ABSTRACT

Title of Thesis: DIRECTION OF PARTNER PSYCHOLOGICAL AGGRESSION AND OUTCOMES OF COUPLE THERAPY: MODERATING EFFECTS OF CLIENTS' PERCEPTIONS OF THERAPEUTIC GAINS

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Research has consistently found that contrary to longstanding beliefs, partner aggression, both in psychological and physical forms, is primarily perpetrated bidirectionally. This study compared conjoint therapy treatment outcomes (dyadic satisfaction, changes in communication patterns, and reductions in physical aggression) for bidirectionally psychologically aggressive couples and couples in which only one partner primarily perpetrated psychological aggression. In addition, the clients' perceptions of therapy were measured continuously over the course of therapy; this factor was examined as a moderator variable. A MANOVA was run on the sample of 64 heterosexual couples, but no significant main effects were found. However, this study and past research on this sample show that these couples did improve on outcome measures. This suggests that regardless of the pattern of aggression perpetration, psychologically aggressive couples may benefit from conjoint therapy. Additionally, post hoc exploratory analyses found significant correlations between reductions in aggression and changes in negative communication patterns.

DIRECTION OF PARTNER PSYCHOLOGICAL AGGRESSION AND OUTCOMES OF COUPLE THERAPY: MODERATING EFFECTS OF CLIENTS' PERCEPTIONS OF THERAPEUTIC GAINS

by

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CHAPTER I: INTRODUCTION

Statement of the Problem

Traditionally, treatments for aggressive behavior in couple relationships have primarily focused on physical violence. These treatments have generally consisted of group interventions for individuals who have been identified as batterers of their intimate partners and have used standard protocols that are delivered in the same manner to all aggressors. These treatments have been based on an assumption that the major goal is to stop aggressive *males* from hurting their *female* partners. However, more recent research findings have indicated that the male batterer – female victim pairing is not the only pattern that exists in relationships involving aggression. Furthermore, it is being recognized that intimate partner violence (IPV) often includes forms of aggression, such as psychological aggression, that do not only involve physical contact and injury.

It has been observed that women are often perpetrators of aggressive behavior in couple relationships (Archer, 2000; McQueen, 2011; Langhinrichsen-Rohling, 2005). In a meta-analysis of the literature from 1967 to 1997, Archer (2000) found that across studies women were more likely to engage in at least one act of physical aggression toward their male partner than vice versa. Furthermore, the assumption that aggression is unidirectional (e.g., men toward women) has lost much support as it has been found consistently that low to moderate level physical violence is commonly reciprocal (Straus, 2008; Whitaker, Haileyesus, Swahn, & Saltzman, 2007). These findings are significant considering the finding that the risk of harm increases when the aggression is bidirectional (Archer, 2000; Whitaker et al., 2007). In light of these findings, researchers have called for future investigations of IPV to examine the bidirectional nature of

violence in intimate relationships (Langhinrichsen-Rohling, 2005; O'Leary & Woodin, 2009). At present, little is known about possibility of different consequences of unidirectional versus bidirectional partner aggression, as well as, whether existing treatments are equally effective for couples with different aggression patterns. The present study addresses this need for information about possible differential treatment effects.

Forms of Partner Aggression

Assessment and treatment of partner aggression need to take into account different forms of aggression. Johnson and Leone (2005) distinguish between *intimate terrorism* (previously termed *patriarchal terrorism*) and *common couple violence*. *Intimate terrorism* often involves severe physical battering, is predominantly unidirectionally perpetrated by males toward females, and is characterized by an overall effort to control the victim that occurs throughout the relationship. Partners who are the victims in these relationships are attacked more frequently, experience violence that is less likely to stop, are injured more often, experience more symptoms of post-traumatic stress disorder, and are more likely to leave their partners permanently by seeking their own residence than are victims of common couple violence (Johnson & Leone, 2005). In contrast, *common couple violence* (also referred to as *situational couple violence*), involves mild to moderate forms of psychological or physical aggression, is more common than intimate terrorism, is more likely to be perpetrated by both members of heterosexual couples, and occurs in couples that do not otherwise have an overall pattern of one partner trying to control the other. For these couples, a variety of situations may escalate conflict to the level of violence (Johnson & Leone, 2005). Compared to those

individuals experiencing intimate terrorism, partners in couples experiencing common couple violence are less likely to seek safety/shelter and establish separate residences (Johnson & Leone, 2005); this suggests that they are more likely to remain in the relationship despite the violence. The term *common couple violence* will be used to describe the milder bidirectional forms of aggressive behavior that were investigated in the present study.

Furthermore, contemporary investigations have expanded beyond forms of physical aggression in couple relationships to examine psychological forms of aggression and to consider psychological aggression as a major form of IPV. Psychological aggression, which involves behaviors that punish or control another person without any physical contact, has been found to be most commonly perpetrated by both partners (Follingstad & Edmundson, 2010). Major forms of psychological aggression include denigrating the partner (e.g., saying that he or she is stupid or ugly), domination/intimidation (e.g., threatening a partner by yelling or behaving in a menacing manner), restrictive engulfment (e.g., controlling the partner's access to resources such as contact with friends), and hostile withdrawal (e.g., refusing to talk to the partner) (Murphy & Hoover, 1999). Psychological aggression has been found to have equal or greater negative effects on victims than physical aggression and often predicts later physical aggression, making it a significant problem in couple relationships (Langhinrichsen-Rohling, 2005; O'Leary, 1999). Consequently, an increasing amount of attention now is being paid to assessment and treatment of psychological aggression in intimate relationships.

Despite the evidence that psychological aggression and mild to moderate physical aggression are more common than battering and that many couples engage in bidirectional aggression, research on treatment has yet to reflect these findings in the design of their studies. Ridley and Feldman (2003) emphasize that historically research on IPV has underemphasized relational patterns and interaction processes in favor of a focus on distal factors (such as the individual traits of batterers) that predict aggression in partner relationships. This over-focus on batterer characteristics and on unidirectional severe battering has de-emphasized the place that common couple violence, that is often bidirectional, has in the lives of the majority of couples experiencing relational hostility and aggression. As a result, researchers are just beginning to address assessment and treatment of this common form of IPV in a systemic way.

One problem is that traditional treatment models still target the male as the "batterer." Court-ordered anger management programs are the standard of treatment; most frequently assigned only to the males in the relationship. Geffner and Rosenbaum (2001) review the current and historical standards of treatment for intimate partner violence. These authors acknowledge that the initial response to this type of intimate violence was the development of shelters for female victims; followed by the development of batterer treatment programs that focused on power, control, and anger management issues through pyschoeducation and cognitive-behavioral interventions (Geffner & Rosenbaum, 2001). However, the problem with such interventions, as highlighted by Corvo, Dutton, and Chen (2008), is that reviews of research findings on the efficacy of mandated batterer treatment programs have found little to no support for improvements in recidivism rates. One of the possible limitations of the traditional

treatment programs may be that they were designed based on the patriarchal terrorism model. While that model may be appropriate for some cases, it fails to address the issues present in couples experiencing common couple violence that is more situational and bidirectional. More attention should be paid to reciprocal forms of violence or aggression in order to accurately address ways to reduce aggression in relationships (McQueen, 2011). Hence, high rates of recidivism may be a reflection of treatment models that do not reflect the pattern of aggression that is occurring.

Furthermore, one-size-fits-all approaches like the standard batterer treatment models fail to recognize that a variety of factors may influence aggression in a couple's relationship. In addition, one-size-fits-all approaches do not always recognize the importance of each individual member's readiness for change and the importance of the couple's relationship status. For example, several studies have stressed the importance of taking a violent individual's readiness to change into account when devising treatment models (Levesque, Driskell, Prochaska, & Prochaska, 2008). Furthermore, many individuals who participate in batterer groups remain in their couple relationships, yet they and their partners never receive direct assistance in managing conflict and anger as a couple. This often leaves the couples at risk for future violence (LaTaillade, Epstein, & Werlinich, 2006). Evidence of different types and patterns of violence, as well as, different personal profiles of violent partners (e.g., mental illness, belief systems, past trauma) (Corvo et al., 2008) suggests that clinicians should move toward individualized treatment in which the therapist tailors interventions to meet the needs of the presenting couple. Relational patterns and triggers can be addressed in a manner that is specific to

the needs of the couple, with couples receiving various combinations of individual and conjoint treatments, depending on their individual and dyadic characteristics.

Conjoint couple therapy is becoming an established treatment for couples who experience aggression (but are judged to be at low risk for therapy-induced violence or harm) and who wish to remain together in a relationship (Harris, 2006; LaTaillade et al, 2006; O'Leary, Heyman, & Neidig, 1999; Stith & McCollum, 2011). Researchers consistently acknowledge concerns that further victimization and violence may occur following couple therapy sessions and that couple therapy has the potential to diminish the extent to which an offender takes responsibility for his or her violent behavior. However, with proper and thorough assessment and intervention that place personal responsibility on individuals for their own aggressive behavior, researchers have found that conjoint treatment is safe and appropriate for treatment of psychological and mild to moderate physical aggression.

Typically, researchers have discussed conjoint treatment for partner violence when levels of violence are mild to moderate and serious physical injuries have not occurred. It is also known that alcoholism, severe mental illness, and other factors that may increase the risk of severe physical battering may be contraindications to conjoint treatment (Holtzworth-Munroe, Meehan, Rehman, & Marshall, 2002). Although the conjoint treatment of partner violence focuses on relational factors, no research has examined whether the effectiveness of conjoint treatment varies according to whether the aggressive behavior is perpetrated by one or by both partners. Theoretically, conjoint interventions that focus on strategies to reduce conflict in the relationship can be effective in either case. On the one hand, conjoint interventions for bidirectional aggression allow

for mutual escalation patterns to be addressed directly, de-escalation strategies to be practiced, and constructive problem solving methods to be learned. On the other hand, for couples in which only one partner is the primary aggressor, conjoint interventions can be used to reduce the individual's aggressive actions while simultaneously empowering a non-aggressive partner to communicate in a more assertive manner. In addition, conjoint treatment can also work on improving the couple's dyadic problem-solving ability. However, empirical evidence is needed to support the assumption that conjoint treatment is an appropriate means of treatment when more than one partner is aggressive. For example, literature on dyadic escalation of aggressive behavior has described how partners very quickly reciprocate negative actions in a virtually automatic manner (Weiss & Heyman, 1997). Therefore, it is possible that interventions for couples with bidirectional aggression may be more challenging than those for couples in which aggression is primarily unidirectional and less likely to escalate. Consequently, more must be known about effects of treating partners in aggressive relationships, depending on the couples' aggression patterns, before adequate decisions can be made regarding the most effective format for their treatment (O'Leary et al., 1999).

Partner Perceptions of Couple Therapy Sessions as a Moderator of Treatment Outcome

Another potential influence on effectiveness of couple therapy for partner aggression is the partners' subjective experiences of the therapy process that occurs during sessions. A growing body of "common factors" research (Blow & Sprenkle, 2001; Sprenkle, Blow, & Dickey, 1999; Sprenkle, Davis, & Lebow, 2009) has identified common characteristics of clients that influence treatment outcome regardless of the specific treatment models and procedures that the therapists use. Studies have examined

perceptions of therapy for males who are undergoing traditional batterer group treatment programs (Scott & Wolfe, 2000; Shamai & Buchbinder, 2010; Silvergleid & Mankowski, 2006). However, there is a paucity of research on partners' perceptions of conjoint therapy for aggressive behavior. The few existing studies fail to examine perceptions during the therapeutic process and resort to asking partners to retrospectively report about significant experiences in therapy. Furthermore, past research has rarely examined both partners' perceptions of the therapeutic process; neither have the studies investigated the associations between client perceptions of therapy sessions and quantitative therapy outcome measures such as changes in levels of aggressive behavior and overall relationship satisfaction. A commonly cited perception of therapy clients is that learning new skills plays a role in successful change (Scott & Wolfe, 2000; Shamai & Buchbinder, 2010; Silvergleid & Mankowski, 2006). Therefore, variation in clients' perceptions of the degree to which therapy sessions contributed to their developing more constructive ways of managing their problems appears to be a potential moderator of the effectiveness of couple therapy for aggressive behavior. The present study examined both the locus of the aggression within the couple (one versus both partners) and the degree to which partners perceive sessions as helping them develop the ability to resolve their problems.

Purpose

The purposes of this study were to address two primary research questions:

1. Do couples experiencing bidirectional aggression differ from those with unidirectional aggression with regard to the therapeutic effectiveness of conjoint partner treatment?

2. Do the partners' perceptions of how helpful sessions are in developing their ability to manage their problems moderate the relationship between locus of aggression (unidirectional versus bidirectional) and therapy outcome?

This study is unique because it categorized couples based on the direction of aggression perpetration. Limitations of past research have been that they have largely focused on unidirectional intimate partner violence. Furthermore, they have equated the phenomenon of intimate partner violence solely with the occurrence of physical aggression, failing to consider psychological aggression in the process. The present researcher hoped that this investigation could have examined both physical and psychological aggression in order to enhance our understanding of the treatment of both types of aggression in close relationships. Unfortunately, due to the small sample size, there was an insufficient number of couples exhibiting unidirectional physical aggression. Therefore, this did not allow for analyses comparing unidirectional and bidirectional patterns of physical aggression. However, the study did examine conjoint therapy outcomes for couples who reported different patterns of psychological aggression perpetration in their relationships.

In addition, this study examined whether or not the partners' perceptions of the degree to which sessions were helpful were related to the degree of therapeutic gain. Olson and Russell (2004) found that clients in conjoint couple therapy have subjective perceptions of therapy that may not match externally assessed indices of therapy outcome. However, these perceptions were examined retrospectively in their study and it is unclear whether or not clients' perceptions would have been consistent with therapeutic outcomes if examined continuously throughout the therapeutic process. Consequently,

the present study used clients' reports of their perceptions that were measured immediately after each session.

Thus, a four by two factorial design was used in this study. Four comparison groups: male-perpetrated, female-perpetrated, lower level bidirectionally perpetrated (i.e., minimal perpetration of aggression), and higher level bidirectionally perpetrated psychological aggression, were compared as one independent variable, and two levels of client perceptions of session helpfulness (higher and lower helpfulness) was examined as a moderating variable. A set of treatment outcome measures comprised the dependent variables. Figure 1 depicts the study's design.

Figure 1. Summary of Study Design.

		Female-Perpetrated	Male-Perpetrated	Lower Levels of Bidirectional Perpetration	Higher Levels of Bidirectional Perpetration
Perceptions of Therapeutic Gains	Higher				
	Lower				

Please note that although this study was unable to examine patterns of physical aggression perpetration as an independent variable group, this author has reviewed literature pertaining to both psychological and physical partner aggression. These two forms of aggression commonly co-occur, and it is this author's hope that despite the limitations of the present study's sample, this rationale may guide future studies' designs on this topic.

Literature Review

Directionality of Partner Aggression

An examination of the literature on IPV reveals that, contrary to popular belief, it is very commonly perpetrated by both members of a couple. Furthermore, there is some evidence that women are more commonly perpetrators of less severe forms of physical partner aggression than are men, and that females and males exhibit comparable levels of psychological aggression toward their partners (Jose & O'Leary, 2009). Whitaker et al. (2007) used data from the 2001 National Longitudinal Study of Adolescent Health, involving a sample of 11,370 adolescents between the ages of 18 and 28 who reported on heterosexual sexual and romantic relationships in the five years preceding the study. Individual questions were asked regarding the respondents' relationships to determine physical violence perpetrated by the respondent and received by the respondent (two questions for each direction), and to determine injuries perpetrated by the respondent and received by the respondent (one question for each direction). Whitaker et al. (2007) found that nearly a quarter of the respondents reported some physical violence in their relationships, and half of this violence was reported to be reciprocal. The authors acknowledged that one of the limitations of the study was that it relied on self-reports of only one member of the relationship, and potential response bias could be reduced if occurrence of violence was reported by both members of each couple.

Straus (2008) examined data from the International Dating Violence Study, in which 13,601 students from 68 universities in 32 countries completed questionnaires. Straus found that overall 29% more females than males perpetrated physical violence, and more surprisingly, 39% more females than males perpetrated more severe forms of

physical violence. Minor violence was defined as the report of one or more behaviors in the last year on the Conflict Tactics Scale – Revised (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) categorized as "minor assault" (pushed, shoved, grabbed, slapped, threw something, twisted arm or hair, etc.); severe violence was defined as the report of one or more behaviors in the last year categorized as "severe assault" on the CTS2 (punched, hit, kicked, choked, slammed against a wall, beat up, burned or scalded, or used a knife or gun). Of the 4,239 students who reported at least one incident of any level of violence (minor or severe) in their relationship, in over two-thirds of the cases both partners were violent, in one-fifth of cases only females were violent, and in one-tenth of cases only males were violent (Straus, 2008). The largest group found in all of the 32 countries examined was that with bidirectional violence (both partners violent) (Straus, 2008). Furthermore, the results indicated that more females than males were likely to engage in more severe acts of violence than their partner (Straus, 2008).

Ridley and Feldman (2003) conducted a study examining the role that women play in responding to conflict situations, and the extent to which they are psychologically and physically aggressive with their partners. The sample consisted of 153 female volunteers who were recruited from a public health clinic. The average age of the participants was 26.9 years (range 18-57 years); 41.2% were Caucasian, 39.3% were Hispanic, 10.7% African American, 2.0% Native American, and 1.3% were Asian American; and 87.5% had an income of less than $25,000 per year (Ridley & Feldman, 2003). Seventy-seven percent of the participants were currently in a relationship, the mean length of the relationships was 2.9 years, and the mean rating for the seriousness of the relationship (measured on a Likert scale from 1 = only a little serious, to 10 = very

serious) was 7.9 (Ridley & Feldman, 2003). The participants were administered a variety of psychometric measures to assess their demographics, self-esteem, adult attachment, interpersonal closeness, abusive behaviors, communication patterns, and marital satisfaction. The results indicated that compared to nonviolent women, women who were frequently and severely physically aggressive were 1.25 times more likely to experience mutual verbal aggression in their relationships (Ridley & Feldman, 2003). The presence of constructive communication is 40-50 times less likely for relationships in which the female falls in this extreme violent group compared to nonviolent groups; furthermore, mutual avoidance and partner demand-female withdraw were more likely to occur in relationships where females were extremely violent (Ridley & Feldman, 2003). This study points to the importance of recognizing female violence in relationships and the increased rate at which couples with female physical violence may experience mutual psychological aggression and less constructive methods of resolving conflict in their relationship.

Moffitt, Robins, and Caspi (2001) also conducted a study to assess the risk factors associated with physical violence in relationships among a sample of 360 young-adults (mean age of 21 years) in a birth cohort from Dunedin, New Zealand. The degree of negative emotionality (propensity to struggle with anxiety, reactions to stress, strong emotions) and rates of physical aggression of both partners were assessed. The results indicated that women were more likely to have behaved aggressively toward their partners (t (355) = 4.81, $p < .01$), although the effect size was small ($d = .21$). There was support for three alternative models proposed to explain the aggression patterns in couple relationships: the perpetrator model (one's negative emotionality significantly

predicts the risk of perpetrating abuse), the victim model (the victim has a negative emotionality that predicts their partner's likelihood of perpetration), and the mutual additive model (the negative emotionality of both partners can mutually influence the likelihood of aggression in the relationship) (Moffitt et al., 2001). The authors concluded that their results were corroborated by the reports by both partners, suggesting that the gender similarity in rates of aggression is a representative finding (Moffitt et al., 2001). Furthermore, they note that these couples fell in the clinical category regarding their rates of aggression perpetration, and they concluded that this strongly suggests that even at a clinical level of aggression, the perpetration is bidirectional. A clinical level of physical aggression was defined as couple violence that resulted in injury, medical treatment, police intervention, or help-seeking for abuse (Moffitt et al., 2001).

