 1983; Levin, 1970; Tenzer, 1987).

Interestingly, both excessive and restricted entitlement attitudes can emerge due to a loss of self-esteem and lead to dysfunctional levels of assertiveness (Grey, 1987;
Kriegman, 1983; Nadkarni, 1994). The individual who possesses an excessive sense of entitlement tends to inappropriately assert his/her right for special considerations and treatment. Conversely, the person who maintains a restricted sense of entitlement fails to assert even the most basic needs.

Finally, normal entitlement attitudes are defined as “those rights which one feels justified in bestowing upon one’s self” and are perceived as necessary for the development of a healthy sense of self-esteem (Nadkarni, 1994). Hence, the ability to assert oneself is essential if one is to possess a healthy sense of entitlement. Theorists tend to agree on the etiology of normal entitlement and suggest that an attentive parent-child relationship is a precondition for its development (Kriegman, 1983; Levin, 1970; Meyer, 1991; Moses & Moses-Hrushovski, 1991). Despite the recent interest in positive psychology, very few studies have examined healthy entitlement.

Although the construct of entitlement was first described clinically by the psychoanalysts as pathology, other schools of thought have explored entitlement attitudes and proposed alternative conceptualizations of the construct’s etiology and its impact on both the individual and society. From a social psychological perspective, entitlement implies a sense of deserving, particularly as it relates to a sense of justice. Therefore a sense of entitlement is crucial for ensuring fair treatment and protecting one’s rights (Nadkarni, 1994). Empirical research in this area primarily has explored entitlement within the context of distributive justice.

Equity theory and relative deprivation theory are two of the most well-known social psychological theories of distributive justice (Adams, 1965; Crosby, 1982). Equity theory asserts that equity exists when an individual perceives his or her
outcomes as being equal to the outcomes of others (Wenzel, 2000). Thus, individuals compare what they receive in relation to what others receive. Perceptions of injustice arise when individuals do not think they have received what they deserve (Nadkarni, 1994). When individuals want, value, and feel entitled to a particular outcome and subsequently observe that someone other than themselves has obtained that outcome, a sense of injustice is experienced (Crosby, 1982). When this occurs or when individuals perceive that entitlements have been violated, individuals generally respond with anger, outrage, or resentment (Crosby, 1982; Lerner, 1987). Affective responses to perceived violations may further include behavioral attempts to rectify such violations (Major, 1994).

In the social psychological literature, behavioral levels of entitlement usually have been inferred, as opposed to measured empirically, from studies exploring the allocation of rewards. More recently, Nadkarni (1994) empirically assessed the relation between entitlement and allocation of rewards and found self-reported levels of entitlement to be positively associated with self-pay. Specifically, individuals who possessed high levels of entitlement paid themselves significantly more money for performance of a task than those who possessed a low sense of entitlement. In contrast to previous studies, Nadkarni did not find gender to impact the allocation of pay. As a result, Nadkarni hypothesized that more liberal constructions of the female role and the advancement of women in the workforce have perhaps led women to exhibit levels of entitlement more equivalent to those of men.

Feminist explorations of entitlement generally have focused on gender differences in the development of entitlement. Feminist theorists attribute differences
in levels of entitlement to social constructions of appropriate male and female roles which may impact the development of masculine and feminine personalities (Chodrow, 1989). For example, women historically have been socialized to foster the development of others and to anticipate and help satisfy their needs. Resultantly, women may not focus on their own personal growth and development and may neglect their own needs. In this regard, women are, in effect, socialized to defer to others and may not recognize their entitlements (Eichenbaum and Orbach, 1984). In extreme cases, women might not even believe that they are entitled at all.

In a study examining the socialization of entitlement in toddlers, mothers’ interventions in conflicts between same-aged, same-sex pairs of toddlers were observed (Ross, Tesla, Kenyon, & Lollis, 1990). Conflicts between toddlers centered on possession or ownership of a toy. Overall, when children were engaged in conflict surrounding possession of the toy, mothers tended to encourage their children to defer to their peers in order to reduce conflict. Such encouragements were made regardless of the child’s rights of ownership or possession of the toy. However, mothers of boys were found to be more supportive of their children than mothers of girls, encouraging their children to stand up for their rights and assert themselves as possessors or owners of the toy. Mothers of girls, however, supported the rights of possession and ownership only for other children and encouraged their children to relent to others. Thus, males may be socialized to assert and demand their perceived entitlements, while women may be socialized to defer their entitlements to others.

While most of the literature reviewed so far has focused on both the developmental and pathological nature of entitlement, current research has begun to
explore entitlement and its relation to the experience of gender role conflict in men. In males, gender role conflict is posited to occur as a result of the socialization of unrealistic and contradictory ideals surrounding the traditional masculine gender role (Magee & Schwartz, in press; O’Neil et al., 1995). Similarly, a sense of entitlement may emerge due to the socialization process, as many of the socialized ideals surrounding masculine gender roles reflect cultural values of patriarchy. These include privilege, power, and control (Magee & Schwartz, in press; Spence & Helmreich, 1978). Thus, socialization may, in effect, teach many men to be entitled and expect privilege. As a result, many conflicts experienced by men may be viewed as a means of enforcing male entitlements in order to defend and protect their masculinity and self-worth. In a study examining gender role conflict and sense of entitlement in men, Magee and Schwartz found positive associations between the gender role conflict patterns Success, Power, and Competition and Restrictive Affectionate Behavior Between Men and the entitlement factor Narcissistic Expectations/Self-Assurance. These associations suggest that men who emphasize achievement and control over others and who restrict or devalue emotional expression are also likely to possess an excessive sense of entitlement.

**Attitudes toward Women**

*History and definition of attitudes toward women.* “Attitudes toward women” emerged as a construct of interest during the feminist movement as women began to challenge social conceptions of the traditional female gender role (Twenge, 1997). In the psychological literature, attitudes are suggested to reflect the predominant values of a patriarchal society and are defined as males’ views toward the roles and
responsibilities of females (Spence & Helmreich, 1972). They pertain to females’ roles in the home, in the bedroom, and in the workplace (Smith, Resick, & Kilpatrick, 1980).

Prior to the feminist movement, women’s roles primarily were those of wife and mother. Thus, their behaviors and responsibilities were centered on their family. As women began to rethink and challenge traditional roles, many encountered social opposition from a society resistant to change given its predominantly male power structure. Such opposition complicated relationships between women and men and, in extreme situations, resulted in dire consequences for both women and men. Harway and O’Neil (1999) hypothesized that recent societal changes regarding expectations and realities in women’s lives have led to an increased incidence of male violence against women. Such violence, they maintain, is an expression of the male’s perceived loss of power and control and the resulting fear associated with such loss. This fear is theorized to result in masculine gender role conflict and to find expression via negative attitudes toward women (O’Neil, 1981).

Negative attitudes toward women are thought to emerge due to men’s fear of femininity. According to O’Neil (1981), fear of femininity leads men to shy away from feelings or behaviors that may cause them to appear feminine. Thus the experience of emotions or performance of behaviors associated with femininity may cause some men to question their masculinity. This questioning may result in feelings of guilt or shame, which fosters the development of negative attitudes toward behaviors associated with femininity, which then leads to overall negative attitudes toward women (O’Neil, 1981). Kilianski (2003), agreeing with O’Neil, concluded that negative attitudes toward women are the direct result of a man’s aversion to femininity
in the self. Support for these hypotheses was established by others who identified the existence of significant relationships between attitudes toward women and masculine gender role conflict (Blazina & Watkins, 2000; O’Neil and Nadeau, 1999; Wood, 2004) and found that more traditional attitudes toward women were related to increased conflict (Wood, 2004).

Since the 1970s, research has explored social attitudes and beliefs surrounding the female role in relation to the male role (Twenge, 1997). According to Spence and Helmreich (1972), attitudes toward women include the expectations imposed on females that are focused on Vocational, Educational, and Intellectual Roles; Freedom and Independence; Dating, Courtship and Etiquette; Drinking, Swearing, and Jokes; Sexual Behavior; and Marital Relations and Obligations. Specific aspects of attitudes towards women directly impact interpersonal relations between men and women and are associated with the perpetration of male violence against women (Cherlin & Walters, 1981; O’Neil & Nadeau, 1999).

It is important to note that attitudes toward women are not always extreme in nature. Rather, they exist along a continuum. At the extreme ends are conservative or traditional attitudes and liberal or feminist attitudes (Spence & Helmreich, 1972). Conservative or traditional attitudes reflect beliefs similar to those possessed in a prior era such as, “a woman’s place is in the home” (Twenge, 1997). Liberal or feminist attitudes reflect beliefs in line with those of the future, such as, “it is okay for a woman to earn more money than her husband’ (Twenge, 1997).

Research on attitudes toward women. Female roles have been and continue to be impacted by social attitudes toward women. Studies indicate that attitudes toward
women impact self-actualization (Hjelle & Butterfield, 1974), career pursuit (Loo & Thorpe, 1998), division of household and economic responsibilities (Powell & Yanico, 1991), and sexual permissibility (Smith et al., 1980). In a study conducted by Hjelle and Butterfield, women were found less likely to reach their full potential when faced with negative attitudes toward their roles. Clearly, negative attitudes toward women could have a profound effect on their lives.

Male expectations of female roles are often contradictory to the roles females are wishing to hold (McHugh & Frieze, 1997). This inconsistency strains interactions between the sexes, especially if the male’s expectations are highly conservative while the female’s expectations of her roles and responsibilities are more liberal (Fletcher, Simpson, Thomas, & Giles, 1999). Within intimate relationships, this opposition can manifest on either a behavioral or psychological level and precipitate male violence against women. This hypothesis is supported by research that shows that attitudes toward women impact interpersonal relationships between men and women (Cherlin & Walters, 1981; O’Neil & Nadeau, 1999).

Several studies have noted that male attitudes or beliefs surrounding the masculine gender role are related to male violence against female intimates (Smith, 1990; Sugarman & Frankel, 1996). In a study conducted by Telch and Lindquist (1984), violent husbands possessed more traditional sex role attitudes than nonviolent husbands. Similarly, college men who subscribed to traditional male attitudes of superiority and authority over others were more likely to endorse a husband’s use of violence against his wife than men who possessed more liberal attitudes of masculinity (Finn, 1986). Vass and Gold (1995) also found a relation between traditional male
attitudes and partner aggressive behavior. Specifically, men who adhered to an exaggerated masculine ideology responded to negative feedback from women with greater anger and reported more past sexual aggression than did men with fewer adherences to that ideology. Men who experience conflict due to their attitudes also are likely to endorse verbal aggression in their interactions with their female partners (Franchina, Eisler, & Moore, 2001). More recently, Fitzpatrick et al. (2004) determined that men who held less egalitarian, more traditional gender-role attitudes tended to report being psychologically abusive. These findings are significant given that verbal abuse is the best predictor of physical aggression in dating relationships (Ryan, 1998).

Relationship beliefs also may be affected by attitudes toward women. For example, Wood (2004) found men who held conservative attitudes about female’s roles and responsibilities were likely to possess more irrational relationship beliefs than their more liberal male counterparts. In addition, men who had excessively conservative views about female’s dating and courtship behavior also tended to possess irrational beliefs surrounding their own sexual perfectionism in intimate relationships (Wood, 2004).

Literature investigating the psychology of men has documented the existence of a relation between attitudes toward women and masculine gender role conflict (O’Neil, 1981) and found such attitudes to moderate the relationship between gender role conflict and relationship beliefs (Wood, 2004). Wood discovered that attitudes toward women became more conservative as levels of masculine gender role conflict increased. Similarly, as gender role conflict in men increased, their desire for tradition in women and women’s roles also increased (Blazina & Watkins, 2000). Still other
studies have shown attitudes toward women to become more negative as levels of masculine gender role conflict increased (Wood et al., 2000). Wood (2004) found that as male gender role conflict increased, attitudes toward women became more conservative and relationship beliefs became more irrational which is consistent with previous research in which masculine gender role conflict related to aggressive attitudes toward women (O'Neil & Nadeau, 1999).

Attitudes toward women's roles also influence male's help-seeking attitudes and behaviors. For example, men with more liberal attitudes toward women's roles in society have more positive help-seeking attitudes and are more likely to have sought counseling than men with more conservative attitudes (Zeldow & Greenberg, 1979, 1980).

Because negative attitudes toward women have the potential to cause harm both at the individual and societal levels, research has targeted identifying factors contributing to negative attitudes toward women. Age has consistently emerged as a significant predictor of attitudes toward females. Spence and Helmreich (1978) found that older males tend to possess more conservative attitudes and beliefs than younger males. Of course, such findings may be a cohort effect that ameliorates as younger generations are socialized through the media to be more accepting of female equity.

Other factors associated with an increase in negative attitudes toward women include geographic location, religious orientation, and education. Overall, male attitudes in the southern United States appear more conservative than male attitudes in other parts of the United States and Canada (Loo & Logan, 1977; Twenge, 1997). Attitudes in the south historically have been more conservative regarding politics and
the presence of married females in the workforce (Rice & Coates, 1995). However, over time, attitudes toward women throughout the U.S. have increasingly become more liberal (Slevin & Wingrove, 1983; Twenge, 1997). Because social attitudes and beliefs traditionally have been grounded in religion, researchers hypothesize that religion may influence attitudes towards women. For example, Glick, Lameiras, and Castro (2002) found Catholic males had more hostile and sexist attitudes toward women than non-Catholic males.

Education is another factor associated with attitudes surrounding female roles. Studies exploring attitudes toward women in college populations indicate that college freshmen tend to possess the most conservative attitudes toward women while graduate students tend to possess the most liberal attitudes toward women (Etaugh, 1975). Moreover, individuals who possess a low grade point average also tend to hold more conservative attitudes toward women. Additional research exploring the association between education and attitudes toward women suggests education may further predict hostility toward women (Glick et al., 2002). Glick et al. found males with less education were more hostile toward females than educated males. Similar associations have been found between educational level and the initiation of male violence against women (Lewis & Fremouw, 2001).

The findings surrounding lack of education and attitudes toward women are in a way encouraging since education has been shown to foster the development of more liberal and healthy attitudes toward women. In fact, educational efforts designed to reduce negative attitudes toward women may prove highly effective in reducing negative attitudes toward women. In a study by Lunneborg (1974), attitudes toward
women were measured before and after a course in women’s issues. At pretest, males demonstrated more conservative attitudes toward women than females. However, posttest scores showed male and female attitudes toward women were equal, with both sexes exhibiting more liberal attitudes than were exhibited prior to the course. Such findings show that education positively impacts male attitudes toward women, as well as female’s.

Attitudes toward women influence career choice and career advancement. Women have traditionally embraced careers associated with the roles of wife and mother (e.g., schoolteacher, nurse); however, they are increasingly entering careers dominated by men. Their entry into male-dominated careers is suggested to cause distress among men, as working females may be perceived as a threat to a man’s sense of masculinity (Segal, 1990). O’Neil and Egan (1992) propose that masculine attempts to stave off this threat include restriction of a female’s attempts at career advancement.

Finally, studies have explored attitudes toward women of ethnically diverse populations. In a study examining attitudes toward women in a Chinese population, Chia, Moore, Lam, Chuang, and Cheng (1994) found that female attitudes toward women were more liberal than in previous studies and were more liberal than their male counterparts. Damji and Lee (1995) compared attitudes toward women in a sample of Canadian Muslims and non-Muslims and found females in both subcultures had more liberal attitudes than males. The researchers also found that females in the non-Muslims sample tended to be more liberal than females in the Muslim sample. Overall, research exploring attitudes toward women suggest that females possess more liberal attitudes toward their roles and responsibilities than do males. Interestingly,
however, males considered as racial minorities often favor more traditional attitudes toward women than white males (Levant & Majors, 1997).

**Attitudes and Efforts at Attitudinal and Behavioral Change**

Thus far, the present discussion has focused on the literature examining attitudes linked with the perpetration of intimate partner violence. In as much as the current study intends to evaluate the efficacy of a psychoeducational intervention in promoting both attitudinal and behavioral change, it is important to consider how attitudes are formed and how attitudes and behaviors are modified. Due to the abundance of research in each of these areas, only literature that guided the development and implementation of the current intervention will be reviewed.

**Definition of attitude.** Petty and Wegener (1998) define “attitude” as an overall evaluation of some aspect of the world. Attitudes affect an individual’s interpretation of issues and events and influence ones perceptions of others. Attitudes consist of three components: affective, behavioral, and cognitive (Breckler, 1984). The affective component refers to an individual’s feelings about a person, object, or issue while the behavioral component refers to an individual’s predisposition to act in a particular way toward the person, object or issue. It is important to note that this component does not pertain to an actual behavior but to an inclination to behave in a certain way. Finally, the cognitive aspect refers to an individual’s beliefs or knowledge about an object or issue.

Attitudes play an important role in information processing and memory (Eagly & Chaiken, 1998). In ambiguous situations, they help organize events and determine what information is attended to, processed, encoded, and remembered. Attitudes also
affect an individual’s goals and expectations and influence the ways in which obstacles are interpreted. They also serve as guides as individuals selectively evaluate information. Generally, information that is contrary to existing attitudes is perceived as unconvincing, and attempts to disprove it are commonly made (Eagly & Chaiken, 1998). Altogether, the relationship between attitudes and behavior are such that attitudes may predict behavior and behavior may affect attitudes.

Several factors determine how likely it is that an attitude toward a behavior will lead to the behavior's occurrence. Eagly and Chaiken (1998) propose that an attitude is more likely to affect behavior when it is strong, relatively stable, directly relevant to the behavior, important, and easily accessed from memory. For instance, when people are repeatedly asked to assert an attitude on a given topic, they are more likely to behave in ways consistent with that attitude compared with those who did not repeatedly express the attitude (Fazio, Chen, McDonel, & Sherman, 1982; Powell & Fazio, 1984). Thus, priming an attitude appears to make it easier to access from memory. In some cases, repeatedly asserting an attitude can make it more extreme (Downing, Judd, & Brauer, 1992).

Most people, however, prefer attitudes and behavior to be consistent (Snyder & Ickes, 1985). Cognitive dissonance occurs when an attitude and a behavior, or two attitudes, are inconsistent. To minimize the discomfort caused by cognitive dissonance, individuals often change attitudes or behaviors in order to achieve greater consistency between the two. However, not all individuals who experience inconsistencies between attitudes and behaviors will make efforts at change.
Processes of attitudinal and behavioral change. Because attitudes frequently influence behavior, efforts to modify behaviors often focus primarily on changing attitudes related to target behaviors. In applied therapeutic settings, the likelihood of altering both attitudes and behaviors in the desired direction may improve if additional factors related to behavior change are considered in the design of interventions. Review of the social influence literature in counseling psychology, revealed a number of applied studies involving attitude change based on Petty and Cacioppo's (1986) elaboration likelihood model (ELM). Additionally, psychotherapeutic efforts at both attitude and behavior change are enhanced when therapeutic factors, stages of group development, and change are considered (Prochaska & DiClemente, 1982; Tuckman & Jensen, 1977; Yalom, 1995).

The Elaboration Likelihood Model of Attitude Change (ELM). The ELM proposes two routes to attitude change: central and peripheral. Central route change occurs when thoughtful consideration is given to both the target of attitude change and the content of the persuasive communication. Gilbert, Heesacker, & Gannon (1991) define persuasive communication is “any verbal or nonverbal expression of which the intent is to change the attitude of the recipient” (p. 198). For central route attitude change to occur, the recipient of the persuasive communication must be motivated to think about the topic of the communication, possess the ability to think about what is being communicated, and have favorable thoughts about the topic (Gilbert, Heesacker, & Gannon, 1991).

Alternately, peripheral route change focuses on factors such as the attractiveness and expertise of the source, the number, as opposed to the strength, of
the arguments, or how others respond to the message. This type of attitude change is based on the use of simple decision rules or cues (Gilbert, Heesacker, & Gannon, 1991). The mere exposure effect also can change attitudes through the peripheral route. Simply becoming familiar with something can change one’s attitude toward it, often, in a favorable way, and can generalize to similar objects or people (Zajonc, 2001). Moreover, efforts at persuasion are more effective if they evoke strong emotions and contain specific information regarding what can be done to bring about a more positive outcome.

Because central route-based attitudes are more long lasting, more strongly influence behavior, and are more resistant to later counterpersuasion than peripheral (Petty & Cacioppo, 1986), prevention programs may be more effective if they evoke central-route attitude change. Additionally, interventions designed to ensure sufficient motivation, ability, and favorability of thoughts regarding the communication may further increase the likelihood that central-route attitude change occurs.

The present study drew heavily on group therapy theory and research in the design and implementation of the psychoeducational intervention. Research in this area suggests that group interventions intended to elicit both attitude and behavioral change may be more effective if specific therapeutic factors and stages of group development and change are considered (Prochaska & DiClemente, 1982; Tuckman & Jensen, 1977; Yalom, 1995). Each of these constructs is described in greater detail below. An explanation of how these factors were incorporated into the design and execution of the intervention employed in this study is found in the Method section.
Yalom's therapeutic factors. Yalom's (1995) theory of group psychotherapy is based on the application and interaction of eleven factors postulated to facilitate therapeutic change. These include: instillation of hope, universality, imparting information, altruism, corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors. It is important to note that these join with other therapeutic factors to modify attitudes and behaviors.

According to Yalom (1995), the instillation and maintenance of hope is a crucial component of any therapeutic endeavor and serves to keep individuals involved in therapy. Often, faith in treatment alone can prove effective. For instance, high pre-therapy expectations of receiving help are predictive of positive therapy outcomes (Piper, 1994). Although client faith in treatment contributes to therapeutic efficacy, it is equally important for the therapist to believe in the treatment process and in the patient's ability to replace unhealthy attitudes or behaviors.

Another factor facilitating change is universality. Most individuals enter therapy with a sense of uniqueness and often believe they are alone in their feelings and experiences. Because many individuals possess interpersonal issues that prevent them from developing intimate relationships, they may not be aware of the troubling feelings and experiences of others. Moreover, they may not perceive themselves as having the opportunity to confide in, and subsequently be validated and accepted by others (Yalom, 1995).

Although modes of treatment vary in how information is presented (i.e., didactic instruction or advice giving), the imparting of information often functions as
the binding force in a group setting. Usually, information is exchanged via didactic instruction, which provides structure and initially helps minimize anxiety resulting from uncertainty. Yalom (1995) postulates that explanation and clarification of an issue or problem may be therapeutic in and of itself as “explanation of a phenomenon is the first step toward its control” (p.10).

The therapeutic factor of altruism also is important in the early stages of group development and change. Group therapy research suggests that clients benefit through giving and rate therapeutic experiences as positive when they believe themselves to be contributing to the process (Yalom, 1995). Frequently, individuals entering therapy feel demoralized and perceive themselves as burdens, having nothing of value to offer others (Yalom, 1995). The realization that they can be of benefit to others by offering support, insight, and reassurance is enlightening and raises self-esteem.

Many who enter psychotherapeutic groups have a history of unpleasant experiences in their primary family group. In many aspects, the therapy group resembles a family, which ultimately leads members to interact as they would with important others in their world. Such interactions provide members the opportunity to relive familial conflicts and to work through these experiences correctly (e.g., corrective recapitulation of the primary family group). By exploring fixed roles and familial structures and providing ground rules for investigating current relationships and testing new behavior, individuals can work through unfinished business and learn how to develop and nurture current relationships (Yalom, 1995).

The development of socializing techniques is an important factor in all therapeutic endeavors. Depending on the type of group, the development and
utilization of social skills may be explicit or more indirect. For example, in some
groups, communication skills (i.e., how to be responsive to others, resolve conflict, and
experience and express empathy) may be taught and modeled. More dynamic groups,
however, may develop social skills by processing the maladaptive behavior of its
members. Often, the therapy group represents the first opportunity an individual has to
receive accurate interpersonal feedback.

The significance of imitative behavior in the therapeutic process is well
documented in the social psychological literature. Generally, imitative behavior is
most prevalent in the early stages of group development as members seek out those
with whom they can identify (Yalom, 1995). For instance, therapists may influence the
communication patterns of group members by modeling empathy and support.
Additionally, group members can benefit by observing the therapy of another with
whom they identify. Even though imitative behavior may be short-lived, it allows the
opportunity for individuals to "try on" a new behavior. According to Yalom, this in
itself is of therapeutic value as "finding out what we are not is progress toward finding
out what we are" (p. 16).

Interpersonal learning is a complex process that encompasses the importance of
interpersonal relationships, the corrective emotional experience, and the group as social
microcosm (Yalom, 1995). According to Yalom, the primary task of group therapy is
to help individuals develop gratifying interpersonal relationships. Through feedback
from others and self-observation, group members become aware of crucial aspects of
their interpersonal behavior (i.e., strengths, maladaptive behaviors, limitations) which
allows them to develop more appropriate interpersonal behaviors. This is a difficult
and potentially painful process that often results in the inappropriate expression of strong emotions such as anger. Such venting allows group members to examine the inappropriate expression of emotions and to correct emotional expression so that they may communicate more effectively with others. Equally important is the bi-directional concept of the group as social microcosm. Initially, group members bring their outside behaviors to the group setting and interact with fellow members as they do in their outside social environment. Eventually, group members will transfer the new behaviors they have learned in group to their outside interpersonal relationships. Each of these steps toward interpersonal learning must be facilitated by the therapist who encourages self-observation and risk-taking, and provides specific, clarified feedback.

Group cohesiveness is broadly defined as the attraction that group members have for their group. It occurs when members value the group and feel they belong and are unconditionally accepted and supported by fellow members (Yalom, 1995). Group cohesiveness fluctuates during the course of the group; however, it is a necessary precondition for the optimal functioning of other therapeutic factors and plays a significant role in a successful group therapy outcome.

Catharsis (the open expression of affect) is vital to the group process and is part of cohesiveness. Yalom (1995) suggests that catharsis is more helpful once supportive group bonds have formed. Additionally, strong emotional expression enhances the development of cohesiveness.

Finally, existential factors that lead to therapeutic change include issues of responsibility, basic isolation, contingency, the capriciousness of existence, the recognition of human mortality, and the ensuing consequences for the conduct of our
life. Yalom (1995) observes that the existential approach in therapy is not a set of technical procedures but a basic attitude toward the individual.

In summary, Yalom's (1995) theory of group psychotherapy proposes that awareness and utilization of therapeutic factors stimulates and promotes behavioral and attitudinal change. Though the therapeutic factors identified by Yalom are reviewed as distinct, they are interdependent and occur and function in varying combinations and degrees. Furthermore, they initiate and reflect different aspects of the process of change. For example, some factors are preconditions for change (e.g., cohesiveness), while others refer to an increase in knowledge (e.g., universality) or actual behavioral change (e.g., development of socializing techniques). Though each factor operates in all therapy groups, their interplay and importance vary among groups and individual members. As a result, clinicians should consider the natural occurrence of each of these factors in the group setting and utilize them to advance the processes of group development and change.

*Stages of group development.* Previous research exploring the nature of therapeutic groups often focuses on the developmental process and how it contributes to the overall effectiveness of groups. The most frequently cited theory of group development, proposed by Tuckman and Jensen (1977), delineates five stages of development: forming, storming, norming, performing, and adjourning. In the first stage, forming, group members rely on safe, patterned behavior and look to the group leader for guidance and direction. Members have a desire for acceptance and evaluate the similarities and differences between themselves and other members. Serious topics and feelings are avoided with discussion centered on defining the scope of the task and
how the group will approach it. To advance from this stage, group members must relinquish the comfort of non-threatening topics and risk conflict.

The next stage, storming, is characterized by interpersonal competition and conflict as group members try to find where they “fit” and attempt to organize for the tasks at hand. Individuals have to bend and mold their feelings, attitudes, and beliefs to suit the group organization. Conflicts over leadership, structure, power, and authority emerge during this stage (Tuckman & Jensen, 1977). Because of the discomfort generated during this stage, some members remain silent and others dominate. Progression to the next stage requires group members’ transitioning from a testing and proving mindset to a problem solving mindset. According to Tuckman and Jensen (1977), the most important step in advancement is the ability to listen.

In the norming stage, relationships among members are characterized by cohesion and shared leadership. Group cohesion occurs when members begin to identify with and trust one another. Members are willing to change their preconceived ideas or opinions on the basis of facts presented by other members and actively ask questions (Tuckman & Jensen, 1977). During this stage, individuals begin to experience a sense of belonging and relief due to the resolution of interpersonal conflicts experienced as a group. Interactions are characterized by openness and sharing of information. The major task functions of this stage include the sharing of feelings and ideas, asking for and giving feedback, and exploring actions related to these tasks.

The fourth stage, performing, is the most productive and is not reached by all groups (Tuckman & Jensen, 1977). During this stage, members become more self-
assured and the need for group approval attenuates. Personal relations become more interdependent and group members focus on problem solving with an emphasis on achievement.

The final stage, adjourning, involves the disengagement from relationships established among members and the termination of task behaviors. A planned conclusion usually includes recognition for participation and achievement and an opportunity for group members to express their thoughts and feelings surrounding participation in the group. As conclusion of group can create feelings of apprehension, time should be allotted for participants to recognize and process these emotions.

Although stages of group development are more frequently considered in the industrial and organizational literature, knowledge of them may allow counseling psychologists to develop more effective group interventions. By planning activities that complement each stage and encouraging advancement to the next, clinicians may facilitate participants progression through the stages.

*Stages of change.* Efforts to modify problem attitudes and behaviors should consider the processes and stages of change (Prochaska & Norcross, 2003). Processes are defined as "the covert or overt activities that people engage in to alter emotion, thinking, behavior, or relationships related to particular problems or patterns in living" (p. 516). Based on research examining how people attenuate addictive behaviors, Prochaska and DiClemente (1983) identified ten processes of change that, when coupled with the stages of change, help people progress. These include consciousness raising, catharsis/dramatic relief, self-re-evaluation, environmental reevaluation, self-liberation, social liberation, counterconditioning, stimulus control, contingency
management, and the helping relationship. Systems of psychotherapy differ over which process of change is most salient; however, most agree that consciousness raising is a central factor (Prochaska & Norcross, 2003).

In any discussion of attitude or behavior change, the impact of common or nonspecific factors in producing change is important. For example, Lambert (1992) suggests that between 10% and 40% of change that occurs among group clients can be attributed to a placebo effect. Additionally, people use many different strategies to overcome problems in their natural environment (Prochaska, Norcross, & DiClemente, 1995). As a result, clinicians should be knowledgeable of change and employ techniques that complement each stage (Prochaska & Norcross, 2003).

The stages of change "represent specific constellations of attitudes, intentions, and behaviors related to an individual’s status in the cycle of change” (Prochaska & Norcross, 2003, p. 519) and include: precontemplation, contemplation, preparation, action, and maintenance. Each stage reflects a set of tasks that must be completed prior to advancement to the next stage. Although the tasks of each stage are invariant, the time it takes an individual to progress through each of the stages varies. What follows is a discussion of each of the stages of change, the tasks that must be accomplished, and the strategies that facilitate advancement.

The first stage, precontemplation, is characterized by resistance to recognize a problem. Individuals in this stage have no intention of changing their behavior and are often unaware of their problems. Frequently, they present for therapy at the request of others. Because precontemplators are not considering behavioral modification, they become involved in little change-process activity. For example, individuals in this
stage process less information about their problems, spend less time on self-evaluation, are less open with others about their problems, experience less emotional reactions surrounding the negative aspects of their problems, and do little to overcome their problems (DiClemente & Prochaska, 1982; Prochaska & DiClemente, 1983). To advance to the next stage, clients need to acknowledge their problems and possess increased awareness of the consequences and negative aspects of their problems. Additionally, individuals should be able to accurately evaluate their self-regulation capacities.

Several change processes assist precontemplators in moving toward the next stage (Prochaska & Norcross, 2003). Consciousness-raising interventions such as didactic instruction, observations, and interpretations help clients become more aware of the causes and consequences of their problems. Such interventions often provide suggestions for treating a problem. Additionally, the process of catharsis assists in advancement to the contemplation stage.

The second stage of change is contemplation. In this stage, people know that a problem exists and are seriously thinking about and evaluating their options for change. People often remain stuck in this stage, must avoid chronic contemplation (i.e., obsessive rumination), and make a decision to take action (Prochaska & DiClemente, 1983).

Consciousness raising activities, especially educational interventions, are effective at this stage. As individuals become increasingly aware of themselves and the nature of their problems, they are able to reevaluate their thoughts and feelings surrounding themselves and their problems. The process of self-reevaluation allows...
them to examine which values they want to act on and which they will let go. If
problems stem from or emanate from an individual's core values, reevaluation will
necessitate changes in their sense of self (Prochaska & Norcross, 2003). Additionally,
the process of reevaluation helps clients to realize the effects their behaviors have on
others, particularly those they care about.

Cognitive, affective and evaluative processes of change are used increasingly as
individuals progress from precontemplation to contemplation and through the
contemplation stage. To prepare for action, individuals must make changes in their
thoughts and feelings surrounding their problems. Additionally, values that reinforce
destructive lifestyles must be reconsidered and perhaps adapted to be consistent with a
healthier lifestyle.

The preparation stage is characterized by intention to change. Individuals in
this stage are planning to take immediate action but have made small behavioral
changes. Although some reductions in problem behaviors are observed, clients have
yet to formulate a specific plan of action. They are however, intending to take action in
the very near future and need to set goals and identify their priorities.

To assist in advancement to the action stage, clinicians must help clients
incorporate what they have learned from past efforts at change that were successful and
those that were failures. Counterconditioning and stimulus control strategies may
assist in the reduction of problem behaviors by teaching individuals to utilize healthier
behaviors in conditions that normally elicit problems and by providing instruction on
the management of situations or cues that elicit problems (Prochaska & Norcross,
2003).
It is important that individuals possess a sense of self-efficacy when preparing for the action stage. They must believe in their ability to change their lives while accepting that forces outside of their control may also change their lives (Prochaska & Norcross, 2003; Bandura, 1982).

The action stage is characterized by overt behavioral change and requires one to be highly committed to making a change. During this stage, behavioral and environmental modifications must occur in order for clients to overcome their problems (Prochaska & Norcross, 2003). To be classified at the action stage, a client must have altered successfully a problem or behavior for a period of one day to six months. People in the action stage must possess behavioral skills such as counterconditioning, stimulus control, and contingency management so that they may interrupt habitual patterns of behavior and adopt more productive ones (Prochaska & Norcross, 2003). During this stage, individuals display increased awareness of the situations that might result in relapse and threaten advancement toward behavioral change. Therapists can provide strategies, if necessary, to increase the probability that clients will be successful.

In the final stage, maintenance, clients consolidate the gains attained during the action stage and actively work to prevent relapse. The maintenance stage represents a continuation of change and in some cases, can last a lifetime. This stage is achieved when the behavior change has been in place for at least six months. Successful maintenance builds on each of the processes that has come before, and involves an
open assessment of the conditions under which a person is likely to be coerced into relapsing. Clients need to assess their alternatives for coping with such conditions without resorting to self-defeating and pathological behaviors.

**Hypotheses**

The preceding literature suggests that preventive interventions designed to reduce intimate partner violence should address risk factors associated with the initiation of abuse (Hage, 2000; Lewis & Fremouw, 2001; O'Neil & Harway, 1997; Walker, 1999). Gender role conflict, attitudes toward seeking psychological assistance, sense of entitlement, attitudes toward women, and poor anger management skills are theoretically and empirically linked to the perpetration of male violence against women. Further, research suggests that preventive interventions may be more effective when implemented in at-risk populations. Inmates typically possess many characteristics (i.e. low education, low SES, substance abuse history) associated with the perpetration of abuse. Moreover, while incarcerated, they reside in an environment that reinforces traditional masculine attitudes and behaviors linked with the commission of relationship violence. This study is based on previous research conducted by Schwartz et al. (2004) that documented the effectiveness of a psychotherapeutic intervention in impacting factors associated with dating violence in a college population. Specifically, study participants evidenced lower gender role conflict related to the restriction of emotional expression and to the restriction of affectionate behavior between men and more healthy self-esteem characterized by an increase in self-reliance and assurance following the intervention.
The current study will determine if an interactive, experiential, psychoeducational group intervention is effective in decreasing risk factors (e.g., gender role conflict, entitlement, traditional attitudes toward women) and increasing protective factors (e.g., positive attitudes toward help-seeking, improved communication and anger management skills) associated with the perpetration of intimate partner violence. Based on the available research, the following hypotheses were tested.

Justification for Hypothesis One

Research has shown that men who rigidly enact traditional male roles utilize a narrow range of interpersonal behaviors (Mahalik, 1999). Education designed to increase knowledge of the ways male socialization occurs to restrict emotional expression may help men view their interpersonal behaviors as learned and thus amenable to change (Harway & O’Neil, 1999).

Hypothesis One

Participants in the experimental group will report lower levels of gender role conflict related to Restrictive Emotionality and Restrictive Affectionate Behavior Between Men after participation in the experimental group than participants in the control group.