Gray and Foshee (1997) examined differences in profiles of adolescents in dating relationships that involve one-sided physical violence versus mutual physical violence. Of 185 respondents who were in the 6^{th} to 12^{th} grades, 77 were in current or recent relationships in which dating violence occurred (Gray & Foshee, 1997). Sixty-two percent of the sample participants were White, 35% were African American, and 3% were Hispanic or Asian (Gray & Foshee, 1997). Questionnaires were filled out by participants that asked them to indicate how many times they engaged in a list of violent acts with their partner – indicating how many times it was initiated by each partner. Analyses revealed that 66.2% of the adolescents reported experiencing mutual aggression in their most recent or current relationship. Other noteworthy findings were that the length of the relationship did not predict the amount or type (mutual versus one-sided) of violence. Furthermore, a higher proportion of males (26%) than females (8%) reported

being victims of partner violence, and a higher proportion of females (29%) than males (4%) reported being perpetrators of violence (Gray & Foshee, 1997). This study is limited by the use of an adolescent sample, so the results should be interpreted cautiously, acknowledging that the findings may not be generalizable to an adult population.

Archer (2000) conducted a meta-analytic review of literature on partner aggression published between 1967 and 1997, including 82 journal articles, books, book chapters, dissertations, and other unpublished sources. Analyses revealed that women were slightly more likely (d = -.05) than men to use one or more acts of physical aggression, and women were also more likely than men to use those types of aggression more frequently (Archer, 2000). However, results also indicated that significantly more men were likely to cause injuries to their partner that were visible (d = .15) or that required medical attention (d = .08) (Archer, 2000). This meta-analysis supports the conclusion that both women and men initiate acts of physical aggression in relationships; however, male-initiated physical violence is more likely to result in injury to their partner. Hence, this is one reason why past research has likely chosen to focus on male-initiated physical violence, and less attention has been paid to female-initiated violence.

Much like the meta-analysis conducted by Archer (2000), Williams, Ghandour, and Kub (2008) conducted a meta-analysis of studies published between 1996 and 2006 to examine the prevalence of female-perpetrated aggression toward males. Sixty-two studies were included in the final analysis; 15 examined perpetration among adolescents, 16 examined perpetration among college students, and 31 focused on perpetration by adult females (Williams et al., 2008). The authors concluded that despite sampling differences across studies, female-perpetrated violence was common for all age groups.

Furthermore, prevalence rates for types of aggression varied, ranging from emotional abuse being the most common, to physical abuse being next most common, and sexual abuse being least common (Williams et al., 2008). This study helps to clarify the question raised earlier of how much the findings of other studies that used adolescent and college-aged samples can be generalized. This meta-analysis by Williams et al. (2008) found similar findings in younger samples for female-perpetrated partner aggression to those found in adult samples.

It has also been found that psychological aggression is commonly enacted reciprocally within couples. Follingstad and Edmundson (2010) conducted an internet survey of individuals (who were 18 years or older, had lived for at least one year with a romantic partner in the past, and had to be U.S. citizens) using the Measure of Psychologically Abusive Behaviors (MPAB; Follingstad & Edmundson, 2010). Participants rated the frequencies of occurrence of 42 psychologically abusive behaviors, reported separately as perpetrated by themselves and by their partners, and the degree to which these psychologically abusive behaviors of their partner influenced their own behaviors. The researchers found that out of the 14 categories of psychological aggression measured, there were significant positive correlations between use of a category by one partner and by the other. These correlations do not demonstrate sequential reciprocity between partners (i.e., one person's aggressive act leading to the other's aggression), but they indicate considerable bidirectionality of aggression.

Furthermore, these results regarding the directionality of aggressive behavior in couple relationships have been replicated in studies examining both physical and psychological aggression. McCarroll, Ursano, Fan, and Newby (2004) examined the

number of individuals who reported “nonmutual” and “mutual” patterns of aggression among enlisted U.S. Army personnel and their spouses. Data collected over a five year period (1998-2002) from 20,959 individuals registered with the Army Central Registry (a confidential victim-based database) who reported being victims of partner aggression (both physical and emotional forms) indicated that 39% were victims of same day mutual abuse, 3% were victims of different day mutual abuse, and 58% were victims of nonmutual abuse (McCarroll et al., 2004). These results indicate that when accounting for the possibility of bidirectional aggression that may not be the same type (i.e., male physical perpetration and female psychological perpetration) there are a significant number of cases that involve bidirectional perpetration. Given such findings that both patterns of unidirectional and bidirectional partner aggression are common, the present study investigated whether the locus of the aggression has an impact on the effectiveness of couple therapy for aggressive behavior.

Treatment of Partner Aggression

Corvo et al. (2008) discuss their views regarding the traditional model of batterer treatment programs. These authors cite that although it has become standard practice for courts to mandate batterers to treatment, there is a dearth of literature demonstrating reductions in recidivism following treatment of the offending population. Furthermore, these authors call for the principle of evidence-based practice (using treatment modalities that have shown efficacy in systematic investigations) to be applied to the treatment of domestic violence. They cite theoretical perspectives that have driven treatment modalities, including feminist/sociocultural, intergenerational transmission, psychopathology, early trauma, attachment disorders, and drug and alcohol abuse. After

reviewing findings of various studies that evaluated the efficacy of batterer treatment programs, Corvo et al. (2008) conclude that there is little evidence to support these treatment modalities and recommend that new innovative approaches should be developed. They suggest that treatments should incorporate and be tailored to address specific influences on domestic violence perpetration (Corvo et al., 2008).

In the study by Moffitt et al. (2002) described previously, the investigators discussed the implications of their finding that the negative emotionality of members of a couple serves as a predictor of violence in their relationship. These authors concluded that both partners contribute to the risk and perpetration of aggression in their relationship; therefore, both partners should be treated. Furthermore, because negative emotionality was a predictor for both partners, and one partner's negative emotionality did not moderate the effects of the other's negative emotionality on aggression perpetration, it was concluded that treatments that aim to improve the negative emotionality of only one partner fail to completely address the problem. Moffitt et al. (2002) call for conjoint treatment when aggression is reciprocal and there is an absence of instances of severe battering that would call into question whether the members of the couple would be safe during the treatment.

Harris (2006) conducted a review of the literature on the treatment of intimate partner violence and acknowledged that there are risks to the use of conjoint treatment. These include risks of re-victimization, providing an opportunity for a perpetrator to justify his or her violence, the victim being held responsible for the abuse, and therapists ignoring power balances in couples' relationships. However, Harris (2006) also suggests that conjoint treatment has many important benefits. These benefits include that it allows

both partners to receive treatment when both are violent, it addresses underlying relationship dynamics that contribute to the violence, it reduces stigma associated with offender-only treatment, and it provides the opportunity for the therapist to shape problematic interaction patterns with both partners. Harris (2006) proposes several important considerations when considering conjoint treatment such as: assessment and assurance that there is not severe violence or battering occurring, ensuring that a no-violence contract is in place, ensuring that neither partner is abusing drugs or alcohol, making sure that the victim has a safety plan, and confirming that both partners desire couple therapy. Harris (2006) also found that studies have shown that women in conjoint treatment are not at a significantly higher risk of injury than those in more traditional treatments; furthermore, these treatments have been found to be at least as effective has other treatment modalities.

Similiarly, McCollum and Stith (2007) acknowledge concerns that conjoint treatment may cause further victimization and that its use might be interpreted as suggesting that a female partner is responsible for the male's aggression toward her. However, these authors argue that there is still a place for couple treatment. They cite several reasons, including that not all couples experience the same type of violence, as some may be experiencing severe one-sided forms of "intimate terrorism" in which one partner is trying to exert control completely in the relationship, whereas others may be experiencing "situational violence" in which both partners lose control at times, and their conflict escalates (McCollum & Stith, 2007). Especially in cases of situational violence, they argue that it is important to work with both partners, who may both be contributing to the violence (McCollum & Stith, 2007). Another reason for using conjoint treatment is

that it allows for other forms of marital discord to be addressed. McCollum and Stith (2007) cite relevant literature that has found that marital discord increases the risk of severe violence in the relationship. Lastly, they note that many partners choose to remain together despite the conflict in their relationship; therefore, assisting them with finding new ways to manage their conflict may be beneficial in preventing the violence from continuing. McCollum and Stith (2007) cite the efficacy of four programs of research on this type of conjoint treatment. In addition, they cite important considerations for effectively using conjoint therapy, including the therapist having expertise in interpersonal violence and couple relationships, the therapist having an awareness of community resources, careful screening of clients for safety and the severity of violence, modifying the therapy structure to promote safety, ongoing assessment throughout therapy, and having plans for high risk situations (McCollum & Stith, 2007). These authors reiterate these concerns and considerations in a later article (Stith & McCollum, 2011).

O'Leary et al. (1999) evaluated a sample of 75 married couples who had experienced repeated acts of husband-to-wife aggression. The couples volunteered for therapy that was provided on a free basis, and they were assigned to either a group conjoint treatment or a gender-specific group treatment led by at least one therapist facilitator and lasting 14 weeks. Each gender-specific group consisted of six to eight individuals; the women's group aimed to help women recognize the violence in their relationship, understand the emotional impact it has on them, learn ways to respond to negative emotional events, and evaluate the relationship status. The men's group aimed to help the men reduce their use of psychologically and physically violent tactics against

their female partners, accept responsibility for their actions, recognize and understand the impact that their violence has on others, learn about the cycle of violence, learn ways to control anger, and learn how to ask for things rather than making commands (O'Leary et al., 1999). The group conjoint treatment consisted of six to eight couples. Its goals were to help the couples decrease aggressive exchanges, accept responsibility for conflict escalation, recognize and control anger, communicate more respectfully, and increase positive exchanges between partners (O'Leary et al., 1999).

Participants in the O'Leary et al. (1999) study completed pre-, post-, and one-year follow up measures as follows: the Modified Conflict Tactics Scale (MCTS; Pan, Neidig, & O'Leary, 1994), a dominance and isolation scale (Tolman, 1989), fearfulness of spouse, attributions of responsibility for violence, the Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988), the Dyadic Adjustment Scale (DAS; Spanier, 1976), the Spouse Verbal Problems Checklist (SVPC; Haynes, Chavez, & Samuel, 1984), fear and aggression due to treatment sessions, and satisfaction with treatment. Before each session clients answered the MCTS, and their fears and aggression due to treatment sessions were evaluated. The results indicated that compared to the wives in the gender-specific group treatment, those in the conjoint treatment reported less fearfulness about participating in treatment with their partner (O'Leary et al., 1999). Marital adjustment increased significantly for men in the conjoint treatment group compared to the gender-specific treatment group (O'Leary et al., 1999). Both types of treatment groups exhibited significant reductions in the amount of mild and severe aggression perpetrated by both partners at post-treatment and follow-up assessments (O'Leary et al., 1999).

Summary. In sum, research findings on the treatment of couples experiencing various forms of psychological and physical aggression have suggested that traditional offender-only treatment modalities tend to have high recidivism rates that limit their effectiveness. Several authors have called for new treatment modalities to adapt to the needs of the couple by addressing other forms of marital discord and adjustment that may heighten the risk for psychological and physical aggression in the relationship. Furthermore, many authors have asserted the appropriateness of conjoint couple treatment, given careful screening to ensure there are not serious forms of physical aggression present in the relationship. When levels of violence are deemed to be moderate, safety precautions have been taken, and the couple wishes to remain in their relationship, conjoint couple treatment may be an appropriate means of treatment. Efficacy studies have revealed that compared to gender-specific treatments (involving standard offender and victim treatment groups), group couple treatments are equally as effective at reducing perpetration of violence in the relationship. Furthermore, group couple treatments yielded significant gains in marital adjustment for males and less fearfulness about treatment with their partner for females. This is important to note because traditionally one primary concern that has been voiced regarding the use of conjoint treatment is that it may put the female partner at greater risk of harm in or out of session. However, research cited here found that, contrary to that concern, females were significantly less fearful of treatment with their partners when seen in conjoint versus female-only groups.

Client Perceptions of Therapy for Partner Aggression

Research on various modalities of therapy (individual, group, and couple) has increasingly investigated characteristics of the clients that can affect the effectiveness of treatments. This "common factors" research indicates that far from being passive recipients of treatment, clients actively think about treatments and respond in ways that can facilitate or interfere with treatment effectiveness (Sprenkle et al., 2009; Tallman & Bohart, 1999). Consequently, it is important to examine evidence regarding clients' perceptions of treatment for partner aggression.

Shamai and Buchbinder (2010) examined the subjective experiences of 25 men who completed group batterer treatment programs in Israel. Participants were recruited following their participation in the programs and were asked to retrospectively reflect on their experience in the treatment programs. Qualitative analysis of respondents' answers revealed that there were three themes that existed: (1) that therapy provided a learning context and the therapist was the teacher, (2) that therapy helped them learn how to control their anger and aggression, and (3) that therapy resulted in the turning point in their lives that stopped the abusive behavior (Shamai & Buchbinder, 2010). Two themes also emerged regarding the men's complaints about therapy: (1) that the female in their relationship was not required to attend therapy, resulting in limited change in the relationship between the partners, and (2) that the female partners were trying to undermine achievements and progress by being aggressive themselves (Shamai & Buchbinder, 2010). These results have limited generalizability due to the sample consisting of Israeli men, so replication studies with samples of men from various cultures would strengthen the applicability of the findings. Furthermore, the study was

conducted on men *after* they completed therapy that used a group format, so it would be helpful to understand how men view the therapeutic process *while* they are undergoing treatment, as well as to understand how they perceive different treatment modalities (in particular, conjoint couple therapy versus gender-specific groups for aggressive individuals).

Silvergleid and Mankowski (2006) evaluated nine men's experiences in a group format batterer treatment program, and 10 of 13 group facilitators were also interviewed about their perceptions of the change process for the men in the group. The participants were all within two weeks of finishing treatment, deemed by the facilitator to have significantly changed, and believed to have the capacity to articulate their change experiences (as judged by the facilitator). Qualitative analyses of the interview transcriptions revealed that the men valued community-level (i.e., criminal justice systems) and extratherapeutic factors (i.e., threats from partners), the facilitators, group-level processes (i.e., balancing support and empathy with accountability, modeling and mentoring each other, and resocialization), and individual psychological development (i.e., new skill development, self-awareness, and deciding to change) as important factors in their change process. Silvergleid and Mankowski (2006) discuss that the overlap between the participants' and facilitators' views of change reflects how facilitators project their understanding of change to the participants, whose interpretations are then used to help the facilitators shape the group activities. Furthermore, the authors discuss how support and respect are cited by both participants and facilitators, but that the participants consider it necessary that this be balanced with confrontation and accountability (Silvergleid & Mankowski, 2006). One limitation of this study is that it did

not examine any quantitative measurements of change; furthermore, participants were not included if they had not made progress in therapy.

Scott and Wolfe (2000) analyzed qualitative interviews of nine males who had been successful at changing their abusive behaviors as deemed by themselves, their therapist, or by their partner after they participated in a group treatment program that lasted between 34 and 40 weeks. Coding of the hour-long interviews revealed that four variables were consistently cited as important in the change process for the participants: taking responsibility for their abusive behavior, developing empathy for their partner, reducing their dependency on their partner and recognizing that their partner had the ability and right to make their own decisions about the relationship, and learning new communication skills (Scott & Wolfe, 2000).

Sirles, Lipchik, and Kowalski (1993) conducted a study of 42 individuals (15 couples, 7 male abusers, and 5 female victims) who had been referred to therapy following an arrest for domestic violence. The purpose of the study was to examine how the individuals viewed the violence and precipitating events, their perceptions of the pro-arrest law that required arrests in cases of domestic violence, and their perceptions of therapy. Ninety-three percent of the individuals were seen together with their partner in therapy for an average of four therapy sessions. Precipitating events were cited in the following order: money problems, alcohol abuse, jealousy, disagreeing about children, sexual problems, rejection by partners, and drug related problems (Sirles et al., 1993). Males' perceptions of therapeutic outcomes were as follows: 54% found therapy to be positive, 23% had mixed feelings about the outcome, and 23% thought it was a negative experience. Females' perceptions of therapy were starkly different: 84% found it to be a

positive experience, 6% had mixed feelings, and 11% were dissatisfied with the experience. Regardless of their perceptions of therapy, 86% of the participants wished to remain in the couple relationship following therapy (Sirles et al., 1993).

A dimension that is related to partners' perceptions of therapy is their perception of research methods used to study partner aggression and its treatment. These methods include questionnaires assessing aggression and dynamics of the relationship, asking couples to engage in conversations about conflict in their relationship, and interviewing partners about points of anger escalation and de-escalation during conflict situations in their relationship. Owen, Heyman, and Slep (2006) assessed the potential risks involved in use of these types of assessments, interviews, and conflict conversations among members of couples who were and were not experiencing interpersonal violence in their relationship. Eighty-five couples completed the study. Results indicated that wives in couples in which interpersonal violence was present rated the impact of these methods as more helpful to themselves personally and to their relationship than individuals who did not have violence in their relationship. Likewise, both men and women provided significant positive impact ratings relating to being asked sensitive questions and participating in conflictual conversations (Owen et al. 2006). Although the sample was not gathered from a clinical population and therefore is not generalizable to couples presenting to clinical settings, the results do indicate that perceptions of procedures and interventions commonly used in therapy (assessment measures, individual interviews, and engaging in conversations regarding conflictual topics) can have positive effects that are perceived by members of the couple. This indicates that the perception of positive and

negative impacts of therapeutic events may be an important factor for members of couples and should be examined in studies of therapy outcome.

A study conducted by Wark (1994) examined clients' and therapists' perceptions of what prompts outcome change in therapy by examining their responses to questionnaires after each therapy session. The participants consisted of five couples (all but one couple were married) and their therapists; four of the couples received less than 11 therapy sessions, and the remaining couple had 16 therapy sessions (Wark, 1994). Clients and therapists were asked to write about the positive and negative aspects of each therapy session at the end of the session. Analysis of these responses indicated that clients found the following to be positive incidents in therapy: positive results, routine of the therapy structure, alternative perspectives offered by the therapists, non-directive therapist style, directive therapist style, and the therapists' focus on positives (Wark, 1994). The incidents that therapists identified as positive in therapy were signs that the clients were ready for change, statements that indicated that model specific techniques were being used, instances when clients interacted with each other during a session, and when the goals for therapy were reached (Wark, 1994). Negative incidents identified by clients were as follows: the therapist did not follow through on assignments, therapists imposed their views, and there was no resolution of the presenting problem. Negative incidents identified by the therapists were as follows: the therapist took responsibility for making change occur and the therapist did not gather enough information from the client (Wark, 1994). This study highlights the importance of recognizing that clients and therapists may have different perceptions of what is and is not helpful for therapy progress to ensue.

Olson and Russell (2004) investigated the "lived experience" of the members of couples in conjoint couple therapy by comparing quantitative outcome measures to qualitative participant interpretations and reactions to these quantitative outcomes. Their study, which included 14 adults (six couples in which both members participated and two individuals who were part of separate couples) seen at a university-based couple and family therapy clinic, evaluated couples quantitatively at six weeks post-treatment and qualitatively two to four weeks after the six-week post-treatment mark. Qualitative results indicated that when participants were told what their quantitative scores were, there was a "visceral validity" in which the participants judged their own interpretations as the "final measure" of whether or not change occurred (Olson & Russell, 2004). Furthermore, participants were often able to take the quantitative data and offer explanations for what external factors influenced or explained the change that the quantitative data demonstrated. For example, when told that they improved in their stress level, participants explained the change by describing the stressors in their lives that had improved (Olson & Russell, 2004). This study was limited by its small sample size and the potential for distortions in memory associated with retrospective accounts. However, the results demonstrate the importance of client ratings of change and the influence of their own perceptions of change processes in therapy.

Therapeutic Outcomes

Simpson, Atkins, Gattis, and Christensen (2008) assessed levels of physical relationship aggression and other relationship quality outcomes in a study of conjoint therapy that was not designed specifically for treating aggression in couples. In a sample of 134 couples who were married an average of 10 years, these authors found that at pre-

treatment couples had high levels of relationship distress, 100% experienced some degree of psychological aggression during the past year, and 45% of the couples experienced physical aggression during the prior year (Simpson et al., 2008). Improvements in marital satisfaction and individual functioning were significantly related to decreases in psychological aggression at post-treatment (Simpson et al., 2008). Furthermore, couples with psychological aggression and mild physical aggression histories did not differ significantly from couples with no history of any aggression with regard to overall therapeutic outcomes. Additionally, couples who experienced more frequent wife aggression at pre-treatment experienced more rapid improvements in therapy than couples who had equal frequencies of aggression by males and females (Simpson et al., 2008). Although this was not the purpose of that study's investigation, the findings suggest that for couples in which aggression is perpetrated by both partners, positive therapy outcomes may be more difficult to achieve. The present study was designed to address this issue further.