Justification for Hypothesis Two

Studies suggest that attitudes toward seeking psychological assistance may be negatively influenced among men who are socialized to value success, power, and competition and who restrict emotional expression (Robertson & Fitzgerald, 1992). Addis and Mahalik (2003) propose that educational processes that aim to reduce the
influence of restrictive masculinity norms may increase men's willingness to seek and receive help. Help seeking may be facilitated further by increasing the perception that the difficulties men face, including the reluctance to seek assistance, is normal among men (Addis & Mahalik, 2003). Interventions that emphasize self-help and problem-solving approaches to difficult and sensitive issues may be more effective at reaching men than traditional therapy (Robertson & Fitzgerald, 1992). By normalizing the issues men face in life and addressing their negative perceptions of therapy, men's help-seeking attitudes and behaviors may improve (Kushner & Sher, 1991).

_Hypothesis Two_

Participants in the experimental group will report more positive attitudes toward seeking professional help after participation in the experimental group than participants in the control group.

_Justification for Hypothesis Three_

The ability to be self-reliant and self-confident is central to a healthy sense of entitlement (Nadkarni et al., in press). Research has indicated that psychoeducation designed to increase awareness of entitlement attitudes and skills building techniques that promote assertive communication is effective in increasing levels of healthy entitlement (Magee & Schwartz, in press).

_Hypothesis Three_

Participants in the experimental group will report more healthy entitlement related to self-reliance and self-assurance after participation in the experimental group than participants in the control group.
**Justification for Hypothesis Four**

Theory suggests that the masculine socialization process in the extreme may foster the development of an exaggerated sense of entitlement that may teach men to expect and demand privileges such as power and control beyond what is appropriate (Hill & Fischer, 2001; O'Neil & Harway, 1997; Hage, 2000). By examining how men are socialized to value power and control and by exploring the impact of exaggerated entitlement attitudes on intra- and interpersonal functioning, men may begin to perceive exaggerated entitlement attitudes as learned and may experience fewer narcissistic expectations or entitlements.

**Hypothesis Four**

Participants in the experimental group will report lower levels of exaggerated entitlement related to narcissistic expectations and self-promotion strategies after participation in the experimental group than participants in the control group.

**Justification for Hypothesis Five**

Research shows that education may foster the development of more liberal and healthy attitudes toward women. In a study conducted by Lunneborg (1974), attitudes toward women were measured before and after a course in women's issues. At pretest, males demonstrated more conservative attitudes toward women than females. However, posttest scores showed male and female attitudes toward women as equal, with both sexes exhibiting more liberal attitudes than were exhibited prior to the course. Such findings suggest that education has the potential to positively impact male attitudes toward women.
Hypothesis Five

Participants in the experimental group will report more egalitarian attitudes toward women after participation in the experimental group than control group participants.

Justification for Hypothesis Six

Research suggests that cognitive-behavioral interventions can increase anger management (Diguiuseppe & Tafrate, 2001). Moreover, education and skills building techniques are successful in helping individuals to recognize the cognitive and behavioral responses that escalate conflict (Harway & O’Neil, 1999). The literature also suggests that exploration of the ways in which individuals assign negative cognitions to the target of anger may increase self-awareness and facilitate the development of more appropriate attitudinal and behavioral responses to anger (Diguiuseppe & Tafrate, 2001). Finally, increased awareness of responses that signal anger may allow individuals to cope with anger.

Hypothesis Six

Participants in the experimental group will report an increase in self-awareness, and a decrease in the use of escalating strategies and negative attributions associated with anger after participation in the experimental group than those in the control group.
CHAPTER 2

METHOD

This section describes the study. It includes the following sections: Participants, Instrumentation, Treatments, Procedure, and Data Analysis.

Participants

A total of 75 participants were recruited from an adult male boot camp program located within a minimum-security state correctional facility in the southern United States. Data collection for this study was completed in accordance with institutional research guidelines as approved by the University Human Use Committee (Appendix A) as well as the state department of corrections in which this study was completed. All participants were guaranteed anonymity and treated in accordance with the ethical guidelines and standards established by the American Psychological Association’s Ethical Principles of Psychologists and Code of Conduct (APA, 2002). Participation was voluntary and no compensation was provided for participation in this study. Informed consent was obtained prior to testing (Appendix B). Confidentiality of participant data was maintained with data viewed by the researcher only. The data obtained in this study were used to aggregate group information and no individual information was analyzed or reported.
**Instrumentation**

**Demographic Questionnaire**

The demographic questionnaire (Appendix C) consists of 11 items designed to gather information on static and dynamic risk factors associated with the perpetration of relationship violence. These questions inquire about the participants’ age, educational level, ethnicity, marital status, and parents’ marital status, number of children, age at first arrest, current criminal conviction, and number of prior incarcerations, substance abuse, and mental health histories.

**Gender Role Conflict Scale**

The Gender Role Conflict Scale (GRCS; O’Neil, Helms, Gable, David, & Wrightsman, 1986) is a 37-item self-report instrument designed to assess men’s thoughts and feelings about their gender role behaviors (Appendix D). Respondents report their agreement with each statement on a Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree), with higher scores corresponding to greater gender-role conflict.

Factor analysis using oblique rotation identified four factors that were used to construct subscales (O’Neil et al., 1986): Success, Power, and Competition (SPC; 13 items), Restrictive Emotionality (RE; 10 items), Restrictive Affectionate Behavior Between Men (RABBM; 8 items), and Conflict Between Work and Family Relations (CBWFR; 6 items). Sample items include “doing well all the time is important to me” (SPC), “strong emotions are difficult for me to understand” (RE), “expressing my emotions to other men is risky” (RABBM), and “finding time to relax is difficult for
me" (CBWFR). Individual subscale scores are obtained by summing the items in each subscale. Higher scores indicate greater levels of that particular construct.

O'Neil et al. (1986) reported subscale test-retest reliabilities over a 4-week period ranging from .72 to .86 for each factor and Cronbach's alphas ranging from .75 to .85 for the four factors. In the current study, internal consistency reliabilities for the total scale and subscales at pretest and (posttest) were as follows: total scale, .87 (.87); SPC, .70 (.75); RE, .79 (.82); RABBM, .83 (.87); CBWFR, .66 (.66).

Factor analysis of the GRCS supports the four-factor structure and construct validity for three of the four subscales (e.g., SPC, RE, RABBM; Good et al., 1995). Concerns about the CBWFR scale were related to a very low correlation between the factor and another measure of the traditional male role. There was also a lower correlation between the scale and overall GRCS scores. Several other studies have confirmed the factor structure using more rigorous confirmatory analysis (Good et al., 1995; Moradi, Tokar, Schaub, Jome, & Serna, 2000; Rogers, Abbey-Hines, & Rando, 1997). The GRCS is unrelated to social desirability (Good et al., 1995) and has convergent validity with other measures of masculinity, including the Masculine Gender Role Stress Scale and the Brannon Masculinity Scale (O'Neil et al., 1995). Full scale validity has been substantiated by positive correlations between GRCS scores and attitudes toward traditional male role norms (Good et al., 1995; Good & Mintz, 1990), anxiety (Cournoyer & Mahalik, 1995; Good & Mintz, 1990; Sharpe & Heppner, 1991), sexual aggression (Rando, Rogers, & Brittan-Powell, 1998; Kaplan et al., 1993), and depression (Good & Mintz, 1990) and by negative correlations with overall psychological well-being (Sharpe & Happner, 1991), family cohesion, marital
satisfaction (Campbell & Snow, 1992), attitudes toward professional help-seeking (Blazina & Watkins, 1996; Good, Dell, & Mintz, 1989), and self-esteem (Sharpe & Heppner, 1991).

*Attitudes Toward Seeking Professional Psychological Help, Short Form*

The Attitudes Toward Seeking Professional Psychological Help (ATSPPH; Fischer & Farina, 1995) is a 10-item measure of attitudes toward seeking professional help for psychological problems (Appendix E). Respondents self-report their agreement on a Likert scale ranging from 0 (disagree) to 3 (agree). Total scale scores range from 0 to 30, with higher scores reflecting more positive attitudes toward seeking professional psychological help.

Fischer and Farina report solid psychometric properties of the ATSPPH. Test-retest reliability over a 4-week interval was .80 and Cronbach’s alpha was .84. In the current study, internal consistency reliabilities at pretest and (posttest) were .61 and (.81). The construct validity of the scale is supported by the finding that the ATSPPH-S displayed significant point-biserial correlations between respondents who had sought help: .24 \((p < .03)\) for women, .49 \((p < .0001)\) for men, and .39 \((p < .0001)\) overall (Fischer & Farina, 1995).

*The Entitlement Attitudes Scale*

The Entitlement Attitudes Scale (EAS; Nadkarni et al., in press) is a 17-item scale designed to measure healthy and unhealthy entitlement (Appendix F). For the first four items, respondents are asked to report their agreement on a Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). For the remaining items,
respondents are asked to indicate "how often each of the following statements is true for you" on a scale ranging from 1 (never) to 7 (always).

Factor analysis using a principal-components analysis with a varimax orthogonal solution, uncovered two factors forming two subscales: Self-Reliance/Self-Assurance (SRSA; 9 items) and Narcissistic Expectations/Self-Promotion (NESP; 8 items). The SRSA factor is a measure of an individual's feelings of self-confidence and perceived ability to stand up for oneself. Sample items include "I feel obliged to fulfill any demand made of me" and "I don't have the courage to stand up for myself when someone infringes on my rights." The NESP factor is a measure of the degree to which an individual expresses a self-centered demanding attitude and is primarily concerned with his or her own interests. Sample items include "I expect to have my way" and "I continue an argument until I win."

Full-scale validity has been substantiated by positive correlations between EAS scores and assertiveness and self-esteem and by negative correlations with social desirability (Nadkarni et al., in press). The EAS factor SRSA has been consistently associated with self-esteem, assertiveness, and greater relationship intimacy. The EAS factor NESP appears unrelated to self-esteem, positively related to higher levels of depression, and negatively related to feelings of control, social desirability and communality.

Nadkarni et al. (in press) reported internal consistency reliabilities using Cronbach's alpha from .68 to .76. In the current study, internal consistency reliabilities for the total scale and subscales at pretest and (posttest) were: total scale, .53 (.50); NESP, .74 (.64); SRSA, .51 (.50).
Attitudes Toward Women Scale

The Attitudes Toward Women Scale (AWS; Spence & Helmreich, 1978) is a 15-item self-report instrument designed to measure beliefs about appropriate responsibilities and rights for women versus those for men (Appendix G). The shortened version contains 15 items selected from the original 55-item scale and is the most frequently used. Respondents are asked to report their agreement with each statement on a Likert scale ranging from 0 (agree strongly) to 3 (disagree strongly). About half of the items present a traditional point of view and the remainder presents an egalitarian point of view. The egalitarian items are reverse scored and item scores, which range from 0 to 3, are summed to obtain a total score. Possible scores thus range from 0 to 45, with high scores indicating more egalitarian attitudes toward the responsibilities and rights of women.

Early investigations of the 15-item version revealed that the shortened version has a unifactorial structure, an internal consistency reliability in the mid .80s, and satisfactory test-retest reliability (Spence & Hahn, 1997). In the current study, internal consistency reliabilities for the total scale at pretest and (posttest) were .60 and (.70).

The Anger Management Scale

The Anger Management Scale (AMS; Stith & Hamby, 2002) is a 36-item scale designed to monitor and evaluate different aspects of the ability to constructively manage anger in intimate relationships (Appendix H). The AMS is scored on a Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). Principal-axis factor analysis identified four factors of the AMS: Escalating Strategies (ES; 15 items);
Negative Attributions (NA; 7 items); Self-Awareness (SA; 6 items); and Calming Strategies (CS; 8 items). The first factor, Escalating Strategies, refers to the presence of cognitions and behaviors that increase the level of anger directed at one’s partner. For example, “When arguing with my partner, I often raise my voice.” The second factor, Negative Attributions, reflects the assignment of negative cognitions (e.g. blame, hurtful intentions) to the target of anger. An example of an item that measures this factor is “My partner does things just to annoy me.” Self-Awareness reflects an individual’s perception of factors (e.g., physiological responses and other changes) that represent increased anger. For example, “I recognize when I am beginning to get angry at my partner.” Finally, Calming Strategies indicates the use of calming and deescalating strategies frequently taught in anger management. For example, “I take time out as a way to control anger at my partner.”

Contributing to the validity of the AMS, Stith and Hamby (2002) found correlations between the AMS and physical, psychological, and sexual partner violence, impulsivity, relationship satisfaction, and alcohol problems. Internal consistency reliability was adequate, with a full-scale Cronbach’s alpha of .87 and subscale alphas ranging between .70 and .83 for the four factors (ES, .83; NA, .79; SA, .70; CS, .73). In the current study, internal consistency reliabilities for the total scale and subscales at pretest and (posttest) were: total scale, .68, (.66); Escalating Strategies, .81, (.77); Negative Attributions, .80, (.76); Self-Awareness, .80, (.63); Calming Strategies, .72, (.73).
Treatments

Experimental Group Treatment (Relationship Conflict Education)

The psychoeducational group treatment is based on a preventive intervention developed by Schwartz et al. (2004) aimed at the prevention of relationship violence (Appendix I). The psychoeducational intervention addresses factors identified by the research literature as influencing an individual's propensity for abuse such as gender role stereotypes and conflicts, and healthy and unhealthy entitlement attitudes. Additionally, the intervention is designed to increase communication and anger management skills as deficits in these skills may contribute to relationship violence.

Group sessions were structured according to Tuckman and Jensen's (1977) stages of group development (e.g., forming, storming, norming, performing, and adjourning). The manualized curriculum was designed to facilitate advancement through the stages of change identified by Prochaska and DiClemente (1982). Certain therapeutic factors (e.g., imparting of information, development of socializing techniques, catharsis, corrective recapitulation of the primary family group, group cohesiveness, universality, interpersonal learning) identified by Yalom (1995) also were used to encourage group development and to stimulate progression.

The first group session (i.e., forming) focused on orientation and definition of group objectives. Primary objectives included establishing community within the group, demonstrating the power of nonverbal communication, and increasing awareness of assertive vs. aggressive communication. Nonverbal communication skills were modeled and discussed with didactic instruction in communication styles (e.g.,
passive, aggressive, assertive) and anger. Experiential activities were used to establish community within the group and to encourage development of socializing techniques.

The goals of the second group session (i.e., storming and norming) were to promote communication between participants and to cultivate expressive speaking and empathic communication skills. Participants were encouraged to share thoughts and feelings and to practice asking for, giving, and receiving feedback. Difficulties associated with this task were identified and processed. Experiential activities were utilized to assist participants in examining familial influences on thoughts, feelings, actions, and relationships with others. Genograms were constructed to assist participants in identifying familial patterns and themes. Familial tactics of conflict resolution, including anger management techniques used by the family of origin, also were explored. Personal socialization factors, such as where and from whom participants learned how to act, and irrational beliefs learned from or perpetuated by the family of origin also were identified and processed.

The third group session (norming and performing) focused on problem solving and emphasized altruism and interpersonal learning. The primary objective was to increase participants' cognizance of anger and its problems when mishandled. To increase awareness of personal experiences of anger, participants were asked to examine cues, triggers, irrational beliefs, and core emotions associated with anger. Alternatives to aggressive behavior were then discussed. Educational information on the process and effects of gender role socialization, as well as patterns of masculine gender role conflict (i.e., control, power, competition, and restrictive emotionality) were provided and discussed with participants. The skills taught during this session

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focused on giving and receiving positive and constructive feedback. Members were encouraged to practice these skills while processing individual experiences of dealing with anger and conflict.

The fourth and final group session (i.e., performing and adjourning) focused on solidifying information attained during the previous sessions and termination of the group. Facilitators assisted participants in generalizing the knowledge gained in the previous sessions from an individual perspective to a social perspective. Participants viewed a videotaped reenactment of couples engaged in various forms of relationship conflict and participated in a facilitated group discussion of the video vignettes. Discussions were specifically designed to increase awareness of the societal problem of relationship conflict, the impact of power and control in relationships, and the relations between self-esteem and violence.

Control Group Treatment (Substance Abuse Education)

The control group intervention was added to determine the effects of treatment. This group was provided current information about substance abuse and substance dependence obtained from common psychoeducational materials and the *Diagnostic and Statistical Manual-IV-TR* (Appendix J). The control group received information to increase awareness of substance abuse, dependence, and drugs of abuse.

The first group session focused on defining substance abuse and dependence. Participants received educational information on the criteria for substance abuse, dependence and the differences between each diagnosis. Information pertaining to the classes of drugs (e.g., depressants, stimulants, opiates, hallucinogens, and marijuana) and their general effects were discussed.

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The remaining group sessions sought to expand on information presented in the initial session. The second group session examined depressants in more detail. Psychoeducational information on the various types of depressants and their effects on physiological and psychological functioning were provided. Since alcohol is the most commonly abused type of depressant in the U.S., a primary focus of this session was on distinguishing between alcohol abuse and dependence.

The third group session explored frequently abused stimulants such as amphetamines, cocaine, and ecstasy. A general overview of the effects of stimulants (e.g., intoxication, overdose, and withdrawal) and their mechanisms of action was presented. Educational information on opiates also was provided.

The fourth and final group session focused on hallucinogens and marijuana and provided an overview of the information presented in previous sessions. Information regarding the effects of hallucinogens and marijuana was given and a review of each class of substance was provided. Participants also received information on substance abuse treatment resources available within the prison and were informed how to access those services while incarcerated.

Procedure

Participants read and signed a consent form explaining the purpose of the study and were informed of the voluntary nature of participation, the lack of compensation for participation, and the procedure used to ensure anonymity of participant data. Consenting participants then received and completed a survey packet containing the Demographic questionnaire, Gender Role Conflict Scale, Attitudes Toward Seeking Professional Psychological Help Scale, Entitlement Attitudes Scale, and the Anger...
Management Scale. Instructions for each were given orally. Upon completion, participants turned the survey packet face down and waited silently for further instruction. Participants then were asked to draw a paper from a box, which contained 78 ballots, with 39 labeled “A” and 39 labeled “B.” By this randomization procedure, participants were then divided into two groups, group A (Experimental) and group B (Control). Initially, Group A consisted of 39 participants and Group B consisted of 36 participants. Participants then were informed that any questions related to the study would be addressed upon its completion in two weeks. The schedule of group sessions for Group A and Group B was provided and the groups were dismissed.

The experimental (i.e., Group A) and control (i.e., Group B) groups met twice a week for ninety minutes over a two-week period. Co-facilitators in each of the groups moderated the educational lecture and provided the appropriate handouts for each session specific to the groups format (i.e., experimental or control). Upon completion of the fourth group session, participants in each of the groups received and completed a post-test survey packet. Instructions for completing each of the instruments were given orally and once completed, debriefing was provided and, finally, all questions were answered.

Two individuals served as co-facilitators for both the experimental and control group treatments. The treatment team consisted of the principal investigator of this study and a member of the mental health staff team at the corrections facility where the study was conducted. Although facilitators differed in terms of gender, both were European American and similar in age (i.e., 34 years, 38 years). Both possessed an
educational background in psychology with one having a Masters in psychology and the other working toward a Doctorate in counseling psychology.

Data Analysis

Several levels of statistical analysis were conducted to assess for differences between groups. Frequencies and percentages were calculated for education level, ethnicity, marital status, number of children, current criminal conviction, and mental health and substance abuse histories. Means and standard deviations were calculated for participants’ current age, years of education, number of prior convictions, and age at first arrest. Internal consistencies, means, and standard deviations were computed for all instruments used. A correlation matrix between all variables examined in this study also was computed. Finally, study hypotheses were analyzed using a multivariate analysis of covariance (MANCOVA).

Hypothesis Testing

All study hypotheses were tested using a multivariate analysis of covariance (MANCOVA). In this analysis, the independent variable was “experimental group” while the dependent variable was comprised of post-intervention scores on the following measures: Gender Role Conflict Scale (GRCS), Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS), Entitlement Attitudes Scale (EAS), Attitudes Toward Women Scale (AWS), and the Anger Management Scale (AMS). Pre-intervention scores on each of these measures were used as the covariates in this analysis.

Because many of the hypotheses predicted changes in subscale scores as opposed to changes in total scale scores, data analysis procedures are reviewed
separately for each hypothesis. However, the reader is reminded that the following review of data analysis procedures for each hypothesis refers to one MANCOVA and is not intended to suggest that multiple MANCOVAs were conducted.

**Hypothesis One**

Hypothesis one was tested using a multivariate analysis of covariance (MANCOVA). The independent variable was “experimental group” and the dependent variable consisted of scores on the Restrictive Emotionality (RE) and Restrictive Affectionate Behavior Between Men (RABBM) subscales of the GRCS administered post-intervention. Pre-intervention scores on these subscales served as the covariates in this analysis.

**Hypothesis Two**

Hypothesis two was tested using a multivariate analysis of covariance (MANCOVA). The independent variable was “experimental group” and the dependent variable consisted of scores on ATSPPH administered post-intervention. Pre-intervention scores on the ATSPPH were used as the covariate in this analysis.

**Hypothesis Three**

Hypothesis three was tested using a multivariate analysis of covariance (MANCOVA). The independent variable was “experimental group” and the dependent variable consisted of scores on the Self-Reliance/Self-Assurance (SRSA) subscale of the EAS administered post-intervention. Pre-intervention scores on the SRSA subscale were used as the covariate in this analysis.
Hypothesis Four

Hypothesis four was tested using a multivariate analysis of covariance (MANCOVA). The independent variable was “experimental group” and the dependent variable consisted of scores on the Narcissistic Expectations/Self-Promotion Strategies (NESP) subscale of the EAS administered post-intervention. Pre-intervention scores on the NESP subscale were used as the covariate in this analysis.

Hypothesis Five

Hypothesis five was tested using a multivariate analysis of covariance (MANCOVA). The independent variable was “experimental group” and the dependent variable consisted of scores on the AWS administered post-intervention. Pre-intervention scores on the AWS were used as the covariate in this analysis.

Hypothesis Six

Hypothesis six was tested using a multivariate analysis of covariance (MANCOVA) with “experimental group” serving as the independent variable. The dependent variable consisted of scores on the Escalating Strategies (ES), Negative Attributions (NA), and Self-Awareness (SA) subscales of the AMS administered post-intervention. Pre-intervention scores on these subscales were used as the covariates in this analysis.
CHAPTER 3

RESULTS

The results of the current study are presented in this chapter. First, sample characteristics are displayed. Next, means, standard deviations and correlations among the variables are provided. Finally, the results of the current study are presented by hypothesis.

Descriptive Statistics and Intercorrelations

Participants

Participants in this study were inmate volunteers from an adult male boot camp program located within a medium security state department of corrections facility in the southern United States. From an initial sample of 75 subjects, data from 73 participants was retained for analysis. Two participants were excluded from the study for failure to complete the four session educational group. In terms of ethnicity, 49% of participants were African American, 40% were European American, 10% were Hispanic, and 1% were Native American. Of the 73 participants, 62% identified themselves as single, married (21%), divorced (10%), or living with someone (8%). All participants were convicted of nonviolent offenses and had 12 months or less to serve on their sentences. Overall, 71% of participants reported their current convictions were drug related with the remainder reporting convictions for burglary/theft (23.3%), parole violation (2.7%), firearms possession (1.4%), and escape (1.4%). A total of 71.2% of inmate volunteers spent time in prison prior to this
incarceration with 98% reporting a history of substance abuse or dependence.

Additionally, one-fourth of the total sample reported receiving a mental health diagnosis at some point in their lives. The means and standard deviations for additional demographic information are presented in Table 1.

Table 1

*Participant Demographic Means and Standard Deviations*

<table>
<thead>
<tr>
<th>Variables</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Sample</td>
<td>24.12</td>
<td>5.30</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>24.59</td>
<td>5.40</td>
</tr>
<tr>
<td>Control Group</td>
<td>23.64</td>
<td>5.22</td>
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<tr>
<td><strong>Years of Education</strong></td>
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<tr>
<td>Total Sample</td>
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<tr>
<td>Experimental Group</td>
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<tr>
<td>Control Group</td>
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<td>1.46</td>
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<tr>
<td><strong>Age at First Arrest</strong></td>
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<tr>
<td>Total Sample</td>
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<tr>
<td>Experimental Group</td>
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<td>4.12</td>
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<tr>
<td>Control Group</td>
<td>16.94</td>
<td>4.50</td>
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<tr>
<td><strong>Number of Prior Convictions</strong></td>
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<td></td>
</tr>
<tr>
<td>Total Sample</td>
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<tr>
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<tr>
<td>Control Group</td>
<td>2.61</td>
<td>2.51</td>
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</table>

Between groups, 57% of experimental group participants identified themselves as ethnic minorities (African American and Hispanic) compared to 63.9% (African American, Hispanic, Native American) of controls. Education level also differed with
43% of experimental group participants reporting 12 years of education or more compared to 22% of controls. The majority of experimental and control group participants were single (57% and 67% respectively) and reported having one or more child (59% and 58% respectively). Seventy-three percent of experimental group participants reported being arrested at least once by age 18 compared to eighty-one percent of control group participants with an overwhelming ninety-five percent of experimental group participants reporting prior convictions in comparison with seventy-two percent of controls. The majority (experimental, 68%; control, 75%) of participants reported their current charges were drug-related with 95% of experimental group participants and 89% of control group participants reporting a history of substance abuse or dependence. Finally, 27% of experimental group participants reported a mental health history compared to 22% reported by controls. Additional descriptive statistics for the control and experimental groups are listed in Table 2.

Correlations among Variables

A correlation matrix was generated for all variables as an informal diagnostic for multicollinearity (Table 3). Overall, most significant correlations between variables were not surprising, as shown previously. However, examination of the correlation matrix revealed a number of associations that appear to be new. Awareness of these associations both contributes to and extends the literature exploring these constructs. Following is a review of the significant correlations between variables that were either unexpected or previously undocumented. A thorough interpretation of results is provided in the Discussion section.
### Table 2

**Means and Standard Deviations for the Control and Experimental Groups**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Control Group</th>
<th>Experimental Group</th>
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<tbody>
<tr>
<td></td>
<td>Pretest $\ (n = 36)$</td>
<td>Posttest $\ (n = 36)$</td>
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<td>$SD$</td>
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</tr>
<tr>
<td>$SD$</td>
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<tr>
<td>Attitudes Toward Women Scale</td>
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<td></td>
</tr>
<tr>
<td>$M$</td>
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<td>4.96</td>
</tr>
<tr>
<td>$SD$</td>
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<tr>
<td>Entitlement Attitudes Scale</td>
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<td>NESP</td>
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*Note:* NESP = Narcissistic Expectations/Self-Promotion; SRSA = Self-Reliance/Self-Assurance; SPC = Success, Power, and Competition; RE = Restrictive Emotionality; RABBM = Restrictive Affectionate Behavior Between Men; CBWFR = Conflict Between Work and Family Relations; ES = Escalating Strategies; NA = Negative Attributions; SA = Self-Awareness; CS = Calming Strategies.
Table 3

<table>
<thead>
<tr>
<th>Measure</th>
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<td>.29*</td>
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<td>-.32**</td>
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<td>.34**</td>
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<td>.04</td>
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<td>-.30*</td>
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<tr>
<td>11. SA</td>
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<tr>
<td>12. CS</td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

Note: * p < .05, ** p < .01. ATSPPH = Attitudes Toward Seeking Professional Psychological Help scale; AWS = Attitudes Toward Women Scale; NESP = Narcissistic Expectations/Self-Promotion Strategies; SRSA = Self-Reliance/Self-Assurance; SPC = Success, Power, and Competition; RE = Restrictive Emotionality; RABBM = Restrictive Affectionate Behavior Between Men; CBWFR = Conflict Between Work and Family Relations; ES = Escalating Strategies; NA = Negative Attributions; SA = Self-Awareness; CS = Calming Strategies.
The most interesting correlations between demographic and scale variables occurred between help-seeking attitudes and both substance abuse ($r = .24, p < .05$) and mental health history ($r = .31, p < .01$). These relationships are somewhat unexpected as studies examining help-seeking attitudes consistently report that those most in need of mental health services are the least likely to seek it.

Significant correlations between the subscales of the Entitlement Attitudes Scale (EAS) and study variables add to the literature using the EAS as a measure of entitlement and advance understanding of the construct. A healthy sense of entitlement (SRSA), which is characterized by self-reliance and self-assurance, was negatively correlated with attitudes toward help-seeking ($r = -.25, p < .05$), and the restrictive emotionality (RE; $r = -.31, p < .01$); and conflict between work and family (CBWFR; $r = -.33, p < .01$) subscales of the Gender Role Conflict Scale (GRCS). Additional negative correlations were observed between healthy entitlement and two subscales of the Anger Management Scale (AMS): Escalating Strategies (ES; $r = -.26, p < .05$); and Negative Attributions (NA; $r = -.31, p < .05$).

A narcissistic sense of entitlement (NESP) was negatively correlated with attitudes toward women (NESP; $r = -.37, p < .01$). This finding is not surprising; however, it further substantiates and empirically validates theories (i.e., feminist, gender role conflict) that have inferred relations between these constructs. In addition, significant positive correlations were found between NESP and the GRCS subscales: success, power, and competition ($r = .28, p < .05$); restrictive emotionality ($r = .42, p < .01$); restrictive affectionate behavior between men ($r = .40, p < .01$); and conflict between work and family ($r = .35, p < .01$). Such associations further advance gender
role conflict theory and suggest that a narcissistic sense of entitlement may underlie all areas in which men may experience conflict related to their gender role. Finally, significant correlations between NESP and the four anger management subscales were detected: Escalating Strategies \((r = .41, p < .01)\); Negative Attributions \((r = .36, p < .01)\); Self-Awareness \((r = -.33, p < .01)\); and Calming Strategies \((r = -.35, p < .01)\).

The largest correlations among variables were between the self-awareness (SA) and calming strategies (CS) subscales \((r = .59, p < .01)\) of the Anger Management Scale (AMS) and the restrictive emotionality subscale of the GRCS and the Escalating Strategies \((r = .49, p < .01)\) and Negative Attributions subscales \((r = .49, p < .01)\) of the AMS. The large correlation involving the AMS subscales is surprising and may indicate that these factors are not as distinct as initially theorized.

**Results by Hypothesis**

Examination of the MANCOVA in its entirety failed to detect a statistically significant difference between the experimental and control group interventions on the combined dependent variable \([F (9, 54) = 1.06, p = .375]\). However, when the results for the dependent variables were considered separately, differences in one variable (attitudes toward women) reached statistical significance. Although it is normal procedure to declare all hypotheses disconfirmed when no significant difference is detected, the difference between groups on post-intervention scores measuring attitudes toward women is significant and may indeed be different if the AWS were standing on its own rather than being diluted with all the other variables. Because of this, the results of each hypothesis are presented separately; however, the reader is reminded...
that the overall statistical analysis failed to detect a statistically significant difference resultanty disconfirming all hypotheses.

**Hypothesis One**

Hypothesis one stated that participants in the experimental group would report lower levels of gender role conflict related to Restrictive Emotionality (RE) and Restrictive Affectionate Behavior Between Men (RABBM) after participation in the experimental group than control group participants. After controlling for pre-intervention scores, no significant differences were detected between the experimental and control groups on post-intervention scores on either the RE, \( F(1, 62) = .97, \ p = .328 \) or the RABBM, \( F(1, 62) = .294, \ p = .590 \) subscales; thus disconfirming hypothesis one.

**Hypothesis Two**

Hypothesis two proposed that participants in the experimental group would report more positive attitudes toward seeking professional psychological help upon conclusion of the experimental intervention than control group participants. After controlling for pre-intervention scores, there was no significant difference between the two groups on post-intervention scores on the Attitudes Toward Seeking Professional Psychological Help scale, \( F(1, 62) = 1.51, \ p = .223 \); thus hypothesis two was not confirmed.

**Hypothesis Three**

Hypothesis three stated that experimental group participants would report an increase in healthy entitlement as indicated by higher scores on the Self-Reliance/Self-Assurance (SRSA) subscale of the Entitlement Attitudes Scale (EAS) than control
group participants following the experimental intervention. After controlling for pre-intervention scores, there was no significant difference between the two groups on post-intervention scores, $F(1, 62) = .225, p = .637$; thus hypothesis three was not confirmed.

**Hypothesis Four**

Hypothesis four proposed that participants in the experimental group would report a decrease in unhealthy entitlement as indicated by lower scores on the Narcissistic Expectations/Self-Promotion Strategies (NESP) subscale of the Entitlement Attitudes Scale after participation in the experimental group than control group participants. After controlling for pre-intervention scores, there was no significant difference between the two groups on post intervention scores, $F(1, 62) = 1.15, p = .289$; thus, hypothesis four was not confirmed.

**Hypothesis Five**

Hypothesis five predicted that participants in the experimental group would report more egalitarian attitudes toward women post-intervention than would control group participants. After controlling for pre-intervention scores, a significant difference between the two groups on post-intervention scores of the Attitudes Toward Women scale was observed, $F(1, 62) = 8.23, p = .006$; however, this difference was not strong enough to overcome the lack of difference in all the other scales. While the significant difference in this analysis is robust, hypothesis five cannot be reported as confirmed, as examination of the MANCOVA in its entirety revealed no significant differences between groups post-intervention.
Hypothesis Six

Hypothesis six proposed that experimental group participants would report lower scores on the Escalating Strategies (ES) and Negative Attributions (NA) subscales of the AMS and higher scores on the Self-Awareness (SA) subscale post-intervention than control group participants. After controlling for pre-intervention scores, no significant differences between the two groups on post-intervention scores were detected: ES subscale, $F(1, 62) = .046, p = .832$; NA subscale, $F(1, 62) = 2.28, p = .135$; SA subscale, $F(1, 62) = 1.15, p = .288$. These results did not confirm hypothesis six.
CHAPTER 4
DISCUSSION

The purpose of the current study was to evaluate the effectiveness of a group intervention in changing male attitudes associated with the perpetration of intimate partner violence in a correctional setting. Specifically, the goals of this intervention were to (a) promote awareness of masculine gender role conflict and thus reduce gender role conflict among participants, (b) affect entitlement attitudes by increasing self-reliance and self-assurance and reducing narcissistic expectations and self-promotion, (c) increase consciousness of male attitudes toward women and foster the development of more positive attitudes toward women, and (d) improve attitudes toward help-seeking.

The discussion of the results begins with a review of significant correlations between variables that were either unexpected or previously undocumented. Next, the six formal hypotheses are discussed. Finally, study implications, limitations, and suggestions for future research are considered.

Correlations among Variables

Although examination of the correlation matrix revealed a number of significant associations between study variables, most were not surprising having been previously established in the literature. However, a number of correlations appear to be new and if replicated, may extend knowledge of these constructs as well as further understanding of the inmate population. Moreover, observed correlations between
variables may prove insightful when attempting to identify potential reasons for the current interventions failure in affecting attitudes associated with the perpetration of intimate partner violence and may assist in the development of more efficacious prevention interventions in the future.

The most informative correlations between demographic and scale variables occurred between substance abuse and mental health history and scale/subscale variables. For instance, small positive correlations were observed between both substance abuse and mental health history and help-seeking attitudes. These relationships are somewhat unexpected as studies examining help-seeking attitudes consistently report that those most in need of mental health services are the least likely to seek it. Although not known, it may be that these associations are influenced by previous experience as prior contact with a mental health professional has been found to positively affect help-seeking attitudes (Murstein & Fontaine, 1993). It is interesting to note however, that the mere exposure provided in both the experimental and control group interventions did not significantly impact help-seeking attitudes among participants in the current study.

Substance abuse also was correlated with Narcissistic Expectations/Self-Promotion Strategies, Restrictive Emotionality, and all Anger Management Scale subscales. These findings suggest that men with a history of substance abuse or dependence may also possess a narcissistic sense of entitlement and restrict emotional expression in both themselves and others. It may be that substance abuse helps to fill the void or sense of emptiness that often accompanies a narcissistic sense of entitlement and serves as a defense against emotions that are difficult or painful to
realize. Additionally, men who reported a history of substance abuse were also likely to utilize maladaptive anger management strategies such as assigning negative attributions to the target of their anger and using escalating responses to conflict situations. These men also tend to have difficulty recognizing personal anger cues and implementing de-escalation strategies when faced with conflict.

The observed correlations between the Gender Role Conflict Scale (GRCS) subscales and the Anger Management Scale (AMS) subscales may help explain the failure of the current intervention and inform development of effective anger management interventions for inmates. Large correlations were observed between Restrictive Emotionality and the Escalating Strategies and Negative Attributions subscales of the AMS indicating that men who are uncomfortable with emotional expression tend to utilize escalating responses to conflict and to assign negative attributions to the target of their anger. Thus mishandled anger may reflect an underlying discomfort with emotional expression or simply reflect poor communication skills. Additionally, small negative correlations were found between Restrictive Emotionality and Self-Awareness and Calming Strategies. Hence, men who restrict emotional expression are also likely to possess decreased self-awareness overall and to not know how to calm themselves when angry. Together, these findings attest to the potential adverse effects of gender role conflict among men and further demonstrate the ways in which gender role conflict impacts the interpersonal relations of men.

The GRCS factors, Restrictive Affectionate Behavior Between Men (RABBM) and Conflict Between Work and Family Relations (CBWFR), were also correlated with
AMS subscales. Specifically, associations were found between RABBM and Escalating Strategies (ES) and between CBWFR and the ES and Negative Attributions (NA) subscales. As a result, it is likely that men who restrict emotional expression in their relations with other men also use escalating responses to conflict. Similarly, men who have difficulty balancing the competing demands of work and family tend to handle anger poorly. It may be that gender role conflict surrounding the overall restriction of emotional expression reflects an underlying ignorance of how to express oneself. This “not knowing” how to express oneself could perhaps explain the associations between RE, RABBM, and poor anger management skills identified in this study.