Stith, Rosen, McCollum, and Thomsen (2004) conducted an analysis of outcomes of treatments of couples presenting with violence, in terms of a reduction of violence and rates of recidivism, by comparing multi-couple group treatment, individual couple treatment (conjoint), and a comparison group that did not receive treatment. Fifty-one couples were included in the study, which recruited participants in the Washington, DC, area. Men and women in the comparison group were significantly younger than both treatment groups (Stith et al., 2004). The rate of treatment completion did not differ across the groups. Relevant to the present study, recidivism rates at a six-month follow-up assessment were 67% for the comparison group, 43% for the individual couple

treatment condition, and 25% for the multi-couple group treatment condition, and at a two year follow-up assessment the individual couple group had 0% recidivism, compared to 13% in the multi-couple group treatment and 50% in the comparison condition (Stith et al., 2004). These results indicate that with regard to treatment of marital aggression and violence, conjoint couple treatment in both the group format and individual couple format can produce favorable reductions in future perpetration of violence.

Bradley, Friend, and Gottman (2011) describe a relationship education program that focuses on skills training, communication, and conflict management for low-income couples with children, who engage in situational forms of violence within their relationship. The couples were recruited from community organizations. A total of 115 couples completed a 22-week series of weekly two-hour group meetings. Results indicated improvements from pre- to post-test with regard to relationship satisfaction (a significant effect for females and a trend toward significance for males), more frequent use of relationship skills, and significantly less conflict for males (but not females). The study did suffer from a high rate of attrition, as 41 subjects withdrew, 19 because of a dissolution of their couple relationship (Bradley et al., 2011). Nevertheless, the results did provide evidence that couples with situational violence can achieve a reduction of conflict behaviors when the partners are treated together. Because the couples received a multi-couple group formatted treatment, it is unknown how efficacious the relationship education program may be if it is delivered in an individual couple therapy format.

Summary of Findings and Directions of the Current Study

To summarize the literature reviewed for the development of this study, several key findings are noted. First, past literature demonstrates that traditionally the primary

treatment for partner aggression has been by means of offender treatment programs that usually consist of groups of male offenders. However, numerous studies have identified the high prevalence of women offenders who engage in both physical and psychological forms of violence against their male partners. Furthermore, studies have found that bidirectional aggressive behavior occurs more often than unidirectional aggression. This pattern has been found consistently across age groups and countries. In light of these findings, many researchers have called for treatment of partner aggression that is adapted to the needs of the presenting couples and that focuses on couples' relational patterns, sources of conflict in the relationship, and marital satisfaction. A number of authors have proposed conjoint treatment for partner aggression as an effective means for treating these couples. Cautions have been emphasized that those who use conjoint treatment need to assess safety needs, and researchers have emphasized that conjoint treatment is only appropriate when there is no severe physical violence present in the relationship. When safety concerns do not contraindicate the use of such treatment, several outcome studies have indicated that conjoint treatments show the lowest rates of recidivism.

Limitations of this past research have included examinations of conjoint treatment done in a group format of several couples, using conjoint treatment that was not specifically designed for treating aggression, and failure of treatment studies to account for the direction of perpetration of the partner aggression. In addition, although past literature has identified that therapy participants perceive and judge their therapy experience (e.g., how much progress they perceive occurring in therapy), this literature has been limited in several ways. Many studies have only examined how men feel about their experiences in offender-only treatment. Additionally, those studies that have

examined females' opinions have not examined their opinions of conjoint treatment; nor have they examined the relationship between the participants' perceptions and the degree of actual change on treatment outcome measures. Furthermore, those studies have largely measured perceptions of therapy after the therapy had been completed, so it is unclear whether or not perceptions assessed *during* the therapy process might differ. Lastly, most of the research that does exist on bidirectional partner violence has been completed on non-clinical samples of adolescents.

The present study addressed the gaps in past literature by examining a clinical sample of adult couples receiving conjoint treatment for aggressive behavior. Perceptions of therapy were gathered from both partners after each therapy session, to acquire a continuous measure throughout the therapy process (rather than a post-therapy recall assessment). Furthermore, to address limitations in prior outcome research, the conjoint treatment that these couples received was designed specifically to address aggression in their relationships. Additionally, treatment was delivered to individual couples rather than in multi-couple group therapy. Lastly, this study examined whether the direction of the psychological aggression perpetration has an effect on the outcome of the couple therapy.

Theoretical Model for the Study

General systems theory as it is applied to the family is based on the assumption that all of the parts (family members) of a system (family) are interconnected; therefore, understanding problems that exist within the system must be approached by looking at the whole system (White & Klein, 2008). General systems theory further assumes that feedback occurs among the components of a system (i.e., the parts influence each other), as well as between the system and its environment (larger, broader systems). Therefore,

outside factors can influence the processes that occur within the family. In turn, stresses and conflict within the family may have impacts on the environment.

Smith, Hamon, Ingoldsby, and Miller (2009) provide detail about these basic assumptions of family systems theory: the family is a unit unto itself that has identifiable characteristics, it is not just a collection of individuals; the locus of dysfunction exists within the family system, not within any one individual member; members of the system exert mutual influences on each other's behavior, with circular causality; implicit rules in the family (relatively stable patterns of how members relate to each other) develop over time (the redundancy principle); positive feedback (amplifying change) and negative feedback (constraining change) loops shape members' behavior; dysfunctional communication (e.g., simultaneous conflicting verbal and nonverbal messages) can lead to relationship problems; family patterns of behaviors create roles for family members; and family types are based on how rigid or open the family boundaries are.

The following are further definitions of the basic principles of general systems theory.

System

The most fundamental principle of general systems theory is that of the *system*. White and Klein (2008) clarify this definition by saying that a system can be distinguished from the environment within which it exists; it also affects this environment. Smith et al. (2009) note that a system is maintained by its boundaries and consists of related and interdependent parts. Thus, the family is a system, and a couple is a subsystem within the family system. Couples comprise their own system, as they

maintain boundaries that separate their subsystem from the larger family context and other aspects of the outside world.

Boundaries

Boundaries define the amount, type, and rate of information sharing between a system or subsystem (e.g., a couple) and the larger environment. Boundaries are defined by their degree of "permeability" – open boundaries are those in which there is no limitation on the amount of information shared with others; closed boundaries are those in which information is only shared among members of the system and kept private from other people (White & Klein, 2008).

Couple Organization

A concept related to boundaries that is described by Fraenkel (1997) is the concept of couple organization: the hierarchy and power each member holds in the relationship and connectedness that exists between members of the couple. With regard to *hierarchy* and *power*, the distribution of power in the couple relationship determines how the couple makes decisions. The power distribution between the members of the couple also determines how disagreements between the partners may be handled. The member of the couple with the most influence is said to have a greater hierarchal position in the couple relationship. These power dynamics influence how the couple may approach issues in their relationship, what standards exist for resolving conflict, and whose opinions or behaviors will finally settle the issue. As couples struggle with these power dynamics, this may play out along the lines of gender; certainly power imbalances within the couple system may lead to aggression and violence directed toward one specific partner. When both partners wish to have power to determine the fate of certain

issues, this may lead to both using physically or emotionally aggressive tactics to wield power and influence.

Connectedness refers to the cohesion and togetherness that the members of the couple share with one another. This may relate to their physical proximity and emotional connection, as well as their agreement on important issues. Hierarchy and connectedness may overlap at times, as when one partner has more power in making decisions regarding the boundaries in their relationship; this may affect the closeness in the relationship. The degree of closeness in the couple relationship and the type of hierarchal relationship that exists between the partners determine the organization of the couple. This also affects how they are organized as a system that is separate from other systems (i.e., the permeability of the boundary around their relationship). Therapists should always be attuned to how the boundaries are experienced and decided on within the couple and between the couple and the outside environment, as this may be representative of the power dynamics and closeness within the couple unit.

Rules of Transformation (Family Rules)

Rules of transformation (also known as family rules) determine the elements of interactions between parts of the system (White & Klein, 2008). Therefore, within a couple system, rules of transformation may determine how one partner will respond to another's psychologically aggressive comments. Both partners may agree that if one is shouting and name-calling, the other has the right to do the same thing back. In this regard, rules may be explicit; however, they may also be implicit (Smith et al., 2009). Smith et al. explain that repeated interaction patterns within a family can lead to the establishment of rules, which may be implicit, through what is referred to as the

"redundancy principle." White and Klein (2008) clarify the function of these rules of transformation; they are meant to take information from the environment and transform that information into an output from the system. In other words, as Smith et al. (2009) explain, these rules help members of the system know how to handle input from anywhere in the system or outside of the system.

Feedback

Feedback and feedback loops are important components of systems theory. As noted earlier, there are two forms of feedback that can occur within a system – positive (deviation amplifying) and negative (deviation dampening) (White & Klein, 2008). Positive feedback reinforces the stimulus and input to continue (e.g., positive feedback occurs in couple conflict when one partner berates the other, and the berated individual reciprocates criticism, leading the first partner to increase the berating). Thus, the term "positive" refers to the feedback's effect on increasing the initial behavior (which could be either positive or negative actions). Conversely, negative feedback decreases the amplitude of the initial (positive or negative) behavior, serving to keep the system in a stable state (e.g., when one partner begins berating, the other partner soothes their partner, calming his or her intense emotions and decreasing the berating behavior and tension in the relationship). Feedback involves loops or circular patterns as each partner's behaviors are influenced by and influence the other's behaviors (Smith et al., 2009).

Circular versus Linear Causality

Smith et al. (2009) describe how each member of a relationship tends to view their own behavior as caused by his or her partner's actions, rarely acknowledging that his or her own behavior also contributed to the couple's pattern. In other words, partners

commonly think in terms of linear rather than circular causal concepts. Systems theorists believe that members of a system all contribute to existing patterns through reciprocal processes based on the feedback loops and rules of transformation present within the system (Smith et al., 2009). Although systems theory at times has been criticized as suggesting that victims of partner violence are partly responsible for their partner's actions, in fact those who apply the theory to IPV argue that each individual is responsible for his or her own aggression. Furthermore, they argue that both members of a couple may be contributing to an atmosphere of conflict and distress and can be expected to contribute to the process of improving couple interactions. Each person is responsible for stopping their own violence, but negative circular patterns between partners also are considered important targets for intervention.

Fraenkel (1997) elaborates on this circular causality in couple systems, explaining that circular causality can be either complementary or symmetrical. Whereas some systems may have symmetrical patterns between partners in which both give similar forms of feedback (e.g., name calling), others may have patterns that are complementary (e.g., one partner demands and the other withdraws). Therefore, these systems may be described as having different behaviors displayed by both partners, but in each case the behaviors are contributing to the other person's reaction, creating a system of mutually fitting and reinforcing behavior. Therefore, both types of circular causality serve to perpetuate the cycle within the relationship, even when the behaviors are not identical. It is important to note that these patterns of causality do not necessarily imply negative outcomes; certainly couples can have complementary patterns that are beneficial for sustaining their relationship.

Variety or Family Flexibility

Variety refers to the degree to which the system has resources to adapt to changes and demands (White & Klein, 2008). This principle is also referred to as family flexibility by some authors such as Smith et al. (2009). Broderick and Smith (1979) described requisite variety, or the ability to process input appropriately and respond. In other words, when couples experience a challenging or new situation, they may lack rules of transformation to dictate their response. They may resort to old rules of transformation that are not effective (such as violence) because they lack variety and flexibility in their repertoire. One function of therapy is to teach these couples and families new skills that can be added to their range of responses and used in situations in which they are challenged by new demands.

Equilibrium

Balancing the inputs and outputs in a system is required for equilibrium. Generally, systems are designed in a manner that maximizes equilibrium between stability and change, in the form of homeostasis (White & Klein, 2008; Smith et al., 2009). In order to maximize equilibrium, systems must utilize feedback and control to balance demands and stresses on the system. For example, a couple whose aggression is escalating to the point of physical violence may want to return to a point of equilibrium in which their disagreement does not elicit a physical altercation. Reaching this point of equilibrium may require feedback from both members voicing a wish to change; furthermore, control will be necessary. Both members must enact change processes to stop the arguments from escalating. Therefore, balancing stability when appropriate and

change when necessary is an important function of the couple system. This basic explanation is elaborated further in the following section describing *system levels*.

System Levels

Systems theory posits that systems are made up of levels (White & Klein, 2008). In the first-order level, there is no way to control errors in the system and interactions are dictated by feedback loops and rules of transformation. However, with second-order levels (and higher-order levels), there is a comparator that monitors input and output, compares these to what the overall goals are, and corrects feedback loops and rules of transformation errors. A related example is that of a couple seeking therapy for violence in their relationship. Before attending therapy, the couple may have implicitly determined through redundant interactions that when an argument begins, both partners will verbally aggress against one another. Feedback loops within the system will allow this to occur, and positive feedback may amplify these negative interactions to the point of violence (which is a strong deviation from the equilibrium that is the couple's goal). This is the first-order system level. However, when the couples attend therapy, the therapist coaches the individuals to become their own comparators and to recognize when these errors, positive feedback, and amplification of conflict are occurring, make corrections, and change the rules of transformation toward the goal of equilibrium and peace in the relationship. The therapeutic process and the therapist determine the second-order system level.

System levels are an important component in the change process for couples. Broderick and Smith (1979) describe the process of the comparator system:

> A system may be characterized as having feedback if it has the ability to perceive its own output at one point as input at some subsequent point. As we shall see in detail below, a system's capability to monitor its own progress toward a set goal, to correct and to elaborate its response, and even change its goals depends upon the complexity of its feedback structure. A system without such a capability… is intrinsically static. (p. 115)

It appears that the system's awareness of the decisions relating to the processes occurring within it is essential in order to create shifts to less conflict-amplifying interactions. Broderick and Smith (1979) explain that at the third level, systems evaluate the problematic interactions they have observed at the second level. However, at the second level these systems are not able to create new solutions on a meta-basis; they are merely able to switch to new rules on a situation-by-situation basis. Therefore, at the third level, when a system is able to take into account feedback experienced at the second level and change their overall rules of transformation that dictate all interactions, the process of "morphogenesis" occurs (Broderick & Smith, 1979). In summary, it requires a process of awareness of the system from level to level to first recognize different ways to correct errors in interactions and create more favorable outcomes that are consistent with their goals. Once these error corrections have been observed and experienced, the system can reflect on these successes and work toward changing the rules of transformation in the system at a more broad, permanent, meta-system basis. The concept of system levels is inherent in the present study's investigation of partners' perceptions of the therapeutic process. If it is essential for the second-order and third-order levels to be aware of the errors in the system in order to produce change in the rules of transformation, this

theoretically could influence their awareness of a need for change and their learning new skills in therapy. Figure 2, Figure 3, and Figure 4 illustrate how these system levels operate.

Figure 2. System Level One.

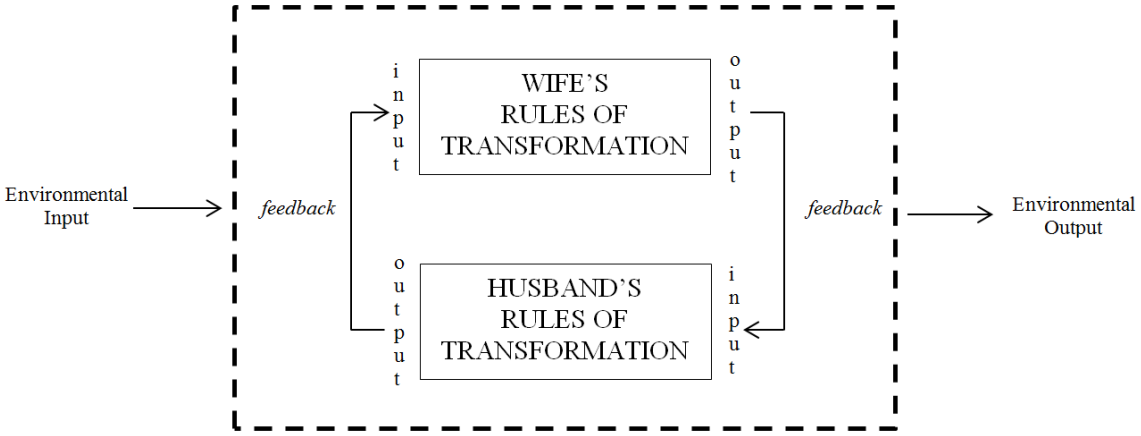


Figure 3. System Level Two.

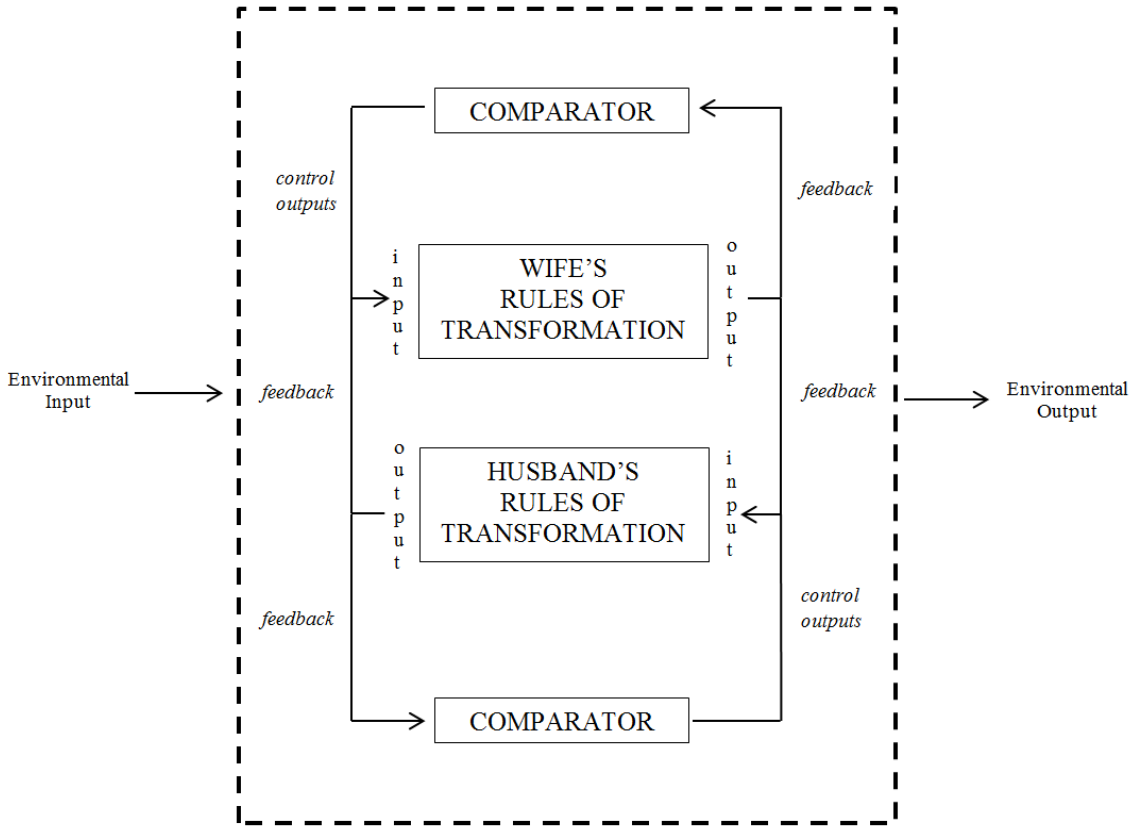
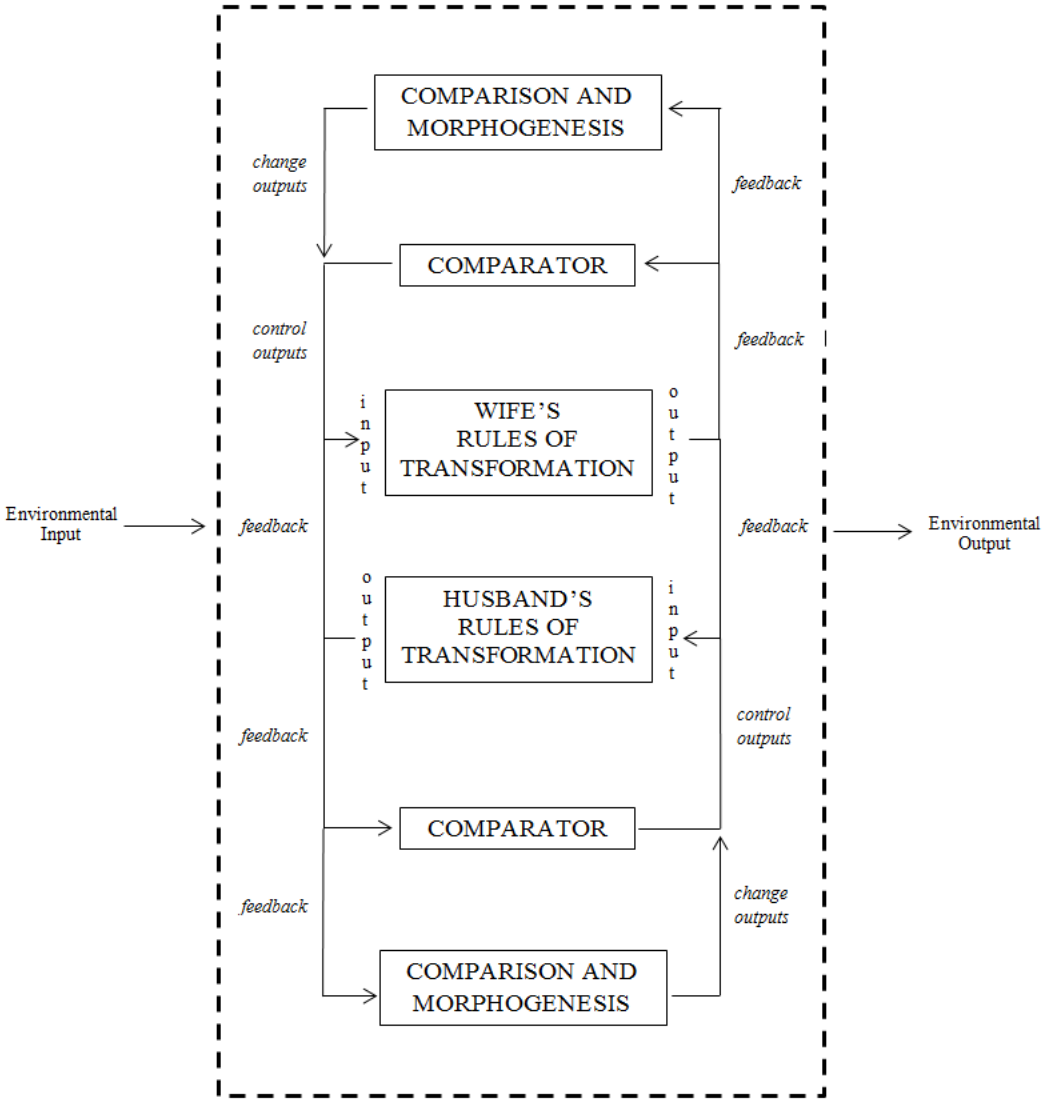


Figure 4. System Level Three.