Restrictive Emotionality was also associated with help-seeking attitudes indicating that men who hold more favorable help-seeking attitudes tend to restrict emotional expressional and feel uncomfortable with the emotional expression of others. This relationship is interesting given that previous research has found restrictive emotionality to generally inhibit help-seeking attitudes and behaviors (Komiya, Good, & Sherrod, 2000; Levant & Pollack, 1995). Similarly, the association between help-seeking attitudes and the Self-Reliance/Self-Assurance subscale of the Entitlement Attitudes Scale suggests that men who have more positive attitudes toward help seeking tend to possess an unhealthy sense of entitlement and are likely to be less self-assured than men with more neutral help-seeking attitudes.

Identified correlations between the EAS subscales and the GRCS subscales confirm and expand previous research documenting associations between these constructs (Magee & Schwartz, in press). In the current study, positive correlations
between narcissistic entitlement and each of GRCS factors (e.g., SPC, RE, RABBM, CBWFR) suggest that men who possess an exaggerated or excessive sense of entitlement are also likely to experience higher levels of gender role conflict than men who maintain a healthy sense of entitlement. Moreover, men who have an inflated sense of entitlement tend to value success, power, and achievement, to restrict emotional expression and correspondingly, to have difficulty establishing close interpersonal relations with other men, and experience conflict balancing the demands of work and family. This is the first known exploration to identify relations between each of the four gender role conflict factors and the Narcissistic Entitlement/Self-Promotion Strategies subscale of the EAS.

Narcissistic entitlement also was correlated with each of the four AMS subscales. Moderate positive correlations were found between narcissistic entitlement and Escalating Strategies and Negative Attributions suggest that men who possess an exaggerated sense of entitlement are likely to use escalating responses to conflict and to assign negative attributions such as blame to the target of their anger. Moderate negative correlations between narcissistic entitlement and Self-Awareness and Calming Strategies subscales suggest that men with a disproportionately high sense of entitlement tend to exhibit little self-awareness surrounding their experience of anger and may lack the skills needed to calm or control their anger. These findings add to the body of research examining narcissistic entitlement and lend support to the literature examining the relationship between entitlement and interpersonal conflict and violence.

Finally, the EAS factor, Self-Reliance/Self-Assurance, was negatively correlated with the RE and CBWFR subscales of the GRCS as well as the ES and NA.
subscales of the AMS. Hence, men who possess a healthy sense of entitlement tend to feel comfortable with emotional expression as well as the competing demands of work and family. Moreover, these men may handle anger more effectively than men who possess unhealthy or an exaggerated sense of entitlement as they tend to minimize the use of escalating responses and negative attributions in conflict situations. Significant correlations between the subscales of the Entitlement Attitudes Scale (EAS) and study variables add to the literature using the EAS as a measure of entitlement and advance understanding of the construct. Although the current study failed to detect any changes in entitlement attitudes post-intervention, the correlational data are encouraging in that healthy entitlement was negatively associated with factors that increase a person’s risk to perpetrate abuse.

Positive and negative correlations among the AMS subscales were detected with the largest being between Self-Awareness and Calming Strategies. The Escalating Strategies subscale was moderately correlated with the Negative Attributions subscale and negatively correlated with Self-Awareness and Calming Strategies suggesting that men who tend to escalate conflict also tend to assign blame to the target of their anger. These men may be unable to recognize personal cues that signal anger and lack the skills needed to deescalate conflict. The strong positive correlation (.59) between Self-Awareness and Calming Strategies suggest that this may be the case as the two are highly correlated and thus closely linked. Altogether, it appears as if the use of escalating responses significantly impedes the effective resolution of conflict through its associations with each of the AMS subscales.
Interpretation of Hypotheses

Hypothesis One

The first hypothesis predicted that experimental group participants would report lower levels of gender role conflict related to Restrictive Emotionality (RE) and Restrictive Affectionate Behavior Between Men (RABBM) after participation in the psychoeducational group than control group participants. Results did not show any significant differences between groups in levels of reported RE and RABBM after participation in the psychoeducational intervention. This hypothesis was not supported by the results of the current study. Although prior research (Schwartz et al., 2004) utilizing a similar intervention was effective in reducing RE in experimental group participants, the current study did not confirm those results. The current results might have been influenced by general characteristics of the sample as well as the environment in which the intervention was conducted. This sample consisted entirely of males incarcerated in a military-style boot camp while the sample utilized by Schwartz et al. consisted of both male and female undergraduate students. As previous research (Komiya, Good, & Sherrod, 2000) has documented the existence of gender differences in the restriction of emotional expression, the failure of the intervention to impact these areas may be reflective of the all-male sample surveyed in this study.

Certain environmental factors may have contributed to the lack of change in the general restriction of emotional expression and the specific expression of emotion between men even after participation in the psychoeducational program. The present study was conducted in an environment that emphasizes aggressive interactions and male gender-role stereotypes. Such a climate may not be conducive to the expression...
of tender emotions as military boot camp programs typically emphasize dominance and physical fitness and employ confrontational modes of expression including repeated verbal insults. As such, participants may not have felt comfortable discussing emotional issues and in some cases may even have feared the potential consequences (i.e., ridicule, reprimand) of revealing their vulnerable side to others. Additionally, participants may feel the need to present themselves as aggressive and uncaring in order to protect themselves from fellow inmates and challenges to their masculinity. Inmates who are perceived as weak or feminine are often taken advantage of by other inmates. Thus, participants may have been unwilling to let their guard down and discuss their true emotions as doing so may have placed them at risk for being bullied, physically harmed, or taken advantage of in other ways.

As thoughtful expression of caring or concern traditionally are not viewed as acceptable masculine forms of communication, male inmates and staff may have difficulties providing emotional feedback and support even in correctional programs that are designed to promote rehabilitation. It may be that the prison environment simply is not “safe” enough to permit inmates or staff to deviate from traditional male patterns of communication. The lack of trust among inmates and staff as well as both parties desire to appear masculine and strong may further hinder effective communication.

Participants’ motivations for participating in this study also may have influenced the current results. Inmates at the study location follow a rigorous schedule consisting of physical labor and mandatory participation in educational and therapeutic activities. As a result, some participants may have volunteered for the study in order to
avoid regularly scheduled activities and may not have been motivated to pay attention during group sessions.

Although characteristics of both the inmate population and the prison environment may have contributed to the lack of change in Restrictive Emotionality and Restrictive Affectionate Behavior Between Men, it is also possible that the psychoeducational intervention itself was ineffective in promoting change in these areas. It may be that the intervention was not powerful enough to lead to a change in participants’ attitudes or that it did not sufficiently address target attitudes and behaviors. Perhaps if the intervention had been longer, participants may have developed more trusting relationships with group members and leaders and felt more comfortable with emotional expression.

Hypotheses Two

Hypothesis two proposed that experimental group participants would report more positive attitudes toward seeking professional psychological help upon completion of the intervention than control group participants. Results did not show any significant differences between groups in reported help-seeking attitudes after participation in the educational groups. The results of this study did not confirm hypothesis two.

Although previous research (Fischer & Farina, 1995; Murstein & Fontaine, 1993) has suggested that mere exposure to mental health services results in more positive attitudes toward seeking psychological assistance, exposure to the psychoeducational intervention in the current study did not impact inmate attitudes toward help-seeking in general. It may be that inmates’ attitudes toward rehabilitation
services tend to be more negative than the attitudes held by other populations, as inmates do not want to expose their vulnerabilities or experience ridicule from others. This lack of change in attitudes may also reflect the suspiciousness of inmates towards the group facilitators, as inmates may be hesitant to self-disclose to anyone working in "the system." Additionally, inmates may be fearful of how documentation of mental health services will be used against them.

In general, correctional settings do not foster feelings of trust and security nor do they facilitate self-disclosure. In the current study, this may be compounded further by the fact that the majority of participants were African Americans while the group facilitators were European American. Studies have consistently shown African Americans under utilize mental health services with these findings often attributed to an overriding sense of cultural mistrust (Snowden, 1999; Whaley, 2001). Given that most mental health professionals in correctional settings are European American (Ferrell, Morgan, & Winterowd, 2000), it is important to consider this potential barrier to treatment in the provision of inmate mental health services to ethnic minorities. Perhaps the current intervention may have yielded different results had an African American served as a group facilitator. Additionally, the limited research on inmate service utilization shows that inmates prefer to seek mental health services from doctoral-level psychologists, and appear to be more reluctant to request assistance from non-doctoral-level-providers (Morgan, Winterowd, & Ferrell, 1999; Morgan, Rozycki, & Wilson, 2004). In the current study, both group facilitators were European American and neither possessed a doctorate in psychology.
Participant characteristics such as age may also contribute to the lack of change in help-seeking attitudes. Research examining the help-seeking attitudes of inmates has shown older inmates possess more favorable attitudes toward seeking psychological assistance than younger inmates (Skogstad, Deane, & Spicer, 2006). In the current study, the mean age of participants was 24 years. Also, participant attitudes may have been influenced by previous experiences with mental health providers both in prison and in the "free" world. Although participants' were not asked about previous treatment, 95% of experimental group participants reported a history of substance abuse or dependence and 27% reported a mental health history. Due to the high rates of substance abuse and incarcerations for drug violations, it is likely that inmates, at some time, were mandated to participate in some form of counseling to address substance abuse and related behaviors. It may be that inmates who have struggled with substance abuse and/or dependence attribute their difficulties with cessation to failed treatment attempts and view all treatment as ineffective. Had information been gathered about previous treatment experiences, more definitive conclusions about inmates' attitudes toward help seeking may have been possible.

The current intervention did not directly try to alter or improve help-seeking attitudes; rather it was hypothesized that attitudes toward help-seeking would improve as a result of exposure to the psychoeducational intervention as suggested by previous authors (Fischer & Farina, 1995). Perhaps the intervention would have been more effective in impacting help-seeking attitudes had it concentrated more on central route attitude change as opposed to peripheral route change.
Additionally, attitudes toward the intervention itself or toward the group experience were not measured. The present study may have been more informative if a specific measure of participant’s attitudes toward the intervention and/or group experience had been included. Future researchers examining the relationship between help-seeking attitudes and therapeutic outcomes may want to consider the inclusion of attitudinal measures specific to the outcome under investigation. Future studies also could address factors that are negatively associated with seeking psychological assistance, such as gender and the perception of stigma associated with counseling. Reducing negative perceptions of psychological treatment has been found to improve the use of mental health services (Kushner & Sher, 1991). Therefore, pretreatment education may be more effective if it addresses concerns about the stigma of receiving psychological help. Additionally, education efforts could focus on the positive outcomes of seeing a psychologist in prison. For example, such efforts could emphasize the ability of psychologists to help inmates cope with and adjust to prison, understand their offending behavior, and help them deal with stress and tension.

Hypotheses Three and Four

Hypotheses three and four examined differences between groups in reported entitlement attitudes after participation in the education groups. Hypothesis three predicted that experimental group participants would report an increase in healthy entitlement as indicated by higher scores on the Self-Reliance/Self-Assurance (SRSA) subscale of the Entitlement Attitudes Scale (EAS) than control group participants. Hypothesis four proposed that experimental group participants would report a decrease in unhealthy entitlement as indicated by lower scores on the Narcissistic
Expectations/Self-Promotion Strategies (NESP) subscale of the EAS than control group participants.

Results did not show any significant differences in SRSA or NESP between groups after participation in the intervention. Hypotheses three and four were not confirmed by study results. Although prior research (Schwartz et al., 2004) utilizing a similar intervention was effective in increasing SRSA in a sample of college students, the current study did not confirm those results. It may be that the punitive nature of the boot camp environment negatively affects the self-esteem of inmates and impedes the development of a healthy sense of entitlement. Constant criticism and confrontation by staff may further negate facilitation of treatment gains. Furthermore, inmates are afforded few, if any, entitlements while incarcerated and may feel worthless, inadequate, and defective as a result of the strain their incarceration has placed on themselves, their family members, and perhaps, even their victims.

The lack of change in NESP may be attributable to the brevity of the intervention, as unhealthy entitlement is theorized to reflect a pathological and distorted self-perception (Meyer, 1991) and as such, may require longer interventions to effect change. Although the intervention did not address self-perceptions, the way in which an individual perceives him or herself in relation to others, is thought to influence an individual's sense of entitlement. Because narcissistic entitlement is thought to serve as a defense against feelings of inferiority sustained as a child, alternate forms of therapeutic assistance, such as individual counseling, may be more effective than group psychoeducation in affecting change. Thus the lack of change in
entitlement attitudes may be attributable to the overall inefficacy of the intervention or to the environment in which it was implemented.

**Hypothesis Five**

Hypothesis five predicted that experimental group participants would report more egalitarian attitudes toward women after participation in the intervention than control group participants. Although overall results of the MANCOVA revealed no significant differences between the experimental and control groups, a robust difference between groups was found in post-intervention scores on the Attitudes Toward Women scale. However, these results were not strong enough to impact the statistical significance of the overall MANCOVA. As such, the results of the current study do not confirm hypothesis five.

Although experimental group participants demonstrated more egalitarian attitudes toward women post-intervention, the observed change was not large enough to conclude that the intervention was effective in developing more positive attitudes toward women. It may be that inmate attitudes toward women did not change because the intervention did not directly address “attitudes toward women.” Instead, the intervention focused on the male and female socialization process with little attention actually given to female gender roles. Perhaps the intervention would have been more effective in fostering development of more egalitarian attitudes toward women had female participants been included in the group and encouraged to share the ways in which females felt restricted by their gender roles.
Hypothesis Six

Hypothesis six proposed that experimental group participants would demonstrate an increase in anger management skills, as evidenced by an increase in Self-Awareness (SA) and a decrease in Escalating Strategies (ES) and Negative Attributions (NA) post-intervention compared to control group participants. Results did not show any significant differences between groups in reported SA, ES, or NA after participation in the intervention. Hypothesis six was not supported by the current results. Prior research (Schwartz et al., 2004) utilizing a similar intervention was effective in increasing self-awareness of anger and decreasing the use of escalating responses to conflict and negative attributions toward the target of anger, the current study did not confirm those results. The current results might demonstrate differences among the sample characteristics and the environment in which both studies were conducted.

Current results also may have been influenced by environmental factors and participants inability to directly apply the skills gained during education sessions to their intimate relationships. First, inmates are afforded limited contact with the outside world. Inmate communications are regulated and monitored. Mail is opened and read by staff, phone conversations are recorded, and visitation, if granted, is supervised. As a result, lack of contact with significant others may have prevented the generalization of any treatment gains to outside relations.

Additionally, 57% of experimental group participants reported being “single” and not involved in a current intimate relationship. As a result, such individuals may not have been motivated to participate in group sessions that focused on effective
communication of anger in relationships and may not have paid attention to the information presented in group sessions.

The modeling of aggressive and confrontational behavior by drill instructors and other prison staff may also have hampered participants’ ability to recognize and alter their own use of escalating responses and negative attributions to the target of anger. Research has shown staff members frequently criticize, insult, and blame inmates confined in boot-camp prisons for their past and current behaviors (Lutze & Murphy, 1999). It may be that anger management interventions are difficult to implement in highly confrontational environments that model and reinforce many of the attitudes and behaviors such interventions are designed to change. It may also be that the intervention itself was ineffective in promoting awareness of mishandled anger among participants. Perhaps a longer intervention that spent more time addressing specific areas of change (i.e., escalating responses, self-awareness, negative attributions) would have produced different results.

Findings and Implications

The purpose of this study was to evaluate a psychoeducational group preventive intervention designed to effect change in factors identified as contributing to the initiation of intimate partner violence in an inmate population. The findings of this study demonstrate that the four-session curriculum based on the work of Schwartz et al. (2004) was ineffective in reducing risk and increasing protective factors associated with intimate partner violence in a selected correctional setting. Participants did not show any significant changes in levels of gender role conflict, sense of entitlement, attitudes toward women, attitudes toward help-seeking, or anger management skills.
after participation in the intervention. A similar intervention previously successful in reducing gender role conflict related to the restriction of emotions, increasing healthy entitlement, and improving anger management skills in a college student population was not effective for participants in this study.

It is possible that the psychoeducational intervention, which is designed to challenge stereotypical male attitudes associated with the perpetration of relationship violence, is simply ineffective due to the material presented, approach used, or group setting. Also, it is conceivable that the current intervention was not effective in the inmate population due to environmental differences, facilitator characteristics, and the difficulties associated with attitude change. Boot camp prisons strongly conform to traditional notions of masculinity and stress the importance of being forceful and strong-willed. Such atmospheres openly reward toughness, bravado, and aggression (Karner, 1998). Drill instructors model forceful control and inadvertently teach inmates to associate success with stereotypical masculine characteristics (Lutze & Murphy, 1999). As such, environmental characteristics and demands may have been too strong for participants to transfer therapeutic gains from the classroom to their current environment. Participants may not have felt “safe” enough in their environment to explore their vulnerabilities and work towards change. Future prevention efforts may want to consider the role of the environment more carefully when developing interventions targeting this population.

The effectiveness of the intervention also may have been affected by facilitator characteristics, such as ethnicity. Research suggests that help-seeking attitudes of minority inmates are negatively affected by a sense of cultural mistrust (Whaley,
2001). In the current study, the majority of participants were ethnic minorities while the group facilitators were European American. Orientation procedures that provide information on cultural barriers to accessing mental health services within the prison may ease the mistrust of newly incarcerated racial minorities. Furthermore, Morgan, Rozycki, & Wilson (2004) found inmates indicated an overall preference for seeking services from psychologists as opposed to a non-doctoral-level provider. In this study, neither facilitator possessed a doctorate. As a result, correctional mental health professionals must be cognizant of the possibility that cultural mistrust may prevent minority inmates from seeking help or even present itself as resistance in therapy. Additionally, prison and mental health administrators may need to re-evaluate hiring practices with a particular focus on hiring more ethnically diverse mental health staff as well as doctoral-level providers.

Finally, the failure of the intervention to affect change among participants may simply reflect the difficulty inherent in any effort to modify attitudes that have developed over a lifetime. Attitude change may only be possible when participants are exposed to more long-term, experientially oriented interventions, in which participants are repeatedly exposed to the facts and consequences associated with the topic of the intervention. In the current study, groups met for ninety minutes twice a week over a two-week period. A lengthier intervention may have given participants more time to process the information presented and to reflect on the ways in which their attitudes and behaviors impact their intimate relationships.