Variables

Independent Variables

The *locus or direction of aggression perpetration* between members of a couple (unidirectional or bidirectional) was one of the independent variables in this study. In the literature, there are various terms used to describe relationships in which both members are aggressive. Mutual abuse, reciprocal abuse, and bidirectional abuse are common

terms that are mentioned. For the purposes of this study, bidirectional aggression was the terminology of choice. “Bidirectional” implies that the aggression is perpetrated by both partners in the relationship, with no indication of the sequence in which it occurs (e.g., immediate reciprocation or at different times) simply that it is perpetrated to some degree by both partners. The terms “mutual” and “reciprocal” aggression are considered by this author to capture the same construct as “bidirectional” aggression.

For the purposes of this study, the definition of psychological aggression, which involves no direct physical contact between the aggressor and victim, is consistent with definitions provided by Murphy and Hoover (1999) in their development of the Multidimensional Emotional Abuse Scale (MDEAS). Verbal and nonverbal threats, property violence, intense verbal aggression, behaviors intended to isolate the partner, intense jealous responses, possessiveness, direct attacks to self-esteem, withholding emotional contact, withdrawing from the partner in aggressive manner, and threats to end the relationship (intended to increase the partner’s anxiety about security of the relationship) are all examples of psychological aggression measured in this study (Murphy & Hoover, 1999).

Four categories of couples were compared. These categories were classified by the direction of psychological aggression perpetration that was present in the relationship. The four categories (and respective definitions) are as follows: Male Unidirectional Aggression (the male partner is the primary aggressor), Female Unidirectional Aggression (the female partner is the primary aggressor); Lower Levels of Bidirectional Aggression (both partners engage in lower levels of aggressive acts – both are minimally

aggressive); and Higher Levels of Bidirectional Aggression (both partners engage in higher levels of aggressive acts).

The second independent variable in this study, which is considered a moderating variable that may influence the association between the direction of aggression perpetration and therapy outcomes, was the partners' perceptions of the effectiveness of therapy sessions. This is a therapy process variable that focuses on a "common factors" characteristic of clients that may contribute to therapy outcome.

Dependent Variables

The dependent variables in this research were therapeutic outcomes. Specifically, pre- to post-therapy changes in measures of physical aggression, positive and negative couple communication, and overall relationship satisfaction were examined as a function of the couple's direction of aggression and partners' positive versus negative perceptions of effectiveness of therapy sessions. More positive therapeutic outcomes were defined as reductions of scores from pre- to post-test on indices of aggressive behavior and negative couple communication, as well as increases in scores on indices of positive communication and overall relationship satisfaction. Physical aggression was included as an outcome variable because the goal of couple therapy was to reduce aggression in the relationships; however, use of the MDEAS psychological aggression scores would be confounded as this measure was used to define the independent variable of couple psychological aggression pattern. Therefore, the physical aggression scores served as an alternative measure of change in level of aggression over the course of therapy.

Table 2.1

Summary of Conceptual and Operational Definitions of Variables and Tools of Measurement

Variable	Conceptual Definition	Operational Definition	Tool of Measurement
Independent Variables			
1) Direction of Aggression Perpetration	This denotes who in the relationship is perpetrating psychologically aggressive acts. Perpetration could be unidirectional (perpetrated by the male or the female partner), higher level bidirectional (perpetrated by both partners at higher levels), or lower level bidirectional (minimal aggression perpetrated by both partners).	Partner and self-reports of psychological aggression perpetration during the four months prior to assessment were measured by the MDEAS. Each partner's overall scores for the male and female were averaged to create an index of perpetration for each member of the couple.	*Multidimensional Emotional Abuse Scale* (MDEAS; Murphy & Hoover, 1999)
2) Client Perceptions of Therapeutic Effectiveness (Moderator Variable)	Self-reported perceptions of therapeutic effectiveness.	Total scores of ratings 0-3 on four questions on the *Couple Session Feedback* were summed for all of the sessions attended by the couples. Male and female total scores were averaged to create the average couple score (range: 0-120). Higher scores indicated greater degrees of positive perceptions of therapy.	*Couple Session Feedback* (Center for Healthy Families, University of Maryland)

Dependent Variables			
1) Therapeutic Outcomes:			
a. Physical Aggression	Perpetration of physical aggression by each partner.	Composite CTS2 scores of perpetration of physical aggression (physical assault and injury subscales) in the past four months as measured by averaged self- and partner-reports of aggression pre- and post-therapy	*Conflict Tactics Scale – Revised* (CTS2; CTS2; Straus et al., 1996)
b. Positive Couple Communication	Self-reports of mutual constructive communication patterns.	Averaged male/female self-report ratings of the couple's communication patterns measured by the Mutual Constructive Communication subscale of the CPQ – measured pre- and post-therapy.	*Communication Patterns Questionnaire* (CPQ; Christensen, 1987)
c. Negative Couple Communication	Self-reports of negative communication patterns (demand-withdraw and mutual avoidance).	Averaged male/female self-report ratings of the couples' communication patterns as measured by the Demand-Withdraw and Mutual Avoidance subscales of the CPQ – measured pre- and post-therapy.	*Communication Patterns Questionnaire* (CPQ; Christensen, 1987)

d. Relationship Satisfaction	Dyadic adjustment and satisfaction with the relationship.	Male and female overall scores will be measured at pre- and post-therapy.	*Dyadic Adjustment Scale* (DAS; Spanier, 1976)

Hypotheses

It was expected that positive therapeutic outcomes would differ on the basis of the direction of aggression perpetration in the couple relationship. When both partners are contributing to the amplification of conflict and aggression through a process of reciprocity, it was expected that the couples would exhibit less change from participating in couple therapy, compared to couples in which aggression is primarily unidirectional. Therefore, one primary hypothesis was derived from these assumptions:

1. Higher level bidirectionally aggressive couples will have less positive therapeutic outcomes compared to couples in which the aggression is primarily unidirectional and compared with couples in which both members exhibit lower level aggression. Less positive therapeutic outcomes will be indicated by less decrease in rates of physical aggression, less increase in positive communication, less decrease in negative communication, and less increase in relationship satisfaction.

Furthermore, according to general systems theory, in order for more pervasive (e.g., second- and third-order) changes to occur, partners must perceive that they have learned valuable new skills to use as an alternative rule of transformation when conflict arises. Therefore, it was hypothesized that:

2. Partners' level of perceptions of the degree to which sessions helped them learn new ways to manage relationship conflict will be positively associated with the degree to which couple therapy results in positive therapeutic changes. Thus,

there will be a main effect of more positive perceptions of session effectiveness on positive therapy outcomes.

3. In addition, it was hypothesized that partners' level of perceptions of the degree to which sessions helped them learn new ways to manage relationship conflict will moderate the relationship between directionality of partner aggression and therapy outcomes. The more that members of couples perceive sessions as teaching them better ways of managing conflict, the less difference there will be in levels of positive outcomes between couples with bidirectional versus unidirectional partner aggression. Thus, positive client perceptions of couple therapy sessions were expected to reduce the degree to which higher level bidirectional partner aggression interferes with gains in couple therapy.

CHAPTER II: METHOD

Sample

This study involved a secondary analysis of previously collected data from client assessments at the Center for Healthy Families (CHF), an outpatient family therapy clinic at the University of Maryland, College Park. The sample consisted of 64 heterosexual couples who sought treatment at the CHF. All couples attending therapy at this clinic, including the couples included in this study's sample, are administered an extensive set of pre-therapy assessment instruments. Couples were selected for this inclusion in this study's analysis based on the following characteristics: seeking couple therapy, stated commitment to working to improve their relationship, at least 18 years of age, heterosexual, report psychological and mild to moderate forms of physical aggression during the past four months, no violence resulting in injury or need for medical treatment, no reported fear of living with or participating in couple therapy with their partner, and no current untreated alcohol or drug abuse. There was no exclusion by race, marital status, occupation, education, religion, etc. Same-sex couples were not included in the study's analysis because a small number of such couples seek therapy at the CHF clinic where the data were collected, resulting in too small a sample for statistical analyses. Data for this study were gathered from the existing data set collected and retained for all couples seeking therapy at the CHF. Couples for which at least one partner's data on the relevant variables were missing for an entire measure were excluded from the analyses.

Of the 64 couples who met these criteria, couples had been together an average of 6.59 years (average of male and female reports). The current relationship status for the couples is summarized in Table 3.1. Females reported an average age of 31.67 years (*SD*

= 8.60); males reported an average age of 33.06 years (*SD* = 8.47). The mean personal yearly gross income reported by females was $27,279 (*SD* = 25,603); for males this was $44,469 (*SD* = 28,038). The distributions of employment status, highest level of education, and race are reported in Table 3.1.

Table 3.1

Demographic Characteristics for the Study Sample

Variables	Females		Males	
Average Age of Partner	*n* = 64[a]		*n* = 64	
	31.67 (8.60)[b]		33.06 (8.47)	
Average Length of Relationship	*n* = 57		*n* = 57	
	6.68 (6.49)		6.50 (6.46)	
Average Personal Yearly Gross Income	*n* = 62		*n* = 62	
	$27,379		$44,469	
Relationship Status:	*n* = 64	%	*n* = 64	%
Married – Living Together	35	54.7	36	56.3
Married – Separated	1	1.6	1	1.6
Living Together, Not Married	18	28.1	17	26.6
Dating, Not Living Together	10	15.6	10	15.6
Employment Status:	*n* = 64	%	*n* = 63	%
Employed Full Time	32	50	45	70.3
Employed Part Time	10	15.6	10	15.6
Homemaker, Not Employed	7	10.9	0	0
Student	7	10.9	4	6.3
Unemployed	7	10.9	2	3.1
Disabled, Unemployed	0	0	1	1.6
Retired	1	1.6	1	1.6
Highest Level of Education:	*n* = 64	%	*n* = 64	%
Some High School	4	6.3	2	3.1
High School Diploma	6	9.4	15	23.4
Some College	15	23.4	11	17.2
Associate's Degree	3	4.7	4	6.3
Bachelor's Degree	10	15.6	10	15.6
Some Graduate Education	8	12.5	7	10.9
Master's Degree	11	17.2	9	14.1
Doctoral Degree	4	6.3	5	7.8
Trade School	3	4.7	1	1.6

Race:	*n* = 64	%	*n* = 64	%
Native American	0	0	1	1.6
African American/Black	13	20.3	12	18.8
Hispanic	8	12.5	3	4.7
White	36	56.3	43	67.2
Asian/Pacific Islander	4	6.3	0	0
Other	3	4.7	5	7.8

Note.
[a] This number signifies the total number of respondents, excluding missing values.
[b] This number is the standard deviation.

Measures

Partners' scores on the MDEAS were used for classifying the couples as having unidirectional or bidirectional aggression. Therapeutic change from pre- to post-therapy was assessed with the CTS2, CPQ, and DAS. The Couple Session Feedback form was used to evaluate the moderator variable.

Multidimensional Emotional Abuse Scale

The Multidimensional Emotional Abuse Scale (MDEAS; Murphy & Hoover, 1999; 2001) provided an overall measure of degree of psychologically aggressive behavior exhibited by each member of a couple. This measure presents a set of 56 items that asks respondents to report how often during the past four months each member of the couple (partner and self) engaged in the behavior listed. Thus, there are two parts to every question. The response scale for each item is as follows: 0 = "Never in the past four months," 1 = "Once," 2 = "Twice," 3 = "Three to Five Times," 4 = "Six to Ten Times," 5 = "Eleven to Twenty Times," 6 = "Twenty or More Times," and 9 = "Never in the Relationship." Murphy and Hoover (2001) found that the internal consistencies (alpha coefficient) of the subscales for reports regarding self and partner were, respectively, .84 and .85 (Restrictive Engulfment), .88 and .91 (Hostile Withdrawal), .89 and .92

(Denigration), and .83 and .91 (Domination/Intimidation). A study by Ro and Lawrence (2007, p. 581) examined the internal consistency of this measure and reported that "MDEAS hostile withdrawal subscales were generally high (most αs > 0.90). MDEAS restrictive engulfment and denigration subscales were generally moderate (most αs ~ .70). The scores for MDEAS dominance/intimidation subscales were generally low (αs < .70)." Those authors concluded that the MDEAS in its current form is more reliable as an overall (unidimensional) measure of psychological abuse (Ro & Lawrence, 2007). Therefore, a total MDEAS score was used in this study rather than scores from individual subscales. Higher total scores on the MDEAS indicate higher levels of psychological aggression. Each partner independently rated their own behaviors, as well as their partner's behaviors. This resulted in two scores to represent each person's psychological aggression (one rated by them and the other rated by their partner). Following the procedures used in other studies of aggressive behavior, the two scores representing the two individuals' perceptions of each person's aggressive behavior were averaged to create an index of the person's psychological aggression perpetration. Taking both partners' reports of each person's aggression perpetration into account minimized the bias that might occur in relying solely on individuals' self-reports in which they may under-report their own perpetration of aggressive behaviors, or solely on partner reports, in which they may over-report aggression by the other person. After scores were averaged for each partner, this averaged score served as an index of the degree to which that partner used the psychologically aggressive tactics measured by the MDEAS during the four months prior to measurement. This measure was completed by participants both before and after couple therapy. A sample of the MDEAS is included in Appendix A.

In order to code the direction of psychological aggression perpetration in the couple, groups were defined based on whether each partner's level of perpetration was below a score of 20, or greater than such a score. This dichotomized the variable for analysis. The investigator had originally aimed to consider perpetration as present if the average score was greater than zero for a given partner. Therefore, if each partner averaged greater than zero, the psychological aggression in the relationship would have been considered bidirectional. Likewise, if only one partner averaged greater than zero, the psychological aggression pattern would have been considered unidirectional. Upon analysis, the investigator discovered that there were no couples in the sample in which psychological aggression was purely perpetrated unidirectionally (with the other partner scoring zero). Therefore, the cutoff point of 20 (out of a total possible score of 168) was considered to be the cutoff point for perpetration of psychological aggression. When one partner scored in the "lower" group, and the other in the "higher" group, this was considered unidirectional psychological aggression with one partner as the primary aggressor. Likewise, when both partners exhibited lower levels of psychological aggression, this was considered minimal perpetration of aggression in the relationship. In contrast, when both partners exhibited higher levels of psychological aggression, this was considered bidirectional aggression in the relationship. Unfortunately, because research on bidirectional aggression is relatively new, this researcher did not have a clear model for group definition procedures. Therefore, the cutoff score of 20 was chosen on two bases. First, it was considered very important that the scores in the "lower" range defined by the cutoff score would represent individuals who were perpetrating a small percentage of the total possible instances of aggression assessed by the psychological aggression

measure. Because the maximum possible score for the measure is 168, a score of 20 is a relatively low score on the entire scale, representing only 8.4% of the maximum amount of possible perpetration. Second, the investigator selected the cutoff score of 20 by examining the number of cases that would fall into the four perpetration direction groups based on several alternative cutoff scores, and a score of 20 produced the most balanced number of cases in the groups (whereas other cutoff scores resulted in one or more groups having too small a sample size to allow use of the MANOVA analysis).

Conflict Tactics Scale – Revised

The Revised Conflict Tactics Scale (CTS2; Straus et al., 1996) is a 78-item measure that asks partners to report the frequencies with which they engaged in specific types of physically and psychologically aggressive acts directed at their partner during the last four months. There are 39 pairs of items, each pair asking how often the person engaged in the behavior himself or herself, and how often the person's partner engaged in that behavior. The response scale for each item indicates the frequency of occurrence: 0 = "not in the past four months, but it has happened in the past," 1 = "once in the past four months," 2 = "twice in the past four months," 3 = "three to five times in the past four months," 4 = "six to ten times in the past four months," 5 = "eleven to twenty times in the past four months," 6 = "more than twenty times in the past four months," and 9 = "never in the relationship." The CTS2 has five subscales: negotiation, psychological aggression, physical assault, sexual coercion, and injury. During the development of the measure, Straus et al. (1996) assessed the internal consistency reliability of the subscales, which were as follows: negotiation ($\alpha = .86$), psychological aggression ($\alpha = .79$), physical assault ($\alpha = .86$), sexual coercion ($\alpha = .87$), and injury ($\alpha = .95$). The CTS2 is

administered to couples at the CHF both before and following couple therapy. A composite physical aggression score for each member of a couple involving the sum of the individual's scores on the two physical violence subscales – physical assault and injury – was computed, with both partners' reports of each individual's behavior averaged, as was done with the MDEAS. This measure provided an indication of the frequency of physical aggression by each partner at pre- and post-therapy. Also note, a sample of the CTS2 is included in Appendix B.

Communication Patterns Questionnaire

The Communication Patterns Questionnaire (CPQ; Christensen, 1987) was used to measure the quality of couple communication before and after couple therapy. This measure was completed by the participants in the present study during the pre- and post-treatment assessments. The version of the CPQ used for the purposes of this study asks a series of questions about each partner's perception of the couple's communication (a) when an issue arises in the relationship, (b) when the issue is being discussed, and (c) after an issue has been discussed. Each question is ranked on a nine-point scale that ranges from "very unlikely" to "very likely." Some of the questions are symmetrical, asking about an aspect of each partner's behaviors, while others ask about similar behavior by both partners. For example, one question in section B (communication during a discussion) states: "Both members suggest possible solutions and compromises." In contrast, another question states: "Man nags and demands while woman withdraws, becomes silent, or refuses to discuss the matter further;" and "Woman nags and demands while Man withdraws, becomes silent, or refuses to discuss the matter further." Results yield three subscales measuring: mutual constructive communication, demand-withdraw

(specifying the direction of each sexes' behavior), and mutual avoidance and withholding. Christensen (1987) reported the reliability of using a mean rating of male and female reports for two of the subscales; the Spearman-Brown correction of the Pearson correlation coefficient and the intraclass correlation coefficient were reported. Christensen (1987) reported these for each subscale respectively: .82 and .80 for the Mutual Constructive Communication subscale, and .74 and .74 for the Demand-Withdraw subscale. Christensen and Shenk (1991) assessed the Cronbach's alpha scores for the three subscales utilized in the current study (adding an evaluation of the Mutual Avoidance subscale) and found that when evaluating male and female reports separately for each subscale, alphas ranged from .62 to .86, with a mean of .71. Christensen and Shenk (1991) found that Mutual Constructive Communication subscale differentiated between nondistressed, clinic, and separating/divorcing couples, whereas the other two subscales only differentiated the nondistressed from the other two groups (clinic and divorcing/separating).

In the present study, male and female partners' scores for each subscale were averaged to compute an overall couple score representing the presence of each of these patterns at pre- and post- therapy assessment. A sample of the CPQ is included in Appendix C.

Dyadic Adjustment Scale

The Dyadic Adjustment Scale (DAS; Spanier, 1976) is a widely used measure of overall relationship quality and satisfaction. The scale consists of 32 items. Spanier constructed the DAS with four subscales: (a) dyadic satisfaction, (b) dyadic cohesion, (c) dyadic consensus, and (d) affectional expression, although typically a total DAS score is

used in research and clinical practice. Total scores can range from 0-151. Spanier (1976) reported that after administering the measure to 218 married and 94 divorced couples, the scale exhibited criterion-related validity by demonstrating a significant difference ($p <$ .001) in mean scores between married and divorced couples. Construct validity was demonstrated by running a correlation between the Locke-Wallace Marital Adjustment Scale (1959) and the DAS; Spanier (1976) found the correlation to be .86 among married and .88 among divorced respondents ($p < .001$). Furthermore, Spanier (1976) reported a Cronbach's alpha coefficient of .96 for the total scale. In the present study male and female partners' reports were evaluated separately. Change scores for the DAS were compared for pre- and post- therapy points of measurement in order to assess the effect of therapy on relationship satisfaction. A sample of the DAS is included in Appendix D.

Couple Session Feedback

The Couple Session Feedback is a paper and pencil questionnaire developed at the Center for Healthy Families clinic at the University of Maryland, College Park. It consists of four items designed to allow each member of a couple to evaluate their experience in therapy for the given treatment session. Each item can be rated based on the statement applicability to the individual's experience in sessions; the answer options are "not at all," "a little," "a moderate amount," and "very much." Question one states: "My partner and I had an opportunity to discuss important concerns about our relationship." Question two states: "This session helped me learn new ways to reduce conflict in our relationship." Question three states: "During the session, my partner and I had an opportunity to think about and address issues in our relationship." Question four states: "Overall, this session was helpful." Each of the four items' responses was coded with a

numerical value between “0” (Not at all) to “3” (Very Much) and averaged for the ten sessions of treatment for each partner.

A decision was made to average these scores after a factor analysis was computed on the four variables. The analysis was run using the scores for the fifth therapy session, as it was assumed that by that point the clients had become familiar with therapy and had formed impressions regarding the degree of progress that was occurring. For the male respondents, the Eigenvalue for component one was 2.52, explaining 62.98 percent of the variance. These results identifying one major factor were confirmed for the male respondents by evaluation of the scree plot. For female respondents, similar trends were observed, with an Eigenvalue of 2.34 for component one, explaining 58.84 percent of the variance. This pattern of one factor accounting for the majority of the variance was also observed on the female scree plot. Interpretation of these analyses warranted utilization of a composite score encompassing all four questions from this questionnaire as an indication of one factor (the client’s perception of therapeutic gains). Therefore, the partners’ total scores for each administration of the Couple Session Feedback form were summed for all questions, for all ten therapy sessions, to create a total composite score (range 0-120).

In order to use an analysis of variance procedure to test the study’s hypotheses in the factorial design that included four levels of the aggression directionality variable, the total composite score for the Couple Session Feedback measure was dichotomized into “higher” and “lower” client ratings of session helpfulness based on a median split of the score distribution within the sample (divided at the 50% cumulative percentage point for the couple scores (average of male and female composite scores). The Couple Session

Feedback variable was then tested for its moderating effect on the therapeutic outcomes described above. A sample of the Couple Session Feedback is included in Appendix E.

Procedure

This was a secondary analysis of pre-existing data stored electronically at the Center for Healthy Families (CHF) at the University of Maryland – College Park. Procedures included accessing this data file and running relevant statistical analyses using pre-existing data for the measures previously mentioned. Because the data were collected previously from members of couples attending the CHF, the present investigator had no direct contact with the subjects.

Data originally were gathered from all participants before commencement of therapy and after completion of therapy. Couples seeking therapy at this clinic were first assessed briefly over the phone to screen for risk of homicide or violence in the relationship. Upon their first visit to the clinic, both members of the couple were administered paper and pencil versions of each measure included in this study along with a battery of other measures assessing aspects of individual and relationship functioning. Partners were separated during administration of these measures to control for threats to validity, including the influence of partner presence on responses; ethically, this also maximized the probability that each member of the couple would feel safe answering questions regarding intimate partner violence without fear of repercussions in the relationship. The Couple Session Feedback form was administered at the end of each couple therapy session without the couple's therapists present.

Couples were selected for inclusion in the study based on a variety of factors. First, both members of the couples had to be at least 18 years of age. The couples had to

be heterosexual, because insufficient numbers of gay male and lesbian couples seek therapy at the clinic to produce an adequate sized sample to examine a sexual orientation effect. The couple had to report psychological aggression and/or mild to moderate levels of physical aggression on the MDEAS and CTS2. However, no violence or aggression resulting in serious injury or injury warranting medical attention could be reported on either of these measures or during a verbal assessment done with each member of the couple. Furthermore, during separate interviews, both members of the couple had to verbalize to the assessing therapists that they felt safe being seen in conjoint therapy with their partner and did not fear potential of injury or harm from their partner. If couples met these criteria, they were told about the study, which is designed to address anger management, conflict resolution, and problematic ways of handling conflict in couple relationships (specifically designed for reducing mild to moderate psychological and physical aggression). Couples who agreed to participate in the study attended ten double therapy sessions at the university-based clinic. All couples completed the full course of treatment within four and a half months of commencing therapy. Each session was 1.5 hours in length; both partners were present for each session. Couples received a discounted rate for therapy ($20 per session) for full completion of the ten weeks of treatment along with pre- and post-assessment measures.

Couple therapists were clinical graduate students in the Couple and Family Therapy Master of Science program at the University of Maryland – College Park, supervised by licensed clinical supervisors approved by the American Association for Marriage and Family Therapy (AAMFT). Couples in the study were treated with a variety of models including (but not limited to) cognitive behavioral therapy, narrative

therapy, emotionally focused therapy, Bowen family systems, and solution-focused therapy. Although a variety of models were used, the primary goal of all treatment modalities was to reduce psychological and physical aggression between members of the couples. A commonality in treatment was that all couples were asked to contract not to engage in aggressive behaviors throughout the course of treatment. Therapists were instructed to monitor client reports of conflict and escalation patterns throughout the therapy process from week-to-week. Furthermore, all therapists were supervised by clinical AAMFT-approved supervisors to monitor adherence to the goals of the study (to reduce aggression in the relationship).

CHAPTER III: RESULTS

Overview of the Analyses

A 4 X 2 multivariate analysis of variance (MANOVA) was used to test the main and interaction effects predicted by the study's hypotheses. As discussed in the Measures section of the Methods chapter, the MDEAS was used to categorize the direction of psychological aggression perpetration for the couples in the study. Pre-therapy measurement MDEAS scores for females ranged from 3.50 – 113.50; the mean pre-therapy measurement score was 28.12 (*SD* = 20.67). Pre-therapy measurement MDEAS scores for males ranged from 2.50 – 99.00, with a mean of 26.32 (*SD* = 15.91). There were an insufficient number of cases in which one member of a couple engaged in no aggression and the other engaged in a higher level of aggression, to categorize them as unidirectional aggression perpetration cases based on their raw scores. Therefore, the investigator dichotomized the distribution of psychological aggression scores using a cutoff level of 20 out of the total possible score of 168. Therefore, individuals whose perpetration score fell below 20 were coded as "lower" in psychological aggression and individuals whose perpetration score was 20.5 or greater were coded as "higher." These lower and higher levels were used to identify who in each couple was perpetrating psychological aggression. On this basis, the couples were categorized into four groups that defined the independent variable of aggression direction: couples in which there was minimal psychological aggression, in that both partners perpetrated lower-level aggression (*n* = 18), bidirectionally-perpetrating couples in which both partners perpetrated higher levels of psychological aggression (*n* = 28), unidirectionally-perpetrating couples in which psychological aggression is perpetrated primarily by the

female (n = 7), and unidirectionally-perpetrating couples in which psychological aggression is perpetrated primarily by the male (n = 11).

For the moderator variable, Couple Session Feedback scores were totaled for each individual across all ten sessions. This resulted in a total score, out of 120, for each individual, as a continuous variable. The individual scores for males and females were then averaged to create an average score for the couple. In order for this score to be utilized in the MANOVA design, scores were dichotomized by a median split of the distribution of couple scores, into "lower" and "higher" levels of positive perceptions of therapy. Based on the cutoff point for the median split being the point at which 50% of the couples fell above and 50% fell below in the score distribution, scores below 98 were coded as "lower" and scores above 98.5 were coded as "higher." The mean scores used for categorization of the independent variable groups (psychological and physical aggression perpetration direction) and the moderator variable groups are displayed in Table 4.1 below.

Table 4.1

Mean Scores Used for Categorization of Independent Variables

Variables	Possible Score Range	Females	Males
MDEAS	0-168	28.12[a] (20.67)[b]	26.31 (15.91)
		Couple	
Couple Session Feedback	0-120	92.84[c] (17.17)	

Note. MDEAS = Multidimensional Emotional Abuse Scale.
[a] This number is the mean at pre-therapy measure.
[b] The number in parentheses is the standard deviation.
[c] This number is the mean total sum across all sessions averaged for males and females.

Missing Values. Respondents' missing values on items of the study's measures were handled in a variety of ways. For the CPQ and DAS, missing values for a respondent were replaced with the mean for that question for the entire sample for that individual's gender. Using that approach, 51 question-level missing values were replaced for DAS items among the entire sample (8,192 question-level items). For the CPQ, 25 missing values were replaced (out of the 8,960 question-level items). For the Couple Session Feedback form, missing values were not replaced and were counted as a score of zero for the item that was missing. Lastly, for the MDEAS and CTS2, the two partners' ratings of each individual's aggressive behavior were averaged for each item to create an index of the individual's perpetration. When one partner failed to answer an item, the other partner's report about the rated person's behavior was used. Therefore, for example, if the female partner reported that in the last four months she kicked her partner twice (indicated with a score of "2"), but her male partner failed to report how many times the female did so, then the female partner's score for that item would be a "2." However, given the same example, if the male did complete that item and reported that his female partner kicked him three to five times in the past four months (indicated with a score of "3"), then the female's score for perpetration on that item would be a "2.5" – the average of the female's and male's reports. For the MDEAS, this method was used to replace 113 item-level missing values (out of a total possible 7,168 question-level values). For the CTS2, this method was used to replace 74 missing values (out of a total possible 19,968 question-level values).

Score Computation. In order to compute therapy outcome scores, change scores were computed for each outcome variables. Post-therapy scores were subtracted from

pre-therapy scores to create a change score for each outcome variable. First, DAS total scores for females and males were computed for pre- and post-therapy assessments. The CTS2 physical assault and injury subscale scores were combined to create a total score indicating the amount of physical aggression perpetrated by each individual at each point of measurement (the average rating for each person's perpetration, as judged by the self and the partner). The CPQ Mutual Constructive Communication subscale, consisting of questions A2, B2, B4, C1, and C3, was summed for each partner and then averaged for both partners to create a couple score. The CPQ Mutual Avoidance subscale, consisting of answers to questions A1, C2, and C4, was summed for both male and female separately and then averaged. Finally, the Demand-Withdraw CPQ subscale was calculated for Male-Demand, Female-Withdraw patterns (A3m, B5m, and B6m) and for Female-Demand, Male-Withdraw patterns (A3w, B5w, and B6w). See Appendix C for the CPQ items.

Analysis to Test Hypothesis 1

This study's first hypothesis was the following: *Higher level bidirectionally aggressive couples will have less positive therapeutic outcomes compared to couples in which the aggression is primarily unidirectional and compared with couples in which both members exhibit lower level aggression. Less positive therapeutic outcomes will be indicated by less decrease in rates of physical aggression, less increase in positive communication, less decrease in negative communication, and less increase in relationship satisfaction.*

The MANOVA revealed no statistically significant main effect difference on the set of dependent variables (CTS2 physical aggression, DAS, Mutual Constructive

Communication subscale of the CPQ, Mutual Avoidance subscale of the CPQ, and Demand-Withdraw subscales of the CPQ) among the four groups defined by who in the couple perpetrated psychological aggression at the pre-therapy assessment point. The multivariate test result was: F (24, 153) = 0.77, p = .765 for the main effect for directionality of aggression.

In a MANOVA, when the overall F test examining differences among the groups on the set of dependent variables is not significant, one typically does not examine the univariate ANOVAs for the individual dependent variables. However, given that this study is the first to investigate the effects of aggression directionality and client perceptions of therapy on outcomes of couple therapy for partner psychological aggression, the investigator decided to examine any effects within the ANOVAs for individual dependent variables that at a minimum reached the level of a statistical trend ($p < .10$). The results of the ANOVAs for the individual independent variables are presented in Table 4.2. In addition, the cell means for each of the dependent variables for the 4 (aggression directionality) X 2 (client perceptions of session helpfulness) design are presented in Table 4.3.

A significant effect was found for the direction of aggression perpetration on the males' DAS change scores, F (3, 56) = 2.78, p = .050. The males' DAS change scores for the four groups were as follows: lower level bidirectional aggression (M = 4.15, SD = 3.50), female-perpetrated aggression (M = 7.16, SD = 5.66), male-perpetrated aggression (M = 15.08, SD = 5.02), and higher level bidirectional aggression (M = 16.25, SD = 2.83). Post hoc pairwise comparisons of this relationship revealed that the difference between the lower level bidirectional group's mean male DAS change score and the higher level

bidirectional group's mean male DAS change score, which was 11.27 with a standard error of 4.48, was significant, with a 95% confidence interval of 2.39 to 20.34 and p = .014 using the LSD post hoc pairwise comparison analysis. Therefore, those two groups were the only pair that differed significantly from each other for the males' mean change in dyadic satisfaction over the course of therapy. For the Scheffe post hoc pairwise comparisons, the significance level for that pair of groups was p = .105, and the Sidak post hoc pairwise comparison revealed a significance level of p = .081.

Therefore, although the results of the MANOVA indicated that within the present sample there was no significant difference among the groups of couples in which both members perpetrated psychological aggression at lower levels, both members perpetrated psychological aggression at higher levels, the female partner primarily perpetrated higher levels of psychological aggression, and only the male partner primarily perpetrated higher levels of psychological aggression with regard to the set of therapeutic outcomes overall, the univariate ANOVA revealed that there was a difference between the groups (just reaching the .05 alpha level) specifically on the males' dyadic satisfaction changes over the course of therapy. More specifically, the males in couples in which both partners perpetrated minimal levels of aggression overall reported less change in their satisfaction with their relationship than couples in which both partners perpetrated higher levels of psychological aggression at pre-therapy.

Analysis to Test Hypothesis 2

The second hypothesis under investigation in this study was: *Partners' levels of perceptions of the degree to which sessions helped them learn new ways to manage relationship conflict will be positively associated with the degree to which couple therapy*

results in positive therapeutic changes. Thus, there will be a main effect of higher positive perceptions of session effectiveness and positive therapy outcomes.

The MANOVA results indicated no significant main effect for higher versus lower client perceptions of session helpfulness, F (8, 49) = 0.56, p = .806. Again, in spite of the overall non-significant multivariate F test, the investigator decided to examine a univariate ANOVA result that indicated a non-significant trend; specifically the effect of client perceptions of helpfulness on change in male-demand, female-withdraw communication assessed with the CPQ. The ANOVA main effect for client perceptions was F (1, 56) = 2.82, p = .099. The mean changes in Male-Demand, Female-Withdraw communication scores were -2.35 for couples who rated the sessions as more helpful and -1.34 for couples who rated the sessions as less helpful. Thus, the trend was for higher perceptions of session helpfulness to be associated with a greater decrease in Male-Demand, Female-Withdraw behavior. Aside from this trend, however, the results of this study did not indicate a difference between couples with higher (more positive) levels of perceptions of session helpfulness and couples with lower levels of perceptions of session helpfulness on the outcome measures – CTS2, DAS, Mutual Constructive Communication subscale of the CPQ, Mutual Avoidance subscale of the CPQ, and Demand-Withdraw subscales of the CPQ.

Analysis to Test Hypothesis 3

The third hypothesis this study tested was the following: *Partners' level of perceptions of the degree to which sessions helped them learn new ways to manage relationship conflict will moderate the relationship between directionality of partner aggression and therapy outcomes. The more that members of couples perceive sessions*

as teaching them better ways of managing conflict, the less difference there will be in levels of positive outcomes between couples with bidirectional versus unidirectional partner aggression. Thus, positive client perceptions of couple therapy sessions are expected to reduce the degree to which higher level bidirectional partner aggression will interfere with gains in couple therapy.

This hypothesis was tested with the interaction effect between directionality of aggression perpetration and level of client perceptions of session helpfulness within the MANOVA. The multivariate test of the interaction effect was not significant; F (24, 153) = 0.70, p = .849 for the interaction of directionality and client perceptions of therapy. Furthermore, there were no statistical trends found among the univariate ANOVAs for the individual dependent variables. Thus, the results of this study did not support the hypothesis that clients' level of perception of therapeutic gains (higher versus lower perceptions of therapeutic gains) moderates the relationship between the direction of aggression perpetration and changes in dyadic satisfaction, couple communication patterns, and partners' aggressive behavior.

Table 4.2

ANOVA Results for Study Variables

	Main Effect One: Perpetration Direction (3, 56)[df]		Main Effect Two: Perception of Therapeutic Gains (1, 56)[df]		Interaction Effect: Perpetration x Perception of Therapeutic Gains (3, 56)[df]	
Outcome Measure	*F*	(Sig.)	*F*	(Sig.)	*F*	(Sig.)
Female DAS Change	.69	(.562)	.09	(.770)	1.02	(.393)
Male DAS Change	2.78	(.050)	.28	(.597)	1.28	(.289)
MCC CPQ Change	.66	(.579)	.02	(.883)	.62	(.606)
MA CPQ Change	.03	(.995)	1.11	(.297)	.20	(.895)
mDfW CPQ Change	.24	(.868)	2.82	(.099)	1.50	(.224)
fDmW CPQ Change	1.05	(.379)	1.47	(.230)	.19	(.905)
Male CTS2 Change	.64	(.596)	.28	(.601)	.38	(.765)
Female CTS2 Change	.08	(.970)	.23	(.635)	.53	(.663)

Note. DAS = Dyadic Adjustment Scale; CPQ = Communication Patterns Questionnaire; CTS2 = Conflict Tactics Scale – Revised; MCC = Mutual Constructive Communication; MA = Mutual Avoidance; mDfW = Male-Demand, Female-Withdraw; fDmW = Female-Demand, Male-Withdraw. Change scores refer to Post- minus Pre-treatment measures.
[df] Degrees of freedom.