Aside from the lack of findings directly related to study hypotheses, ancillary findings contribute to the understanding of the inmate population and the relationship
between study variables. What follows is an examination of observed correlations between demographic and scale/subscale variables. It should be noted that this analysis is exploratory in nature, as the current study did not predict any associations among variables. However, identified relationships between variables present implications for correctional, as well as noncorrectional, psychologists and mental health professionals.

In the current study, several correlations between substance abuse and scale/subscale variables were found. Examination of the nature of these relationships provides additional information about substance abusers and offers considerations for professionals who treat addictive disorders. As substance abuse history was associated with both narcissistic entitlement and restrictive emotionality, therapists working with this population may want to evaluate the entitlement attitudes of clients and assist them in developing a more healthy sense of entitlement. Because narcissistic entitlement is thought to emerge as a defense against feelings of inferiority and shame, it may be revealing for clients to explore the ways through which both their defenses and their substance use "protect" them from experiencing or expressing vulnerable emotions.

Therapists might consider the ways in which multicultural differences impact the restriction of emotional expression among men of varying ethnic backgrounds and explore these differences with male clients. In addition to its association with substance abuse, the desire to ward off painful emotions often presents itself therapeutically, as resistance to treatment. As research has shown individuals who are more closed to their emotions to also perceive greater stigma associated with receiving psychological treatment, public education efforts designed to increase mental health
Service utilization may be more effective if such efforts attempt to increase comfort with and openness to emotions.

Finally, as a history of substance abuse was associated with a lack of awareness surrounding personal anger cues and de-escalation techniques, individuals working with male substance abusers may want to incorporate conflict resolution and anger management skills training into their treatment. As inability’s to effectively identify, communicate, or de-escalate emotions have been associated with relapse, therapists may want to evaluate these skills among individual clients and provide relevant education if needed. Additionally, by exploring how gender role expectations imposed by society contribute to or maintain both substance abuse behaviors and the restriction of emotions, therapists may help male clients view many of their maladaptive attitudes and behaviors as learned and thus amenable to change.

The identified relationships among entitlement attitudes and study variables contribute to the limited body of literature that has utilized the Entitlement Attitudes Scale. Previous research examining the relation between entitlement and gender role conflict found that men who exhibit an excessive sense of entitlement tend to place an excessive focus on achievement and control over others and to restrict or devalue emotional expression. In the current study, exaggerated entitlement was associated with each of the four GRCS factors, suggesting that men who exhibit this type of entitlement also are likely to have difficulty expressing caring feelings to other men as well as difficulty balancing work and family responsibilities. It may be that these correlational differences reflect actual differences in entitlement attitudes among the college student and inmate samples surveyed, with unhealthy entitlement more closely

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linked with the experience of gender role conflict among inmates; however, definitive conclusions can not be drawn from one small study. As an exaggerated sense of entitlement is often characteristic of certain personality disorders (e.g., antisocial, narcissistic) understanding the relations between gender role conflict and narcissistic entitlement may allow therapists and other professionals to develop more appropriate interventions. Understanding the relationship between gender role conflict and exaggerated entitlement in a correctional setting may help explain the adjustment process for inmates to the prison environment.

In addition to its relation with the GRCS subscales, narcissistic entitlement was associated with each of the four AMS subscales. Such findings suggest that not only do men who exhibit exaggerated entitlement tend to experience gender role conflict but also experience difficulty managing anger. As a result, consideration of the relationship among these variables may assist in the design of more efficacious interventions. Because narcissistic entitlement is thought to reflect a pathological and distorted self-perception, longer interventions may be more effective than short-term interventions in effecting change among men with an exaggerated sense of entitlement.

Analysis of the associations between healthy entitlement and study variables was somewhat encouraging as findings suggest that men who possess a healthy sense of entitlement tend to experience less emotional restriction and less conflict related to balancing work and family responsibilities. Moreover, negative associations between healthy entitlement and the use of escalating responses and negative attributions in conflict situations provides further support for the idea that a healthy sense of entitlement may ultimately serve as a protective factor against involvement in intimate
partner violence. Resultantly, education and prevention efforts that target those at risk for perpetrating abuse may want to consider the role of a sense of entitlement in healthy human functioning.

Exploration of the relationship between gender role conflict and the ability to constructively manage anger provides further support for the inclusion of these variables in the design of interventions aimed at reducing interpersonal conflict or violence. Although correlations were found between each of the four GRCS factors and each of the four AMS subscales, the most noteworthy relationships were between restrictive emotionality and the escalating strategies and negative attributions subscales. It may be that men who tend to escalate conflict by assigning negative attributions to the target of their anger do so because they lack alternatives for dealing with and expressing their emotions. In therapeutic settings, practitioners might consider assessing gender role conflict related to restrictive emotionality and consider the degree to which discomfort with emotional expression impacts the intra- and interpersonal functioning of male clients. Additionally, education and prevention efforts designed to increase conflict resolution and anger management skills should explore the potential influence of gender role socialization on the expression of emotions, thus normalizing men's fears surrounding the expression of vulnerable emotions.

In summary, the current study was an effort to address recent calls made by counseling psychology to increase empirical efforts in the area of primary prevention and to conduct more research examining treatment outcomes in the inmate population. Although study results failed to support the efficacy of a selected psychoeducational
intervention in decreasing risk and increasing protective factors associated with intimate partner violence in one inmate population, the current study offers a number of contributions to the psychological literature.

First, the failure of the intervention in an inmate population raises questions about the design of the psychoeducational program as well as the nature of the boot camp environment. Although it is entirely possible that the intervention is simply not effective in impacting change in study variables, it is also possible that characteristics of the boot camp environment prevented participants from transferring therapeutic gains from the therapy room to the prison environment. Correctional settings that strongly conform to traditional notions of masculinity are suggested to inhibit inmate adjustment and efforts at rehabilitation (Lutze, 1998). Research on inmate adjustment shows that safety, support, emotional feedback, and positive interactions with others are important for prosocial change (Goodstein & Wright, 1989; Lutze, 1998); however, these attributes may be compromised in atmospheres that emphasize male gender role stereotypes and may be magnified in the boot camp setting.

Second, exploratory research based on analysis of the correlations between demographic and scale/subscale variables advances understanding of the constructs examined in this study. In addition to increasing knowledge of the relationships between constructs, the findings of this study provide further evidence regarding the validity of study constructs and enhance understanding of the inmate population. Overall, the results of this study have important implications for those working to prevent or reduce the occurrence of relationship violence, as well as for those working to improve the intra- and interpersonal functioning of men. As it is likely that
psychologists will at some time provide therapeutic services to offender clients, an awareness of the issues faced by this diverse population is important.

**Limitations**

Although the current study utilized accepted methodology, the following limitations should be noted when interpreting the results of this study. First, the ineffectiveness of the intervention in changing attitudes associated with the perpetration of relationship violence raises questions surrounding the design and implementation of the intervention. For example, the efficacy of the current intervention may have been limited by its approach and format (e.g., a cognitive psychoeducational group) as well as facilitator characteristics, such as gender, age, and ethnicity.

Participant characteristics present additional limitations. The sample was comprised of adult male inmates incarcerated in a military-style boot camp program. All subjects were non-violent offenders and were housed within a medium security correctional facility in the southern US. The majority of participants were ethnic minorities with an average age of 24 years. As sample characteristics are not representative of the general population, results should not be generalized to other populations of offenders, correctional settings, geographic areas, age groups, or ethnic backgrounds. In addition, a larger sample may have increased the possibility of seeing smaller changes in attitudes associated with the initiation of partner violence. Although post-hoc analysis of power (.80) determined the sample size to be adequate, a larger and more diverse sample may have yielded different results.
Another potential limitation that should be considered when interpreting results is the environment in which the study was conducted. This study was implemented in a military-style boot camp prison located within a medium security state department of corrections facility. Boot camp prisons have been criticized for emphasizing aggressive interactions and male gender role stereotypes leading some to question the impact such an environment has on an inmate's ability to undergo prosocial adjustment (Lutze & Murphy, 1999; Morash & Rucker, 1990). Research examining the influence of the prison environment on inmates' adjustment, found inmates who defined the environment as highly masculine were more likely to report greater levels of isolation, stress, helplessness, assertiveness, and conflict with staff and other inmates (Lutze & Murphy, 1999). Such findings suggest that boot camp environments may be limited in their ability to provide the safety and support needed for inmates to pursue personal change.

Finally, the use of self-report measures, which are susceptible to response bias, may further limit interpretation of study results. As no measure of social desirability was used, it is impossible to determine if participants were motivated to respond to certain items more favorably. The instruments used in this study may present additional limitations as well. First, there is a lack of psychometric data for prison inmates on the scales used in this study. Also, a number of measures were found to possess poor internal consistency reliabilities, raising questions surrounding the use of these measures in the inmate population.
Future Research

Although the current study was not effective in decreasing risk and increasing protective factors associated with intimate partner violence, future research is clearly needed to address the limitations noted in this study. As counseling psychology is committed to the areas of primary prevention and early intervention, research efforts must continue to focus on the development and evaluation of effective programs designed to prevent, and ultimately eliminate, intimate partner violence. Future efforts may want to examine the utility of this intervention or other interventions in a less restrictive environment or with an ethnically diverse population. As research suggests correctional environments differ in the degree to which they subscribe to and reinforce traditional notions of masculinity (Lutze & Murphy, 1999), it may be informative to examine the efficacy of the current intervention in prisons of differing security levels or in prisons for women. Future research may want to consider obtaining a larger sample size and assigning fewer participants to each treatment condition even if it means increasing the total number of groups. Finally, researchers may want to consider assessing participants’ stage of change prior to group assignment as it may be beneficial to make group assignments based on where participants are in the change process.

Exploratory research identified numerous correlations between the constructs measured in this study. In correctional settings, future studies could explore the relation between gender role conflict, entitlement, and inmate adjustment. As both gender role conflict and an exaggerated sense of entitlement are thought to impede healthy functioning, they may also impact an inmate’s adjustment to prison. It may
also be interesting to examine the existence of identified relationships in other populations as well. Future research may want to consider the role of narcissistic entitlement in the relationship between the GRCS and the AMS. It may be that the relationship between gender role conflict and anger management is mediated by narcissistic entitlement. Finally, unexpected patterns were observed in internal consistency reliability scores for many of the instruments used pre- and posttest. Future research may want to examine these patterns further and explore potential reasons for this occurrence in the inmate population.

As the inmate population continues to increase, more research is needed to increase understanding of this population as well as the impact of the correctional environment on inmate adjustment and rehabilitation. As untreated offenders have higher rates of recidivism (Bakker & Riley, 1996), researchers may want to focus on identification of factors that influence help-seeking in prison and explore strategies that aim to increase mental health service utilization by inmates. There also is a need for more group treatment outcome studies with the inmate population as helping inmates to avoid future criminal behavior and become productive members of society has important implications for society.
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APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL
MEMORANDUM

TO: Ms. Melani Magee Wheeler and Dr. Walt Buboltz

FROM: Barbara Talbot, University Research

SUBJECT: HUMAN USE COMMITTEE REVIEW

DATE: October 22, 2007

In order to facilitate your project, an EXPEDITED REVIEW has been done for your proposed study entitled:

"Evaluation of a Psychoeducation Intervention Designed to Impact Attitudes Associated with Interpersonal Conflict and Help-Seeking Behaviors in an Inmate Population"

# HUC-367

The proposed study’s revised procedures were found to provide reasonable and adequate safeguards against possible risks involving human subjects. The information to be collected may be personal in nature or implication. Therefore, diligent care needs to be taken to protect the privacy of participants and to assure that the data are kept confidential. Informed consent is a critical part of the research process. The subjects must be informed that their participation is voluntary. It is important that consent materials be presented in a language understandable to every participant. If you have participants in your study whose first language is not English, be sure that informed consent materials are adequately explained or translated. Since your reviewed project appears to do no damage to the participants, the Human Use Committee grants approval of the involvement of human subjects as outlined.

Projects should be renewed annually. This approval was finalized on April 24, 2007 and this project will need to receive a continuation review by the IRB if the project, including data analysis, continues beyond April 24, 2008. Any discrepancies in procedure or changes that have been made including approved changes should be noted in the review application. Projects involving NIH funds require annual education training to be documented. For more information regarding this, contact the Office of University Research.

You are requested to maintain written records of your procedures, data collected, and subjects involved. These records will need to be available upon request during the conduct of the study and retained by the university for three years after the conclusion of the study. If changes occur in recruiting of subjects, informed consent process or in your research protocol, or if unanticipated problems should arise it is the Researchers responsibility to notify the Office of Research or IRB in writing. The project should be discontinued until modifications can be reviewed and approved.
If you have any questions, please contact Dr. Mary Livingston at 257-4315.

* Note:

Dr. Gary Stokely, prisoner representative, and the IRB Board made the following recommendations

1. The project director should give the warden a progress report both before the study begins and after the study is completed.

2. Dr. Stokely recommended the Anger Management Scale questionnaire be given last since it is the one that would be the most emotionally reactive.

3. Please be reminded that in case of any unexpected, adverse effects they should be reported to the IRB.
APPENDIX B

HUMAN SUBJECTS CONSENT FORM
HUMAN SUBJECTS CONSENT FORM

The following is a brief summary of the project in which you are asked to participate. Please read this information before signing the statement below.

TITLE OF PROJECT: Evaluation of a psychoeducational intervention designed to impact attitudes associated with interpersonal conflict and help-seeking behaviors in an inmate population

PURPOSE OF STUDY/PROJECT: To evaluate the efficacy of a group psychoeducational preventive intervention in reducing or changing male attitudes associated with interpersonal conflict and seeking psychological assistance.

PROCEDURE: Participation in a psychoeducational group and completion of pre-post test measures.

INSTRUMENTS: Gender Role Conflict Scale, Entitlement Attitudes Scale, Attitudes Toward Women Scale, Anger Management Scale, Attitudes Toward Seeking Professional Psychological Help Scale, Demographic Questionnaire.

RISKS/ALTERNATIVE TREATMENTS: There are no risks associated with participation in this study. It requires voluntary completion of a survey packet of the aforementioned instruments and voluntary participation in four psychoeducational group sessions. Participation is voluntary and participants are encouraged to notify group facilitators if any information discussed during the course of group sessions causes discomfort or distress. Participants will also be informed of the procedure for obtaining mental health services within Forcht Wade should the need arise.

BENEFITS/COMPENSATION: None.

I, ________________________________, attest with my signature that I have read and understood the following description of the study, "Evaluation of a psychoeducational intervention designed to impact attitudes associated with interpersonal conflict and help seeking behaviors in an inmate population", and its purposes and methods. I understand that my participation in this research is strictly voluntary and my participation or refusal to participate in this study will not affect my relationship with the IMPACT boot camp program or Forcht Wade Correctional Center in any way. Further, I understand that I may withdraw at any time or refuse to answer any questions without penalty. Upon completion of the study, I understand that the results will be freely available to me upon request. I understand that the results of my survey will be confidential, accessible only to the principal investigators, myself, or a legally appointed representative. I have not been requested to waive nor do I waive any of my rights related to participating in this study.

________________________________________  ________________________
Signature of Participant or Guardian        Date

CONTACT INFORMATION: The principal experimenters listed below may be reached to answer questions about the research, subjects' rights, or related matters.

Melani Magee Wheeler (318.455.6122)        Dr. Walter Buboltz (318.257.4039)

Members of the Human Use Committee of Louisiana Tech University may also be contacted if a problem cannot be discussed with the experimenters:

Dr. Les Guice (257-3056)
Dr. Mary M. Livingston (257-2292 or 257-4315)
APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE
Demographic Questionnaire

Please complete the following questions by either filling in the blank or marking the appropriate response.

1. Age: _____

2. Race/Ethnicity: ______ White ______ Black ______ Hispanic ______ Asian
   ______ Native American ______ Other/Unknown

3. What is the highest grade you completed in school? ______

4. Marital Status: ______ Single ______ Married ______ Divorced
   ______ Remarried ______ Widowed ______ Living with someone

5. Parents Marital Status: ______ Married to Each Other ______ Divorced
   ______ Separated ______ Never Married ______ One or Both Parents Deceased
   ______ Unknown

6. Number of Children: ______

7. Age at First Arrest: ______

8. Current Criminal Conviction(s): _______________________________________

9. Number of Prior Incarcerations: ______

10. Do you have a history of substance abuse?  Yes  No

    If you answered yes, which of the following substances is (was) your drug of choice? Please select only one option.

        ______ alcohol ______ marijuana ______ cocaine ______ amphetamines
        ______ opiates ______ hallucinogens ______ benzodiazepines

        Other: ______________________________________________________________________

11. Have you ever received a mental health diagnosis?  Yes  No

    If you answered yes, what was your diagnosis? If you are not sure, please answer

    "Unsure." ______________________________________________________________________

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APPENDIX D

GENDER ROLE CONFLICT SCALE
The Gender Role Conflict Scale

**GRCS**

*Instructions:* In the space to the left of each sentence below, write the number which most closely represents the degree that you Agree or Disagree with the statement. There is no right or wrong answer to each statement; your own reaction is what is asked for.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
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<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

1. _____ Moving up the career ladder is important to me.
2. _____ I have difficulty telling others I care about them.
3. _____ Verbally expressing my love to another man is difficult for me.
4. _____ I feel torn between my hectic work schedule and caring for my health.
5. _____ Making money is part of my idea of being a successful man.
6. _____ Strong emotions are difficult for me to understand.
7. _____ Affection with other men makes me tense.
8. _____ I sometimes define my personal value by my career success.
9. _____ Expressing feelings makes me feel open to attack by other people.
10. _____ Expressing my emotions to other men is risky.
11. _____ My career, job, or school affects the quality of my leisure or family life.
12. _____ I evaluate other people’s value by their level of achievement and success.
13. _____ Talking (about my feelings) during sexual relations is difficult for me.
14. _____ I worry about failing and how it affects my doing well as a man.
15. _____ I have difficulty expressing my emotional needs to my partner.

16. _____ Men who touch other men make me uncomfortable.

17. _____ Finding time to relax is difficult for me.

18. _____ Doing well all the time is important to me.

19. _____ I have difficulty expressing my tender feelings.

20. _____ Hugging other men is difficult for me.

21. _____ I often feel that I need to be in charge of those around me.

22. _____ Telling others of my strong feelings is not part of my sexual behavior.

23. _____ Competing with others is the best way to succeed.

24. _____ Winning is a measure of my value and personal worth.

25. _____ I often have trouble finding words that describe how I am feeling.

26. _____ I am sometimes hesitant to show my affection to men because of how others might perceive me.

27. _____ My needs to work or study keep me from my family or leisure more than I would like.

28. _____ I strive to be more successful than others.

29. _____ I do not like to show my emotions to other people.