Table 4.3

Mean Outcome Scores for Study Groups

Perception of Therapeutic Gains	Lower Levels of Bidirectional Aggression		Female-Perpetrated Aggression		Male-Perpetrated Aggression		Higher Levels of Bidirectional Aggression	
	M	*(SD)*	*M*	*(SD)*	*M*	*(SD)*	*M*	*(SD)*
LOWER	(n = 9)		(n = 4)		(n = 3)		(n = 16)	
Female DAS Change	10.70	(18.85)	0.68	(21.88)	23.62	(24.83)	10.27	(24.64)
Male DAS Change	-1.53	(12.69)	9.31	(17.92)	19.00	(13.00)	11.18	(15.26)
MCC CPQ Change	-0.64	(9.12)	5.25	(11.21)	2.67	(3.18)	2.75	(6.59)
MA CPQ Change	-1.61	(5.10)	-2.63	(1.25)	-2.50	(6.54)	-2.06	(5.76)
mDfW CPQ Change	-0.61	(4.72)	1.25	(3.88)	-0.33	(7.15)	-2.59	(4.76)
fDmW CPQ Change	-0.17	(5.02)	-0.13	(4.23)	-3.67	(2.75)	-3.50	(7.03)
Female CTS2 Change	-0.28	(0.87)	0.25	(0.50)	-0.83	(0.76)	2.47	(12.78)
Male CTS2 Change	-0.44	(0.73)	0.50	(1.00)	-0.50	(2.29)	-0.09	(2.66)
HIGHER	(n = 9)		(n = 3)		(n = 8)		(n = 12)	
Female DAS Change	15.84	(14.26)	6.00	(8.00)	6.41	(21.84)	25.37	(33.50)
Male DAS Change	9.84	(9.22)	5.00	(6.25)	11.15	(13.17)	21.32	(19.67)
MCC CPQ Change	1.89	(12.78)	-1.33	(9.46)	1.94	(8.59)	5.95	(8.16)
MA CPQ Change	-4.78	(3.74)	-3.33	(3.89)	-2.81	(4.25)	-4.17	(5.65)
mDfW CPQ Change	-3.14	(5.33)	-6.33	(8.61)	-1.00	(2.75)	1.65	(4.94)
fDmW CPQ Change	-2.92	(5.95)	-2.83	(2.84)	-5.44	(3.45)	-4.01	(4.49)
Female CTS2 Change	-0.83	(2.69)	0.83	(1.44)	-0.31	(0.88)	-2.00	(3.84)
Male CTS2 Change	-0.94	(2.26)	0.50	(1.00)	-0.13	(0.44)	-1.33	(2.80)

Note. DAS = Dyadic Adjustment Scale; CPQ = Communication Patterns Questionnaire; CTS2 = Conflict Tactics Scale – Revised; MCC = Mutual Constructive Communication;

MA = Mutual Avoidance; mDfW = Male-Demand, Female-Withdraw; fDmW = Female-Demand, Male-Withdraw. Change scores refer to Post- minus Pre-treatment measures.

Exploratory Correlational Analyses

Correlational analyses were computed to further explore the relationships among the variables. This allowed for variables that initially were continuous to be analyzed as such rather than being dichotomized as was required for the MANOVAs. Because of the number of correlational analyses run, the significance level was set at the $p < .01$ level in order to reduce the likelihood of accepting a spurious effect as significant. Results of the correlational analyses, including significant findings at the $p < .01$ level and trends less than the .05 level, are reported in Table 4.4 and discussed below.

The correlational analyses indicated that partners' rates of perpetration were positively correlated. Female and male partners' MDEAS scores at the pre-therapy assessment were significantly strongly positively correlated ($r = .76$, $p < .001$). This suggests a high level of reciprocity in psychologically aggressive behavior between partners. The analyses also found that female and male physical aggression scores (measured by the CTS2 physical assault and injury subscale scores combined) at pre-therapy were significantly positively correlated, consistent with the idea that partners' engagement in aggressive behavior tends to be a mutual process. Furthermore, both female and male partners' MDEAS scores at pre-therapy were positively correlated with both female and male CTS2 scores at pre-treatment. This suggests that the use of one type of aggression is associated with the use of the other type (physical and psychological).

Another observation made from the correlational analyses was that change was generally made by both partners in tandem. Female change scores on the MDEAS and

male change scores on the MDEAS were significantly positively correlated, indicating that the greater the change in perpetration of psychological aggression in one partner, the greater the change in perpetration of psychological aggression in the other partner in the same direction. Additionally, female and male change scores on physical aggression showed a trend toward a positive correlation. These correlations add to the overall evidence of positive reciprocity for change between partners.

In addition, higher rates of aggression at pre-treatment were associated with more positive changes in therapy. For instance, MDEAS scores at pre-therapy were significantly negatively correlated with change scores on this measure, suggesting that higher pre-treatment levels of psychological aggression are associated with a greater reduction in the perpetration of psychological aggression. Although this might reflect regression to the mean for initial high scores on the measure, it also may be due to couples with higher initial levels of psychological aggression having more "room for improvement." Furthermore, both female and male levels of psychological aggression at intake were positively correlated with both female and male DAS change scores, indicating that the greater the initial level of psychological aggression, the more improvement was seen over the course of therapy for the dyadic satisfaction of both members of the couple. Female MDEAS pre-therapy scores showed a trend toward significance on the DAS change scores; male MDEAS pre-therapy scores were significantly positively correlated with the DAS change scores. It was also found that female CTS2 pre-therapy scores exhibited a trend toward a positive association with more positive client perceptions of therapeutic gains.

This pattern of higher rates of aggression at pre-therapy being associated with improvements in therapy also existed for communication patterns. For instance, male pre-therapy levels of psychological aggression were significantly negatively correlated with changes in female-demand, male-withdraw communication. A trend toward the same relationship existed between the female pre-therapy levels of psychological aggression and reduction in the female-demand, male-withdraw communication pattern. This suggests that the higher the level of psychological aggression at intake, the greater the couple's improvement on the negative communication pattern of female-demand, male-withdraw. Decreases in both the females' and the males' scores on the MDEAS were also positively associated with the decreases in the female-demand, male-withdraw communication pattern. This indicates the relationship between this negative communication pattern and the presence of psychological aggression. Furthermore, positive communication patterns were also associated with aggression, more specifically, physical aggression in this sample. Male pre-therapy CTS2 physical aggression scores showed a trend toward a positive correlation with increases in the positive communication pattern of mutual constructive communication scores on the CPQ. This same relationship approached a trend for the females, $r = .21$, $p = .052$ (using the $p < .01$ level for significance). Therefore, there was a tendency for greater physical aggression at the beginning of therapy to be associated with greater the increase in couples' may gain use of positive communication skills.

Congruence of change was observed among the communication patterns. Concerning the negative communication patterns measured by the CPQ, a trend was found for changes in the male-demand, female-withdraw and changes in the female-

demand, male-withdraw patterns to be positively correlated, although the magnitude of the association was modest (r = .21). Furthermore, decreases in couples' mutual avoidance over the course of therapy were significantly correlated with decreases in both the male-demand, female-withdraw and female-demand, male-withdraw communication patterns. These correlations suggest that couples decreased or increased their use of the different types of negative communication patterns consistently; for instance, if they reduced their use of mutual avoidance, they also reduced their demand-withdraw patterns as well.

The couples' perceptions of therapy were positively correlated with male increases in scores on the DAS. A positive correlational trend existed between clients' Couple Session Feedback scores and female increases on the DAS. This suggests that more positive perceptions of therapy sessions throughout treatment tended to be associated with increases in dyadic satisfaction from pre- to post-therapy.

Lastly, male and female dyadic satisfaction changes from pre- to post- therapy were significantly positively correlated. This indicates congruence in the satisfaction levels of the partners. Furthermore, the changes in the dyadic satisfaction scores were correlated with changes in several of the communication patterns in the couple. Statistically significant positive correlations were found between female and male changes in dyadic satisfaction (measured by the DAS) and changes in the couple's scores for mutual constructive communication patterns measured by the CPQ. This indicates that the more that the couple increased their positive communication, as measured by the CPQ, the more satisfied they became with their relationship over the course of therapy. Additionally, decreases in the use of the negative communication patterns (female-

demand, male-withdraw and mutual avoidance) were associated with increases in female dyadic satisfaction over the course of therapy. Interestingly, there was a trend toward female decreases in scores on the CTS2 being correlated with increases in male dyadic satisfaction. This indicates that changes in one partner's aggression patterns may affect the relationship satisfaction of the other member.

Table 4.4

Correlations Among Study Variables

Correlated Variables	Pearson Correlation	Significance Level
Female MDEAS Pre-Treatment:		
Male MDEAS Pre-Treatment	.76	< .001
Female CTS2 Pre-Treatment	.30	.008
Male CTS2 Pre-Treatment	.22	.044
Female MDEAS Change Score	-.79	< .001
Male MDEAS Change Score	-.53	< .001
Female-Demand, Male-Withdraw Change Score	-.22	.041
Female-Demand, Male-Withdraw Pre-Treatment	.37	.001
Female-Demand, Male-Withdraw Post-Treatment	.25	.025
Female DAS Change Score	.21	.048
Male DAS Change Score	.25	.025
Male MDEAS Pre-Treatment:		
Female CTS2 Pre-Treatment	.25	.022
Male CTS2 Pre-Treatment	.25	.024
Female MDEAS Change Score	-.54	< .001
Male MDEAS Change Score	-.73	< .001
Female-Demand, Male-Withdraw Change Score	-.29	.010
Female-Demand, Male-Withdraw Pre-Treatment	.44	< .001
Female DAS Change Score	.34	.003
Male DAS Change Score	.40	<.001
Female MDEAS Change Score:		
Male MDEAS Change Score	.72	< .001
Female-Demand, Male-Withdraw Change Score	.30	.008
Female DAS Change Score	-.26	.019
Male DAS Change Score	-.25	.022

Male MDEAS Change Score:		
Female-Demand, Male-Withdraw Change Score	.37	.001
Female DAS Change Score	-.49	< .001
Male DAS Change Score	-.43	<.001
Female MDEAS Post-Therapy Score:		
Female-Demand, Male-Withdraw Post-Treatment	.28	.013
Male MDEAS Post-Therapy Score:		
Female-Demand, Male-Withdraw Post-Treatment	.27	.014
Female CTS2 Pre-Treatment:		
Male CTS2 Pre-Treatment	.69	< .001
Female MDEAS Change Score	-.22	.041
Couple Session Feedback Score	.22	.041
Male CTS2 Pre-Treatment:		
Couple MCC Change Score	.26	.020
Female CTS2 Change Score:		
Male DAS Change Score	-.22	.042
Male CTS2 Change Score:		
Female CTS2 Change Score	.28	.012
Couple Session Feedback Score:		
Female DAS Change Score	.25	.021
Male DAS Change Score	.39	.003
Female DAS Change Score:		
Male DAS Change Score	.50	< .001
MCC Change Score	.30	.008
MCC Post-Therapy Score	.35	.002
Mutual Avoidance Change Score	-.27	.016
Mutual Avoidance Post-Therapy Score	-.21	.046
Female-Demand, Male-Withdraw Change Score	-.24	.042
Male DAS Change Score:		
MCC Change Score	.30	.009
MCC Post-Therapy Score	.22	.040
Couple Mutual Avoidance Change Score:		
Male-Demand, Female-Withdraw Change Score	.36	.002
Female-Demand, Male-Withdraw Change Score	.41	< .001
Couple Male-Demand, Female-Withdraw Change Score:		
Female-Demand, Male-Withdraw Change Score	.21	.046

Note. Change scores refer to Post- minus Pre-treatment measures. MDEAS = Multidimensional Emotional Abuse Scale; DAS = Dyadic Adjustment Scale; CTS2 = Conflict Tactics Scale – Revised; MCC = Mutual Constructive Communication. Due to the number of correlations computed, only correlations that reached the $p < .01$ significance level were considered statistically significant.

CHAPTER IV: DISCUSSION

The overall purpose of this study was to examine the effects of couple therapy for partner violence, taking in to account the bidirectional perpetration that commonly has been found to exist among clinical couples (Moffitt et al., 2001) and within the general population (Archer, 2000; Follingstad & Edmunston, 2010; Gray & Foshee, 1997; McCarroll et al., 2004; Ridley & Feldman, 2003; Straus, 2008; Whitaker et al., 2007). Researchers have only recently recognized this type of common reciprocal couple aggressive behavior and new treatment modalities are now being developed and tested for treatment efficacy. Therefore, this research comes at a time of great change in the partner aggression field. The overall aim of recent research has been to find efficacious modalities (including conjoint therapy) to treat couples presenting with couple aggression in their relationships. However, to date the studies have applied couple interventions generically to all couples who have presented with mild to moderate aggression perpetrated by one or both partners and it is not known if the *pattern* of aggression may influence the effectiveness of treatment. The present study postulated that couples in which both partners behave aggressively may respond differently to conjoint couple treatment for aggression than couples in which aggression is primarily perpetrated by only one partner. More specifically, it was expected that couples who were bidirectionally psychologically aggressive would have less positive therapeutic outcomes than couples in which only one partner behaved aggressively. Although conjoint couple treatment, a recently developed form of treatment for partner aggression, has been demonstrated to be effective and it has been shown that it does not result in an escalation of violence, before this study it was not known whether or not conjoint treatment was

equally effective for bidirectionally aggressive partners and couples in which only one partner primarily aggresses. This study tested the outcomes of conjoint treatment for partner aggression as a function of the directionality of the aggression perpetration. The outcome variables that were examined were levels of overall relationship satisfaction, positive communication behavior, negative communication behavior, and acts of physical aggression.

In addition, this study tested whether clients' perceptions of their couple therapy experience moderated the relationship between aggression perpetration directionality and therapy outcomes. Clients' perceptions of therapy are often evaluated in therapy outcome studies and investigated as a potential influence on treatment outcome (Olson & Russell, 2004). However, client perceptions of the process of therapy have rarely been examined in the context of conjoint couple therapy (typically, the perceptions of individual batterers in group therapy programs are assessed). In addition, studies usually assess clients' perceptions of therapy retrospectively rather than measuring them immediately after each treatment session. This author aimed to add to the body of research on the *process* of therapy by investigating the effect of session-by-session client perceptions of the helpfulness of therapy on therapy outcomes. Therefore, both partners' perceptions of session helpfulness were assessed after each session and were investigated as a potential influence on couple therapy effectiveness (both as a main effect and as a moderator of the relationship between aggression directionality and degrees of positive changes in couple functioning).

Summary of Findings. Based on the MANOVA conducted to test for group differences in outcomes across the set of dependent variables, this study did not find

significant differences among the unidirectionally and bidirectionally aggressive groups with regard to their outcomes in therapy. Although differences in therapy outcomes were not observed among the aggression directionality groups, prior studies using the same sample have found significant improvements in therapeutic outcomes from pre- to post-therapy for these couples overall on a variety of different measures (Hrapczynski, Epstein, Werlinich, & LaTaillade, 2012; LaTaillade, Epstein, & Werlinich, 2006). Therefore, this suggests that among the sample in the current research study, couples generally show improvements in several areas of relationship functioning based on their participation in couple therapy, but unidirectionally and bidirectionally aggressive couples do not differ with regard to their overall outcomes.

It also had been hypothesized that clients' perceptions that therapy sessions were helpful would moderate aggression directionality group differences in therapy outcomes (i.e., that couples in the four aggression perpetration groups would be less different in their therapy outcomes when they perceived sessions as more helpful). However, no significant aggression directionality by client perception interaction effect was found. The only effect that was found involving client perceptions was a trend for those who reported that sessions were more helpful to exhibit a greater decrease in the male-demand, female-withdraw pattern of communication.

Given the overall lack of effects on therapy outcomes of the direction of psychological aggression perpetration and client perceptions of therapy, post-hoc correlational analyses were conducted to explore the relationships among the study variables. The correlational analyses revealed significant relationships among many of the study variables for the overall sample. Most notably, with regard to patterns in the

couple's communication, there were consistent correlations relating to the female-demand, male-withdraw pattern. Couples who exhibited higher levels of this pattern before therapy commenced had higher pre-therapy scores for psychological aggression; furthermore, the same correlation existed at post-therapy. Decreases in the degree of use of this female-demand, male-withdraw pattern over the course of therapy were correlated with decreases in rates of psychological perpetration for both sexes. This suggests that this pattern, which has been discussed in prior research to be a dysfunctional communication pattern (Christensen, 1987), is related to the degree to which psychological aggression is present in the relationship. Consequently, therapeutic interventions that are intended to reduce psychological aggression should take into account couples' use of female-demand, male-withdraw communication.

Although the overall low level of physical aggression in the sample had led to a decision not to attempt to compare groups of couples based on their pattern of physical aggression perpetration, the correlational analyses indicated a modest but significant positive correlation between pre-therapy physical aggression and increases in mutual constructive communication. Couples with higher levels of physical aggression before beginning therapy showed a greater use of positive communication in their relationship over the course of therapy. This suggests that these couples may have more room to grow in therapy and a greater chance to improve their communication while in therapy. However, no significant correlation existed between post-therapy scores on the CTS2 and the mutual constructive communication pattern. Therefore, these results should be interpreted cautiously as it is unclear what the exact relationship is between these variables. One other significant relationship that existed with mutual constructive

communication was that changes in the couples' use of this pattern were positively associated with increases in partners' overall relationship satisfaction. The cross-sectional relationship between these two variables does not allow for conclusions about the causal direction between them, but assessments of clinical couples should take both their constructive communication and satisfaction levels into account.

Lastly, with regard to communication patterns, there was a positive correlation between the changes in the mutual avoidance and the demand-withdraw patterns. This suggests that as couples decrease their use of some negative communication patterns, they also decrease their use of other negative communication patterns. In this case, the two patterns that decreased in tandem both involve withdrawal by at least one partner.

Other noteworthy correlations existed with regard to the couple's perception of the therapeutic process as helpful in addressing their relationship problems. These perceptions of therapy helpfulness were positively associated with increases in the partners' reports of relationship satisfaction. It is notable that this association was not found in the MANOVA, which involved dichotomizing clients' perceptions of session helpfulness into "higher" versus "lower" levels, whereas this post-hoc correlational analysis that used the full range of perception scores did detect a significant effect. Again, as this is a correlational analysis, it is not possible to determine the cause and effect in this relationship.

Limitations and Directions for Future Studies

This study's results must be interpreted with caution for several reasons. First, the study had a small sample size, which limited the numbers of couples who fell into the four different groups based on their perpetration levels of psychological aggression. In

addition, the interaction effect testing the groups based on the direction of perpetration by the groups based on their perceptions of therapeutic gains resulted in even smaller group sizes. These small groups limited the statistical power and ability of the analyses to detect group differences. This small sample was confounded with the greater problem that the entire sample consisted of couples in which partners exhibited a degree of bidirectional perpetration of psychological aggression. Therefore, although the groups were categorized based on higher and lower levels of psychological aggression, there were not any groups that had pure unidirectional aggression (i.e., one member scoring zero on the MDEAS measure). It would behoove the researchers of future studies to use a larger sample size that may result in more diversity in perpetration levels among the couples.

Additionally, because there were not any cases of pure unidirectional psychological aggression, the researcher was challenged with determining a proper cutoff point for the classification of unidirectional aggression. The cutoff score of 20 (out of 168) on the MDEAS was used because this rate was considered low enough in the total possible range of scores that it could be presumed that the individual was relatively non-aggressive, and that the other partner was the "primary" aggressor. However, it could be argued that this calls into question the MDEAS' ability to capture unidirectional and bidirectional aggression. Future research should consider whether or not there is a difference between psychological aggression that occurs a limited number of times, possibly in reaction to the present circumstances (i.e., a "state" occurrence of psychological aggression), and psychological aggression that is ongoing, consistent and more deliberate (i.e., a consistent "trait" or relational pattern). Another response option could be added to the MDEAS that allows for the respondent to indicate that an

aggressive behavior only occurred once in the given time frame of measurement (in this study – four months) and has never happened before in the relationship. Therefore, this would suggest that the behavior should not be used to classify the person as a perpetrator of psychological aggression.

Alternatively, the challenges of this research study may have existed because psychological aggression is likely to be bidirectional due to partners reciprocating negative verbal actions almost automatically (Weiss & Heyman, 1997). Because psychological aggression does not involve the use of physical force, it may be easier for partners to reciprocate it, and therefore easier for both partners to perpetrate. Possibly, researchers should accept that psychological aggression is most commonly a bidirectional occurrence. However, it will be difficult to draw that conclusion without more research on the subject. This author strongly suggests that with regard to psychological aggression, future researchers find better ways to capture the rates of perpetration and judge what levels constitute bidirectional and unidirectional perpetration.

In addition, the low levels of physical aggression within the sample prevented analysis of perpetration groups based on this variable. A larger sample size would aid in the investigation of treatment for physically aggressive couples defined by the primary perpetrator in the relationship. It is unclear whether or not similar classification problems exist for physical aggression perpetration as were found for psychological aggression. This author suggests that both types of aggression be examined in future studies. It is possible that treatment outcomes may differ for bidirectionally versus unidirectionally physically aggressive couples (differentiating between mild and moderate levels of

aggression). Research is needed to establish whether or not conjoint couple therapy is appropriate for both types of physically aggressive couples.

Another limitation of the study relating to the small sample size is that separate analyses of the male and female scores on the Couple Session Feedback form were not possible. A larger sample may allow for comparison of these scores; it is possible that partners' perceptions may differ significantly if a larger sample were used in which the power to detect differences would be higher. This author also encourages future researchers to follow the procedure used in the present study and to take into account the gap in prior research that uses retrospective accounts of the client's perceptions of the therapy rather than a continuous measurement of this variable.

Lastly, the use of a behavioral observation would strengthen the findings relating to communication patterns observed on the CPQ. Client's self-reports are valuable measures, but these would be more reliable measures of actual behavior if examined in conjunction with a behavioral observation of communication behavior as well.

Interpretation of Findings

With these limitations in mind, it is important to discuss what this study's findings did tell us about treating psychologically aggressive couples using conjoint treatment. This study was primarily exploratory because there has been a lack of research on the topic of bidirectional aggression in the past. The MANOVA results did not find that couples in which only one partner is the primary perpetrator of psychological aggression differ from couples in which both partners engage in lower or higher levels of psychological aggression with one another on the measured therapeutic outcomes overall. However, more research is needed to see if these results can be replicated in studies with

larger sample sizes, with which one may be able to define the groups under investigation more clearly. Despite the lack of group differences, this study and prior studies on this sample have found that overall couples seem to improve from the conjoint treatment protocol given to this sample (e.g., LaTaillade et al., 2006). This suggests that regardless of the pattern of aggression perpetration in the couple, conjoint couple treatment is a viable treatment modality for couples experiencing psychological aggression in general.

Furthermore, findings that there was a significant difference between the groups on the males' changes in dyadic satisfaction over the course of therapy is an added piece of evidence regarding the efficacy of conjoint partner treatment with couples experiencing aggression. The post hoc analyses revealed that this difference was between males in the group of couples in which both partners perpetrate minimal levels of aggression and males in the group of couples in which both partners perpetrate higher levels of aggression. Therefore, this suggests that when a couple has a pattern in which both partners are more highly aggressive with one another, the male may become more satisfied with the relationship while participating in conjoint couple therapy than if the couple has minimal levels of psychological aggression perpetrated between them. Therefore, with regard to the males' happiness with the relationship, these more highly bidirectionally aggressive couples may have more to gain from therapy than less aggressive couples. This finding was strengthened by the consistent correlation between higher levels of aggression at pre-therapy and greater reductions in both psychological and physical aggression over the course of therapy. Furthermore, higher levels of physical aggression for the females at pre-therapy were associated with more positive perceptions of therapeutic gains. Therefore, these findings suggest that the greater the

presenting level of aggression in the relationship, the more growth may be witnessed in conjoint couple therapy. This adds to the conclusion that conjoint couple therapy is an appropriate means of treatment for couples presenting with psychological aggression and mild to moderate levels of physical aggression.

Furthermore, this study was grounded in general systems theory, with hypotheses formulated on this basis. It was expected that couples who were psychologically aggressive may be amplifying their interactions through the use of negative communication patterns that provide positive feedback in conflict situations to continue with the same aggressive patterns. The fact that the female-demand, male-withdraw pattern (which has been demonstrated to be a negative communication pattern) was consistently correlated with the presence of psychological aggression perpetration on the MDEAS for *both sexes*, seems to support this theory. It appears that something about the demand-withdraw communication pattern is related to whether or not feedback is interpreted as warranting further action that perpetuates the current communication in the relationship (which for these couples, was perpetration of psychological aggression by both partners). Therefore, referring back to Figure 2, it could be that if a female partner's actions are to pursue in times of conflict, and a male's actions are to withdraw, each partner is interpreting the other's actions (demand or withdraw) as feedback and is using that information to define the rules of transformation in conflict. For instance, if the wife is upset about something and interprets the output that her husband is withdrawing as "he does not care," she may move to psychological aggression as a means of pursuing him. He may take this demanding and pursuing behavior as output himself and feel violated that she has said hurtful things or will not leave him alone. He may use this as

justification (in his rules of transformation) for retaliating and using psychological aggression himself. He may then withdraw again, prompting his wife to pursue more and continue the cycle. Thus, the couple interactions comprise a *cycle* in which both partners are engaging in the demand-withdraw pattern, interpreting the feedback, using the feedback (input) to determine their actions, and perpetuating the psychological aggression. Without more analysis of this correlation, it is impossible to know the specifics of the relationship. All that can be gathered from this study's results is that this sample did exhibit some type of relationship between the female-demand, male-withdraw pattern and levels of psychological aggression perpetrated by *both sexes*.

Furthermore, the trend that existed for the second main effect suggested that those couples with lower perceptions of therapeutic effectiveness differed from couples with higher perceptions of therapeutic effectiveness with regard to their changes on the male-demand, female-withdraw pattern. If the couples' perceptions of therapeutic effectiveness are a reflection of their awareness of the changes they are making (i.e., Couple Session Feedback question number two states "This session helped me learn new ways to reduce conflict in our relationship."), it could be argued that they are achieving second-order changes (refer to Figure 3). In essence, consistent with systems theory, this would mean that in therapy they are developing their comparator and learning to control their outputs. Therefore, being aware of their acquisition of new skills and judging the therapy experience as positive allows them to better monitor and control their behaviors, especially those such as the demand-withdraw pattern that is correlated with their perpetration of psychological and physical aggression. However, because this was only observed as a trend, and the couples' higher versus lower perceptions of therapy were not

significantly related to their changes in physical aggression, the extent to which this relationship exists remains unclear.

It is possible that there was not enough variation in the couples' rates of physical aggression (as an outcome measure) to identify differences. If this was the case, it is possible that the couples were aware of these changes and also improved in their reductions of aggression in the relationship, and the variation in the sample was just too small to detect this. It is clear that the couples did improve; however, whether or not they needed to be aware of this in order for the second- and third-order changes in the system to happen is not clear. Future research could aim to clarify the nature of this relationship. It is hoped that future research will use the general systems theory framework to understand how feedback, control, and monitoring can work to reduce aggression in couple relationships.

Implications for Clinical Practice

The application of this study's findings to clinical practice is promising as this research strengthens the body of research on the outcome of conjoint couple therapy. Although no significant results were found with regard to the hypotheses overall, the results speak to the benefits of conjoint couple therapy for couples experiencing a range of patterns of psychological aggression in their relationship. It does not appear from these findings that couples do worse or better in therapy if aggression is perpetrated primarily by only one partner or by both partners, and this is promising considering that the goal of therapy is to find modalities that work for a variety of different types of couples. Couples present in varied ways; since we know that the couple dynamics may differ for the specific couple being treated, it is helpful to have results that suggest that despite

differences, couples are likely to improve. This may be a reflection of conjoint therapy's ability to tailor interventions to treat the presenting couple's needs. Furthermore, those couples that presented with both members perpetrating higher levels of psychological aggression actually exhibited the greatest degrees of change in the male's dyadic satisfaction. This suggests that clients presenting with higher levels of aggression experience improvements just as much as, if not more than, clients presenting with little or low level aggression. Therefore, because all of the groups of couples improved, this suggests that conjoint treatment is appropriate for a range of levels and patterns of psychological aggression in couples. Lastly, the correlational findings regarding the clients' perceptions of therapy and their relationship to dyadic satisfaction remind us that the couple will be the ultimate judge of therapeutic benefits.

Conclusions

In light of several studies that have indicated that bidirectional aggression is common in couples, this research has examined the possibility that best-practice models for treatment may not include a one-size-fits-all approach. Results of this study found that bidirectionally aggressive couples did not differ from unidirectionally aggressive couples with regard to their outcomes in conjoint couple therapy. However, these results do support the idea that both types of presenting couples, with low to moderate levels of psychological and physical aggression, can benefit from conjoint couple therapy. This is an important gain in the development of treatment modalities that considers common couple violence to exist in the presence of negative communication patterns in the couple relationship. Addressing these patterns with both partners present appears to have documented support. As this is the first study of its kind that takes into account

bidirectional aggression and methods for treatment, future studies should examine this issue further. Future studies could strengthen these findings with inclusion of larger, more diverse, samples that include a greater range of aggression perpetration by both sexes. Additionally, while this study did not find differences in treatment outcome for unidirectionally versus bidirectionally aggressive couples, more research is needed to establish whether or not any differences exist. An examination of bidirectional aggression in the future may need to find more accurate ways to classify bidirectional versus unidirectional psychological aggression.

APPENDICES

Appendix A.

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MDEAS (ASSESSMENT)

Gender: _____ Date of Birth: _____ Therapist Code: _____ Family Code: _____

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please circle how many times you did each of these things IN THE PAST 4 MONTHS, and how many times your partner did them in the **IN THE PAST 4 MONTHS**. If you or your partner did not do one of these things in the past 4 months, but it happened before that, circle 0.

(0) Not in the past four months, but it did happen before
(1) Once
(2) Twice
(3) 3-5 times
(4) 6-10 times
(5) 11-20 times
(6) More than 20 times
(9) This has never happened

Never in PAST 4 MONTHS	Once	Twice	3-5	6-10	11-20	20+	Never in relationship
0	1	2	3	4	5	6	9

How Often in the last 4 months?

1. Asked the other person where s/he had been or who s/he was with in a suspicious manner.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
2. Secretly searched through the other person's belongings.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
3. Tried to stop the other person from seeing certain friends or family members.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
4. Complained that the other person spends too much time with friends.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
5. Got angry because the other person went somewhere without telling him/her.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
6. Tried to make the other person feel guilty for not spending enough time together.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
7. Checked up on the other person by asking friends where s/he was or who s/he was with.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
8. Said or implied that the other person was stupid.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
9. Called the other person worthless.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
10. Called the other person ugly.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
11. Criticized the other person's appearance.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
12. Called the other person a loser, failure, or similar term.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9

Never in PAST 4 MONTHS	Once	Twice	3-5	6-10	11-20	20+	Never in relationship
0	1	2	3	4	5	6	9

How Often in the last 4 months?

13. Belittled the other person in front of other people.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
14. Said that someone else would be a better girlfriend or boyfriend.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
15. Became so angry that s/he was unable or unwilling to talk.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
16. Acted cold or distant when angry.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
17. Refused to have any discussion of a problem.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
18. Changed the subject on purpose when the other person was trying to discuss a problem.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
19. Refused to acknowledge a problem that the other felt was important.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
20. Sulked or refused to talk about an issue.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
21. Intentionally avoided the other person during a conflict or disagreement.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
22. Became angry enough to frighten the other person.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
23. Put her/his face right in front of the other person's face to make a point more forcefully.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
24. Threatened to hit the other person.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
25. Threaten to throw something at the other person.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
26. Threw, smashed, hit, or kicked something in front of the other person.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
27. Drove recklessly to frighten the other person.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9
28. Stood or hovered over the other person during a conflict or disagreement.	You:	0 1 2 3 4 5 6	9
	Your partner:	0 1 2 3 4 5 6	9

Appendix B.

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Revised

CTS2 (ASSESSMENT)

Gender: _____ Date of Birth: _____ Therapist Code _____ Family Code _____

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please circle how many times you did each of these things **IN THE PAST 4 MONTHS**, and how many times your partner did them in the **IN THE PAST 4 MONTHS**. If you or your partner did not do one of these things in the past 4 months, but it happened before that, circle "0".

How often did this happen?

0 = Not in the past 4 months, but it did happen before
1 = Once in the past 4 months
2 = Twice in the past 4 months
3 = 3-5 times in the past 4 months
4 = 6-10 times in the past 4 months
5 = 11-20 times in the past 4 months
6 = More than 20 times in the past 4 months
9 = This has never happened

		Never
1. I showed my partner I cared even though we disagreed	0 1 2 3 4 5 6	9
2. My partner showed care for me even though we disagreed	0 1 2 3 4 5 6	9
3. I explained my side of a disagreement to my partner	0 1 2 3 4 5 6	9
4. My partner explained his/her side of a disagreement to me	0 1 2 3 4 5 6	9
5. I insulted or swore at my partner	0 1 2 3 4 5 6	9
6. My partner did this to me	0 1 2 3 4 5 6	9
7. I threw something at my partner that could hurt him/her	0 1 2 3 4 5 6	9
8. My partner did this to me	0 1 2 3 4 5 6	9
9. I twisted my partner's arm or hair	0 1 2 3 4 5 6	9
10. My partner did this to me	0 1 2 3 4 5 6	9
11. I had a sprain, bruise, or small cut because of a fight with my partner	0 1 2 3 4 5 6	9
12. My partner had a sprain, bruise, or small cut because of a fight with me	0 1 2 3 4 5 6	9
13. I showed respect for my partner's feelings about an issue	0 1 2 3 4 5 6	9
14. My partner showed respect for my feelings about an issue	0 1 2 3 4 5 6	9
15. I made my partner have sex without a condom	0 1 2 3 4 5 6	9
16. My partner did this to me	0 1 2 3 4 5 6	9
17. I pushed or shoved my partner	0 1 2 3 4 5 6	9
18. My partner did this to me	0 1 2 3 4 5 6	9
19. I used force (like hitting, holding down, or using a weapon) to make my partner have oral or anal sex	0 1 2 3 4 5 6	9
20. My partner did this to me	0 1 2 3 4 5 6	9
21. I used a knife or gun on my partner	0 1 2 3 4 5 6	9
22. My partner did this to me	0 1 2 3 4 5 6	9
23. I passed out from being hit on the head by my partner in a fight with me	0 1 2 3 4 5 6	9
24. My partner passed out from being hit on the head in a fight with me	0 1 2 3 4 5 6	9
25. I called my partner fat or ugly	0 1 2 3 4 5 6	9
26. My partner called me fat or ugly	0 1 2 3 4 5 6	9
27. I punched or hit my partner with something that could hurt	0 1 2 3 4 5 6	9
28. My partner did this to me	0 1 2 3 4 5 6	9
29. I destroyed something belonging to my partner	0 1 2 3 4 5 6	9
30. My partner did this to me	0 1 2 3 4 5 6	9
31. I went to a doctor because of a fight with my partner	0 1 2 3 4 5 6	9
32. My partner went to a doctor because of a fight with me	0 1 2 3 4 5 6	9

How often did this happen?

0 = Not in the past 4 months, but it did happen before
1 = Once in the past 4 months
2 = Twice in the past 4 months
3 = 3-5 times in the past 4 months
4 = 6-10 times in the past 4 months
5 = 11-20 times in the past 4 months
6 = More than 20 times in the past 4 months
9 = This has never happened

		Never
33. I choked my partner	0 1 2 3 4 5 6	9
34. My partner did this to me	0 1 2 3 4 5 6	9
35. I shouted or yelled at my partner	0 1 2 3 4 5 6	9
36. My partner did this to me	0 1 2 3 4 5 6	9
37. I slammed my partner against a wall	0 1 2 3 4 5 6	9
38. My partner did this to me	0 1 2 3 4 5 6	9
39. I said I was sure we could work out a problem	0 1 2 3 4 5 6	9
40. My partner was sure we could work it out	0 1 2 3 4 5 6	9
41. I needed to see a doctor because of a fight with my partner, but I didn't	0 1 2 3 4 5 6	9
42. My partner needed to see a doctor because of a fight with me, but didn't	0 1 2 3 4 5 6	9
43. I beat up my partner	0 1 2 3 4 5 6	9
44. My partner did this to me	0 1 2 3 4 5 6	9
45. I grabbed my partner	0 1 2 3 4 5 6	9
46. My partner did this to me	0 1 2 3 4 5 6	9
47. I used force (like hitting, holding down, or using a weapon) to make my partner have sex	0 1 2 3 4 5 6	9
48. My partner did this to me	0 1 2 3 4 5 6	9
49. I stomped out of the room or house or yard during a disagreement	0 1 2 3 4 5 6	9
50. My partner did this to me	0 1 2 3 4 5 6	9
51. I insisted on sex when my partner did not want to (but did not use physical force)	0 1 2 3 4 5 6	9
52. My partner did this to me	0 1 2 3 4 5 6	9
53. I slapped my partner	0 1 2 3 4 5 6	9
54. My partner did this to me	0 1 2 3 4 5 6	9
55. I had a broken bone from a fight with my partner	0 1 2 3 4 5 6	9
56. My partner had a broken bone from a fight with me	0 1 2 3 4 5 6	9
57. I used threats to make my partner have oral or anal sex	0 1 2 3 4 5 6	9
58. My partner did this to me	0 1 2 3 4 5 6	9
59. I suggested a compromise to a disagreement	0 1 2 3 4 5 6	9
60. My partner did this to me	0 1 2 3 4 5 6	9
61. I burned or scalded my partner on purpose	0 1 2 3 4 5 6	9
62. My partner did this to me	0 1 2 3 4 5 6	9
63. I insisted my partner have oral or anal sex (but did not use physical force)	0 1 2 3 4 5 6	9
64. My partner did this to me	0 1 2 3 4 5 6	9
65. I accused my partner of being a lousy lover	0 1 2 3 4 5 6	9
66. My partner accused me of this	0 1 2 3 4 5 6	9
67. I did something to spite my partner	0 1 2 3 4 5 6	9
68. My partner did this to me	0 1 2 3 4 5 6	9
69. I threatened to hit or throw something at my partner	0 1 2 3 4 5 6	9
70. My partner did this to me	0 1 2 3 4 5 6	9
71. I felt physical pain that still hurt the next day because of a fight with my partner	0 1 2 3 4 5 6	9
72. My partner still felt physical pain the next day because of a fight we had	0 1 2 3 4 5 6	9
73. I kicked my partner	0 1 2 3 4 5 6	9
74. My partner did this to me	0 1 2 3 4 5 6	9
75. I used threats to make my partner have sex	0 1 2 3 4 5 6	9
76. My partner did this to me	0 1 2 3 4 5 6	9
77. I agreed to try a solution to a disagreement my partner suggested	0 1 2 3 4 5 6	9
78. My partner agreed to try a solution I suggested	0 1 2 3 4 5 6	9

Appendix C.

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CPQ (ASSESSMENT)

Gender: _____ Date of Birth: _____ Therapist Code: _____ Family Code: _____

Directions: We are interested in how you and your partner typically deal with problems in your relationship. Please rate each item on a scale of 1 (=very unlikely) to 9 (=very likely).