30. _____ Telling my partner my feelings about him/her during sex is difficult for me.

31. _____ My work or school often disrupts other parts of my life (home, family, health, leisure).

32. _____ I am often concerned about how others evaluate my performance at work or school.
<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td></td>
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<tr>
<td>4</td>
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<tr>
<td>3</td>
<td></td>
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<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

33. _____ Being very personal with other men makes me feel uncomfortable.

34. _____ Being smarter or physically stronger than other men is important to me.

35. _____ Men who are overly friendly to me, make me wonder about their sexual preference (men or women).

36. _____ Overwork and stress, caused by a need to achieve on the job or in school, affects/hurts my life.

37. _____ I like to feel superior to other people.
APPENDIX E

ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP SCALE
Attitudes Toward Seeking Professional Psychological Help Scale

ATSPPH

Instructions: Please read each statement and circle the response that best describes your level of agreement with each statement.

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
   Agree Partly Agree Partly Disagree Disagree

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflict.
   Agree Partly Agree Partly Disagree Disagree

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
   Agree Partly Agree Partly Disagree Disagree

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.
   Agree Partly Agree Partly Disagree Disagree

5. I would want to get psychological help if I were worried or upset for a long period of time.
   Agree Partly Agree Partly Disagree Disagree

6. I might want to have psychological counseling in the future.
   Agree Partly Agree Partly Disagree Disagree

7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.
   Agree Partly Agree Partly Disagree Disagree
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Partly Agree</th>
<th>Partly Disagree</th>
<th>Disagree</th>
</tr>
</thead>
</table>

9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Partly Agree</th>
<th>Partly Disagree</th>
<th>Disagree</th>
</tr>
</thead>
</table>

10. Personal and emotional troubles, like many things, tend to work out by themselves.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Partly Agree</th>
<th>Partly Disagree</th>
<th>Disagree</th>
</tr>
</thead>
</table>
APPENDIX F

ENTITLEMENT ATTITUDES SCALE
The Entitlement Attitudes Scale

EAS

Please indicate how much you agree or disagree with the following statements according to the seven-point scale:

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Neutral</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

1. I am more optimistic about other people's success than I am about my own.
2. It is easy for people to take advantage of me without my realizing it.
3. When I don't get what I feel is rightfully mine it makes me angry.
4. When I ask people to do things for me I feel like I am imposing.

Now please indicate how much the following statements are true for you according to the seven-point scale:

<table>
<thead>
<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

5. I feel obliged to fulfill any demand made of me.
6. I am easily intimidated by opinionated people.
7. I don't have the courage to stand up for myself when someone infringes on my rights.
8. I hesitate to assert my preferences or opinions over someone else's.
9. I insist upon getting my due.
10. I expect other people to do special favors for me.
11. Looking out for my own welfare is my main responsibility.
12. I expect to have my way.
13. I hesitate to ask friends for support because I don't want to be a burden.
14. I expect to be catered to.
15. I continue an argument until I win.
16. I can't seem to say "no" even when I really don't want to do something.
17. I like to be fussed over.
APPENDIX G

ATTITUDES TOWARD WOMEN SCALE
The Attitudes Toward Women Scale

AWS

Instructions: The statements listed below describe attitudes toward the roles of women in society which different people have. There are no right or wrong answers, only opinions. You are asked to express your feeling about each statement by indicating whether you: (A) agree strongly, (B) agree mildly, (C) disagree mildly, or (D) disagree strongly.

1. Swearing and obscenity are more repulsive in the speech of a woman than of a man.
   A  B  C  D
   Agree strongly Agree mildly Disagree mildly Disagree strongly

2. Under modern economic conditions with women being active outside the home, men should share in household tasks such as washing dishes and doing the laundry.
   A  B  C  D
   Agree strongly Agree mildly Disagree mildly Disagree strongly

3. It is insulting to women to have the "obey" clause remain in the marriage service.
   A  B  C  D
   Agree strongly Agree mildly Disagree mildly Disagree strongly

4. A woman should be free as a man to propose marriage.
   A  B  C  D
   Agree strongly Agree mildly Disagree mildly Disagree strongly

5. Women should worry less about their rights and more about becoming good wives and mothers.
   A  B  C  D
   Agree strongly Agree mildly Disagree mildly Disagree strongly

6. Women earning as much as their dates should bear equally the expense when they go out together.
   A  B  C  D
   Agree strongly Agree mildly Disagree mildly Disagree strongly
7. Women should assume their rightful place in business and all the professions along with men.

   A  B  C  D
   Agree strongly  Agree mildly  Disagree mildly  Disagree strongly

8. A woman should not expect to go to exactly the same places or to have quite the same freedom of action as a man.

   A  B  C  D
   Agree strongly  Agree mildly  Disagree mildly  Disagree strongly

9. Sons in a family should be given more encouragement to go to college than daughters.

   A  B  C  D
   Agree strongly  Agree mildly  Disagree mildly  Disagree strongly

10. It is ridiculous for a woman to run a locomotive and for a man to darn socks.

    A  B  C  D
    Agree strongly  Agree mildly  Disagree mildly  Disagree strongly

11. In general, the father should have greater authority than the mother in the bringing up of children.

    A  B  C  D
    Agree strongly  Agree mildly  Disagree mildly  Disagree strongly

12. The intellectual leadership of a community should be largely in the hands of men.

    A  B  C  D
    Agree strongly  Agree mildly  Disagree mildly  Disagree strongly

13. Economic and social freedom is worth far more to women than acceptance of the ideal of femininity, which has been set up by men.

    A  B  C  D
    Agree strongly  Agree mildly  Disagree mildly  Disagree strongly

14. There are many jobs in which men should be given preference over women in being hired or promoted.

    A  B  C  D
    Agree strongly  Agree mildly  Disagree mildly  Disagree strongly
15. Women should be given equal opportunity with men for apprenticeship in the various trades.

   A   B   C   D
   Agree strongly  Agree mildly  Disagree mildly  Disagree strongly
APPENDIX H

ANGER MANAGEMENT SCALE
The Anger Management Scale

AMS

The following statements are about you or the relationship between you and your partner. Please read each statement and decide how much you agree with it.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When my partner picks a fight with me, I fight back.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>2. When my partner won't give in, I get furious.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>3. I often take what my partner says personally.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>4. My partner believes I have a short fuse.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>5. I can feel my blood rising when I start to get mad at my partner.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>6. Taking a break from my partner is a good way for me to calm down.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>7. When my partner is around, I feel like a bomb waiting to explode.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>8. I prefer to get out of the way when my partner hassles me.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>9. It is my partner's fault when I get mad.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>10. When my partner is nice to me I wonder what my partner wants.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>11. No matter how angry I am, I am responsible for my behavior toward my partner</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>12. When my partner provokes me, I have a right to fight back.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>15</td>
<td>There is nothing I can do to control my feelings when my partner hassles me.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>16</td>
<td>My partner is rude to me unless I insist on respect.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>17</td>
<td>My partner likes to make me mad.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>18</td>
<td>When my partner annoys me, I blow up before I even know that I am getting angry.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>19</td>
<td>I recognize when I am beginning to get angry at my partner.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>20</td>
<td>I am able to remain calm and not get angry at my partner.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>21</td>
<td>I can usually tell when I am about to lose my temper at my partner.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>22</td>
<td>I take time out as a way to control my anger at my partner.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>23</td>
<td>I take a deep breath and try to relax when I’m angry at my partner.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>24</td>
<td>I can set up a time-out period during an argument with my partner.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>25</td>
<td>When I feel myself getting angry at my partner, I try to tell myself to calm down.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>26</td>
<td>I often think of something pleasant to keep from thinking about my anger at my partner.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>27</td>
<td>When I’m angry at my partner, I try to handle my feelings so no one gets hurt.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>28</td>
<td>If I keep thinking about what made me mad, I get angrier.</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>---</td>
<td>------------------</td>
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</tr>
<tr>
<td>29. When arguing with my partner, I often raise my voice.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>30. I do something to take my mind off my partner when I’m angry.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>31. When I’m mad at my partner, I say what I think without thinking of the consequences.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>32. When my partner’s voice is raised, I don’t raise mine.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>33. My partner thinks I am very patient.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>34. I can calm myself down when I am upset with my partner.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>35. When I feel myself starting to get angry at my partner, I try to stick to talking about the problem.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>36. I am even-tempered with my partner.</td>
<td>1 2 3 4</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX I

EXPERIMENTAL GROUP TREATMENT
OUTLINE FOR EXPERIMENTAL GROUP TREATMENT

I. Session One: General Introduction and Styles of Communication

A. Welcome and Introductions
   1. Thank members for participation
   2. Introductions
   3. Distribute and discuss “Group Rules” and “Confidentiality” handouts

B. Review Objectives for Session One
   1. To establish community within the group
   2. To demonstrate the power of nonverbal communication
   3. To increase participant awareness of assertiveness and its impact on relationships

C. Non-Verbal Communication
   1. Ask for examples of how individuals communicate non-verbally
   2. Note that approximately 70% of all communication is non verbal
   3. Present brief overview of non-verbal communication including
   4. Demonstrate non-verbal cues and ask members of group to interpret
   5. Non-Verbal Birthday Line-Up

D. Aggression
   1. Ask participants if they know the difference between assertive and aggressive communication
   2. Explain basic concepts of assertive communication

E. Descriptions of Communication Approaches:
   1. Passive
   2. Aggressive
   3. Passive-aggressive
   4. Assertive

F. Anger
   1. Ask members what they think of when they hear the word “anger”
   2. Discuss anger as a normal emotion

G. Wrap-Up
   1. Invite participants to share impressions of first session
II. Session Two: Empathic Communication and Reflective Listening

A. Welcome
   1. Ask members if they have any questions/comments regarding initial group session
   2. Process any questions/comments

B. Objectives for Session 2
   1. To demonstrate empathic communication skills
   2. To examine the influence of our family of origin on our thoughts, feelings, actions, and relationships with others

C. Empathic Listening
   1. Distribute handout: *Principles of Empathic Communication*
   2. Review handout with group
      - Define terms such as selective and attentive listening
      - Clarify the four autobiographical responses (explain if necessary)
      - Ask if anyone has any questions/comments

D. Genogram
   1. Distribute Genogram handout (Genogram & The Diagram)
   2. Review purpose of the activity
   3. Define Genogram – STRESS CONFIDENTIALITY – and remind members they only have to share what they are comfortable sharing
   4. Explain how to complete the diagram using sample genogram
   5. Have participants complete their own Genograms
   6. Proceed with questions

E. Closing
   1. Invite participants to share impressions of second session
   2. What, if anything, did you find useful / not useful?
III. Session Three: Assertive Communication and Anger

A. Welcome
   1. Check-in on reactions and responses to last group session
   2. Process any questions/comments

B. Objectives for Session 3
   1. Demonstrate assertive communication
   2. Examine group members experience of anger and learn anger management skills

C. Assertive Communication
   1. Discuss skills associated with assertive communication
   2. Distribute handouts on “I statements” and “Assertive communication” and review
   3. Encourage group to practice assertive communication in their group interactions

D. Personal Experience with Anger
   1. Teach MACE Wheel and show MACE diagram
   2. Discuss examples
   3. Distribute “Anger” handout and complete and process during group
      - Ask members to provide supportive comments and practice empathic communication skills
   4. Discuss how to intervene to control anger at each stage

E. Closing
   1. Invite participants to share impressions of second session
   2. What, if anything, did you find useful / not useful?
IV. Session Four: Relationship Conflict and Violence

A. Welcome
   1. Check-in on reactions and responses to last group session
   2. Process any questions/comments

B. Objectives for Session 4
   1. Increase awareness of the societal problem of relationship conflict and violence
   2. Increase awareness of the impact of power and control in relationships
   3. Increase awareness between self-esteem and violence

F. Discussion of societal problem of violence
   1. Differences between emotional and physical abuse
   2. Statistics
   3. Media influence

G. Power and Control
   1. View video clip of relationship violence
   2. Process feelings/thoughts about video
   3. Discuss relationship between violence and low self-esteem

H. Development of Social Conscience
   1. Discuss what can be done to decrease violence
   2. Discuss what can be done if violence is seen or heard

I. Self-Value
   1. Facilitators model verbalizations of personal characteristics they value about themselves
   2. Have group members verbalize what they value about themselves
   3. Facilitators model verbalizations of personal characteristics they value in other group members
   4. Have group members verbalize what they value about other group members

J. Closing
   1. Discuss impressions of fourth session
   2. Discuss impressions of group as a whole
RELATIONSHIP AWARENESS GROUP

As a member of this group I agree to:

1. Commit myself to attending all sessions and arriving on time.

2. Keep all information discussed, including names of members, completely confidential and sign a contract to this effect.

3. Be open and honest in my sharing. I will share to the degree that I feel comfortable and work toward more comfort and more sharing.

4. Be respectful of other group members. I will learn and use appropriate communication skills and avoid causing distress for any other group member.

5. Avoid monopolizing the session. I realize that through group interaction I can gain insight and learn skills. Therefore, I will honor the opportunity for each member to contribute.

6. Seek additional assistance from group facilitator or other mental health professionals if issues discussed in group cause extreme discomfort.
GROUP CONFIDENTIALITY STATEMENT

I am aware of the personal and confidential nature of discussion within this group and I agree to respect fellow members by maintaining confidentiality outside the group setting. I realize that sharing personal information about any other member, including reference to name’s of members, might emotionally harm individual participants and impair the group’s effectiveness.

Signature  Date
"Seek first to understand, then be understood."

Principles of Empathic Communication

Character & Communication
- Communication is the most important skill in life
- If you want to interact effectively with others, or influence others, you first need to understand others
- You have to build the skills of empathic listening on a base of character that inspires openness and trust

Empathic Listening
- Most people listen with intent to reply
- When another person speaks, we are usually ‘listening’ at one of four levels
  - Ignoring (not listening)
  - Pretending (acting like we are listening)
  - Selective listening (hearing what we want or choose to hear)
  - Attentive listening (paying attention to what someone is saying; actually hearing what someone is saying)

Very few of us ever practice the highest form of listening -- empathic listening
- Only 10% of our communication is represented by the words we say, another 20% by our sounds, and 70% by body language
- Empathic listening is risky

Four Autobiographical Responses
- Because we listen autobiographically (from the perspective of our own paradigms), we tend to respond in one of four ways:
  - We evaluate (judge; assess)
  - We probe (question; scrutinize)
  - We advise (give advice; counsel)
  - We interpret (translate; explain)
- The language of logic is different from the language of sentiment and emotion.
- As long as responses are logical, we are at liberty to ask questions and give advice. The moment responses become emotional, empathic listening is necessary.
- Empathic listening involves four developmental stages:
  - Restate content
  - Rephrase the content
  - Reflect feeling
  - Rephrase the content and reflect the feeling
- Empathic listening allows us to turn transactional opportunities into transformational opportunities.
- As you learn to listen deeply to other people, you will discover tremendous differences in perceptions.

The key to empathic listening is to genuinely seek the welfare of the individual to whom you are listening.
Reflective Listening

A reflective listener will respond by:
- Repeating as nearly as possible what s/he heard word for word
- Re-phrasing the speaker’s statement in one’s own words
- Describing what they think the other person feels about what they just said

Example of reflective listening responses to a single statement:

Speaker: “My dorm mate cuts up when we are supposed to be working.”

Listener:
- “Your dorm mate cuts up when you are supposed to be working.”
- “Whenever you are supposed to be working, he acts silly and messes around.”
- “It makes you kind of angry when you are working and he cuts up and gets you in trouble.”

Example of reflective listening responses during a conversation:

Speaker: “I called my girlfriend last night. She said she was busy and to call her back in 5 minutes. When I called her back, she wasn’t there.

Listener:
- “You called your girlfriend last night. She said she was busy and to call back. When you called back she wasn’t there.”
- “You wanted to talk to your girlfriend but weren’t able to.”
- “You miss your girlfriend and wonder what she’s doing and why she didn’t answer the phone.”
Genogram

**Purpose of this activity:**

Our families have a powerful influence on how we think and feel about the world and how we relate to other people. As we age and mature, we begin to understand who we are, whom we chose as friends and partners, and how we relate to others. We may begin to see how the ways that our family members think and act toward one another are patterns that extend across several generations. The purpose of this activity is to help you begin to see how your family has shaped the way you relate with others and feel about the world. By understanding how our families influence us, we can consciously choose which patterns we want to continue in our lives and which things we want to change.

**What is a genogram?**

A genogram is a special format for drawing a family tree that records information about family members and their relationships across three generations. Genograms display information graphically in a way that allows you to identify the themes and patterns in your family. Most people enjoy this activity because they gain insights about how they fit into their family and how the generations continue to influence each other. You may also gain a greater appreciation and understanding of your family’s strengths and struggles as you look at your family in this new way.

Both parts of the genogram ask for fairly personal information about you and your family. All information on the genogram is confidential!! Share only what you feel comfortable sharing.

**If you find that you have difficulties of any kind in doing this assignment, please be sure to let the group facilitator know. Participation in this activity is VOLUNTARY.**
The Diagram

Required Information:

A. Three generations:

1. Include yourself, your brothers and/or sisters, step- and half- brothers/ sisters. If you have a spouse and children, please list them as well.

2. Include your parents. If you have a stepparent, include him/her as well. You may also include other family members who were influential to you.

3. Include your grandparents. If you have a step grandparent, include him/her as well.

4. Include any other family member that has been influential to you.

B. Place your father’s family on the left and your mother’s family on the right. Males are represented as squares, females as circles.

C. Arrange brothers and/or sisters chronologically by age with the oldest on the left and the youngest on the right.

D. Identify yourself with a double circle or a double square.

E. Indicate family members who have died by placing an X through the circle or square.

F. Indicate the quality of the relationships between people with the appropriate symbolic lines. There must be relationship lines:

- Between your parents
- Between your grandparents
- From your parents to their parents
- From you to your brothers and/or sisters
- From you to your parents
- From you to any other influential family member you may have included

**If any of these people are deceased, draw the lines that applied when they were living. Use the definitions on the next page to select the appropriate lines.

G. Study your completed genogram for patterns of repetition (themes). A theme is a pattern of attitudes, values, and/or behaviors/rituals that exists within and across the generations in the ways people relate to each other.