A. WHEN SOME PROBLEM IN THE RELATIONSHIP ARISES:	Very Unlikely								Very Likely
1. Both members avoid discussing the problem.	1	2	3	4	5	6	7	8	9
2. Both members try to discuss the problem.	1	2	3	4	5	6	7	8	9
3. Man tries to start a discussion while Woman tries to avoid a discussion.	1	2	3	4	5	6	7	8	9
Woman tries to start a discussion while Man tries to avoid a discussion.	1	2	3	4	5	6	7	8	9

B. DURING A DISCUSSION OF A RELATIONSHIP PROBLEM:	Very Unlikely								Very Likely
1. Both members blame, accuse, and criticize each other.	1	2	3	4	5	6	7	8	9
2. Both members express their feelings to each other.	1	2	3	4	5	6	7	8	9
3. Both members threaten each other with negative consequences.	1	2	3	4	5	6	7	8	9
4. Both members suggest possible solutions and compromises.	1	2	3	4	5	6	7	8	9
5. Man nags and demands while Woman withdraws, becomes silent, or refuses to discuss the matter further.	1	2	3	4	5	6	7	8	9
Woman nags and demands while Man withdraws, becomes silent, or refuses to discuss the matter further.	1	2	3	4	5	6	7	8	9
6. Man criticizes while Woman defends herself.	1	2	3	4	5	6	7	8	9
Woman criticizes while Man defends himself.	1	2	3	4	5	6	7	8	9
7. Man pressures Woman to take some action or stop some action, while Woman resists.	1	2	3	4	5	6	7	8	9
Woman pressures Man to take some action or stop some action, while Man resists.	1	2	3	4	5	6	7	8	9
8. Man expresses feelings while Woman offers reasons and solutions.	1	2	3	4	5	6	7	8	9
Woman expresses feelings while Man offers reasons and solutions.	1	2	3	4	5	6	7	8	9
9. Man threatens negative consequences and Woman gives in or backs down.	1	2	3	4	5	6	7	8	9
Woman threatens negative consequences and Man gives in or backs down.	1	2	3	4	5	6	7	8	9
10. Man calls Woman names, swears at her, or attacks her character.	1	2	3	4	5	6	7	8	9
Woman calls Man names, swears at him, or attacks his character.	1	2	3	4	5	6	7	8	9
11. Man pushes, shoves, slaps, hits, or kicks Woman.	1	2	3	4	5	6	7	8	9
Woman pushes, shoves, slaps, hits, or kicks Man.	1	2	3	4	5	6	7	8	9

(Over)

C. AFTER A DISCUSSION OF A RELATIONSHIP PROBLEM:	Very Unlikely								Very Likely
1. Both feel each other has understood his/her position	1	2	3	4	5	6	7	8	9
2. Both withdraw from each other after the discussion.	1	2	3	4	5	6	7	8	9
3. Both feel that the problem has been solved.	1	2	3	4	5	6	7	8	9
4. Neither partner is giving to the other after the discussion.	1	2	3	4	5	6	7	8	9
5. After the discussion, both try to be especially nice to each other.	1	2	3	4	5	6	7	8	9
6. Man feels guilty for what he said or did while Woman feels hurt.	1	2	3	4	5	6	7	8	9
Woman feels guilty for what she said or did while Man feels hurt.	1	2	3	4	5	6	7	8	9
7. Man tries to be especially nice, acts as if things are back to normal, while Woman acts distant.	1	2	3	4	5	6	7	8	9
Woman tries to be especially nice, acts as if things are back to Normal while Man acts distant.	1	2	3	4	5	6	7	8	9
8. Man pressures Woman to apologize or promise to do better, while Woman resists.	1	2	3	4	5	6	7	8	9
Woman pressures Man to apologize or promise to do better, while Man resists.	1	2	3	4	5	6	7	8	9
9. Man seeks support from others (parent, friend, children).	1	2	3	4	5	6	7	8	9
Woman seeks support from others (parent, friend, children).	1	2	3	4	5	6	7	8	9

Appendix D.

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Revised – For Couples Within Families Only

DAS (ASSESSMENT)

Gender: _____ Date of Birth: _____ Therapist Code: _____ Family Code: _____

Most persons have disagreements in their relationship. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. Place a checkmark (√) to indicate your answer.

	Always Agree	*Almost Always Agree*	*Occasionally Disagree*	*Frequently Disagree*	*Almost Always Disagree*	*Always Disagree*
1. Handling family finances						
2. Matters of recreation						
3. Religious matters						
4. Demonstrations of affection						
5. Friends						
6. Sex relations						
7. Conventionality (correct or proper behavior)						
8. Philosophy of life						
9. Ways of dealing with parents and in-laws						
10. Aims, goals, and things believed important						
11. Amount of time spent together						
12. Making major decisions						
13. Household tasks						
14. Leisure time interests and activities						
15. Career decisions						

	All the time	*Most of the time*	*More often than not*	*Occasionally*	*Rarely*	*Never*
16. How often do you discuss or have you considered divorce, separation or terminating your relationship?						
17. How often do you or your partner leave the house after a fight?						
18. In general, how often do you think that things between you and your partner are going well?						
19. Do you confide in your partner?						

(Over)

	All the time	*Most of the time*	*More often than not*	*Occasionally*	*Rarely*	*Never*
20. Do you ever regret that you married (or lived together)?						
21. How often do you or your partner quarrel?						
22. How often do you and your partner "get on each others' nerves"?						

HOW OFTEN WOULD YOU SAY THE FOLLOWING EVENTS OCCUR BETWEEN YOU AND YOUR MATE? CIRCLE YOUR ANSWER.

23. Do you kiss your partner?

EVERYDAY ALMOST EVERYDAY OCCASIONALLY RARELY NEVER

24. Do you and your partner engage in outside interests together?

ALL OF THEM MOST OF THEM SOME OF THEM VERY FEW OF THEM NONE OF THEM

25. Have a stimulating exchange of ideas?

NEVER LESS THAN ONCE A MONTH ONCE OR TWICE A MONTH ONCE OR TWICE A WEEK ONCE A DAY MORE OFTEN

26. Laugh together?

NEVER LESS THAN ONCE A MONTH ONCE OR TWICE A MONTH ONCE OR TWICE A WEEK ONCE A DAY MORE OFTEN

27. Calmly discuss something?

NEVER LESS THAN ONCE A MONTH ONCE OR TWICE A MONTH ONCE OR TWICE A WEEK ONCE A DAY MORE OFTEN

28. Work together on a project?

NEVER LESS THAN ONCE A MONTH ONCE OR TWICE A MONTH ONCE OR TWICE A WEEK ONCE A DAY MORE OFTEN

THESE ARE SOME THINGS ABOUT WHICH COUPLES SOMETIMES AGREE AND SOMETIMES DISAGREE. INDICATE IF EITHER ITEM BELOW CAUSES DIFFERENCES OF OPINION OR HAVE BEEN PROBLEMS IN YOUR RELATIONSHIP DURING THE PAST FEW WEEKS. CHECK "YES" OR "NO."

29. Being too tired for sex. Yes ___ No ___

30. Not showing love. Yes ___ No ___

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

EXTREMELY UNHAPPY FAIRLY UNHAPPY A LITTLE UNHAPPY HAPPY VERY HAPPY EXTREMELY HAPPY PERFECT

32. Which of the following statements best describes how you feel about the future of your relationship? Check the statement that best applies to you.

___ 6. I want desperately for my relationship to succeed, and would go to almost any length to see that it does.

___ 5. I want very much for my relationship to succeed, and will do all I can to see that it does.

___ 4. I want very much for my relationship to succeed, and will do my fair share to see that it does.

___ 3. It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.

___ 2. It would be nice if my relationship succeeded, but I refuse to do any more than I am doing now to keep the relationship going.

___ 1. My relationship can never succeed, and there is no more that I can do to keep the relationship going.

DAS. .Rev.7/10

Appendix E.

center for healthy families
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COUPLE
SESSION FEEDBACK

Session #: _____ Date: _____ Therapist Code: _____

Gender: _____ Date of Birth: _____ Therapist Code: _____ Family Code: _____

Your therapist will use your feedback to understand what you have found useful so your therapist's work with you can be more helpful. It will also be used in research to study the therapy process.

1. My partner and I had an opportunity to discuss important concerns about our relationship.

   Not At All A Little A Moderate Amount Very Much

2. This session helped me learn new ways to reduce conflict in our relationship.

   Not At All A Little A Moderate Amount Very Much

3. During the session, my partner and I had an opportunity to think about and address issues in our relationship.

   Not At All A Little A Moderate Amount Very Much

4. Overall, this session was helpful.

   Not At All A Little A Moderate Amount Very Much

5. What was most helpful about this session?

6. What was least helpful about this session?

Appendix F.

Morgan Anne Childers

From: University of Maryland IRB <no-reply@umresearch.umd.edu>
Sent: Wednesday, February 15, 2012 12:14 PM
To: Norman B. Epstein; Morgan Anne Childers
Subject: IRB Protocol Approval

UNIVERSITY OF MARYLAND
INSTITUTIONAL REVIEW BOARD

Initial Application Approval

DO NOT REPLY TO THIS EMAIL ADDRESS AS IT IS UNMONITORED

To: Principal Investigator, Dr. Norman Epstein, Family Science
Student, Morgan Anne Childers, Family Science

From: James M. Hagberg
IRB Co-Chair
University of Maryland College Park

Re: IRB Protocol: 12-0094 - Direction of Partner Aggression and Outcome of Couple Therapy: Moderating Effects of Clients' Perceptions of Therapeutic Gains

Approval Date: February 15, 2012

Expiration Date: February 15, 2015

Application: Initial

Review Path: Exempt

The University of Maryland, College Park Institutional Review Board (IRB) Office approved your Initial IRB Application. This transaction was approved in accordance with the University's IRB policies and procedures and 45 CFR 46, the Federal Policy for the Protection of Human Subjects. Please reference the above-cited IRB Protocol number in any future communications with our office regarding this research.

Recruitment/Consent: For research requiring written informed consent, the IRB-approved and stamped informed consent document will be sent via mail. The IRB approval expiration date has been stamped on the informed consent document. Please note that research participants must sign a stamped version of the informed consent form and receive a copy.

Continuing Review: If you intend to continue to collect data from human subjects or to analyze private, identifiable data collected from human subjects, beyond the expiration date of this protocol, you must submit a Renewal Application to the IRB Office 45 days prior to the expiration date. If IRB Approval of your protocol expires, all human subject research activities including enrollment of new subjects, data collection and analysis of identifiable, private information must cease until the Renewal Application is approved. If work on the human subject portion of your project is complete and you wish to close the protocol, please submit a Closure Report to irb@umd.edu.

Modifications: Any changes to the approved protocol must be approved by the IRB before the change is implemented, except when a change is necessary to eliminate an apparent immediate hazard to the subjects. If you would like to modify an approved protocol, please submit an Addendum request to the IRB Office.

Unanticipated Problems Involving Risks: You must promptly report any unanticipated problems involving risks to subjects or others to the IRB Manager at 301-405-0678 or jsmith@umresearch.umd.edu

Additional Information: Please contact the IRB Office at 301-405-4212 if you have any IRB-related questions or concerns. Email: irb@umd.edu

The UMCP IRB is organized and operated according to guidelines of the United States Office for Human Research Protections and the United States Code of Federal Regulations and operates under Federal Wide Assurance No. FWA00005856.

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REFERENCES

Archer, J. (2000). Sex differences in aggression between heterosexual partners: A meta-analytic review. *Psychological Bulletin, 126,* 651-680.

Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8,* 77-100.

Blow, A. J., & Sprenkle, D. H. (2001). Common factors across theories of marriage and family therapy: A modified Delphi study. *Journal of Marital and Family Therapy, 27,* 385-401.

Bradley, R. P. C., Friend, D. J., & Gottman, J. M. (2011). Supporting healthy relationships in low-income, violent couples: Reducing conflict and strengthening relationship skills and satisfaction. *Journal of Couple and Relationship Therapy, 10,* 97-116.

Broderick, C., & Smith, J. (1979). The general systems approach. In W. R. Burr, R. Hill, F. I. Nye, & I. L. Reiss, *Contemporary theories about the family: General theories/theoretical orientations* (Vol. II, pp. 112-129). New York: The Free Press.

Christensen, A. (1987). Detection of conflict patterns in couples. In K. Hahlweg & M. J. Goldstein (Eds.), *Understanding major mental disorder: The contribution of family interaction research* (pp. 250-265). New York: Family Process Press.

Christensen, A., & Shenk, J. L. (1991). Communication, conflict, and psychological distance in nondistressed, clinic, and divorcing couples. *Journal of Consulting and Clinical Psychology, 59,* 458-463.

Corvo, K., Dutton, D., & Chen, W. (2008). Toward evidence-based practice with domestic violence perpetrators. *Journal of Aggression, Maltreatment & Trauma*, *16*, 111-130.

Follingstad, D. R., & Edmundson, M. (2010). Is psychological abuse reciprocal in intimate relationships? Data from a national sample of American adults. *Journal of Family Violence*, *25*, 495-508.

Fraenkel, P. (1997). Systems approaches to couple therapy. In W. K. Halford & H. J. Markman (Eds.), *Clinical handbook of marriage and couples interventions* (pp. 379-413). Chichester, England: Wiley.

Geffner, R. A., & Rosenbaum, A. (2001). Domestic violence offenders: Treatment and intervention standards. *Journal of Aggression, Maltreatment & Trauma*, *5*(2), 1-9.

Gray, H. M., & Foshee, V. (1997). Adolescent dating violence: Differences between one-sided and mutually violent profiles. *Journal of Interpersonal Violence*, *12*, 126-141.

Harris, G. E. (2006). Conjoint therapy and domestic violence: Treating the individuals and the relationship. *Counselling Psychology Quarterly*, *19*, 373-379.

Haynes, S. N., Chavez, R. E., & Samuel, V. (1984). Assessment of marital communication and distress. *Behavioral Assessment*, *6*, 315-322.

Holtzworth-Munroe, A., Meehan, J.C., Rehman, U., & Marshall, A.D. (2002). Intimate partner violence: An introduction for couple therapists. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd ed., pp. 441-465). New York: Guilford.

Hrapczynski, K. M., Epstein, N. B., Werlinich, C.A., & LaTaillade J. J. (2012). Changes

in negative attributions during couple therapy for abusive behavior: Relations to changes in satisfaction and behavior. *Journal of Marital and Family Therapy*. Advance online publication. doi: 10.1111/j.1752-0606.2011.00264

Johnson, M. P., & Leone, J. M. (2005). The differential effects of intimate terrorism and situational couple violence: Findings from the National Violence Against Women Survey. *Journal of Family Issues, 26,* 322-349.

Jose, A., & O'Leary, K. D. (2009). Prevalence of partner aggression in representative and clinic samples. In K. D. O'Leary & E. M. Woodin (Eds.), *Psychological and physical aggression in couples* (pp. 15-35). Washington, DC: American Psychological Association.

Langhinrichsen-Rohling, J. (2010). Controversies involving gender and intimate partner violence in the United States. *Sex Roles, 62,* 179-193.

Langhinrichsen-Rohling, J. (2005). Top 10 greatest "hits": Important findings and future directions for intimate partner violence research. *Journal of Interpersonal Violence, 20,* 108-118.

LaTaillade, J. J., Epstein, N. B., & Werlinich, C. A. (2006). Conjoint treatment of intimate partner violence: A cognitive behavioral approach. *Journal of Cognitive Psychotherapy: An International Quarterly, 20,* 393-410.

Levesque, D. A., Driskell, M. M., Prochaska, J. M., & Prochaska, J. O. (2008). Acceptability of a stage-matched expert system intervention for domestic violence offenders. *Violence and Victims, 23,* 432-445.

McCarroll, J. E., Ursano, R. J., Fan, Z., & Newby, J. H. (2004). Patterns of mutual and nonmutual spouse abuse in the U.S. Army (1998-2002). *Violence and Victims, 19,*

453-468.

McCollum, E. E., & Stith, S. M. (2007). Conjoint couple's treatment for intimate partner violence: Controversy and promise. *Journal of Couple and Relationship Therapy, 6,* 71-82.

McQueen, D. (2011). Domestic violence is most commonly reciprocal. *The Psychiatrist, 35,* 33.

Moffitt, T. E., Robins, R. W., & Caspi, A. (2001). A couples analysis of partner abuse with implications for abuse-prevention policy. *Criminology and Public Policy, 1,* 5-36.

Murphy, C. M., & Hoover, S. A. (1999). Measuring emotional abuse in dating relationships as a multifactorial construct. *Violence and Victims, 14,* 39-53.

Murphy, C. M., & Hoover, S. A. (2001). Measuring emotional abuse in dating relationships as a multifactorial construct. In K. D. O'Leary & R. D. Maiuro (Eds.), *Psychological abuse in violent domestic relations* (pp. 29-46). New York: Springer.

O'Leary, K. D. (1999). Psychological abuse: A variable deserving critical attention in domestic violence. *Violence and Victims, 14,* 3-23.

O'Leary, K. D., Heyman, R. E., & Neidig, P. H. (1999). Treatment of wife abuse: A comparison of gender-specific and conjoint approaches. *Behavior Therapy, 30,* 475-505.

O'Leary, K. D., & Woodin, E. M. (Eds.) (2009). *Psychological and physical aggression in couples: Causes and interventions*. Washington, DC: American Psychological Association.

Olson, M. M., & Russell, C. S. (2004). Understanding change in conjoint psychotherapy: Inviting clients to comment upon the validity of standardized change scores. *Contemporary Family Therapy, 26,* 261-278.

Owen, D. J., Heyman, R. E., Slep, A. M. S. (2006). The risk of partner aggression research: Impact of laboratory couples conflict protocols on participants. *Violence and Victims, 21,* 483-497.

Pan, H. S., Neidig, P. H., & O'Leary, K. D. (1994). Male-female and aggressor-victim differences in the factor structure of the Modified Conflict Tactics Scale. *Journal Interpersonal Violence, 9,* 366-382.

Ridley, C. A., & Feldman, C. M. (2003). Female domestic violence toward male partners: Exploring conflict responses and outcomes. *Journal of Family Violence, 18,* 157-170.

Ro, E., & Lawrence, E. (2007). Comparing three measures of psychological aggression: Psychometric properties and differentiation from negative communication. *Journal of Family Violence, 22,* 575-586.

Scott, K. L., & Wolfe, D. (2000). Change among batterers: Examining men's success stories. *Journal of Interpersonal Violence, 15,* 827-842.

Shamai, M., & Buchbinder, E. (2010). Control of the self: Partner-violent men's experience of therapy. *Journal of Interpersonal Violence, 25,* 1338-1362.

Silverglied, C. S., & Mankowki, E. S. (2006). How batterer intervention programs work: Participant and facilitator accounts of processes of change. *Journal of Interpersonal Violence, 21,* 139-159.

Simpson, L. E., Atkins, D. C., Gattis, K. S., & Christensen, A. (2008). Low-level

relationship aggression and couple therapy outcomes. *Journal of Family Psychology, 22,* 102-111.

Sirles, E. A., Lipchik, E., & Kowalski, K. (1993). A consumer's perspective on domestic violence interventions. *Journal of Family Violence, 8,* 267-276.

Smith, S. R., Hamon, R. R., Ingoldsby, B. B., & Miller, J. E. (2009). *Exploring family theories*. New York: Oxford University Press.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and Family, 38,* 15-28.

Spanier, G. (1989). *Manual for the Dyadic Adjustment Scale*. North Tonawanda, New York: Multi-Health Systems.

Sprenkle, D. H., Blow, A. J., & Dickey, M. H. (1999). Common factors and other nontechnique variables in marriage and family therapy. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 329-359). Washington, DC: American Psychological Association.

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice*. New York: Guilford.

Stith, S. M., & McCollum, E. E. (2011). Conjoint treatment of couples who have experienced intimate partner violence. *Aggression and Violent Behavior, 16,* 312-318.

Stith, S. M., Rosen, K. H., McCollum, E. E., & Thomsen, C. J. (2004). Treating intimate partner violence within intact couple relationships: Outcomes of multi-couple versus individual couple therapy. *Journal or Marital and Family Therapy, 30,*

305-318.

Straus, M. A. (2008). Dominance and symmetry in partner violence by male and female university students in 32 nations. *Children and Youth Services Review, 30*, 252-275.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The Revised Conflict Tactics Scale (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17*, 283-316.

Tallman, K., & Bohart, A. C. (1999). The client as a common factor: Clients as self-healers. In M. Hubble, B. Duncan, & S. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 91-131). Washington, DC: American Psychological Association.

Tolman, R. (1989). The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims, 7*, 159-177.

Wark, L. (1994). Therapeutic change in couples' therapy: Critical change incidents perceived by therapists and clients. *Contemporary Family Therapy, 16*, 39-52.

Weiss, R. L., & Heyman, R. E. (1997). A clinical-research overview of couples interactions. In W.K. Halford & H.J. Markman (Eds.), *Clinical handbook of marriage and couples interventions* (pp. 13-41). Chichester, England, Wiley.

Whitaker, D. J., Haileyesus, T., Swahn, M., & Saltzman, L. S. (2007). Differences in frequency of violence and reported injury between relationships with reciprocal and nonreciprocal intimate partner violence. *American Journal of Public Health, 97*, 941-947.

White, J. M., & Klein, D. M. (2008). *Family theories* (3rd ed.). Thousand Oaks, CA:

Sage.

Williams, J. R., Ghandour, R. M., Kub, J. E. (2008). Female perpetration of violence in heterosexual intimate relationships: Adolescence through adulthood. *Trauma, Violence, and Abuse, 9*, 227-249.