H. The group leaders will now ask a series of questions to assist you in identifying family themes.
Very Close or Fused: Extreme involvement in each other’s lives. May represent physical and/or emotional dependency for any number of reasons that might include chronic illness, psychological distress, or a deep sense of closeness.

\[ \square = \bigcirc \]

Close: Emotional Closeness. Intimacy balanced with a sense of interdependency in sharing feelings, beliefs, attitudes, and values.

\[ \square = \bigcirc \]

Amicable: On friendly terms. Interactions are harmonious and good-natured. People involved get along with each other and have no significant conflicts.

\[ \square = \bigcirc \]

Distant: Emotional distance that is characterized by the people being emotionally and/or physically separated from one another. There is a little sharing of feelings, beliefs, attitudes, or values. Communication is kept to non-emotional and non-personal topics.

\[ \square \cdash \cdash \bigcirc \]

Confictual: A relationship characterized by disagreement, arguing, and conflict. Communication is generally a battle. There is a lot of blaming, defensiveness, attacking, withdrawing, shaming, and hurting.

\[ \square \bigcirc \bigcirc \bigcirc \bigcirc \]

Very Close and Conflictual: A relationship that is characterized by BOTH a high level of conflict and emotional closeness.

\[ \square \cdash \cdash \bigcirc \bigcirc \bigcirc \]

Cut-Off: Complete physical and/or emotional separation. People have no contact with each other for a period of time. Please include dates.

\[ \square \bigcirc \bigcirc \bigcirc \bigcirc \]

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Questions for Genogram Activity

A. How were conflicts resolved?
   1. By your parents?
   2. By other family members?

B. What were the major conflicts your family experienced as you were growing up?
   1. Are they conflicts in your life now?
   2. Are there any conflicts that have been passed down from generation to generation?

C. Who served as your main “role model?”
   1. How are their relationships with others?
   2. How are your relationships with others different?

D. Where and from whom did you learn how you should act?
   1. How a man should act?
   2. How a woman should act?
   3. Was whoever taught you right about men and women?

E. Irrational Beliefs
   1. Where did you learn them?
   2. Are you perpetuating them?

F. How was anger dealt with in your family of origin?
   1. Where did they learn how to deal with anger?
   2. What have you learned about anger or dealing with your anger since you left home?

G. Myths and Legends
   1. What have you discovered that you learned while growing up that is not true for you anymore?
   2. What is true for your parents and/or grandparents that is not true for you?

H. Significant Dates
   1. How old were you when someone significant died or left?
   2. What impact did it have on the family and you?
Irrational Ideas

1. The idea that it is a dire necessity for an adult to be loved or approved of by almost everyone for virtually everything he does.

2. The idea that one should be thoroughly competent, adequate, and achieving, in all possible respects.

3. The idea that certain people are bad, wicked, or villainous and that they should be severely blamed and punished for their sins.

4. The idea that it is terrible, horrible, and catastrophic when things are not going the way one would like them to go.

5. The idea that human unhappiness is externally caused and that people have little or no ability to control their sorrows or rid themselves of their negative feelings.

6. The idea that if something is or may be dangerous or fearsome, one should be terribly occupied and upset with it.

7. The idea that it is easier to avoid facing many life difficulties and self-discipline.

8. The idea that the past is all-important and that because something once strongly affected one's life, it should indefinitely do so.

9. The idea that people and things should be different from the way they are and that it is catastrophic if perfect solutions to the grim realities of life are not immediately found.

10. The idea that maximum human happiness can be achieved by inertia and inaction or by passively "enjoying oneself."

11. The idea that one should become quite upset over other people's problems and disturbances.
Anger Worksheet

Think of some general cues that let you know when you are getting angry (e.g., feeling hot, clinching fists).

What are some triggers that make you angry (e.g., specific incidents, criticism, feeling blamed)?

How did you rationalize your anger (e.g., everyone is out to get me; I am being treated unfairly)?

What was your core emotion (e.g., sadness, fear, insecurity, disappointment)?

Do you feel that the way you were socialized especially as a man affected how you expressed your anger (e.g., men don’t cry)?
Basic Communication Guidelines for Speaking

1. State your views in a subjective manner by using “I” statements.
   Example: “I think that we are wasting time,” instead of “We are wasting time.”

2. State your feelings. They show the importance of what you are saying.

3. Be specific by describing subject matter in terms of behaviors and actions. Avoid generalizations, analyzing the other person’s motivations, and characterizations of others. This gives the other person specific information about your thoughts, feelings, and desires. It also offers them the opportunity to change.

4. If there are any direct or indirect criticisms in your statement, try also to include the basic positive underlying feelings or expectations. These are usually the reasons it is worth talking with someone about a problem you are having with them.

5. When it is possible, make a statement about what you would like to see happen, being specific and stating your feelings.
Button Analysis

"Buttons" are the parts of your personality that, when pushed, result in a strong, angry reaction. The people who are closest to you are the ones most capable of "pushing you buttons." This is because they know you very well, and because you care about them and how they treat you. Examples of things that push buttons are if your partner puts you down in front of others, won't respond to you (silent treatment), criticizes you about something that is important to you (like your ability as a provider), or pays more attention to others than to you. The kinds of issues that often push men's buttons include financial problems, in-laws, child rearing, and jealousy. Identifying what pushes your buttons is the first step in getting more control over your reactions. It can help you to stop people from intentionally or unintentionally manipulating you.

For this assignment, list at least three things that your partner does that push your buttons. Think of a specific incident when s/he pushed your buttons in these three ways. Describe what led up to the incident and what was actually said that made you angry.
APPENDIX J

CONTROL GROUP TREATMENT
OUTLINE FOR CONTROL GROUP INTERVENTION

A. Session One: Defining Substance Abuse and Dependence
   A. Welcome and Introductions
   B. Thank members for participation
   C. Review group objectives
   D. Distribute handout “Definitions” and review with group
   E. Discuss handout and answer any questions
   F. Closing

B. Session Two: Drugs of Abuse
   A. Answer any questions from last session
   B. Distribute handouts “Classes of Drugs and their Effects” and “Depressants”
      and review the information on depressants with group
   C. Discuss handout and answer any questions
   D. Closing

C. Session Three: Drugs of Abuse
   A. Answer any questions from last session
   B. Distribute handout “Stimulants and Opiates” and review with group
   C. Discuss handout and answer any questions
   D. Closing

D. Session Four: Drugs of Abuse and Wrap-Up
   A. Answer any questions from last session
   B. Distribute handout “Hallucinogens and Marijuana” and review with group
   C. Discuss handout and answer any questions
   D. Closing
DEFINITIONS

**Drug**: any substance, natural, or artificial that by its chemical nature alters structure or function in a living organism.

**Illicit Drug**: a drug that is unlawful to possess and/or use.

**Drug Misuse**: the use of a prescribed substance in greater amounts than, or for purposes other than, those prescribed by a physician or dentist.

**Drug Abuse**: the use of a substance in a manner, amounts, or situations such that the drug use causes problems or greatly increases the chances of problems occurring. The problems may be social, legal, occupational, psychological, or physical. Almost any drug, even if prescribed by a physician, has the potential to cause some problems.

**Drug Addiction**: usually characterized by frequent use of a drug (usually at least daily) and the fact that a great deal of the individual’s behavior is focused on using the drug, obtaining the drug, talking about the drug, or on paraphernalia associated with the drug’s use. This description could apply to many other activities such as sex, gambling, Internet, video games, etc.

**Cross-Addiction/Cross-Dependence**: occurs when use of one drug will relieve the withdrawal symptoms of another drug.

**Designer Drug**: a substance on the drug market that is a chemical analogue or variation of another psychoactive drug.

DSM-IV-TR Criteria for Substance Abuse
A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences, suspensions, or expulsions from school; neglect of children or household)

2. recurrent substance use in situations in which it is physically hazardous (e.g., driving when impaired)

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3. recurrent substance-related legal problems (e.g., arrests for substance related disorderly conduct)

4. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

DSM-IV-TR Criteria for Substance Dependence

A. A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance as defined by either of the following:
   a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   b. markedly diminished effect with continued use of the same amount of the substance

2. Withdrawal, as manifested by either of the following:
   a. the characteristic withdrawal syndrome for the substance
   b. the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms

3. The substance is often taken in larger amounts or over a longer period than was intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from the effects of the substance.

6. Important occupational, social, or recreational activities are given up or reduced because of substance use.

7. The substance use is continued despite knowledge of having persistent or recurrent physical or psychological problems likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite the recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).
Classes of Drugs and Their Effects

1. Depressants (i.e., alcohol, tranquilizers, barbiturates)
   - Decrease central nervous system activity.
   - In moderate doses, depressants reduce feelings of tension and anxiety and produce a state of relaxed euphoria.
   - In extremely high doses, depressants can slow down vital life functions to the point of death.
   - Typical effects of alcohol: relaxation, lowered inhibition, impaired physical and psychological functioning
   - The effects of high doses or chronic consumption of alcohol: disorientation, unconsciousness, possible death
   - Typical effects of barbiturates/tranquilizers: reduced tension, impaired reflexes and motor functioning, drowsiness
   - The effects of high doses or chronic use of barbiturates/tranquilizers: shallow breathing, clammy skin, weak and rapid pulse, coma, possible death

2. Stimulants (i.e., amphetamines, cocaine, ecstasy)
   - Increase neural firing and arouse the nervous system
   - Increase blood pressure, respiration, heart rate, and overall alertness
   - Stimulants can elevate mood to the point of euphoria and heighten irritability.
   - Typical effects of stimulants: increased alertness, pulse, and blood pressure; elevated mood; suppressed appetite; agitation; sleeplessness
   - The effects of high doses or chronic use of stimulants: hallucinations, paranoid delusions, convulsions, long-term cognitive impairments, brain damage, possible death

3. Opiates (i.e., opium, morphine, heroin)
   - Opiates provide pain relief and cause mood changes including intense euphoria.
   - Typical effects of opiates: euphoria, pain relief, drowsiness, impaired motor and psychological functioning
   - The effects of high doses or chronic use of opiates: shallow breathing, convulsions, coma, possible death

4. Hallucinogens (i.e., LSD, mescaline, psilocybin)
   - Hallucinogens are powerful mind-altering drugs that produce hallucinations.
   - Hallucinogens intensify or distort sensory experience and can blur the boundaries between reality and fantasy.
   - The mental effects of hallucinogens are always unpredictable.
   - Typical effects of hallucinogens: hallucinations and visions, distorted time perception, loss of contact with reality, nausea
   - The effects of high doses or chronic use of hallucinogens: psychotic reactions (delusions, paranoia), panic, possible death

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5. Marijuana
- Sometimes classified as a hallucinogen, a sedative, or in a class by itself
- THC (tetrahydrocannabinol) is the major active ingredient. THC binds to receptors on neurons throughout the brain.
- Typical effects of marijuana: mild euphoria, relaxation, enhanced sensory experiences, increased appetite, impaired memory and reaction time
- The effects of high doses or chronic use of marijuana: fatigue, anxiety, disorientation, sensory distortions, possible psychotic reactions, exposure to carcinogens

DEA Schedule of Commonly Abused Drugs

Schedule I Drugs:
- available for research purposes only and have no approved medical use
- require greater storage security and have a quota on manufacturing, among other restrictions
- HAVE A HIGH POTENTIAL FOR ABUSE
- Marijuana, hash, GHB, methaqualone, PCP, LSD, mescaline, psilocybin, fentanyl, heroin

Schedule II Drugs:
- Available only by prescription (unrefillable) and require a form for ordering
- HIGH POTENTIAL FOR ABUSE
- Barbiturates, PCP analogs, codeine, fentanyl analogs, morphine, opium, oxycodone, hydrocodone, amphetamine, cocaine

Schedule III Drugs:
- Available by prescription, may have 5 refills in 6 months, may be ordered orally
- Barbiturates, ketamine, codeine, morphine, opium

Schedule IV Drugs
- Same availability as Schedule III Drugs
- Benzodiazepines, Rohypnol, codeine

Schedule V Drugs:
- Most available OTC
DEPRESSANTS

General Information

* Depressants decrease activity of the central nervous system. In moderate doses, depressants reduce feelings of tension and anxiety and produce a state of relaxed euphoria. In extremely high doses, depressants can slow down vital life functions to the point of death.

* All depressants may possess the following intoxication effects / health consequences:
  * Reduced anxiety, feeling of well-being, lowered inhibitions
  * Slowed pulse and breathing; lowered blood pressure; poor concentration / fatigue; confusion; impaired coordination, memory, and judgment; addiction; respiratory depression and arrest; death

Types of Depressants

* Barbiturates
  * Amytal, Nembutal, Seconal, Phenobarbital
  * DEA Schedule II, III, and V
  * Can be injected or swallowed
  * Intoxication effects and potential health consequences:
    * Sedation, drowsiness / depression, unusual excitement, fever, irritability, poor judgement, slurred speech, dizziness, life-threatening withdrawal

* Benzodiazepines
  * Ativan, Halcion, Librium, Valium, Xanax
  * DEA Schedule IV
  * Can be injected or swallowed
  * Intoxication effects and potential health consequences:
    * Sedation, drowsiness / dizziness

* Flunitrazepam
  * Rohypnol (associated with sexual assaults)
  * DEA Schedule IV
  * Can be swallowed or injected
  * Intoxication effects and potential health consequences:
    * Visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug’s effects

* GHB (Gamma-hydroxybutyrate)
  * DEA Schedule I
  * Can be swallowed
  * Intoxication effects and potential health consequences:
    * Drowsiness, nausea / vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death

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• Methaqualone
  • Quaalude, Sopor, Parest
  • DEA Schedule I
  • Can be injected or swallowed
  • Intoxication effects and potential health consequences:
    • Euphoria / depression, poor reflexes, slurred speech, coma

• Alcohol
  • The most widely used depressant and the most frequently used recreational drug.
  • Alcohol tolerance develops gradually and can lead to physiological dependence.
  • Alcohol Abuse and Dependence often associated with abuse of, or dependence on, other substances (e.g., marijuana, cocaine, and nicotine).
  • Alcohol may be used to alleviate unwanted side effects of other drugs of abuse or when other drugs of abuse are unavailable.
  • Symptoms of depression, anxiety, or insomnia may precede or accompany alcohol-related disorders.
  • Alcohol intoxication may result in amnesia or “blackouts.”
  • Alcohol related disorders are associated with an increased risk of accidents, violence, and suicide.
  • Approximately 1 in 5 ICU admissions in urban hospitals related to alcohol.
  • Approximately 40% of people in the US experience an alcohol-related accident in their lifetime.
  • Alcohol accounts for up to 55% of vehicle-related fatalities.
  • Alcohol abuse and dependence associated with the commission of criminal acts.
  • More than 50% of all murders and their victims believed to have been intoxicated at the time of the murder.
  • Severe alcohol intoxication may contribute to feelings of sadness and irritability and disinhibition, which may further contribute to suicide attempts and completions.
  • Alcohol-related disorders contribute to occupational problems (e.g., absenteeism, job-related accidents, and low productivity).
  • Alcohol abuse and dependence occurs among individuals of all educational levels and socioeconomic status.
  • In homeless individuals, alcohol abuse and dependence rates are high.
  • Alcohol Abuse vs. Alcohol Dependence

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STIMULANTS AND OPIATES

STIMULANTS

Amphetamines
- Typically prescribed to reduce appetite and fatigue, to decrease the need for sleep, and sometimes to reduce depression
- Overused to boost mood and energy
- Tolerance quickly develops
- Frequently injected which greatly increases blood pressure and can lead to heart failure, stroke, and potential brain damage
- IV use also increases risk of disease transmission (HIV, Hepatitis)
- Excess of dopamine activity may lead to amphetamine psychosis (schizophrenia-like hallucinations and paranoid delusions)
- When use is discontinued, many users experience a “crash”
  - May sleep for 1 or 2 days and wake up depressed, exhausted, or irritable
  - Occurs because norepinephrine and dopamine supplies are depleted

Cocaine
- Derived from the coca plant
- Usually inhaled or injected
- Produces excitation, sense of increased strength, and euphoria
- Increases activity of norepinephrine and dopamine by blocking reuptake
- Once widely used as a local anesthetic in eye, nose, and throat surgery
- Novocaine still used in dental medicine
- 1885 – John Pemberton – Coca Cola
- Large doses of cocaine can produce fever, vomiting, convulsions, hallucinations, and paranoid delusions
- Severe depressive “crash” can occur after a cocaine “high”
- Tolerance develops to many of the drugs effects
- Chronic use associated with increased risk of cognitive impairment and brain damage
- Crack is a chemically converted form of cocaine that can be smoked
  - Faster, more intense effects
  - Overdose can cause sudden death from cardiorespiratory arrest

Ecstasy (MDMA)
- Artificially synthesized by altering the molecular structure of amphetamine
- New chemical structure partly resembles both methamphetamine and mescaline
- Ecstasy is sometimes classified as a hallucinogen even though its hallucinogenic effects are relatively mild
- Produces feeling of pleasure, elation, empathy, and warmth
- Primarily alters serotonin functioning by interfering with reuptake
- Short-term overabundance of serotonin boosts mood but may cause hyperactivity and agitation

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- When drug wears off, the user may feel sluggish and depressed (due to serotonin depletion)
- Tolerance develops
- May cause memory problems, sleep difficulties, and a diminished capacity to enjoy sexual pleasure

**OPIATES**

- Opiates are derivatives of opium which is a product of the opium poppy
- Opiates provide pain relief and cause mood changes including intense euphoria
- Opiates bind to and stimulate receptors normally activated by endorphins
- Increase dopamine activity which may induce euphoria
- Heroin developed by Bayer company in 1889
- Initially thought to be a nonaddictive painkiller
- Rapid development of tolerance and highly addictive
- Made illegal in US in 1920s
- High doses can reduce breathing and may lead to coma or death
- Prescription opiate abuse (Lortab, Oxycontin, Methadone)
HALLUCINOGENS AND MARIJUANA

HALLUCINOGENS

- Mind-altering drugs that produce hallucinations
- Many derived from natural sources
- Mescaline – peyote cactus
- Psilocybin – mushrooms
- Natural hallucinogens considered scared in many tribal cultures
- LSD and PCP are synthetic
- Hallucinogens distort or intensify sensory experience and can blur boundaries between reality and fantasy
- Mental effects are unpredictable
- Tolerance develops rapidly but decreases quickly
- Scientists still do not know how LSD produces its effects

MARIJUANA

- Product of the hemp plant (cannabis sativa)
- Most widely used illegal drug in the US
- THC (tetrahydrocannabinol) is the major active ingredient
- Binds to receptors throughout the brain
- Brain produces its own THC-like substance (Cannabinoids)
- With chronic use, THC may increase GABA activity which slows down neural activity and produces the relaxing effects
- THC also increases dopamine activity, which may cause feelings of pleasure
- Marijuana smoke contains more cancer-causing substances than does tobacco smoke
- High doses can lead to negative changes in mood, sensory distortions, and feelings of panic and anxiety
- When a user is “high,” marijuana can impair reaction time, thinking, memory, learning, and driving skills
- Repeated use leads to tolerance
- Chronic users may experience mild withdrawal symptoms such as restlessness, nausea / vomiting, sleep disruptions, and irritability
- Approximately 5 to 10 percent develop dependence